



# GPW14 OUTPUT INDICATORS METADATA PACKAGE

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This document presents the complete metadata for the output indicators underpinning WHO's Fourteenth General Programme of Work (GPW14). These indicators form the foundation for monitoring the results of WHO's contributions in countries, providing a consistent and transparent basis for performance measurement and reporting.

Each output indicator is linked to a specific GPW14 output and is supported by a detailed metadata entry. The metadata describes the indicator's formulation, rationale, criteria, method of measurement, data sources, frequency of reporting, and achievement thresholds. Where relevant, the metadata also specifies how the indicator links to broader outcome indicators and outlines the process used for validation.

The indicators and associated metadata were developed through a rigorous, consultative process involving the three levels of the Organization, in line with WHO's commitment to accountability, results-based management, and country impact.

This metadata package is intended for **internal use** as a reference across the Organization, supporting planning, monitoring, reporting, and performance reviews during the GPW14 period.

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### 1.1.1.WHO supports countries in developing health vulnerability and adaptation assessments, and national adaptation plans, and provides guidance, capacity-building and piloting of interventions to enhance the climate resilience of health systems through a One Health approach

#### 1.1.1.IND1\_UID798: Number of countries having conducted a climate change and health vulnerability and adaptation assessments and having developed the health component of their National Adaptation Plans

#	Metadata field	Summary
1	GPW14 Output	1.1.1. WHO supports countries in developing health vulnerability and adaptation assessments, and national adaptation plans, and provides guidance, capacity-building and piloting of interventions to enhance the climate resilience of health systems through a One Health approach
2	GPW14 Output indicator code	1.1.1.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries having conducted a climate change and health vulnerability and adaptation assessments and having developed the health component of their National Adaptation Plans
4	Output/Leading Indicator (Country Level Formulation)	Climate change and health vulnerability and adaptation assessment (V&A) and health component of National Adaptation Plan (NAP) or standalone Health National Adaptation Plan (HNAP) developed
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Index of national climate change and health capacity (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator counts how many countries have completed both climate and health vulnerability and adaptation assessment (V&A) and developed a Health National Adaptation Plan (HNAP) or the health component of their National Adaptation Plan (NAP).
12	Criteria	<p>Countries are counted under this indicator if:</p> <ul style="list-style-type: none"> <li>• They report that they have developed both a Vulnerability and Adaptation assessment (V&amp;A) and a Health National Adaptation Plan (HNAP)/health component of their National Adaptation Plan (NAP), and</li> <li>• They provide evidence, such as: <ul style="list-style-type: none"> <li>○ An electronic copy of the plan or assessment, or</li> <li>○ Validation by the respective WHO Regional Office.</li> </ul> </li> </ul> <p>Reporting can occur through:</p> <ul style="list-style-type: none"> <li>○ The WHO Global Survey on Health and Climate Change, or</li> </ul>

		<ul style="list-style-type: none"> <li>Regional Offices and Country offices providing country-specific updates as part of ongoing monitoring of the COP26 Health Commitments via ATACH.</li> </ul>
13	Numerator	Number of countries that have completed both a V&A and an HNAP /health component of their NAP with supporting evidence.
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets the criteria as outlined in Field 12. This means that it has completed both a V&amp;A and an HNAP/health component of their NAP and submitted valid documentation or received validation by the WHO Regional Office.</p> <p><b>Partially achieved:</b> The country has either completed a V&amp;A or an HNAP/health component of their NAP, but not both, OR both are in draft/in progress but not validated.</p> <p><b>Not achieved:</b> The country has not initiated a V&amp;A or an HNAP/health component of their NAP or has not provided any evidence or reporting to WHO.</p>
17	Rationale	In order for countries to be able to address the health impacts from climate change they will first need to understand and measure them, and then develop comprehensive plans to address those. The proposed indicator aims to capture the preparatory work that will need to be advanced at country level before moving to effective climate change and health interventions.
18	Measurement method	<p>WHO collects data for this indicator through its Global Survey on Health and Climate Change,</p> <p>In addition:</p> <ul style="list-style-type: none"> <li>Countries that have joined the WHO Alliance for Transformative Action on Climate and Health (ATACH) report progress achieved regarding V&amp;A and HNAPs/health component of their NAP</li> </ul> <p>To meet GPW14 reporting requirements, updates for this specific output indicator will also be collected annually through:</p> <ul style="list-style-type: none"> <li>Regional Offices, who will recontact national focal points to request updated information</li> </ul>
19	Estimation method (if applicable)	Not applicable – data are directly reported and validated.
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria for having both a V&A assessment and a Health National Adaptation Plan (HNAP)/health component of their NAP in place.
21	Calculation type	Cumulative
22	Target setting methodology	<p>Targets have been set based on consultations with Regional Offices. The methodology considers:</p> <ul style="list-style-type: none"> <li>The current development trajectory of each country in addressing the health impacts of climate change</li> <li>The country's capacity to progress in this area</li> </ul>

		<ul style="list-style-type: none"> <li>○ The country's membership in the WHO Alliance for Transformative Action on Climate and Health (ATACH)</li> <li>○ The planned support and engagement from WHO at all three levels (Country, Regional, HQ)</li> <li>○ The estimated time required for countries to develop both V&amp;As and HNAPs</li> <li>○ Whether one of the documents have already been completed</li> </ul>
23	How target is realistic for PB2026-2027	<p>The targets are considered realistic based on:</p> <ul style="list-style-type: none"> <li>○ Existing national plans, technical assistance, financing, and climate-health initiatives</li> <li>○ WHO's planned scale-up of technical assistance</li> <li>○ Strong WHO regional presence and tailored country-level support</li> <li>○ Ongoing capacity-building efforts aligned with the expected needs and timelines</li> </ul>
24	Data sources	WHO Global Survey on Health and Climate Change; updates from ATACH; reports from Regional and Country Offices.
25	Process of validation	Triangulation of data through ATACH monitoring, WHO regional/country updates, and submission of supporting documents.
26	Limitations	Some countries' reports may not meet the technical definitions of a V&A or HNAP, despite submission. Definitions are shared in survey instructions, but not always followed.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	CAMPBELL-LENDRUM, Diarmid <campbelllendrumd@who.int>



**1.1.1.IND2\_UID 826 : Number of countries integrating meteorological information into surveillance and response systems for at least one climate-sensitive health risk (e.g. extreme heat, or climate-sensitive infectious disease) benefiting from WHO technical guidance or support**

#	Metadata field	Summary
1	GPW14 Output	1.1.1. WHO supports countries in developing health vulnerability and adaptation assessments, and national adaptation plans, and provides guidance, capacity-building and piloting of interventions to enhance the climate resilience of health systems through a One Health approach
2	GPW14 Output indicator code	1.1.1.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries integrating meteorological information into surveillance and response systems for at least one climate-sensitive health risk (e.g. extreme heat, or climate-sensitive infectious disease) benefiting from WHO technical guidance or support
4	Output/Leading Indicator (Country Level Formulation)	Meteorological information integrated into surveillance and response systems for at least one climate-sensitive health risk (e.g. extreme heat, or climate-sensitive infectious disease)
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Index of national climate change and health capacity (D); Annual mean levels of fine particulate matter (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator measures how many countries have integrated meteorological information into surveillance and response systems for at least one climate-sensitive health risk.
12	Criteria	<ul style="list-style-type: none"> <li>• Country is counted under this indicator if <ul style="list-style-type: none"> <li>○ it reports, through the WHO Global Survey on Health and Climate Change, that it has integrated meteorological information into surveillance and response systems for at least one climate-sensitive health risk, after being reviewed by relevant WHO staff.</li> <li>○ it is verified as having achieved “integration” i.e.: <ul style="list-style-type: none"> <li>▪ it reports that meteorological information is used in surveillance and response systems for at least one climate-sensitive health risk through the WHO Global Survey on Health and Climate Change; OR</li> </ul> </li> </ul> </li> </ul>

		<ul style="list-style-type: none"> <li>▪ Country-specific updates are received from Regional Offices.</li> <li>○ Attribution to WHO is confirmed when Regional Offices report using WHO guidance, tools, or having received technical assistance or training from WHO.</li> <li>▪ Verification is based on country-specific updates from Regional Offices detailing the type of support provided to Member States in integrating meteorological information into surveillance and response systems.</li> </ul>
13	Numerator	Number of countries reporting integration of meteorological data into health surveillance and response systems for at least one climate-sensitive health risk
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets the criteria as outlined in Field 12. This means it reported, through the WHO Global Survey on Health and Climate Change, that meteorological information is integrated into surveillance and response systems for at least one climate-sensitive health risk, and this has been reviewed and verified by WHO staff. In addition, attribution to WHO is confirmed through Regional Office reporting that WHO guidance, tools, or technical assistance were used in the integration process.</p> <p><b>Partially achieved:</b> The country has taken steps toward integration but does not fully meet all criteria. For example, integration may be in development, developed but not yet operational, or reported without verification by WHO staff or confirmation of WHO support. The response may reflect early implementation stages or limited scope without clear documentation of WHO's role.</p> <p><b>Not achieved:</b> The country has not reported any integration of meteorological information into surveillance and response systems for climate-sensitive health risks, or there is insufficient information to verify the integration and attribute it to WHO support.</p>
17	Rationale	The proposed indicator measures climate change and health implementation at country level and capture how countries are using integrated meteorological and health data to understand climate-related health risks and/or use that information to enhance health decision-making.
18	Measurement method	WHO collects data through the Global Climate and Health Survey. To meet GPW14 reporting requirements, updates for this specific output indicator will also be collected annually through Regional Offices, who will recontact national focal points to request updated information. All submissions are reviewed by WHO staff responsible for monitoring to ensure completeness and consistency.
19	Estimation method (if applicable)	Not applicable – data are directly reported and validated.

20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria for integration of meteorological information into surveillance and response systems
21	Calculation type	Cumulative
22	Target setting methodology	<ul style="list-style-type: none"> <li>• The target has been set based on consultations with Regional Offices.</li> <li>• It includes reasonable assumptions about the current and planned engagement from all three levels of WHO (HQ, Regional, and Country Offices).</li> <li>• It considers the historical progress of countries, their capacity to implement the integration, and the level of support WHO can provide to ensure successful integration.</li> </ul>
23	How target is realistic for PB2026-2027	<p>The targets are considered realistically achievable by 2026–2027 due to the following factors:</p> <ul style="list-style-type: none"> <li>• Existing national plans and historical progress in integrating meteorological information into health systems</li> <li>• Reasonable timeframe for countries to establish necessary integration systems</li> <li>• Strong regional presence and engagement by WHO</li> <li>• Planned scale-up of technical assistance and tailored capacity-building efforts</li> <li>• Ongoing climate-health initiatives supported by WHO</li> <li>• Regular engagement with countries through surveys and annual updates, ensuring continuous monitoring and timely support</li> </ul>
24	Data sources	WHO Global Survey on Health and Climate Change; Country-specific updates from Regional Offices; Information from climate and health projects implemented at the country level with WHO support.
25	Process of validation	<ul style="list-style-type: none"> <li>• Data reviewed by WHO staff in charge of monitoring.</li> <li>• Annual updates may be cross-checked with regional and country office information.</li> <li>• Triangulated with country-level climate and health project data.</li> </ul>
26	Limitations	Updates will be provided every 2/3 years through the comprehensive WHO Global Survey on Climate and Health, and annual updates will require additional data collection.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	CAMPBELL-LENDRUM, Diarmid <campbelllendrumd@who.int>

### 1.2.1. WHO develops norms, standards, policy guidance and strengthens capacity in countries to reduce greenhouse gases and other pollutants from the health sector, and engage other sectors (such as food, transport, energy, education) to reduce their emissions

**1.2.1.IND1\_UID 358 : Number of countries with strengthened health sector capacity to understand the health risks of air pollution and evaluate the effectiveness of interventions using tools like health impact assessment, enabled by WHO**

#	Metadata field	Summary
1	GPW14 Output	1.2.1. WHO develops norms, standards, policy guidance and strengthens capacity in countries to reduce greenhouse gases and other pollutants from the health sector, and engage other sectors (such as food, transport, energy, education) to reduce their emissions
2	GPW14 Output indicator code	1.2.1.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries with strengthened health sector capacity to understand the health risks of air pollution and evaluate the effectiveness of interventions using tools like health impact assessment, enabled by WHO
4	Output/Leading Indicator (Country Level Formulation)	Number of health workforce who completed trainings on air pollution and health, including health impact assessment of air pollution
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Mortality rate attributed to household and ambient air pollution (D); Annual mean levels of fine particulate matter (D); Proportion of population with primary reliance on clean fuels and technology (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator counts the number of countries where health sector capacity has been strengthened to address air pollution and conduct health impact assessments, enabled through WHO training and tools.
12	Criteria	A country is considered to have strengthened capacity to understand air pollution health risks and evaluate interventions if at least one of the following actions has been completed, with evidence of WHO contribution: <ul style="list-style-type: none"> <li>Completion by government officials of the WHO Air Pollution and Health Training Toolkit for Health Workers (APTH), hosted by the WHO Academy: <a href="#">WHO APTH Toolkit</a></li> </ul>

		<ul style="list-style-type: none"> <li>Participation in national or regional training workshops (in-person preferred, online acceptable) covering one or more of the following WHO tools: APTH, AirQ+, BAR-HAP, CLIMAQ-H</li> </ul> <p>WHO's contribution is confirmed through:</p> <ul style="list-style-type: none"> <li>Verified participation in WHO-led trainings</li> <li>Monitoring of WHO Academy enrollment</li> <li>Regular surveys to Member States gathering feedback on WHO tools and their impact</li> </ul>
13	Numerator	Number of countries where at least one of the criteria has been met
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets the criteria as outlined in Field 12. This means that at least one of the specified actions has been completed with verified WHO contribution.</p> <p><b>Partially achieved:</b> The country has engaged with relevant tools or training but does not fully meet the defined criteria for strengthened capacity. For example, training may have involved only non-government stakeholders or may have covered broader environmental health topics without specific use of WHO tools. In some cases, engagement may have occurred, but WHO's contribution cannot be confirmed, or documentation is incomplete.</p> <p><b>Not achieved:</b> There is no evidence of training completion, participation in WHO-led workshops, or any other engagement with WHO-supported tools relevant to air pollution and health. WHO involvement is not documented, and the country's health sector capacity in this area remains unstrengthened.</p>
17	Rationale	Ministries of Health are not always actively engaged in advocating for clean air for health due to a lack of awareness or evidence-based advice and tools. Engaging the health sector in multi-sectoral action, through health impact assessment of air pollution in sectoral policies for example requires countries to have a critical mass of health workforce understanding 1) their role in tackling air pollution, 2) the direct impacts of air pollution, as well as 3) the basic principles of health impact assessments to engage in multi-sectoral action. This indicator reflects WHO's added value by tracking efforts to build a critical mass of health professionals who understand the impacts of air pollution and can support multisectoral actions
18	Measurement method	<ul style="list-style-type: none"> <li>Tracking enrollment in WHO training</li> <li>Monitoring downloads of relevant WHO toolkits</li> <li>Requests for country support plans</li> <li>Survey feedback from WHO country offices</li> </ul>
19	Estimation method (if applicable)	Not applicable- data are directly counted based on documented participation or official reporting
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria for strengthened capacity
21	Calculation type	Cumulative

22	Target setting methodology	<ul style="list-style-type: none"> <li>Based on discussions among HQ, Regional Offices, and WCOs</li> <li>Informed by available donor-specific funding</li> </ul>
23	How target is realistic for PB2026-2027	Countries targeted are part of a network of activities led by WHO regional offices.
24	Data sources	WHO online training platform; Toolkit download records; Country support plan records; WHO reports and surveys
25	Process of validation	Triangulation through surveys with Member States as part of global consultation processes linked to the air pollution health roadmap
26	Limitations	<ul style="list-style-type: none"> <li>Training completion does not guarantee knowledge retention or policy action</li> <li>High staff turnover and lack of institutional memory both in national agencies as well as WHO</li> <li>Limited financial and human resources for environmental health</li> <li>Lack of political will in some contexts</li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Heather Adair-Rohani <adairrohan@who.int>

#### 1.2.1.IND2\_UID 359: Number of countries with national air quality standards aligned with WHO air quality guidelines

#	Metadata field	Summary
1	GPW14 Output	1.2.1. WHO develops norms, standards, policy guidance and strengthens capacity in countries to reduce greenhouse gases and other pollutants from the health sector, and engage other sectors (such as food, transport, energy, education) to reduce their emissions
2	GPW14 Output indicator code	1.2.1.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries with national air quality standards aligned with WHO air quality guidelines
4	Output/Leading Indicator (Country Level Formulation)	Development or revision of air quality standards to align with WHO air quality guidelines
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active

8	Linked outcome indicators (Direct (D) or indirect (I))	Mortality rate attributed to household and ambient air pollution (D); Annual mean levels of fine particulate matter (D); Proportion of population with primary reliance on clean fuels and technology (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	Tracks the number of countries whose national air quality standards are aligned with WHO air quality guidelines.
12	Criteria	<p>A country is counted under this indicator if its national air quality standards are aligned with WHO air quality guidelines or interim targets. Alignment is assessed based on the following:</p> <ul style="list-style-type: none"> <li>• WHO has a database compiling air quality standards, including the values and averaging times for various pollutants.</li> <li>• WHO is currently establishing a joint monitoring framework on air quality standards with UNEP, as part of their work on ambient air quality legislation assessment.</li> </ul> <p>Source: <a href="#">WHO Air Quality Standards Tool</a></p>
13	Numerator	Number of countries with national air quality standards aligned with WHO guidelines
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets the criteria as outlined in Field 12. Its national air quality standards are aligned with WHO air quality guidelines, based on a review of pollutant values and averaging times in national legislation, as recorded in WHO's database or verified through a joint monitoring framework with UNEP.</p> <p><b>Partially achieved:</b> The country has initiated a revision or development process for air quality standards and has draft legislation or policies under review that indicate a clear intention to align with WHO air quality guidelines, but the process is not yet complete or formally adopted.</p> <p><b>Not achieved:</b> The country has no available evidence of national air quality standards aligned with WHO air quality guidelines, and there is no documented process underway to revise or develop such standards.</p>
17	Rationale	WHO publishes reports on the health impact of air pollution since 1958 and Air Quality Guidelines (AQG) since 1987, which provides a set of evidence-based recommendations of limit values for specific air pollutants developed to help countries achieve air quality to protect public health. The latest updated WHO AQG was in 2021 and is not binding but serves as a guide for countries to develop their national air quality standards (NAQS) in order to protect health.
18	Measurement method	<ul style="list-style-type: none"> <li>• WHO compiles data on national air quality standards from public sources and with support from WHO Regional Offices.</li> <li>• A joint monitoring initiative with UNEP is being explored.</li> <li>• Standards are reviewed for alignment with WHO guidelines (pollutant type, value, and averaging time)</li> </ul>

19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria.
21	Calculation type	Cumulative
22	Target setting methodology	<ul style="list-style-type: none"> <li>Regular discussions with Regional Offices and UN partners.</li> <li>Target informed by feedback from Member States during the Global Conference on Air Quality and Health.</li> </ul>
23	How target is realistic for PB2026-2027	<ul style="list-style-type: none"> <li>Ongoing projects related to air quality standards are already in place.</li> <li>WHO is leveraging existing activities</li> </ul> <p>These elements contribute to the feasibility of achieving the targets within the 2026–2027 timeframe</p>
24	Data sources	WHO air quality standards database, version 2.1
25	Process of validation	<ul style="list-style-type: none"> <li>Triangulation with Member States through surveys and regional consultations</li> <li>A dedicated Member State survey will support the updated roadmap on air pollution</li> </ul>
26	Limitations	Availability of documents in the public domain and/or language issues.
27	Expected frequency of reporting	Annual
28	Date last published	15 June2025
29	Technical focal point	Heather Adair-Rohani < adairrohaniania@who.int>

### 1.2.1.IND3\_UID 569: Number of countries implementing national plans to develop a low-carbon and sustainable health system

#	Metadata field	Summary
1	GPW14 Output	1.2.1. WHO develops norms, standards, policy guidance and strengthens capacity in countries to reduce greenhouse gases and other pollutants from the health sector, and engage other sectors (such as food, transport, energy, education) to reduce their emissions
2	GPW14 Output indicator code	1.2.1.IND3
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries implementing national plans to develop a low-carbon and sustainable health system
4	Output/Leading Indicator (Country Level Formulation)	Roadmap to inform the implementation of a low-carbon, sustainable health system developed (National assessment of GHG emissions from the health sector; development of emission reduction plan)
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output



7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Healthcare sector greenhouse gas emissions (D); Annual mean levels of fine particulate matter (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator measures the number of countries that have developed a GHG national assessment and an emission reduction plan.
12	Criteria	<p>Countries must have:</p> <ul style="list-style-type: none"> <li>• Conducted an assessment of GHG emissions of their national health system</li> <li>• Developed plans to reduce GHG emissions from the health sector</li> <li>• Reported progress through WHO channels — either directly to Headquarters, or via Regional or Country Offices — confirming WHO's contribution to the effort.</li> </ul> <p><b>All criteria must be met to be counted</b></p>
13	Numerator	Number of countries meeting the criteria as described in field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets the criteria as outlined in Field 12, having conducted a national GHG emissions assessment and developed plans to reduce emissions from the health system</p> <p><b>Partially achieved:</b> The country has completed one of the required steps (e.g. assessment or planning) but has not yet completed the other.</p> <p><b>Not achieved:</b> The country has not conducted a national GHG emissions assessment, has not developed relevant plans, or no evidence is available.</p>
17	Rationale	Assessing GHG emissions and developing a roadmap is the first essential step to real implementation at country level of interventions aiming to reduce GHG emissions in the health sector. This is the only proposed indicator with a direct link to the proposed outcome indicator for 1.2 on GHG emissions from healthcare.
18	Measurement method	<ul style="list-style-type: none"> <li>• Data are collected through WHO's Global Survey on Health and Climate Change, conducted every 2–3 years.</li> <li>• Countries that have joined the WHO Alliance for Transformative Action on Climate and Health (ATACH) report progress achieved regarding developing low-carbon and sustainable health systems.</li> <li>• To meet GPW14 reporting requirements, updates for this output indicator will also be collected annually through: <ul style="list-style-type: none"> <li>○ Regional Offices, who will recontact national focal points to request updated information</li> </ul> </li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria.

21	Calculation type	Cumulative
22	Target setting methodology	<ul style="list-style-type: none"> <li>Based on consultations with Regional Offices</li> <li>Reflects assumptions about current and planned engagement from all three levels of WHO (Headquarters, Regional Offices, and Country Offices)</li> <li>Considers historical progress made by countries on similar initiatives</li> <li>Considers whether countries have committed to building low-carbon sustainable health systems as part of ATACH, or whether they have a net zero goal</li> <li>Includes assessment of countries' capacity to assess emissions and develop a national plan within the timeframe</li> <li>Builds on the level of support WHO can provide to enable successful implementation</li> </ul>
23	How target is realistic for PB2026-2027	<ul style="list-style-type: none"> <li>The targets are considered achievable based on existing national plans, financing, ongoing climate-health initiatives, and consultations with Regional Offices.</li> <li>Countries will have sufficient time during 2026–2027 to establish their action plans.</li> <li>WHO's strong regional presence ensures continuous engagement and country follow-up.</li> <li>A planned scale-up of technical assistance and tailored capacity-building efforts will support countries in meeting the targets.</li> </ul>
24	Data sources	<ul style="list-style-type: none"> <li>WHO Global Climate and Health Survey</li> <li>WHO online repository of climate and health plans and assessments <a href="https://www.atachcommunity.com/our-impact/progress-tracker/">https://www.atachcommunity.com/our-impact/progress-tracker/</a></li> <li>Updates provided by WHO Regional and Country Offices</li> <li>Monitoring data submitted through the WHO Alliance for Transformative Action on Climate and Health (ATACH)</li> </ul>
25	Process of validation	Data are triangulated with updates provided to WHO as part of the monitoring function of the ATACH and regular reports provided by WHO Regional and Country Offices.
26	Limitations	Reported data (i.e., actual plans and assessments of GHG emissions at national level) will have to be reviewed to ensure that plans and assessments fulfill the criteria to be considered as assessments of GHG at national level (and not at facility level) and national plans. These definitions are included in the instructions provided as part of the WHO Global Survey on Health and Climate Change but not always followed by respondents at national level.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Diarmid Campbell-Lendrum < campbelllendrumd@who.int >

### 2.1.1. WHO supports countries in designing policies and regulations, shaping resource allocation and investment, building capacity and in establishing partnerships within and beyond the health sector to address social determinants and reduce health inequities, particularly for populations in situations of vulnerability

#### 2.1.1.IND1\_UID 840: Number of countries implementing intersectoral policies, plans and strategies to advance health equity with WHO support

#	Metadata field	Summary
1	GPW14 Output	2.1.1. WHO supports countries in designing policies and regulations, shaping resource allocation and investment, building capacity and in establishing partnerships within and beyond the health sector to address social determinants and reduce health inequities, particularly for populations in situations of vulnerability
2	GPW14 Output indicator code	2.1.1.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries implementing intersectoral policies, plans and strategies to advance health equity with WHO support
4	Output/Leading Indicator (Country Level Formulation)	Implementation of intersectoral policies, plans, and strategies to advance health equity with WHO support
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Percentage of countries advancing gender equality in and through health by actions addressing GPW outcomes (index) (D); Does the government provide non-national (including refugees and migrants) equal access to (i) essential and/or (ii) emergency healthcare (I); Proportion of population covered by at least one social protection benefit (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	Tracks how many countries are implementing intersectoral policies, plans and strategies to advance health equity with WHO support
12	Criteria	<p>A country is counted under this indicator if the intersectoral policy, plan, or strategy being implemented <b>meets all three</b> of the following criteria.</p> <ul style="list-style-type: none"> <li>It addresses at least one of the 14 recommendations from <a href="#">the World Report on the Social Determinants of Health Equity, or one of its sub-recommendations</a>.</li> </ul>

		<ul style="list-style-type: none"> <li>It describes implementation/operationalisation work in terms of proof of concept in at least 2 or more local areas; OR if at least one element from each of the 4 dimensions of WHO four-pillars models is operational at the national level. See for all elements <a href="#">Working together for equity and healthier populations</a></li> <li>And if a related WHO global or regional tool or direct technical assistance was used in the operationalization of the strategy, plan or policy <ul style="list-style-type: none"> <li>The reports of regional focal points will be checked for explicit mention of use of a related WHO global or regional tool or direct technical assistance in the operationalization of the strategy, plan or policy.</li> <li>The reporting country and regional advisers will be asked to retrieve documents and news briefs to obtain documentary evidence of the assistance by WHO.</li> </ul> </li> </ul>
13	Numerator	Number of countries that meet the defined inclusion criteria for implementing intersectoral policies, plans, or strategies to advance health equity with WHO support.
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets the criteria as outlined in Field 12, including: implementation of an intersectoral policy, plan, or strategy addressing at least one recommendation from the World Report on the Social Determinants of Health Equity; operationalization demonstrated at subnational or national level; and clear attribution to WHO through use of WHO tools or technical assistance.</p> <p><b>Partially achieved:</b> The country has initiated or adopted an intersectoral policy, plan, or strategy that may address the recommendations, but it is either not fully operationalized or lacks sufficient evidence of WHO support or use of WHO tools.</p> <p><b>Not achieved:</b> There is no evidence of a qualifying intersectoral policy, plan, or strategy aligned with the indicator criteria, or WHO's contribution cannot be confirmed.</p>
17	Rationale	WHO supports countries in designing strategies, policies and regulations, shaping resource allocation and investment, building capacity, and in establishing partnerships beyond public health to address the social determinants of health in order to reduce health inequities, particularly for populations in situations of vulnerability. Meaningful progress requires proactive and comprehensive strategies, as recommended in the World Report on the Social Determinants of Health Equity requested by WHA74.16, and by relevant regional and national social determinants of health equity commissions, to integrate health, social and environmental impacts into economic and development thinking, and in the way that health sectors engage intersectorally on determinants, for change towards health equity.

18	Measurement method	<p>Measurement is based on multiple sources of evidence, coordinated as follows:</p> <ul style="list-style-type: none"> <li>• <b>Primary data source:</b> The Primary Health Care (PHC) survey, conducted every 2–3 years, captures whether countries have implemented intersectoral or Health in All Policies (HiAP) strategies, their operational status, geographic coverage, and reference to health equity.</li> <li>• <b>Supporting evidence:</b> WHO regional and country advisers help identify relevant national policies or plans and provide additional context through reporting.</li> <li>• <b>Eligibility check:</b> Countries are counted only if their submitted strategy or policy meets all three defined inclusion criteria (see Field 12).</li> <li>• <b>Verification:</b> WHO reviews retrieved documents, including submitted policies, reports, and related materials, to confirm eligibility and WHO's contribution.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria.
21	Calculation type	Cumulative
22	Target setting methodology	<p>The target was set by building on a baseline of countries that had already met the inclusion criteria through consistent work in previous biennia. An expanded number of countries was projected as a feasible goal across all regions, considering the following factors:</p> <ul style="list-style-type: none"> <li>• Newly established network mechanisms now provide technical assistance for implementation of the World Report on the Social Determinants of Health Equity</li> <li>• The WHO focal point network has demonstrated effectiveness in supporting countries even with limited resources</li> <li>• Funding is already secured for a portion of the targeted countries, while others are upper middle-income or high-income countries expected to require less financial input</li> <li>• Most of the targeted countries are already engaged in relevant equity networks and have foundational policies or plans in place</li> </ul> <p>The selected target is therefore based on a qualitative assessment of WHO's operational reach, regional engagement capacity, and the readiness of countries to move from planning to implementation during the biennium.</p>
23	How target is realistic for PB2026-2027	<p>The target is considered realistic due to a combination of technical, institutional, and financial factors:</p> <ul style="list-style-type: none"> <li>• Countries already engaged in equity-focused networks and WHO-supported initiatives are well-positioned to advance from planning to implementation.</li> <li>• WHO's regional and country focal point networks are in place and functioning, enabling direct technical assistance and follow-up.</li> <li>• Mechanisms for knowledge-sharing, peer learning, and operational guidance are active and accessible to Member States.</li> </ul>

		<ul style="list-style-type: none"> <li>• A portion of countries already have funding secured, and others are expected to progress using domestic resources.</li> <li>• The indicator criteria are clearly defined and measurable, facilitating systematic identification and verification of progress.</li> </ul> <p>Together, these elements create a supportive environment for countries to reach the target by the end of the 2026–2027 biennium.</p>
24	Data sources	Primary Health Care (PHC) survey, conducted every 2–3 years; Retrieved national policies, strategies, and related documents; Consultations with WHO regional advisers; Special Initiative for Action on the Social Determinants of Health Equity
25	Process of validation	<ul style="list-style-type: none"> <li>• Cross-checking of reports: <ul style="list-style-type: none"> <li>○ Validation relies on triangulation of information from country, regional, and headquarters reporting mechanisms.</li> <li>○ This includes responses to the Primary Health Care (PHC) survey and follow-up review of country reports on implementation of intersectoral strategies, plans, or policies.</li> </ul> </li> <li>• Use of the Country Action Knowledge-Sharing Hub: <ul style="list-style-type: none"> <li>○ The Hub, developed around the governance recommendations from the World Report on the Social Determinants of Health Equity (Section 3), provides information on: <ul style="list-style-type: none"> <li>▪ Country-level processes undertaken</li> <li>▪ Tools used in implementation</li> </ul> </li> <li>○ This Hub is used to complement and validate country-reported activities.</li> </ul> </li> <li>• Departmental verification: <ul style="list-style-type: none"> <li>○ Where needed, WHO departments are consulted to verify and clarify reported activities and the use of WHO tools or technical assistance.</li> </ul> </li> <li>• Survey frequency and interim reporting: <ul style="list-style-type: none"> <li>○ The PHC survey is expected to run every 2–3 years.</li> <li>○ In the years between surveys, validation relies on: <ul style="list-style-type: none"> <li>▪ Updates from regional advisers</li> <li>▪ Reporting from the Special Initiative on the Social Determinants of Health Equity</li> </ul> </li> </ul> </li> <li>• Survey-based cross-checking criteria: When available, the PHC survey also serves as a secondary tool to verify compliance with indicator criteria through specific questions, including: <ul style="list-style-type: none"> <li>▪ Governance and accountability: <i>"Does this coordination mechanism have a clear framework for implementation and accountability, including time-bound actions?"</i></li> <li>▪ Leadership at all levels: <i>"Are there committees within the country's government legislative branch (e.g. parliamentary committees) devoted to addressing population health and health equity implications of policies in other sectors?"</i></li> <li>▪ Resources, financing and capabilities: <i>"Are there national systems or structures set up to offer training on</i></li> </ul> </li> </ul>

		<i>Health in All Policies, inter/multi-sectoral action, or social determinants of health to civil service/public sector staff?" "Are there national systems or structures set up to capture and disseminate best practices, lessons learnt and innovations on Health in All Policies, inter/multi-sectoral action, or social determinants of health?"</i>
26	Limitations	The World report and the other publications described above as informing the criteria, as well as the PHC survey, have all been developed in the recent 1-2 years. Over time, a rigorous system of country strategy/policy reporting is being developed that will call for refinement of these instruments, survey questions and criteria for knowledge-sharing and peer-to-peer exchange. These changes will inform the core elements of a Social Determinants of Health Equity Strategic Guide. Into this will be integrated WHO-UN Country Team roles and tools, including those references the SDGs and human rights, which are less specified at present. As these processes evolve, the indicator calibration and definitions will evolve over the period of initial measurement (5 years)
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Nicole Valentine <valentin@who.int>

**2.1.1.IND2\_UID 1380 : Number of countries adopting measures to address conflicts of interest/industry interference/commercial influence in public health policies and programming at national or subnational levels, with WHO technical assistance**

#	Metadata field	Summary
1	GPW14 Output	2.1.1. WHO supports countries in designing policies and regulations, shaping resource allocation and investment, building capacity and in establishing partnerships within and beyond the health sector to address social determinants and reduce health inequities, particularly for populations in situations of vulnerability
2	GPW14 Output indicator code	2.1.1.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries adopting measures to address conflicts of interest/industry interference/commercial influence in public health policies and programming at national or subnational levels, with WHO technical assistance
4	Output/Leading Indicator (Country Level Formulation)	Adoption of measure to address conflicts of interest and industry interference in public health policies and programming at national or sub-national level, with WHO technical assistance
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output

7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Prevalence of obesity among children and adolescents (aged 5–19 years) (%) (D); Prevalence of obesity among adults aged ≥18 years (D); Age-standardized prevalence of current tobacco use among persons aged 15 years and older (D); Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol (D); Proportion of population covered by at least one social protection benefit (I); Does the government provide non-national (including refugees and migrants) equal access to (i) essential and/or (ii) emergency healthcare (I); Proportion of urban population living in slums, informal settlements or inadequate housing (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks the number of countries that have adopted at least one measure to address conflicts of interest or industry interference in public health policy or programming, at the national or sub-national level, with technical assistance from WHO.
12	Criteria	<p>A country is counted under this indicator if it has adopted at least one of the following qualifying measures, with technical assistance from WHO, at the national or sub-national level:</p> <ul style="list-style-type: none"> <li>• Measure 1: Regulation on lobbying, COI, and political finance (industry specific measure; comprehensive measure)</li> <li>• Measure 2: Conflicts of interest safeguards (industry specific measure; comprehensive measure)</li> <li>• Measure 3: Lobbying safeguards in place (industry specific measure; comprehensive measure)</li> </ul> <p>To verify WHO's contribution, one of the following forms of documentation is required:</p> <ul style="list-style-type: none"> <li>a) documentation of support through public channels such as WHO media story or official coverage, or through offline documentation such as concept note, communications, event programme</li> <li>b) documentation through technical products such as case studies, technical reports or status reports.</li> </ul>
13	Numerator	Number of countries that have adopted one or more qualifying measures with WHO support
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets the criteria as outlined in Field 12. It has adopted at least one comprehensive, industry-specific measure to address conflicts of interest or industry interference in public health policies or programming at the national or sub-national level, and WHO's contribution is verified through appropriate documentation.</p> <p><b>Partially achieved:</b> The country has developed or proposed a relevant measure that aligns with the criteria but has not yet formally adopted it, or</p>



		<p>the measure adopted is not yet comprehensive, industry-specific, or fully implemented. WHO's contribution is expected but has not yet been fully documented.</p> <p><b>Not achieved:</b> The country has no relevant measure adopted, proposed, or under development, or there is no evidence of WHO's contribution to support such a measure.</p>
17	Rationale	This indicator is important because these measures are critical for the successful implementation of GPW14. However, data on this issue—particularly as it relates to public health—is not currently being collected by any institution, despite the large positive spillover effects across WHO outcomes and outputs. The current political climate further underscores the urgency and relevance of this issue.
18	Measurement method	Data are collected through the Commercial Determinants of Health (CDOH) Regional Focal Point (RFP) network, which is already operational.
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria.
21	Calculation type	Cumulative
22	Target setting methodology	Targets are set based on information from WHO technical teams, identifying countries where WHO is supporting implementation—whether through headquarters, regional, or country office levels—and as an assessment of where these efforts are already in process.
23	How target is realistic for PB2026-2027	The targets are considered realistic because they are informed by discussions with WHO regional and country office counterparts. WHO support is expected to continue at one or more levels (HQ, regional, or country), ensuring that progress is sustained even if there are organizational changes.
24	Data sources	Data are collected through the Commercial Determinants of Health (CDOH) Regional Focal Point (RFP) network.
25	Process of validation	Data is provided directly by WHO Technical teams, supported by documentation from the Ministries of Health.
26	Limitations	As a new indicator, initial uptake and reporting may be delayed; with a time lag for results.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Monika Kosinska <kosinskam@who.int>

## 2.1.2. WHO supports countries in developing evidence-informed policies across sectors at all levels of government and adapts public health measures to meet the health needs of populations such as migrants and displaced people

### 2.1.2.IND1\_UID 295: Number of countries implementing at least two WHO-recommended measures to provide equitable health services for migrants, refugees and displaced populations

#	Metadata field	Summary
1	GPW14 Output	2.1.2. WHO supports countries in developing evidence-informed policies across sectors at all levels of government and adapts public health measures to meet the health needs of populations such as migrants and displaced people
2	GPW14 Output indicator code	2.1.2.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries implementing at least two WHO-recommended measures to provide equitable health services for migrants, refugees and displaced populations
4	Output/Leading Indicator (Country Level Formulation)	Implementation of at least two WHO-recommended measures, to provide equitable health services for migrants, refugees, and displaced populations
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Does the government provide non-national (including refugees and migrants) equal access to (i) essential and/or (ii) emergency healthcare (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks how many countries have implemented at least two WHO-recommended measures aimed at providing equitable health services to migrants, refugees, and displaced populations
12	Criteria	<p>A country is considered under this indicator if it has implemented <b>at least two</b> of the following WHO-recommended measures to provide equitable health services for migrants, refugees, and displaced populations:</p> <ul style="list-style-type: none"> <li>• Integration of refugees and migrants in national health legislations/plans/strategies</li> <li>• Integration of refugees and migrants in national public health emergency preparedness and response plans</li> <li>• Integration of refugees and migrants in national disaster risk reduction plans</li> </ul>

		<ul style="list-style-type: none"> <li>• Integration of refugees and migrants in national labour strategies/plans</li> <li>• Institutionalization of training for health workers on competencies for culturally sensitive care</li> <li>• Review of health system to assess capacity and responsiveness to the needs of refugees and migrants</li> <li>• Institutionalization of anti-discrimination campaigns</li> <li>• Integration of refugees and migrants in risk communication and community engagement strategies</li> <li>• Collection, analysis, and use of disaggregated data on migratory status for policy making</li> <li>• Establishment/presence of a national research capacity on refugee and migrant health, led by MoH, for policy making</li> </ul> <p>To qualify under this indicator:</p> <ul style="list-style-type: none"> <li>• A declaration of implementation is mandatory</li> <li>• Countries must also provide supporting documentation</li> </ul>
13	Numerator	Number of countries that have implemented at least two WHO-recommended measures
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets the criteria as outlined in Field 12, having formally declared and submitted documentation confirming the implementation of at least two WHO-recommended measures to provide equitable health services for migrants, refugees, and displaced populations.</p> <p><b>Partially achieved:</b> The country has formally declared implementation of at least one WHO-recommended measure and has submitted supporting documentation or has declared at least two measures but has not yet submitted the required documentation for both.</p> <p><b>Not achieved:</b> The country has not declared or documented the implementation of any WHO-recommended measures, or the submission is incomplete or missing for declared measures.</p>
17	Rationale	This indicator is important because it is the only means to measure the progress of evidence-based approach by countries in addressing the public health aspects of migration.
18	Measurement method	Data are collected through a global survey covering 12 specific measures linked to the 6 priorities of the Global Action Plan (GAP) on promoting the health of refugees and migrants.
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that have reported implementing at least two of the WHO-recommended measures, and that have submitted both a declaration and supporting documentation to confirm implementation.
21	Calculation type	Cumulative
22	Target setting methodology	The rationale was the global political environment, aiming to set targets that are not overly ambitious

23	How target is realistic for PB2026-2027	There is national and regional understanding of the public health needs related to migrants, refugees and displaced populations and all drivers of migration/displacement
24	Data sources	GAP Monitoring Framework survey data submitted by Ministries of Health
25	Process of validation	<ul style="list-style-type: none"> <li>• Data are submitted directly by Ministries of Health</li> <li>• They are given space to upload supporting documents to confirm their declarations</li> </ul>
26	Limitations	Limitations include the reporting bias by Member States, also due to the possible different definitions of refugee and migrant populations at country level
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Saverio Bellizzi < bellizzis@who.int>

**2.2.1. WHO develops norms, standards and technical packages to address risk factors for communicable and noncommunicable diseases, violence and injuries, prevent poor nutrition and strengthen food safety and reduce environmental health risks, and supports countries in their implementation, including in the monitoring and development of legislation and regulations**

**2.2.1.IND1\_UID 328: Number of countries that have strengthened at least one PWER measure from the MPOWER technical package, enabled by WHO technical support**

#	Metadata field	Summary
1	GPW14 Output	2.2.1.WHO develops norms, standards and technical packages to address risk factors for communicable and noncommunicable diseases, violence and injuries, prevent poor nutrition and strengthen food safety and reduce environmental health risks, and supports countries in their implementation, including in the monitoring and development of legislation and regulations
2	GPW14 Output indicator code	2.2.1.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have strengthened at least one PWER measure from the MPOWER technical package, enabled by WHO technical support
4	Output/Leading Indicator (Country Level Formulation)	Country has strengthened at least one PWER measure from the MPOWER technical package, enabled by WHO technical support
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Age-standardized prevalence of current tobacco use among persons aged 15 years and older (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	Tracks the number of countries that, with WHO technical support, have strengthened at least one of the PWER tobacco control measures (Protect, Warn, Enforce bans, Raise taxes) to the best-practice level as defined by WHO.
12	Criteria	To be considered as having “strengthened” its tobacco control approach and counted under this indicator, a country must have achieved best-practice level (Group 5) in all four PWER measures of the MPOWER technical package:

		<ul style="list-style-type: none"> <li>The WHO Report on the Global Tobacco Epidemic monitors country implementation of the MPOWER technical package using a standardized categorization scale for each measure. Each country is assessed and assigned to one of five levels (Groups 1 to 5) per measure, with Group 5 representing best-practice implementation. PWER includes the following four measures: <ul style="list-style-type: none"> <li>Protect people from tobacco smoke</li> <li>Warn about the dangers of tobacco</li> <li>Enforce bans on tobacco advertising, promotion and sponsorship</li> <li>Raise taxes on tobacco</li> </ul> Only countries that reach Group 5 for all four PWER measures meet the full achievement threshold for this indicator. </li> <li>In addition, the technical team applies benchmarking to assess progress toward full achievement, based on incremental improvements in the MPOWER categorization</li> <li>WHO's contribution is considered verified if: <ul style="list-style-type: none"> <li>The country is one of the 34 countries currently supported under the Bloomberg Philanthropies Partnership or the Bill and Melinda Gates Initiative, where TFI has longstanding engagements: OR</li> <li>The country has requested support from WHO (at HQ, Regional, or Country Office level), and WHO has been able to respond and engage.</li> </ul> </li> </ul>
13	Numerator	Number of countries that have achieved best-practice level (Group 5) in all four PWER measures (Protect, Warn, Enforce, Raise) of the MPOWER technical package and where WHO's technical support can be verified either through formal engagement (e.g. Bloomberg/Gates initiatives) or through direct support requests met by WHO.
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	TBD
17	Rationale	This indicator is important because it demonstrates the progress in global tobacco control and the strengthening of the WHO Framework Convention on Tobacco Control (a Sustainable Development Goal). It reflects WHO's added value because WHO provides direct technical assistance to support and encourage countries to combat the tobacco industry and reduce the burden caused by the tobacco epidemic.
18	Measurement method	<ul style="list-style-type: none"> <li>Data are collected through the WHO Report on the Global Tobacco Epidemic, which monitors the implementation of the MPOWER technical package using a standardized five-level categorization for each measure. A full description can be found in the <a href="#">Technical Notes</a> of the report</li> </ul>

		<ul style="list-style-type: none"> <li>The assessment focuses on whether countries meet the defined inclusion criteria (see Field 12)</li> <li>Data collection is conducted by WHO with country consultation and document review, including policies, laws, and survey data</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The total number of countries meeting the defined inclusion criteria (see Field 12) is counted to produce the global aggregate. Each country is counted once if it meets all conditions for inclusion during the reporting cycle.
21	Calculation type	Cumulative
22	Target setting methodology	The targets are based upon public health strategies that have been developed as part of ongoing collaborations with Bloomberg Philanthropies in large high burden countries, Bill and Melinda Gates Foundation in the AFR regions and requests received for country technical support.
23	How target is realistic for PB2026-2027	<ul style="list-style-type: none"> <li>The following countries are currently receiving WHO support under these efforts (as of 2 May 2025) <i>Bangladesh, Botswana, Burkina Faso, Cambodia, Cameroon, Chad, China, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gabon, Gambia, Ghana, India, Indonesia, Israel, Kenya, Lao People's Democratic Republic, Liberia, Malaysia, Maldives, Mauritania, Mexico, Montenegro, Namibia, Nepal, Nigeria, Pakistan, Papua New Guinea, Philippines, Rwanda, Senegal, Sierra Leone, South Africa, Thailand, Uganda, Ukraine, Viet Nam, Zambia</i></li> <li>However, it is acknowledged that progress is unpredictable, and not all countries are expected to reach best-practice level. The team anticipates that at least <b>one country</b> may newly achieve full PWER best-practice every two years, though it is not possible to specify which ones.</li> <li>Funding is available for all countries prioritized by the collaborations established with the Bloomberg Philanthropies and Bill and Melinda Gates Foundation. These prioritizations are based upon burden and alignment with broader public health strategies. This donor funding covers a total of 34 countries– this also allows the No Tobacco Unit (TFI) to extend support to other countries as requested.</li> <li>Along with Regional colleagues and other technical units such as the Fiscal Policies for Health Unit (TAX) and the Public Health Law and Policies Unit (LAW) in HQ, TFI regularly develops strategies and plans to respond to and address country technical support requests.</li> <li>Together with colleagues, TFI also works to identify opportunities where countries can be encouraged or assisted to strengthen tobacco control.</li> </ul>
24	Data sources	The WHO Report on the Global Tobacco Epidemic
25	Process of validation	All data are validated against documents including policies, legislations and surveys. Countries are consulted on all data prior to publication and are requested to sign off on WHO's assessments. For further details please see the <a href="#">Technical Notes</a> in the WHO Report on the Global Tobacco Epidemic
26	Limitations	<ul style="list-style-type: none"> <li>Data are currently analyzed on a biennial basis, making it difficult to assess yearly progress for some tobacco control measures</li> </ul>

		<ul style="list-style-type: none"> <li>WHO aims to minimize the burden on countries and WHO Country Offices by completing the data assessment and requiring minimal country inputs</li> </ul>
27	Expected frequency of reporting	Biennial
28	Date last published	15 June 2025
29	Technical focal point	Hebe Naomi Gouda < <a href="mailto:goudah@who.int">goudah@who.int</a> >; Vinayak Prasad < <a href="mailto:prasadvi@who.int">prasadvi@who.int</a> >

### 2.2.1.IND2\_UID 797: Number of countries integrating WHO guidance on water, sanitation, hygiene and health in policies, plans, regulations or in monitoring systems

#	Metadata field	Summary
1	GPW14 Output	2.2.1.WHO develops norms, standards and technical packages to address risk factors for communicable and noncommunicable diseases, violence and injuries, prevent poor nutrition and strengthen food safety and reduce environmental health risks, and supports countries in their implementation, including in the monitoring and development of legislation and regulations
2	GPW14 Output indicator code	2.2.1.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries integrating WHO guidance on water, sanitation, hygiene and health in policies, plans, regulations or in monitoring systems
4	Output/Leading Indicator (Country Level Formulation)	Integration of WHO guidance on water, sanitation, hygiene and health in policies, plans, regulations, or in monitoring systems
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Proportion of population using safely managed drinking water services (D); Proportion of population using (a) safely managed sanitation services and (b) a hand-washing facility with soap and water (D); Mortality rate attributed to unsafe water, unsafe sanitation, and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All [WASH] services) (D); Proportion of people who have suffered a foodborne diarrhoeal episode of non-typhoidal salmonellosis (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	Tracks the number of countries that integrate WHO guidance on water, sanitation, hygiene and health in policies, plans, regulations or monitoring systems



12	Criteria	<p>A country is counted under this indicator if <b>at least one</b> of the following is true:</p> <ul style="list-style-type: none"> <li>It integrates WHO guidance on WASH (water, sanitation, hygiene and health) into: <ul style="list-style-type: none"> <li>Policies</li> <li>Plans</li> <li>Regulations</li> </ul> </li> </ul> <p>Based on GLAAS survey question A3, this includes the use of risk management approaches such as:</p> <ul style="list-style-type: none"> <li>Water safety plans</li> <li>Sanitation safety plans</li> </ul> <ul style="list-style-type: none"> <li>It integrates WHO guidance into national monitoring systems, as evidenced by: <ul style="list-style-type: none"> <li>Reporting WASH financial flows or system performance using WHO methodologies such as TrackFin</li> <li>Improved monitoring of on-site sanitation through the Safely Managed On-Site Sanitation (SMOSS) initiative</li> </ul> </li> <li>In the future: Countries that integrate the forthcoming WHO hand hygiene guidelines into national programmes will also be included.</li> </ul>
13	Numerator	Number of countries that meet at least one of the criteria listed in field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets the criteria as outlined in Field 12, by integrating WHO guidance on WASH into national policies, plans, or regulations and/or by incorporating WHO methodologies into national monitoring systems.</p> <p><b>Partially achieved:</b> The country has taken steps toward integration, such as initiating revisions of policies, plans, or monitoring systems to align with WHO guidance, but does not yet meet the full criteria outlined in Field 12.</p> <p><b>Not achieved:</b> There is no evidence that the country has integrated WHO guidance into policies, plans, regulations, or monitoring systems as defined in Field 12, or relevant data is not available.</p>
17	Rationale	<p>Globally, inadequate WASH is responsible for 1.4 million deaths annually, largely from diarrhoea, but also from acute respiratory infections linked to unsafe hand hygiene practices, as well as undernutrition and soil-transmitted infections. Cholera outbreaks remain a major public health concern, with cases surpassing 470,000 in 2022—a reminder of the urgent need for improved WASH services. WHO’s guidelines on drinking-water quality, and sanitation and health and related risk management approaches are key resources for countries, and the forthcoming hand hygiene guidelines for community settings will further support disease prevention and outbreak control. Monitoring coverage of water, sanitation and hygiene services, financial flows and other aspects of the enabling environment is essential for achieving Sustainable Development Goal (SDG) 6 and reducing preventable deaths. Reliable data enables targeted interventions, stronger policies, and</p>

		greater accountability. WHO's role in supporting evidence-based regulations, integrating WASH into health policies, strengthening national monitoring, and providing technical leadership ensures countries can improve public health outcomes, prevent WASH-related disease outbreaks, and save lives.
18	Measurement method	<p>Data for this indicator is collected through two primary mechanisms:</p> <ul style="list-style-type: none"> <li> <b>Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS)</b>            GLAAS is a UN-Water initiative implemented by WHO and UNICEF. It collects country-led survey data on financial flows, governance, policies, and human resources in WASH systems.           <ul style="list-style-type: none"> <li>Countries complete the GLAAS survey through a multistakeholder process.</li> <li>WHO reviews submissions via Country and Regional Offices for consistency and completeness.</li> <li>GLAAS specifically measures integration of WHO guidance through survey question A3, which captures the use of risk management approaches such as water and sanitation safety plans.</li> </ul> </li> <li> <b>WHO/UNICEF Joint Monitoring Programme (JMP)</b>            JMP is the official mechanism for global WASH monitoring under SDG targets 6.1 and 6.2.           <ul style="list-style-type: none"> <li>It collects data from household surveys, national censuses, and statistical offices.</li> <li>JMP provides standardized, comparable data on access to drinking water, sanitation, and hygiene.</li> <li>It tracks population coverage and national WASH system performance over time.</li> </ul> </li> <li>Additional measurement aspect           <ul style="list-style-type: none"> <li>Final determination of whether a country is counted under the indicator is based on whether it meets at least one of the integration criteria described in field 12.</li> </ul> </li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria.
21	Calculation type	Cumulative
22	Target setting methodology	<p>The 2026 and 2027 targets were set by:</p> <ul style="list-style-type: none"> <li>Compiling information on all criteria for all Member States, including planned engagements and pilots for the next biennium across multiple programmatic areas of work in water, sanitation, hygiene and health.</li> <li>Selecting target countries based on feasibility of implementation leading up to 2027 and identifying overlaps across targeted countries in different areas of work, resulting in a robust set of target countries.</li> </ul>
23	How target is realistic for PB2026-2027	<ul style="list-style-type: none"> <li>The target countries were selected based on feasibility of implementation by 2027, considering planned support, funding, and</li> </ul>

		<p>engagement from the regional and country offices, as well as strength of support and collaboration with partners in country.</p> <ul style="list-style-type: none"> <li>• In addition, countries that are targeted for intervention for multiple areas of work were prioritized in the identification of target countries, Hence it is realistic to expect that the targets will be achieved in 2026 and 2027</li> </ul>
24	Data sources	<a href="#">WHO/UNICEF UN-Water GLAAS 2024/2025 survey cycle</a> ; JMP country, regional and global <a href="#">WASH data</a>
25	Process of validation	<p>Throughout the 15 years of the GLAAS survey implementation, WHO has improved its rigorous feedback mechanism for reviewing each country survey submission and communicating with governments focal points. The GLAAS survey validation process involves multiple steps to ensure data accuracy and reliability. After national governments complete the survey as part of a wide multistakeholder process at country level, results are submitted to WHO through WHO Country and Regional Offices, who review the responses for consistency, completeness, and alignment with existing data sources. This includes cross-checking with previous GLAAS cycles, the JMP data, and other relevant datasets. WHO then engages with country focal points to clarify any missing data, discrepancies and request additional information if needed. Finalized data undergoes further quality control before being included in global analyses and reports, ensuring that GLAAS provides a robust evidence base for WASH policy and investment decisions. Country highlights/profiles are produced and shared with focal points before publication. Indicators of the improved quality of GLAAS data include an increase in the number of stakeholders involved in the process at country level, as well as an improvement in WASH financial data over GLAAS cycles thanks to an increasing number of countries developing WASH accounts that feed into the results. The validation process for JMP data involves several key steps. First, data is collected through household surveys, censuses, and national statistical sources, which are then reviewed for consistency and completeness. JMP compares the data across multiple sources and develops internationally comparable estimates based on a linear model. National authorities are consulted to clarify or validate the data through a country-consultation process facilitated by WHO and UNICEF country offices. The country consultation aims to engage national statistical offices and other relevant national stakeholders to review the draft estimates and provide technical feedback to the JMP team. The final validated data is then aggregated and used to generate global estimates of WASH access, producing data that is reliable and comparable across countries and over time.</p>
26	Limitations	<ul style="list-style-type: none"> <li>• The limitations of GLAAS data include <ul style="list-style-type: none"> <li>○ potential gaps in country participation, as not all countries complete the survey and may vary based on political priorities, as well as availability of seed funding</li> <li>○ Additionally, GLAAS relies on self-reported data from national governments, which may be subject to differences in</li> </ul> </li> </ul>

		<p>interpretation of the questions and differences in national definitions</p> <ul style="list-style-type: none"> <li>• The limitations of JMP data include <ul style="list-style-type: none"> <li>○ data gaps at country-level, as countries may not have reliable or recent data, or the data may exist but are not accessible, leading to gaps in global and regional estimates.</li> <li>○ There is also often a discrepancy between JMP estimates and national data, as countries may use different methodologies, definitions, or reporting standards.</li> </ul> </li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Fiona Gore <goref@who.int>

### **2.2.1.IND3\_UID 1210: Number of countries adopting evidence-based legislative and policy reform to prevent and respond to violence against children, enabled by WHO technical support**

#	Metadata field	Summary
1	GPW14 Output	2.2.1. WHO develops norms, standards and technical packages to address risk factors for communicable and noncommunicable diseases, violence and injuries, prevent poor nutrition and strengthen food safety and reduce environmental health risks, and supports countries in their implementation, including in the monitoring and development of legislation and regulations
2	GPW14 Output indicator code	2.1.1.IND3
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries adopting evidence-based legislative and policy reform to prevent and respond to violence against children, enabled by WHO technical support
4	Output/Leading Indicator (Country Level Formulation)	Number of legislative or policy changes aligned with WHO technical packages for the prevention and response to violence against children adopted at the national level, enabled by WHO support
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries

11	Indicator definition	This indicator counts the number of countries that adopt or reform legislation or policies to prevent and respond to violence against children, with WHO technical support.
12	Criteria	<p>A country will be counted under this indicator if it submits written evidence of legislative or policy reform aligned with WHO technical packages for the prevention and response to violence against children. The country must provide this documentation to the WHO Regional Office (RO) and Headquarters (HQ) for evaluation.</p> <p>A range of different policies and legislation can be submitted, with different criteria, and this will vary across Member States included in the biennium targets</p> <p>The following criteria apply to determine alignment with WHO guidance:</p> <ul style="list-style-type: none"> <li>• <b>National Action Plans</b> should include <ul style="list-style-type: none"> <li>○ at least one evidence-based strategy from the INSPIRE technical package</li> <li>○ Specified roles for each stakeholders</li> <li>○ A timeline and costed</li> <li>○ Define measurable targets for reducing or responding to violence against children</li> </ul> </li> <li>• <b>Standard operating procedures for caring for VAC victims</b> should: <ul style="list-style-type: none"> <li>○ align with the LIVES CC approach and basic principles in working with children and adolescents exposed to violence,</li> <li>○ include recognition of signs and symptoms</li> <li>○ cover referral to services</li> </ul> </li> <li>• <b>Corporal punishment legislation</b> should clearly prohibit physical punishment in all settings, including in the home, alternative care settings, day care, schools, penal institutions and as a sentence for crime.</li> </ul>
13	Numerator	Number of countries adopting or reforming legislation or policy, aligned with WHO packages and enabled by WHO support.
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> Written evidence of new or updated legislation, policy, standard operating procedures (SOPs) or a national action plan that is aligned with evidence-based practice</p> <p><b>Partially achieved:</b> Legislation, policies, SOPs, national action plans, or national action plan are not fully aligned with evidence-based practice or are still in development</p> <p><b>Not achieved:</b> The country has not submitted any new or updated legislation, policy, SOP, or national action plan related to the prevention and response to violence against children for review. There is no evidence of development, drafting, or revision of such documents, and no indication of engagement with WHO technical support in this area</p>
17	Rationale	This indicator is important to monitor countries' progress towards the SDGs and WHO's own work aimed at ending violence against children, including

		the monitoring of government pledges made at the Ministerial conference on ending violence against children.
18	Measurement method	<ul style="list-style-type: none"> <li>Data collected through the Prevention of Violence (PVL) Regional Focal Point (RFP) network.</li> <li>Countries submit written evidence of policy/legislation to Regional Offices (RO) and Headquarters (HQ)</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The total number of countries that meet the criteria is counted.
21	Calculation type	Cumulative
22	Target setting methodology	<ol style="list-style-type: none"> <li>Some Member States have requested support in developing and/or implementing particular policies or legislation.</li> <li>Follow-up on country pledges made at the Ministerial conference on ending violence against children, November 2024.</li> </ol>
23	How target is realistic for PB2026-2027	The adoption and/or reform of policies and legislation are lengthy processes and given current funding crisis, achievement of the targets by 2026-2027 will be challenging. Political will, regional engagement, and sufficient human resources in RO's and HQ will be critical for the achievement of the targets.
24	Data sources	Written submissions of policies, legislation, or SOPs by Member States through the PVL RFP network.
25	Process of validation	Legislation, policies, SOPs or national action plans, will be evaluated at regional and HQ levels to assess consistency with existing WHO evidence-based technical packages, frameworks, guidelines and/or handbooks.
26	Limitations	1-2 years may be insufficient to see change in the indicator. Funding crisis makes any progress on the indicators very difficult at the country level and in terms of the support that regional offices can offer
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Stephanie Burrows <burrowss@who.int>

### 2.2.1.IND4\_UID 1329: Number of countries that have made a legislative or policy change to improve road safety, enabled by WHO technical support

#	Metadata field	Summary
1	GPW14 Output	2.2.1.WHO develops norms, standards and technical packages to address risk factors for communicable and noncommunicable diseases, violence and injuries, prevent poor nutrition and strengthen food safety and reduce environmental health risks, and supports countries in their implementation, including in the monitoring and development of legislation and regulations
2	GPW14 Output indicator code	2.2.1.IND4
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have made a legislative or policy change to improve road safety, enabled by WHO technical support

4	Output/Leading Indicator (Country Level Formulation)	Adoption of legislative or policy changes to improve road safety and achieve best practice (defined according to the criteria laid out in the Global status report on road safety)
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Death rate due to road traffic injuries (D); Prevalence of insufficient physical activity a) in adolescents (aged 11-17) b) in adults (aged 18-65) (I); Index of national climate change and health capacity (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	Tracks the number of countries that, with WHO support, adopt legislative or policy changes to improve road safety based on best practice standards from the Global Status Report on Road Safety.
12	Criteria	<p>A country is counted under this indicator if it:</p> <ul style="list-style-type: none"> <li>• Is targeted for WHO technical support in road safety</li> <li>• Makes legislative or policy changes aligned with domains in the <a href="#">Global Status Report on Road Safety (2023)</a>.</li> </ul> <p>Below are the WHO best practice criteria for legislation on the five key risk factors :</p> <ul style="list-style-type: none"> <li>○ Speeding: National law exists, urban limits are set at 50 km/h or lower, and local authorities can further modify this limit</li> <li>○ Drink driving: National law exists, alcohol levels are defined by BAC, alcohol limits per general driving population are <math>\leq 0.05</math> g/dl and for novice drivers <math>\leq 0.02</math> g/dl</li> <li>○ Motorcycle helmet use: National law exists, and it covers all riders, on all road types, and all engine types, and the helmet must be fastened and meet a standard</li> <li>○ Seat-belt use: National law exists, and it applies to all seating positions in vehicles</li> <li>○ Child restraint system use: National law exists, children up to the age of 10 years, or 135 cm in height, must use a child restraint system meeting a standard in addition to the prohibition of children of a particular age/height being prohibited from sitting in the front seats</li> </ul>
13	Numerator	Number of countries that meet the defined criteria for policy or legislative change in road safety
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if	<b>Achieved:</b> countries identified for WHO technical support make legislative changes that put them in the top category (ie, they meet best practice) on one

	benchmarking is applied)	<p>or more of the domains identified in the global status report. They fully meet the criteria as outlined in Field 12.</p> <p><b>Partially achieved:</b> the countries targeted for WHO technical support make changes to legislation or policy across the domains outlined in the global status report but do not achieve the level of best practice.</p> <p><b>Not achieved:</b> The countries identified for WHO technical support in this area do not make any legislative or policy change on the criteria specified in the global status report.</p>
17	Rationale	This indicator is important for the successful implementation of GPW14 and is directly linked with the outcome indicator on road safety (SDG 3.6) for which WHO is the custodian agency. It also contributes to the achievement of the global outcomes on physical activity improvements and on reducing the impact of climate change.
18	Measurement method	<ul style="list-style-type: none"> <li>• Data are collected through the violence and injury technical network of regional focal points already in operation.</li> <li>• While the global status report is not done annually, annual monitoring of legislative improvements will be done for countries receiving WHO support</li> <li>• To ensure comparability over time, it is important to clarify how consistency in measurement will be maintained across reporting cycles. For this indicator, consistency is expected to be straightforward, as the referenced legislative standards are well-established and do not evolve frequently. As such, the same criteria can be applied from one year to another, allowing for reliable year-on-year comparison</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	Total number of countries meeting the defined criteria will be counted and reported globally.
21	Calculation type	Cumulative
22	Target setting methodology	<ul style="list-style-type: none"> <li>• Targeted countries are those with current engagement with WHO in making improvements to road safety legislation, these are countries that have reached out to WHO to seek guidance and support to making improvements in legislation.</li> <li>• It also included countries where there are active initiatives/projects being implemented to improve road safety legislation.</li> </ul>
23	How target is realistic for PB2026-2027	The countries included in the targets are those that have committed to implementing changes and those where there are currently resources available to implement changes.
24	Data sources	WHO technical teams; Documentation from Ministries of Health and Transport; <a href="#">Global Status Report on Road Safety (2023)</a>
25	Process of validation	Data is provided directly by WHO Technical teams, supported by documentation from the Ministries (of health, transport)
26	Limitations	Legislative and policy changes are very time-consuming, so the ability to see change quickly is likely to be limited. The ability of HQ, RO and CO to provide support to countries towards change will also be limited by the current funding situation.



27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Nhan Tran < trann@who.int>

**2.2.1.IND5\_UID 1382: Number of countries that have adopted technical support packages and guidance to tackle alcohol population-based policy measures, in line with WHO policies and resolutions**

#	Metadata field	Summary
1	GPW14 Output	2.2.1. WHO develops norms, standards and technical packages to address risk factors for communicable and noncommunicable diseases, violence and injuries, prevent poor nutrition and strengthen food safety and reduce environmental health risks, and supports countries in their implementation, including in the monitoring and development of legislation and regulations
2	GPW14 Output indicator code	2.2.1.IND5
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have adopted population-based policy measures to tackle alcohol consumption, in line with WHO policies and resolutions
4	Output/Leading Indicator (Country Level Formulation)	New or revised alcohol policy measures adopted and adapted to national and subnational context.
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	Tracks the number of countries that have adopted new or updated alcohol technical packages, policies, or evidence based population interventions aligned with WHO-recommended measures to reduce the acceptability, availability, and affordability of alcohol
12	Criteria	A country is counted under this indicator if it has new or revised alcohol policy measures (e.g. policy, laws, regulations, decree, technical standards) in line with WHO SAFER package interventions
13	Numerator	Number of countries adopting new or updating technical interventions, policy and evidence-based population interventions, technical standards, etc.

14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets the criteria as outlined in Field 12. It has formally adopted a new or revised alcohol control, policy, law or regulatory measure, resolution, technical standard aligned with at least one WHO SAFER intervention.</p> <p><b>Partially achieved:</b> The country has submitted, drafted, or approved (but not yet adopted) a new or revised alcohol control measure aligned with a WHO SAFER intervention. This includes official proposals under review or in advanced process.</p> <p><b>Not achieved:</b> The country has no draft, no submission, and no recent policy measure towards the adoption of WHO SAFER-aligned measures.</p>
17	Rationale	The indicator captures how alcohol technical packages, guidelines, policy and evidence briefs are implemented by countries to restrict alcoholic beverage acceptability, availability and affordability
18	Measurement method	Data is collected from direct country support, mandatory survey, observatory of the unit on 3 high-impact policies (so called dashboard).
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the criteria
21	Calculation type	Cumulative
22	Target setting methodology	This reflects the expression of interest from country officials during intercountry learning opportunities offered during 2023 and 2025.
23	How target is realistic for PB2026-2027	<ul style="list-style-type: none"> <li>Political commitment to apply population- and evidence-based interventions to prevent alcohol consumption, particularly among young people.</li> <li>Country understanding of the long-term demographic and health benefits (“generational dividend”) of reducing alcohol consumption implied.</li> </ul>
24	Data sources	Newly issued national policies, laws, regulations, standards, local resolutions, WHO regional and country office reports
25	Process of validation	Data are validated using official documentation such as newly issued policies, laws, and regulations
26	Limitations	<ul style="list-style-type: none"> <li>In high-income countries (HICs), data sources may be fragmented</li> <li>In low- and middle-income countries (LMICs), validation may rely on partners and other initiatives to cross-check information</li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Juan Tello < telloj@who.int>

**2.2.1.IND6\_UID 1383: Number of countries with at least one of the following policies – national policy on physical activity; national policy on walking and cycling; national physical activity guidelines; national physical activity communications campaign; brief interventions on physical activity in primary healthcare–enabled by WHO technical support**

#	Metadata field	Summary
1	GPW14 Output	2.2.1. WHO develops norms, standards and technical packages to address risk factors for communicable and noncommunicable diseases, violence and injuries, prevent poor nutrition and strengthen food safety and reduce environmental health risks, and supports countries in their implementation, including in the monitoring and development of legislation and regulations
2	GPW14 Output indicator code	2.2.1.IND6
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries with at least one of the following policies – national policy on physical activity; national policy on walking and cycling; national physical activity guidelines; national physical activity communications campaign; brief interventions on physical activity in primary healthcare–enabled by WHO technical support
4	Output/Leading Indicator (Country Level Formulation)	Adoption of at least one of the following policies: national policy on physical activity, national policy on walking and cycling; national physical activity guidelines; national physical activity communications campaign; brief interventions on physical activity in primary health care, enabled by WHO technical support
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Prevalence of insufficient physical activity (a) in adolescents (aged 11–17) (b) in adults (aged 18–65) (D); Prevalence of obesity among children and adolescents (aged 5–19 years) (%) (I); Prevalence of obesity among adults aged ≥18 years (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator counts how many countries have implemented at least one of five key physical activity-related policies, enabled by WHO technical support
12	Criteria	Country is considered under this indicator: <ul style="list-style-type: none"> <li>• If it has at least one of the following in place: <ul style="list-style-type: none"> <li>○ a national policy on physical activity</li> <li>○ a national policy on walking and cycling</li> <li>○ national physical activity guidelines</li> <li>○ a national physical activity communications campaign</li> <li>○ brief interventions on physical activity in primary healthcare</li> </ul> </li> </ul>

		<ul style="list-style-type: none"> <li>• Policies must have been enabled by WHO technical support <ul style="list-style-type: none"> <li>○ WHO provides technical support through HQ, regional, and country offices. This includes: <ul style="list-style-type: none"> <li>▪ Use of a Situational Analysis tool to guide the development of national physical activity (PA) policy</li> <li>▪ Sharing of WHO PA guidelines for adoption and adaptation</li> <li>▪ Guidance on the development of effective communication campaigns</li> <li>▪ Dissemination and support to implement for specific WHO toolkits on walking and cycling and brief interventions in PHC</li> </ul> </li> <li>○ Countries are requested to submit documentation or links to verify implementation, and these are checked during data validation.</li> </ul> </li> </ul>
13	Numerator	Number of countries with at least one relevant policy enabled by WHO support
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets the criteria as outlined in Field 12. It has formally adopted at least one of the five listed policies or interventions, with evidence of WHO support</p> <p><b>Partially achieved:</b> The country has drafted or approved (but not yet adopted) at least one of the policies, or has submitted formal documentation under review, with WHO support involved.</p> <p><b>Not achieved:</b> The country has no draft, no submission, and no recent activity toward adopting any of the five policy areas</p>
17	Rationale	Indicator directly measures the impact of WHO technical support to countries to advance key policies recommended to promote and enable increased physical activity, thereby contributing to achievement of the agreed voluntary global target of a 15% relative reduction in prevalence of physical inactivity in adolescents and adults by 2030 (WHA71.6 WHO's global action plan on physical activity 2018–2030).
18	Measurement method	<ul style="list-style-type: none"> <li>• Data collected through the WHO NCD Country Capacity Survey</li> <li>• Covers each of the five policy areas</li> <li>• Conducted every two years since 2013</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	Total number of countries meeting the defined criteria will be counted and reported globally.
21	Calculation type	Cumulative
22	Target setting methodology	A detailed analysis of country data as presented in the 1st Global Status Report on Physical Activity (2022) clearly identified implementation gaps. We identified the key policy areas which can be led by or strongly supported by MoH, with coordination across other government areas, as needed. These

		identified key policies and gaps in implementation include policy recommendation such as Tackling NCDs: best buys and other recommended interventions for the prevention and control of noncommunicable diseases (2024), (namely, public communications campaigns on physical activity and brief intervention on physical activity delivered through primary care services), as well as key cornerstone policies as recommended by Global action plan on physical activity 2018-2030 such as: national physical activity policy, national policy on walking and cycling and national physical activity guidelines as these anchor national approaches to reducing physical inactivity and achieving the 2030 target.
23	How target is realistic for PB2026-2027	WHO have developed a series of policy implementation guidance tools to support MS in the development and implementation of these policy areas. Achievement of targets will however rely on continuing technical support and capacity building initiatives delivered by three levels of WHO, as required. Tracking progress will require ongoing implementation of the bi-annual NCD country capacity survey and data verification processes which are supported by RO and HQ technical unit on physical activity.
24	Data sources	WHO NCD Country Capacity Survey
25	Process of validation	All responses to the WHO NCD Country Capacity Survey are validated at the country and regional office level. Member States are also requested to submit documents or links to provide evidence to support responses. Links are checked and final response verified. Discrepancies are followed up until resolved
26	Limitations	Reporting requires the continuation of the WHO NCD Country capacity survey at regular interval and adequate resources to support response validation.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Fiona BULL < bullf@who.int>; Juana Willumsen < willumsenj@who.int>

**2.2.2. WHO supports countries to ensure comprehensive access to promotion and preventive health services to populations (such as tobacco and alcohol cessation services, physical activity counselling and nutrition counselling, including for breastfeeding), and to monitor their implementation**

**2.2.2.IND1\_UID 776: Number of countries reviewing or implementing new population-based alcohol policy measures, in line with WHO resolutions**

#	Metadata field	Summary
1	GPW14 Output	2.2.2. WHO supports countries to ensure comprehensive access to promotion and preventive health services to populations (such as tobacco and alcohol cessation services, physical activity counselling and nutrition counselling, including for breastfeeding),and to monitor their implementation
2	GPW14 Output indicator code	2.2.2.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries reviewing or implementing new population-based alcohol policy measures, in line with WHO resolutions
4	Output/Leading Indicator (Country Level Formulation)	Implementation of new or revised population-based alcohol policy measures in line with WHO resolutions
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	Tracks the number of countries that have newly implemented or revised population-wide alcohol control policies in line with WHO recommendations and resolutions.
12	Criteria	<p>A country is counted under this indicator</p> <ul style="list-style-type: none"> <li>if it has revised or implemented a new policy, law, resolution or standard for alcohol control</li> </ul> <p>The policy, laws and standards must address at least one high-impact area defined in the WHO SAFER initiative:</p> <ol style="list-style-type: none"> <li>Strengthen restrictions on alcohol availability.</li> <li>Advance and enforce drink driving countermeasures.</li> </ol>

		3. Facilitate access to screening, brief interventions, and treatment. 4. Enforce bans or comprehensive restrictions on alcohol advertising, sponsorship, and promotion. 5. Raise prices on alcohol through excise taxes and pricing policies. 6. Labelling including health warnings to inform consumers.
13	Numerator	Number of countries adopting a new or revised at least one high-impact policy measures
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets the criteria as outlined in Field 12. It has formally adopted a new or revised alcohol control policy, law, regulation or standard aligned with at least one WHO SAFER intervention. Adoption must be documented through official government records</p> <p><b>Partially achieved:</b> The country has made significant progress toward adoption, such as having a draft measure submitted, approved, or under advanced review process. The proposed measure must be aligned with at least one SAFER intervention.</p> <p><b>Not achieved:</b> The country has not initiated any formal process toward adopting or revising alcohol control policies aligned with WHO SAFER interventions. No draft, submission, or recent legislative or policy or standard activity is reported.</p>
17	Rationale	The indicator captures the high-impact interventions (alcohol policy measures) that countries adopt and adapt to restrict alcoholic beverage acceptability, availability and affordability with a cross-sectoral approach by strengthening their governance
18	Measurement method	Data is collected from direct country support, mandatory survey, observatory of the unit on 3 high-impact policies (so called dashboard).
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the criteria
21	Calculation type	Cumulative
22	Target setting methodology	Expression of interest of countries in the priority areas of high-impact interventions.
23	How target is realistic for PB2026-2027	<ul style="list-style-type: none"> <li>Political commitment in countries</li> <li>and available resources from donors' and WHO collaborating centres resources</li> </ul>
24	Data sources	Country submissions; Mandatory WHO survey; WHO observatory dashboard
25	Process of validation	<ul style="list-style-type: none"> <li>Submitted policies are validated through review of legal texts and implementation evidence</li> <li>Cross-checked with other sources in LMICs if necessary</li> </ul>
26	Limitations	<ul style="list-style-type: none"> <li>In High-Income Countries (HICs) the sources may be fragmented</li> <li>In Low- and Middle-Income Countries (LMICs), WHO may rely on partners and other initiatives to validate and cross check information</li> </ul>

27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Juan TELLO <telloy@who.int>

**2.2.2.IND2\_UID 1386: Number of countries that have strengthened cessation services (i.e. O from MPOWER), enabled by WHO efforts**

#	Metadata field	Summary
1	GPW14 Output	2.2.2. WHO supports countries to ensure comprehensive access to promotion and preventive health services to populations (such as tobacco and alcohol cessation services, physical activity counselling and nutrition counselling, including for breastfeeding), and to monitor their implementation
2	GPW14 Output indicator code	2.2.2.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have strengthened cessation services (i.e. O from MPOWER), enabled by WHO efforts
4	Output/Leading Indicator (Country Level Formulation)	Country has strengthened cessation services (i.e. O from MPOWER), enabled by WHO efforts
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Age-standardized prevalence of current tobacco use among persons aged 15 years and older (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	Number of countries that have reached best-practice level for the “O” (Offer help to quit tobacco use) measure in the MPOWER package, due to WHO’s support.
12	Criteria	<p>A country is considered under this indicator if it has achieved “best-practice” level for the “O” measure in MPOWER, based on the criteria defined in the WHO Report on the Global Tobacco Epidemic:</p> <ul style="list-style-type: none"> <li>The WHO Report on the Global Tobacco Epidemic monitors the adoption of the MPOWER technical package of tobacco control measures and has applied defined criteria to each measure to assess a country’s accomplishment.</li> </ul>



		<p>These criteria categorize each country into one of 5 groups for each measure including O.</p> <p>The highest level of achievement (group 5) is considered ‘best-practice’ for that measure. O represents one of these measures and a country can be considered to have “strengthened” cessation or O policy if they have attained the O measures at best-practice level.</p> <ul style="list-style-type: none"> <li>• In addition, the technical team applies benchmarking to assess progress toward full achievement, based on incremental improvements in the MPOWER categorization</li> <li>• WHO’s contribution is considered verified if: <ul style="list-style-type: none"> <li>○ The country is one of the 34 countries currently supported under the Bloomberg Philanthropies Partnership or the Bill and Melinda Gates Initiative, where TFI has longstanding engagements: OR</li> <li>○ The country has requested support from WHO (at HQ, Regional, or Country Office level), and WHO has been able to engage and respond to these requests</li> </ul> </li> </ul>
13	Numerator	Number of countries that have achieved “best-practice” level in cessation services (“O” of MPOWER) with WHO’s support
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets the criteria as outlined in Field 12. It has achieved “best-practice” level in cessation services (“O” of MPOWER) with WHO support</p> <p><b>Partially achieved:</b> The country has moved up at least one group in cessation services (“O” of MPOWER) as described in Field 12 with WHO support.</p> <p><b>Not achieved:</b> The country has no change in the level of achievement in cessation services (“O” of MPOWER) as described in Field 12 with WHO support.</p>
17	Rationale	This indicator is important because it demonstrates the progress made to help people to quit tobacco use, one of the key measures of the MPOWER technical package and of the WHO Framework Convention on Tobacco Control. This indicator helps to assess progress towards SDG3a and the NCD Global Action Plan. This indicator reflects WHO’s added value because WHO supports countries strengthening cessation services and provides normative guidance on clinical standards.
18	Measurement method	The data is collected through the data collection mechanism of the WHO Report on the Global Tobacco Epidemic and uses the country reports prepared by the Convention Secretariat of the Framework. For full details please see the <a href="#">Technical Notes</a> of the report.
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the criteria (i.e. “best-practice” level for “O”).
21	Calculation type	Cumulative

22	Target setting methodology	The targets are based upon ongoing collaborations with Bloomberg Philanthropies in large high burden countries, Bill and Melinda Gates Foundation in the AFR regions and requests received for country technical support.
23	How target is realistic for PB2026-2027	<ul style="list-style-type: none"> <li>The following countries are currently receiving WHO support under these efforts (as of 2 May 2025) <i>Bangladesh, Botswana, Burkina Faso, Cambodia, Cameroon, Chad, China, Côte d'Ivoire, Democratic Republic of the Congo, Ethiopia, Gabon, Gambia, Ghana, India, Indonesia, Israel, Kenya, Lao People's Democratic Republic, Liberia, Malaysia, Maldives, Mauritania, Mexico, Montenegro, Namibia, Nepal, Nigeria, Pakistan, Papua New Guinea, Philippines, Rwanda, Senegal, Sierra Leone, South Africa, Thailand, Uganda, Ukraine, Viet Nam, Zambia</i></li> <li>However, it is acknowledged that progress is unpredictable, and not all countries are expected to reach best-practice level. The team anticipates that at least two countries in each region achieve positive policy shifts in O such that they move up a group as described in Question 1 (i.e. a total of 12 countries improves every year). Realistically we expect <b>1 to 2 countries</b> from this target list to achieve O measures at best-practice level.</li> <li>Funding is available for all countries prioritized by the collaborations established with the Bloomberg Philanthropies and Bill and Melinda Gates Foundation. These prioritizations are based upon burden and alignment with broader public health strategies. This donor funding covers a total of 34 countries.</li> <li>Along with Regional colleagues, the No Tobacco Unit (TFI) regularly provide technical guidance and specialized technical assistance to respond to and address country technical support requests based on WHO clinical treatment guideline for tobacco cessation and other tobacco cessation policy recommendations. TFI also works to engage with governments and partners including Bloomberg Initiative partners to identify opportunities where countries can be encouraged or assisted to strengthen their tobacco cessation services</li> </ul>
24	Data sources	The WHO Report on the Global Tobacco Epidemic; Country reports submitted to the Convention Secretariat
25	Process of validation	The data is validated through the country office and when all assessments are made according to best-practice criteria the analyses are countries are consulted for their review and sign-off prior to publication.
26	Limitations	<ul style="list-style-type: none"> <li>Due to the effort and resources required to monitor the MPOWER technical package the data is compiled and published every two years making it difficult to disaggregate progress annually.</li> <li>Burden due to data collection on countries is minimal because data is shared with the Convention Secretariat and countries are only asked to sign-off on the assessment (surveys are not implemented)</li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025

29	Technical focal point	Hebe Gouda <goudah@who.int> ; Vinayak Prasad < <a href="mailto:prasadvi@who.int">prasadvi@who.int</a> >; Dongbo Fu <fud@who.int>
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**2.2.2.IND3\_UID 1387: Number of countries with established multisectoral collaboration and communication mechanism for food safety events (SPAR score at least 4)**

#	Metadata field	Summary
1	GPW14 Output	2.2.2. WHO supports countries to ensure comprehensive access to promotion and preventive health services to populations (such as tobacco and alcohol cessation services, physical activity counselling and nutrition counselling, including for breastfeeding),and to monitor their implementation
2	GPW14 Output indicator code	2.2.2.IND3
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries with established multisectoral collaboration and communication mechanism for food safety events (SPAR score at least 4)
4	Output/Leading Indicator (Country Level Formulation)	Established multisectoral collaboration and communication mechanism for food safety events (SPAR score at least 4)
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Proportion of people who have suffered a foodborne diarrhoeal episode of non-typhoidal salmonellosis (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	Tracks the number of countries that have established multisectoral collaboration and communication mechanisms for food safety events, as indicated by achieving a SPAR score of 4 or above.
12	Criteria	<p>A country will be counted under this indicator if it achieves <b>a score of at least 4</b> in the food safety capacity indicator as assessed through the SPAR tool. The following apply:</p> <ul style="list-style-type: none"> <li>Countries are requested to use the latest version of WHO's States Parties Self-Assessment Annual Reporting (SPAR) tool, currently <a href="#">the 2nd edition, published in 2021</a>.</li> </ul> <p>The criteria required to achieve level 4 are specified in the tool, along with detailed definitions of key terms in the footnotes, which ensure consistency across countries.</p>

		<ul style="list-style-type: none"> <li>Validation of the self-assessed score may be supported by additional mechanisms such as After Action Reviews (AAR), Simulation Exercises (SimEx), and Voluntary External Evaluations (JEE), although these are voluntary.</li> </ul>
13	Numerator	Number of countries with a SPAR score $\geq 4$ for food safety multisectoral mechanisms
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets the criteria as outlined in Field 12, by having an established multisectoral collaboration and communication mechanism for food safety and scoring 4 or above in the relevant section of the SPAR tool (2nd edition).</p> <p><b>Partially achieved:</b> The country reports progress toward establishing a multisectoral mechanism for food safety but has not yet reached a SPAR score of 4; it may be at level 2 or 3 based on the latest self-assessment.</p> <p><b>Not achieved:</b> The country has not reported having a multisectoral collaboration and communication mechanism for food safety or scores below level 2 in the SPAR tool.</p>
17	Rationale	<p>The proposed indicator is being measured annually for all WHO Member States through the IHR (2005) Monitoring and Evaluation Framework's State Parties self-assessment Annual Reporting (SPAR) tool 2nd edition. This is one of the defined expected outputs under the Global Strategy for Food Safety 2022-2030 leading towards the reduction of foodborne disease burden including foodborne diarrhoeal diseases which linked to GPW14 outcome indicator: Proportion of people who have suffered a foodborne diarrheal episode of non-typhoidal salmonellosis).</p> <p>To support countries in achieving the required capacities, WHO plays a systematic role through its co-hosting of the FAO/WHO International Food Safety Authorities Network (INFOSAN). INFOSAN Emergency Contact Points are key to establishing multisectoral coordination mechanisms at the national level. WHO contributes to strengthening these mechanisms by providing technical assistance and capacity-building. This work is supported by World Health Assembly Resolution WHA73.5, which recognizes national INFOSAN capacities as essential for building robust food safety systems and achieving the capacities assessed through the SPAR tool.</p>
18	Measurement method	Data is annually collected and reported to the World Health Assembly as part of the IHR (2005) Monitoring and Evaluation Framework, especially through the <a href="#">IHR (2005) States Parties self-assessment annual reporting tool, 2nd edition</a> .
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria (SPAR score $\geq 4$ )
21	Calculation type	Cumulative

22	Target methodology setting	Under the current Global Strategy for Food Safety (2022–2030), the goal is for 100% of countries to reach at least 80% capacity in establishing a multisectoral collaboration mechanism by 2030. Interim targets for 2026 and 2027 were set by identifying the gap between the current status and the 2030 goal, and by estimating a realistic progression over time. This approach provides a stepwise path toward full global coverage while aligning with WHO’s strategic direction and capacity-building mandate.
23	How target is realistic for PB2026-2027	We have strong enabling instruments and mandates that make this target realistically achievable. These include the Global Strategy for Food Safety, which sets a specific global target for this indicator; WHO’s core capacity-building activities, as mandated by the World Health Assembly (WHA) resolution; and the Regional Strategy in the AFRO, which defines targets aligned with the global vision. Furthermore, the co-hosting of INFOSAN by WHO and FAO, an essential counterpart for engaging the agriculture sector, further strengthens the initiative by enhancing multisectoral collaboration. That said, achieving these goals requires sustainable and predictable funding as a critical enabling condition.
24	Data sources	<a href="#">IHR (2005) SPAR Tool (2nd edition)</a> ; <a href="#">WHO Global Strategy for Food Safety 2022–2030</a>
25	Process of validation	Under the IHR (2005) Monitoring and Evaluation Framework, there are three other methods to validate the functionalities of the capacity measured under the SPAR, namely: After action reviews (AAR), Simulation exercises (SimEx), and Voluntary External Evaluations (JEE). Although these are voluntary, validation can be assessed using the results from these mechanisms.
26	Limitations	Data is based on self-reporting by countries, which may affect objectivity and consistency
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Yuki Minato < <a href="mailto:minatoy@who.int">minatoy@who.int</a> >; Elaine Borghi < <a href="mailto:borghie@who.int">borghie@who.int</a> >;

### **2.2.2.IND4\_UID1388: Number of countries having adopted a policy package to achieve all targets included in the comprehensive implementation plan on maternal, infant and young child nutrition, enabled by WHO efforts**

#	Metadata field	Summary
1	GPW14 Output	2.2.2. WHO supports countries to ensure comprehensive access to promotion and preventive health services to populations (such as tobacco and alcohol cessation services, physical activity counselling and nutrition counselling, including for breastfeeding), and to monitor their implementation
2	GPW14 Output indicator code	2.2.2.IND4
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries having adopted a policy package to achieve all targets included in the comprehensive implementation plan on maternal, infant and young child nutrition, enabled by WHO efforts

4	Output/Leading Indicator (Country Level Formulation)	Adoption of national policy package to achieve all targets included in the Comprehensive implementation plan on maternal, infant and young child nutrition, enabled by WHO efforts
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Prevalence of anaemia in women aged 15 to 49 years, by pregnancy status (D); Prevalence of wasting in children under 5 years of age (D); Prevalence of stunting in children under 5 years of age (D); Exclusive breastfeeding under six months (D); Prevalence of overweight (weight for height more than +2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age (D); Prevalence of obesity among children and adolescents (aged 5–19 years) (%) (I); Prevalence of obesity among adults aged ≥18 years (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	The indicator tracks whether countries have adopted national policy packages that align with the Global Nutrition Targets for maternal, infant, and young child nutrition, based on WHO-supported efforts and monitored through the WHO Global database on the Implementation of Food and Nutrition Action (GIFNA).
12	Criteria	<p>A country is counted under this indicator if it has adopted national policy targets that align with the Global Nutrition Targets, as monitored through the <a href="#">WHO Global database on the Implementation of Food and Nutrition Action (GIFNA)</a>. These policy targets must be relevant to the country context, based on public health significance thresholds defined by WHO.</p> <p>Specifically, a country is considered to have adopted a relevant policy package if:</p> <ul style="list-style-type: none"> <li>• It has included a target for exclusive breastfeeding, which is applicable to all countries regardless of prevalence.</li> <li>• It has also included targets for one or more of the following conditions if the national prevalence exceeds recognized levels for public health significance: Stunting&gt;20%; Anaemia&gt;20%; Low birth weight &gt;15%; Child overweight&gt;10%; Wasting&gt;5%</li> </ul> <p>WHO's contribution is inherent, as it leads the global nutrition target setting, monitoring, and advocacy.</p>
13	Numerator	Number of countries that have adopted policy packages aligned with the Global Nutrition Targets.
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes

16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets the criteria as outlined in Field 12, having adopted a national policy package that includes all relevant Global Nutrition Targets based on its national context and public health thresholds, with evidence of alignment to WHO guidance.</p> <p><b>Partially achieved:</b> The country has adopted a policy package that includes some, but not all, of the relevant Global Nutrition Targets as required by its national context, or the targets are not fully aligned with WHO guidance.</p> <p><b>Not achieved:</b> The country has not adopted any relevant policy package aligned with the Global Nutrition Targets, or existing policies do not meet the relevance criteria defined by national prevalence thresholds.</p>
17	Rationale	This indicator consolidates data collection on country policy progress related to the Global Nutrition Targets for maternal, infant and young child nutrition, addressing all forms of malnutrition. WHO is mandated to support countries in reaching the Global Nutrition Targets adopted by the WHA, as described in the Comprehensive Implementation Plan on maternal infant and young child nutrition, and through issuing guidelines, defining best-practice and developing technical packages in these areas.
18	Measurement method	Policy progress data are collected through the WHO Global database on the Implementation of Food and Nutrition Action (GIFNA), which used a variety of WHO policy surveys and collection via the WHO network, as well as partners' databases in relevant technical areas.
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria
21	Calculation type	Cumulative
22	Target setting methodology	<p>Targets were set based on expected progress in countries engaged in WHO flagship initiatives such as:</p> <ul style="list-style-type: none"> <li>• <a href="#">WHO Accelerating anaemia reduction</a></li> <li>• <a href="#">WHO Acceleration plan to stop obesity</a></li> <li>• <a href="#">WHO Global Breastfeeding Collective</a></li> <li>• <a href="#">WHO Global action plan on child wasting</a></li> </ul>
23	How target is realistic for PB2026-2027	<ul style="list-style-type: none"> <li>• The Global Nutrition Targets are high priority areas for WHO Member States, they are part of the WHO flagship initiatives mentioned</li> <li>• Many countries reconfirmed their commitments at the recent <a href="#">Nutrition for Growth (N4G) Conference in March 2025</a></li> </ul>
24	Data sources	<a href="#">WHO Global database on the Implementation of Food and Nutrition Action (GIFNA)</a> ; <a href="#">Nutrition data platform</a> ; WHO policy surveys and network inputs; Partner databases in nutrition-related technical areas
25	Process of validation	Data are checked for accuracy, consistency and reliability against national policy document and review and assessment by WHO technical programme.
26	Limitations	Challenges may include obtaining the recent policy documents from countries. The current system mitigates this challenge through utilization of a variety of data sources.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025



29	Technical focal point	Kaia Engesveen < engesveenk@who.int>
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**2.2.2.IND5\_UID 1502: Number of countries implementing national policies to eliminate trans-fatty acids from the food supply and reduce sodium and sugars consumption, in alignment with WHO guidelines, best-practice and technical packages**

#	Metadata field	Summary
1	GPW14 Output	2.2.2. WHO supports countries to ensure comprehensive access to promotion and preventive health services to populations (such as tobacco and alcohol cessation services, physical activity counselling and nutrition counselling, including for breastfeeding), and to monitor their implementation
2	GPW14 Output indicator code	2.2.2.IND5
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries implementing national policies to eliminate trans-fatty acids from the food supply and reduce sodium and sugars consumption, in alignment with WHO guidelines, best-practice and technical packages
4	Output/Leading Indicator (Country Level Formulation)	Implementation of national policies to eliminate trans-fatty acids from the food supply and reduce sodium and sugars consumption in alignment with WHO guidelines, best-practice and technical packages
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Proportion of population aged 15+ with healthy dietary pattern (D); Prevalence of raised blood pressure in adults aged ≥18 years (D); Prevalence of obesity among children and adolescents (aged 5–19 years) (%) (D); Prevalence of obesity among adults aged ≥18 years (D); Prevalence of overweight in children under 5 years of age (D); Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks the number of countries that have implemented national policies for eliminating trans-fatty acids, and for reducing sodium and sugars consumption, based on WHO-recommended best practices and technical packages.
12	Criteria	A country is counted under this indicator if it implements: <ul style="list-style-type: none"> <li>• A best-practice trans-fatty acids TFA policy (Score 4 in the <a href="#">TFA Country Score Card</a>)</li> <li>• At least one mandatory sodium reduction policy and mandatory declaration of sodium content (Score 3 in the <a href="#">Sodium Country Score Card</a>)</li> </ul>



		<ul style="list-style-type: none"> <li>At least one mandatory sugars reduction policy and mandatory declaration of sugars content (Score 3 in the <a href="#">Sugars Country Score Card</a>)</li> </ul> <p>The details of the scoring are described on the respective score cards.</p>
13	Numerator	Number of countries meeting the criteria listed in Field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets all three criteria as outlined in Field 12, including having: a best-practice TFA policy (Score 4), at least one mandatory sodium reduction policy with mandatory sodium labelling (Score 3), and at least one mandatory sugars reduction policy with mandatory sugars labelling (Score 3).</p> <p><b>Partially achieved:</b> The country meets one or two of the three criteria, indicating partial implementation of the recommended policies.</p> <p><b>Not achieved:</b> The country does not meet any of the three criteria, meaning none of the policy areas are fully implemented.</p>
17	Rationale	This indicator consolidates data collection on country policy progress in key healthy diet areas: elimination of trans-fatty acids (TFA) from the food supply and reduction of sodium and sugars consumption. Consolidation ensures focus on all three areas, avoiding siloed approaches and promoting comprehensive policies. At country level the three areas are often addressed together, for example in labeling and food procurement and service policies. WHO is the leading UN agency for healthy diets, issuing guidelines, defining best-practice and developing technical packages in these areas.
18	Measurement method	Policy progress data are collected through the WHO Global database on the Implementation of Food and Nutrition Action (GIFNA), which used a variety of WHO policy surveys and collection via the WHO network, as well as partners' databases in relevant technical areas.
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria
21	Calculation type	Cumulative
22	Target setting methodology	<p>Targets were set based on expected progress in countries engaged in WHO flagship initiatives such as:</p> <ul style="list-style-type: none"> <li><a href="#">WHO Acceleration plan to stop obesity</a></li> <li><a href="#">WHO REPLACE Trans fat-free</a></li> <li><a href="#">Global RECAP</a></li> </ul> <p>As well as ongoing technical assistance to countries in the areas of policies for healthier food and healthier food environments.</p>
23	How target is realistic for PB2026-2027	<ul style="list-style-type: none"> <li>Policies for healthier food and healthier food environments to eliminate trans fat and reduce sodium and sugars are high priority areas for WHO Member States, they are part of the flagship initiatives mentioned, as well as the WHO Best buys for healthy diets and NCD reduction.</li> </ul>

		<ul style="list-style-type: none"> <li>Many countries reconfirmed their commitments at the recent Nutrition for Growth (N4G) <a href="#">Conference in March 2025</a></li> </ul>
24	Data sources	<a href="#">WHO Global Database on the Implementation of Food and Nutrition Action (GIFNA)</a> ; Partner databases relevant to sodium, TFA, and sugars policies; Country-submitted policy documents
25	Process of validation	Data are checked for accuracy, consistency and reliability against national policy document and review and assessment by WHO technical programme.
26	Limitations	Challenges may include obtaining the recent policy documents from countries. The current system mitigates this challenge through utilization of a variety of data sources.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Kaia Engesveen <engesveenk@who.int>

### 2.3.1. WHO develops guidance and supports countries to strengthen their capacity to engage with and empower individuals and communities, and all levels of government across sectors to increase health literacy, enable healthier behaviours, advance co-benefits, and improve governance and implementation of settings-based approaches and health promotion policies

#### 2.3.1.IND1\_UID 804: Number of countries that have implemented a national or subnational healthy settings policy or programme aligned with WHO guidance, or with or through WHO technical support

#	Metadata field	Summary
1	GPW14 Output	2.3.1. WHO develops guidance and supports countries to strengthen their capacity to engage with and empower individuals and communities, and all levels of government across sectors to increase health literacy, enable healthier behaviours, advance co-benefits, and improve governance and implementation of settings-based approaches and health promotion policies
2	GPW14 Output indicator code	2.3.1.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have implemented a national or subnational healthy settings policy or programme aligned with WHO guidance, or with or through WHO technical support
4	Output/Leading Indicator (Country Level Formulation)	Implementation of national policies or programmes in at least one healthy setting category, aligned with WHO guidance or with WHO technical support
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Proportion of cities, municipalities and localities in regional Healthy City networks that are health-promoting (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	Tracks how many countries have implemented a national or subnational healthy settings policy or programme aligned with WHO guidance or with or through WHO technical support
12	Criteria	A country is included under this indicator if it has implemented a healthy settings policy or programme at the national or subnational level that is aligned with WHO guidance or has been developed with WHO technical support, and supported by a monitoring and evaluation framework.

		Settings may include cities, municipalities, communities, islands, villages, housing, schools, universities, markets, and workplaces.
13	Numerator	Number of countries that fully meet the criteria under Field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> Healthy setting policy or programme aligned with WHO guidance, institutionalized implementation at national or subnational levels, and has a monitoring and evaluation framework. Settings include cities, municipalities, communities, islands, villages, housing, schools, universities, markets and workplaces.</p> <p><b>Partially achieved:</b> Healthy setting policy or programme aligned with WHO guidance, implemented at national or subnational levels, with room for improvement with regard to institutionalization, monitoring and evaluation. Settings include cities, municipalities, communities, islands, villages, housing, schools, universities, markets and workplaces.</p> <p><b>Not achieved:</b> Activities applying the settings-based approach are implemented in an ad-hoc manner or is project-based, and there is no formal programme established by the national or subnational government.</p>
17	Rationale	<p>WHO seeks to promote health and well-being in the settings where people live, work and play through creating healthy and health-enabling environments. The Ottawa Charter outlines five key action areas, which are WHO's core mandate and which comprehensively addresses the determinants of health -- build healthy public policy, create supportive environments, strengthen community action, develop personal skills and reorient health services. WHO, with our knowledge of the social, economic, commercial and environmental determinants of health, our expertise in health literacy, community engagement, and in strengthening health services, is best placed to support countries to take action across these domains within key settings such as cities, islands, villages, schools, workplaces, markets, among others. <b>This indicator provides evidence of the extent a health lens is applied and institutionalized within the governance of macro- and micro-settings and whether implementation is localized or nation-wide.</b></p> <p>It is supported by various World Health Assembly and Regional Committee resolutions that endorse the healthy settings approach (e.g., WHA Decision A76(22), regional health promotion strategies in AFRO, PAHO, SEARO, and WPRO).</p>
18	Measurement method	Data is collected by WHO Country and Regional Offices. They assess whether implementation aligns with WHO guidance.
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria under field 12.
21	Calculation type	Cumulative

22	Target setting methodology	Target countries are set based on regional and/or country office's engagement, assessment of progress, whether the objective is in workplans and whom RO/CO considers likely to achieve the standard (i.e. green status).
23	How target is realistic for PB2026-2027	(1) These programs have existing governmental support. (2) These countries have the objectives in their workplans. (3) WHO is providing technical and sometimes financial support to ensure the plans are operationalized and implemented.
24	Data sources	WHO Country and Regional Offices
25	Process of validation	In the first round, WHO Regional Offices will review the data from WHO Country Offices and assess whether implementation is aligned in principle with WHO guidance. In the second round, WHO HQ will review the data in consultation with WHO Regional and Country Offices.
26	Limitations	There may be limitations in WHO Regional and Country Offices in terms of capacity to provide timely data for reporting purposes and differences in their assessment.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Trinette Lee <leet@who.int>

**2.3.1.IND2\_UID 807 : Number of countries with national or subnational policies on promoting health and well-being that have integrated a comprehensive health promotion approach, aligned with WHO guidance, or with or through WHO technical support**

#	Metadata field	Summary
1	GPW14 Output	2.3.1. WHO develops guidance and supports countries to strengthen their capacity to engage with and empower individuals and communities, and all levels of government across sectors to increase health literacy, enable healthier behaviours, advance co-benefits, and improve governance and implementation of settings-based approaches and health promotion policies
2	GPW14 Output indicator code	2.3.1.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries with national or subnational policies on promoting health and well-being that have integrated a comprehensive health promotion approach, aligned with WHO guidance, or with or through WHO technical support
4	Output/Leading Indicator (Country Level Formulation)	Implementation of national policies on promoting health and well-being that have integrated a comprehensive health promotion approach, aligned with WHO guidance, or with WHO technical support
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input,	Output

	Process, Output, Outcome)	
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Country uses societal dialogue as a mechanism for prioritizing and co-shaping the health agenda (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks the number of countries with national or subnational policies that integrate a comprehensive health promotion approach, aligned with WHO guidance or with or through WHO technical support.
12	Criteria	<p>A country is counted under this indicator if it has national or subnational policies on promoting health and well-being that integrate a comprehensive health promotion approach, aligned with WHO guidance or developed with WHO technical support. The assessment focuses on national-level policies and programmes, except in countries with a decentralized system.</p> <p>A <b>comprehensive health promotion approach</b> includes the following core elements:</p> <ul style="list-style-type: none"> <li>• promotion of intersectoral action,</li> <li>• strengthening community/social participation and empowerment,</li> <li>• development of healthy settings,</li> <li>• focus on addressing the social determinants of health with an equity perspective,</li> <li>• reorientation of health services towards health promotion.</li> </ul> <p>Policies are identified and assessed by WHO Regional and Country Offices, based on their engagement and support to countries</p>
13	Numerator	Number of countries whose national or subnational policies on promoting health and well-being meet all the criteria outlined in Field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> There are national or subnational policies on promoting health and well-being that integrate a comprehensive health promotion approach and there are documented good practices. A comprehensive health promotion approach has the following elements: promotion of intersectoral action, strengthening community/social participation and empowerment, development of healthy settings, focus on addressing the social determinants of health with an equity perspective, reorientation of health services towards health promotion. (*The focus is on national policies/programmes except for countries with a decentralized system.)</p> <p><b>Partially achieved:</b> There are national or subnational policies on promoting health and well-being that partially integrate a comprehensive health promotion approach. A comprehensive health promotion approach has the following elements: promotion of intersectoral action, strengthening community/social participation and empowerment, development of healthy</p>

		<p>settings, focus on addressing the social determinants of health with an equity perspective, reorientation of health services towards health promotion. (*The focus is on national policies/programmes except for countries with a decentralized system.)</p> <p><b>Not achieved:</b> Absence of or limited national or subnational policies on promoting health and well-being that include a health promotion approach. For example, focuses on only one component or only on individual-based health promotion actions such as health education, promotion of healthy lifestyles, etc. (*The focus is on national policies/programmes except for countries with a decentralized system.)</p>
17	Rationale	<p>Health promotion approaches are essential strategies aimed at improving health and well-being as these are grounded in evidence-based practice and address the root causes of ill health at the systems-level. The health promotion approach to promoting health and well-being is comprehensive and holistic, framed within the Ottawa Charter action areas, and enhances the effectiveness and impact of vertical programs. Empowering individuals and communities are also key to increasing their control over their own health and to ensuring interventions meet their needs. These are vital to fostering healthier societies and populations by preventing diseases and promoting good health. Mandates: 1. Sustainable Development Goals 3, 4 and 11 2. Alma-Ata Declaration (1978) 3. Declaration of Astana on Primary Health Care (2018) 4. WHA75.19 Well-being and health promotion 5. Decision WHA76(22) on Achieving well-being: a global framework for integrating well-being into public health utilizing a health promotion approach 6. WHA77.2 Social participation for universal health coverage, health and well-being 7. PAHO Strategy and Plan of Action on Health Promotion within the context of the Sustainable Development Goals 2019-2030 8. AFRO Strengthening community protection and resilience: Regional Strategy for Community Engagement 2023-2030 in the WHO African Region</p>
18	Measurement method	Data is collected through WHO Regional and Country Offices who make the assessment. This indicator is about WHO health promotion focal points providing support to governments to integrate holistic health promotion approaches to vertical health and non-health sector programs and strategies (e.g. nutrition, road safety, physical activity, among others).
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria under field 12.
21	Calculation type	Cumulative
22	Target setting methodology	Target countries are set based on regional and/or country office's engagement, assessment of progress and whom RO/CO considers likely to achieve the standard (i.e. green status).
23	How target is realistic for PB2026-2027	Targets are realistic as they reflect regional and/or country office's engagement with the countries, assessment of the progress and commitment to achieving these targets.
24	Data sources	WHO Regional and Country Offices

25	Process of validation	WHO Regional and Country Offices will provide the data based on their assessment. WHO HQ will then review the data in consultation with WHO Regional and Country Offices.
26	Limitations	There may be limitations in WHO Regional and Country Offices in terms of capacity to provide timely data for reporting purposes and differences in their assessment.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Trinette Lee <leet@who.int>



### 3.1.1. WHO strengthens country capacity and provides guidance on the design, delivery, quality and measurement of integrated -services

#### 3.1.1.IND1\_UID 481: Number of countries that have developed or updated existing quality of care and patient safety strategies/plans, based on WHO guidance

#	Metadata field	Summary
1	GPW14 Output	3.1.1. WHO strengthens country capacity and provides guidance on the design, delivery, quality and measurement of integrated -services
2	GPW14 Output indicator code	3.1.1.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have developed or updated existing quality of care and patient safety strategies/plans, based on WHO guidance
4	Output/Leading Indicator (Country Level Formulation)	Country has developed or updated existing quality of care and patient safety strategies/plans based on WHO guidance.
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Coverage of WASH in healthcare facilities (D); Proportion of births attended by skilled health personnel (I); Maternal mortality ratio (I); Neonatal mortality rate (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	The indicator counts the number of countries that have developed or updated a quality of care and patient safety strategy/plan in alignment with WHO guidance.
12	Criteria	<p>A country is considered to have achieved this indicator if it scores at Level 5 (Advanced) according to the WHO progress matrix. These levels are defined based on the following <b>attributes</b>:</p> <ol style="list-style-type: none"> <li>1. National policy, strategy, or plan exists</li> <li>2. Status of Operationalization</li> <li>3. Includes strategies to improve quality with goals and indicators</li> <li>4. MoH unit to support the management and implementation of QoC and patient safety</li> <li>5. Committee responsible for coordinating QoC and patient safety across all levels and settings</li> <li>6. Dedicated funding allocated in the government budget</li> </ol> <p>With additional consideration given to the following attributes, where data are available:</p>

		<ul style="list-style-type: none"> <li>• Developed through a consultative stakeholder process, inclusive of communities and/or civil society</li> <li>• Defines a set of quality planning, improvement and control/assurance interventions</li> <li>• Includes specific mention defining the use of facility and provider regulatory mechanisms such as licensing, certification, external evaluations or accreditation</li> <li>• Includes specific mention of mechanisms to be enacted across service delivery platforms including primary care, community and outreach care, referral care and in-patient hospital care</li> </ul> <p>The attributes reflect the range of package components and sub-components described in: Primary Health Care Measurement Framework and Indicator technical specifications; Global Patient Safety Action Plan 2021-2030 Towards eliminating avoidable harm in health care; Delivering quality health services: a global imperative for universal health coverage (WHO , 2018); Handbook for national quality policy and strategy: A practical approach for developing policy and strategy to improve quality of care, WHO 2018</p> <p>See “Measurement method” in Field 18 for more details on the calculation.</p>
13	Numerator	Number of countries whose quality of care and patient safety strategies or plans are assessed as being at Level 5 (Advanced) in the WHO progress matrix
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country meets the criteria as outlined in Field 12, meaning it is assessed at Level 5 (Advanced) on the progress matrix, meaning a score of at least 80</p> <p><b>Partially achieved:</b> The country has made measurable progress and is assessed at Level 4 (Established), or Level 3 (Moderate), meaning a score between 40-79 on the progress matrix</p> <p><b>Not achieved:</b> The country is assessed at Level 2 (Progressing) and Level 1 (Emerging) (score: 0–39), indicating minimal or no foundational elements in place for quality of care and patient safety strategies.</p>
17	Rationale	This indicator responds to member countries request to accelerate efforts to improve quality of care and patient safety as expressed in the WHA resolutions: • WHA55.18: Quality of care - patient safety • WHA69.11 Health in the 2030 Agenda for Sustainable Development • WHA69.24 Strengthening integrated, people-centred health services • WHA72.2: Primary health care • WHA72.6 Global action plan on patient safety • WHA72.7: Patient safety: Water, sanitation and hygiene in health care facilities • WHA74(13): Decision of Global patient Safety Action Plan 2021-30 And the following reports and technical guidance: • Delivering quality health services: a global imperative for universal health coverage (WHO , 2018) • Handbook for national quality

		policy and strategy: A practical approach for developing policy and strategy to improve quality of care, WHO 2018 WHO is the main actor that is supporting member countries to develop and implement these strategies and plans. The organization adds value by ensuring the critical linkages needed to be established between QOC and PS policies strategies and overall efforts, with and within other health systems strengthening efforts and relevant policies, including those on health financing and UHC, PHC approach, health workforce, service delivery and models of care, integration in diseases and population specific programmes, etc.
18	Measurement method	<p>At the country level, the indicator score is calculated as follows:</p> <ul style="list-style-type: none"> <li>A preliminary score is calculated by adding up the score for the 6 attributes mentioned in Field 12.  <math display="block">\text{Preliminary score} = \sum_{n=1}^6 \text{Attribute score } n</math> </li> <li>The preliminary score is then <b>normalized to a scale of 0 to 100</b> to determine the overall score for comparison and further aggregation, where necessary:  <math display="block">\text{Overall score} = [\text{Preliminary score}] / 6 * 100</math> </li> <li>Overall score is rounded to the nearest integer (whole number) before being matched to the corresponding level in the progress matrix. <ul style="list-style-type: none"> <li>Level 1 – Emerging: 0–19</li> <li>Level 2 – Progressing: 20–39</li> <li>Level 3 – Moderate: 40–59</li> <li>Level 4 – Established: 60–79</li> <li>Level 5 – Advanced: 80–100</li> </ul> </li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria under field 12.
21	Calculation type	Cumulative
22	Target setting methodology	<p>Targets were set by identifying countries that are close to meeting the achievement threshold of 80. Specifically:</p> <ul style="list-style-type: none"> <li>Countries with scores between 70–79 were targeted for achievement by 2026.</li> <li>Countries with scores between 60–69 were targeted for achievement by 2027.</li> </ul>
23	How target is realistic for PB2026-2027	<ul style="list-style-type: none"> <li>Targets are realistic because the focus is on countries that are near the required performance level.</li> <li>WHO is actively engaging regional offices to help countries close to the 60 threshold improve.</li> </ul>
24	Data sources	Assessing Health Systems for UHC: A rapid review of policies, plans, and practices, including PHC; WHO Global Patient Safety Report 2024; WHA72.6: Global action on patient safety • Delivering quality health services: a global imperative for universal health coverage (WHO, 2018)
25	Process of validation	Expert review and consultation across the three levels of WHO; Ministry of Health review

26	Limitations	Country data reporting face challenges due to dependence of this indicator on the policy development process and resources for implementation. Quality of reporting depends on the accuracy of the data collected - as the data is qualitative, it relies on the respondent's knowledge of each process step, which may affect consistency and reliability.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Diana Zandi <zandid@who.int>; Blerta MALIQI < <a href="mailto:maliqib@who.int">maliqib@who.int</a> >; Nikhil Gupta<ngupta@who.int>

### 3.1.1.IND2\_UID 482: Number of countries that have strengthened monitoring of access to equitable and quality health services, based on WHO guidance

#	Metadata field	Summary
1	GPW14 Output	3.1.1. WHO strengthens country capacity and provides guidance on the design, delivery, quality and measurement of integrated -services
2	GPW14 Output indicator code	3.1.1.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have strengthened monitoring of access to equitable and quality health services, based on WHO guidance
4	Output/Leading Indicator (Country Level Formulation)	Country has strengthened monitoring of access to equitable and quality health services based on WHO guidance
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Number of countries that improved health information systems, measured by the SCORE Index (D); % of population reporting perceived barriers to care (geographical, sociocultural, financial) (D); Coverage of essential health services (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator counts the number of countries that have adopted monitoring systems aligned with WHO guidance to track access to equitable and quality health services.
12	Criteria	A country is considered to have achieved this indicator if it scores at Level 4 (Established) or Level 5 (Advanced) on the WHO progress matrix. To meet the criteria, a country must demonstrate an up-to date assessments that reflect the application of WHO-recommended tools and systems to

		<p>monitor access to equitable and quality health services. Specifically, the country, based on its context, must <b>demonstrate up-to date assessments</b> in the following areas:</p> <ol style="list-style-type: none"> <li>1. people's perceptions and needs of the health system</li> <li>2. barriers to accessing care and health outcomes</li> <li>3. out-of-pocket spending on health</li> <li>4. patient-reported experiences</li> <li>5. patient-reported outcomes of care</li> <li>6. provider experiences of care</li> <li>7. facilities in primary care settings</li> <li>8. facilities in hospital settings</li> <li>9. community health needs</li> </ol> <p>And:</p> <ol style="list-style-type: none"> <li>10. Existence of community-led monitoring systems</li> </ol> <p>See "Measurement method" in Field 18 for more details on the calculation</p>
13	Numerator	Number of countries that score in Level 4 or Level 5 of the progress matrix
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country meets the criteria as outlined in Field 12, meaning it is assessed at Level 4 (Established) or Level 5 (Advanced) on the progress matrix, meaning a score of at least 60</p> <p><b>Partially achieved:</b> The country has made measurable progress and is assessed at Level 3 (Moderate) or Level 2 (Progress), meaning a score between 20–59 on the progress matrix</p> <p><b>Not achieved:</b> The country is assessed at Level 1 (Emerging) (score: 0–19), indicating minimal or no foundational elements in place for quality of care and patient safety strategies.</p>
17	Rationale	<p>This indicator is essential for strengthening health systems to advance universal health coverage (UHC). As the ultimate goal is health for all, countries need to be able to track how their decisions, actions and investments are addressing and making progress towards the desired results, equitable access to quality, people-centered services. Performance assessment is central to these efforts for improving decision-making and accountability. To support countries to undertake performance assessments, WHO has developed the "Primary Health care measurement framework and indicators – monitoring health systems through a primary health care lens" as well as a series of methods, data collection tools and guidance to support countries to strengthen measurement and monitoring capacities. This indicator captures the extent to which WHO-recommended monitoring and assessment tools/systems are present in countries.</p>
18	Measurement method	<p>At the country level, the indicator score is calculated as follows:</p> <ul style="list-style-type: none"> <li>• A preliminary score is calculated by adding up the score for the 10 attributes mentioned in Field 12.</li> </ul> <p style="text-align: center;">Preliminary score = <math>\sum_{n=1}^{10} \text{Attribute score } n</math></p>

		<ul style="list-style-type: none"> <li>The preliminary score is then <b>normalized to a scale of 0 to 100</b> to determine the overall score for comparison and further aggregation, where necessary: Overall score = [Preliminary score]/10*100</li> <li>Overall score is rounded to the nearest integer (whole number) before being matched to the corresponding level in the progress matrix. <ul style="list-style-type: none"> <li>Level 1 – Emerging: 0–19</li> <li>Level 2 – Progressing: 20–39</li> <li>Level 3 – Moderate: 40–59</li> <li>Level 4 – Established: 60–79</li> <li>Level 5 – Advanced: 80–100</li> </ul> </li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria under field 12.
21	Calculation type	Cumulative
22	Target setting methodology	It is anticipated that countries within 10% of the lower bound for the “Established” level ((i.e., ~60) will achieve the target by 2026 and 2027.
23	How target is realistic for PB2026-2027	The availability of resources (personnel and financial) to support and expand country monitoring systems will determine whether this is realistically achievable.
24	Data sources	Assessing Health Systems for UHC: A rapid review of policies, plans, and practices, including PHC; SCORE assessment; Regional Office input; WHA 72.2
25	Process of validation	Expert review and consultation across the three levels of WHO; Ministry of Health review
26	Limitations	Nothing extraordinary to be discussed at this time. The standard data challenges and constraints on reporting on qualitative indicators applies.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Cristin Fergus <fergusc@who.int>

### 3.1.1.IND3\_UID 483: Number of countries that have an integrated universal health coverage package of priority services that meets core WHO criteria

#	Metadata field	Summary
1	GPW14 Output	3.1.1. WHO strengthens country capacity and provides guidance on the design, delivery, quality and measurement of integrated -services
2	GPW14 Output indicator code	3.1.1.IND3
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have an integrated universal health coverage package of priority services that meets core WHO criteria

4	Output/Leading Indicator (Country Level Formulation)	Country has an integrated UHC package of priority services that meets core WHO criteria
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Integrated services and models of care composite indicator (D); Service availability and readiness index (% of facilities with service availability, capacities and readiness (WASH, infection prevention and control, availability of medicines, vaccines, diagnostics, priority medical devices, priority assistive products) to deliver universal healthcare package) (D); Coverage of essential health services (I); Health facility density and distribution (by type and level of care) (I); Service utilization rate (primary care visits, emergency care visits, hospital admissions) (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator counts how many countries have developed an integrated universal health coverage (UHC) package that meets WHO-defined criteria. It reflects a country's effort to define and implement essential health services aligned with PHC and UHC goals.
12	Criteria	<p>A country is considered to have achieved this indicator if it scores <b>Level 5 (Advanced)</b> on the WHO progress matrix.</p> <p>The levels on the matrix are defined <b>based on the following attributes</b>:</p> <ol style="list-style-type: none"> <li>1. There is a package of services for universal health coverage, which defines a priority set of health interventions to be delivered to a population;</li> <li>2. Package includes the following types of interventions: <ul style="list-style-type: none"> <li>• Promotion and prevention;</li> <li>• Self-care services;</li> <li>• Emergency and critical care;</li> <li>• Surgical interventions;</li> <li>• Rehabilitation;</li> <li>• Palliative care.</li> </ul> </li> <li>3. Package includes the following categories of services (for specific services, see <a href="https://uhcc.who.int">https://uhcc.who.int</a>): <ul style="list-style-type: none"> <li>• Foundations of care (includes services to address emergency syndromes and common signs and symptoms in primary care - as well as core continuity and coordination services (see <a href="https://uhcc.who.int">https://uhcc.who.int</a>/, "Foundations of care" section);</li> <li>• Reproductive and sexual health;</li> <li>• Growth, development and ageing (includes interventions on healthy development, nutrition, physical activity, and sleep);</li> </ul> </li> </ol>

		<ul style="list-style-type: none"> <li>• Communicable diseases;</li> <li>• Non-communicable diseases;</li> <li>• Mental health, neurological and substance use disorders;</li> <li>• Violence and injury.</li> </ul> <ol style="list-style-type: none"> <li>4. Services in the package are mapped to specific service delivery platforms;</li> <li>5. The package defines the health workforce and products required for the implementation of the package;</li> <li>6. An analysis of the cost of the package has been performed and the results incorporated into decision making.</li> <li>7. The package includes and designates key services needed for readiness to respond to emergency events for which the country is at risk;</li> <li>8. The package designates core services to be maintained during public health emergencies.</li> <li>9. The process for the development of the service package involves a wide range of stakeholders (such as public and private service practitioners, subnational health service managers, health workers, people requiring health services and their families, community leaders and donor agencies);</li> <li>10. There is a mechanism for routine revision of the package (to ensure it meets changing population health needs) as part of national planning processes.</li> </ol> <p>These attributes reflect the range of package components and sub-components described in the <a href="#">Primary Health Care Measurement Framework and Indicator technical specifications</a></p> <p><i>Key terms:</i> A package of services for universal health coverage ("UHC package") is a set of health interventions to which a population is guaranteed access through a range of government assurance mechanisms, such as direct financing or direct provision for some groups, mandatory contribution and pre-payment schemes, and regulatory structures that constrain what public and private entities must pay for or deliver.</p> <p>See "Measurement method" in Field 18 for more details on the calculation</p>
13	Numerator	Number of countries meeting the criteria defined in the field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets the criteria as outlined in Field 12 and has a score of 80 or above (Level 5 – Advanced).</p> <p><b>Partially achieved:</b> The country scores between 40–79 (Level 3 or 4) and shows progress toward full implementation.</p>



		<b>Not achieved:</b> The country scores below 40 (Level 1 or 2), indicating limited or early-stage progress.
17	Rationale	The concept of PHC is rooted in a whole-of-society approach that ensures meeting population health needs throughout the life course but also addresses different health service needs such as prevention and promotion of health services. To meet this broad requirement, countries must formulate services for UHC that address these health needs. The exercise of specifying a UHC package is a value-laden process, requiring decision-makers and system stewards to establish a strategic policy position and equitable framework for protected access to health services when faced with competing priorities. The services for UHC should be defined based on a transparent process, based on explicit criteria, informed by local service delivery capacity and engage a wide range of relevant stakeholders. Mandate: WHA 72.2
18	Measurement method	At the country level, the indicator score is calculated as follows: <ul style="list-style-type: none"> <li>• A preliminary score is calculated by adding up the weighted score for the attributes mentioned in Field 12.</li> <li>• The preliminary score is then <b>normalized to a scale of 0 to 100</b> to determine the overall score for comparison and further aggregation, where necessary: <math display="block">\text{Overall score} = [\text{Preliminary score}] / 20 * 100</math> </li> <li>• Overall score is rounded to the nearest integer (whole number) before being matched to the corresponding level in the progress matrix. <ul style="list-style-type: none"> <li>○ Level 1 – Emerging: 0–19</li> <li>○ Level 2 – Progressing: 20–39</li> <li>○ Level 3 – Moderate: 40–59</li> <li>○ Level 4 – Established: 60–79</li> <li>○ Level 5 – Advanced: 80–100</li> </ul> </li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria under field 12.
21	Calculation type	Cumulative
22	Target setting methodology	These targets are based on scaled responses to the WHO "Health Systems Assessment for UHC" survey, rapid consultation with regional focal points, and reference to the WHO Service Planning, Delivery and Implementation (SPDI) platform. They will be validated at HQ, regional and country level prior to submission for EB.
23	How target is realistic for PB2026-2027	We will conduct a structured consultation with regional focal points to confirm RO capacity for support. In addition, WHO's UHC Service Planning, Delivery and Implementation (SPDI) platform is available to support all countries in package design and implementation, which greatly accelerates this process. SPDI includes automated and customisable functionality to support all elements of the metadata, including package content, linkage of services to platforms, definition of sub-packages for emergency contexts, and health workforce and products requirements to support costing.

24	Data sources	Assessing Health Systems for UHC: A rapid review of policies, plans, and practices, including PHC; <a href="#">WHO's UHC Service Planning, Delivery &amp; Implementation (SPDI) Platform</a> ; WHA 72.2
25	Process of validation	Expert review and consultation across the three levels of WHO; Ministry of Health review
26	Limitations	We do not foresee any challenges, except for the standard challenges encountered during global reporting on quality indicators.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Teri Reynolds < <a href="mailto:reynoldst@who.int">reynoldst@who.int</a> >; John Fogarty < <a href="mailto:fogartyj@who.int">fogartyj@who.int</a> >

### 3.1.2. WHO strengthens national institutional capacities for essential public health functions and improve the resilience of health systems

#### 3.1.2.IND1\_UID 1339: Number of countries with defined multisectoral coordination mechanism(s) for the delivery of essential public health functions and public health services

#	Metadata field	Summary
1	GPW14 Output	3.1.2. WHO strengthens national institutional capacities for essential public health functions and improve the resilience of health systems
2	GPW14 Output indicator code	3.1.2.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries with defined multisectoral coordination mechanism(s) for the delivery of essential public health functions and public health services
4	Output/Leading Indicator (Country Level Formulation)	Country has defined multisectoral coordination mechanism(s) for the delivery of Essential Public Health Functions and public health services
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Institutional capacity for essential public health functions (meeting criteria) (D); Integrated services and models of care composite indicator (D); Primary healthcare-oriented governance and policy composite (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	<p>This indicator tracks the number of countries that have defined multisectoral coordination mechanism(s) to coordinate the planning and delivery of EPHFs and public health services.</p> <p>Examples of multisectoral coordination mechanism include national entity mandated/assigned for multisectoral coordination for EPHFs (e.g., autonomous national public health institute (NPHI), semi-autonomous institution under the national health authority, department within the Ministry of Health); a clearly defined network of agencies or intersectoral committee for public health or utilize One-Health platform adapted for EPHFs that operate through the Ministry of Health, or under the office of Prime Minister, or Head of Government; etc.</p>
12	Criteria	<p>Countries are considered to have met the criteria for this indicator if they have demonstrated up to date assessments that capture <b>attributes</b> of multisectoral coordination mechanism for EPHFs as follows:</p> <p>A multisectoral mechanism(s) or entity(s) for coordinating EPHFs delivery</p>

		<ol style="list-style-type: none"> <li>1. exists / operates under the government</li> <li>2. with clearly defined mandate or responsibility to coordinate (and carry out where relevant) the EPHFs within and across health and allied sectors</li> <li>3. based on the country's adoption or adaptation of the EPHFs e.g., in national policies, strategies, framework or plans for public health; terms of reference; memorandum of understanding; records of multisectoral meetings; records of multi-agency simulation exercises etc.)</li> </ol> <p>WHO's unified list of EPHFs is as below for reference: • monitoring and surveillance of population health status, risks, protective and promotive factors, threats to health, and health system performance and service utilization; • managing public health emergencies for international and national health security; • establishing effective public health institutional structures, leadership, coordination, accountability, regulations and laws; • supporting effective and efficient health systems and multisectoral planning, financing and management for public health; • protecting populations against health threats, for example, environmental and occupational hazards, communicable and noncommunicable diseases, including mental health conditions, food insecurity, and chemical and radiation hazards; • prevention and early detection of communicable and noncommunicable diseases, including mental health conditions, and prevention of injuries; • promoting health and well-being as well as actions to address the wider determinants of health and inequity; • strengthening community engagement, participation and social mobilization for health and well-being; • developing and maintaining an adequate and competent public health workforce; • improving appropriateness, quality and equity in the provision of and access to health services; • advancing public health research and knowledge development; • promoting equitable access to and rational use of safe, effective and quality-assured health products, supplies, equipment and technologies.</p>
13	Numerator	Number of countries that have achieved the criteria mentioned in Field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country meets the criteria as outlined in Field 12, meaning it is assessed at Level 4 (Established) or Level 5 (Advanced) on the progress matrix, meaning a score of at least 60</p> <p><b>Partially achieved:</b> The country has made measurable progress and is assessed at Level 3 (Moderate) or Level 2 (Progress), meaning a score between 20–59 on the progress matrix</p> <p><b>Not achieved:</b> The country is assessed at Level 1 (Emerging) (score: 0–19), indicating minimal or no foundational elements in place</p>
17	Rationale	This indicator is core for measuring and monitoring the institutional capacity for Essential Public Health Functions (EPHFs) in countries. Given that

		<p>EPHFs/public health are dispersed within and across health and allied sectors, strengthening institutional capacity requires clear multisectoral coordination mechanisms for public health. For member states, 194 have ministry of health or equivalent and at least 107 of them have national public health institute or equivalent. However, there is lack of clarity in defined multisectoral coordination mechanisms for delivering EPHFs and public health services comprehensively and in an integrated manner within and across health and allied public health sectors. This indicator will allow countries to benchmark their current status for institutionalization of EPHFs and the level of intersectoral coordination for public health. WHO has a unique added value as the lead UN agency for public health and can facilitate convening and coordination of responsible authorities at country level (including ministries of health, national public health institutions, allied public health sectors) for EPHFs. WHO has the body of knowledge and technical expertise to drive institutional reforms and develop capacity for essential public health functions and services from national to subnational levels. WHO's leadership role will be key in driving global efforts for adapting and applying the EPHFs for building health systems resilience in various contexts including fragile, conflict and violence-affected contexts. This indicator is related to the World Health Assembly and Regional Committee resolutions WHA 69.1, WHA 72.2, AFR/RC73/5, CD61.R11, EM/RC69/R.2, EUR/RC74(5), SEA/RC76/R3, WPR/RC74/R6, etc.</p>
18	Measurement method	<p>Data is collected through assessment tool “Assessing health systems for UHC: A rapid review of policies, plans and practices, including PHC”; IANPHI routine information collection from national public health institutes in Member States; etc.</p> <p>At the country level, the indicator score is calculated as follows:</p> <ul style="list-style-type: none"> <li>A preliminary score is calculated by adding up the score for the 3 attributes mentioned in Field 12. <math display="block">\text{Preliminary score} = \sum_{n=1}^3 \text{Attribute score } n</math> </li> <li>The preliminary score is then <b>normalized to a scale of 0 to 100</b> to determine the overall score for comparison and further aggregation, where necessary: <math display="block">\text{Overall score} = [\text{Preliminary score}]/3 \times 100</math> </li> <li>Overall score is rounded to the nearest integer (whole number) before being matched to the corresponding level in the progress matrix. <ul style="list-style-type: none"> <li>Level 1 – Emerging: 0–19</li> <li>Level 2 – Progressing: 20–39</li> <li>Level 3 – Moderate: 40–59</li> <li>Level 4 – Established: 60–79</li> <li>Level 5 – Advanced: 80–100</li> </ul> </li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that have achieved this indicator.
21	Calculation type	Cumulative

22	Target methodology setting	Target countries for 2026 were selected based on current score within 5% of the lower end of the Level 4 (Established - 60 - 79) that is those with at least (at least 57 score but less than 60) Target countries for 2027 were selected based on current score within the next 5% of the lower end of the Level 4 (Established - 60 - 79), that is, those with at least (at least 54 score but less than 57). This approach is based on the consideration of the demonstrated capacity and potential feasibility of establishing and advancing capacities in countries with score (54 and above), in addition some countries have been selected based on ongoing country support work and request for support to improve their institutional capacities for public health.
23	How target is realistic for PB2026-2027	Factors that would contribute to achieving targets for 2026 and 2027 include country demonstration of some foundational capacities (e.g., in Levels 2 and 3) for attaining established and advanced capacities (Levels 4 and 5). There are also established technical tools to guide countries, ongoing technical support to countries in developing and strengthening their national public health institutions, ongoing joint working with the International Association of National Public Health Institutes, and continued advocacy to national authorities and partners including donors on strengthening institutional capacities for EPHFs.
24	Data sources	Assessing health systems for UHC: A rapid review of policies, plans and practices, including PHC”; International Association of National Public Health Institutes (IANPHI) for the preliminary baseline data; A Global Health Strategy for 2025-2028 - advancing equity and resilience in a turbulent world: fourteenth General Programme of Work. ; WHA 69.1 Strengthening essential public health functions in support of the achievement of universal health coverage. ; WHA 72.2 Primary health care. ; AFR/RC73/5 framework for sustaining resilient health systems to achieve universal health coverage and promote health security, 2023–2030 in the WHO African Region. ; CD61.R11 Strategy for Strengthening the Essential Public Health Functions to Accelerate Health Systems Transformation 2024–2034. ; EM/RC69/R.2 Building resilient health systems to advance universal health coverage and ensure health security in the Eastern Mediterranean Region. ; EUR/RC74(5) Health emergency preparedness, response and resilience in the WHO European Region 2024–2029. ; SEA/RC76/R3 Delhi Declaration on strengthening primary health care as a key element towards achieving universal health coverage. ; WPR/RC74/R6 Health workforce. ; Building health systems resilience for universal health coverage and health security during the COVID-19 pandemic and beyond: WHO position paper. ; WHO global strategy on integrated people-centred health services 2016-2026. ; Political Declaration of the High-level Meeting on Universal Health Coverage “Universal health coverage: moving together to build a healthier world”. ; Political Declaration of the High-level Meeting on Universal Health Coverage “Universal Health coverage: expanding our ambition for health and well-being in a post-COVID world”. ; Global strategy on human resources for health: Workforce 2030. ; IANPHI Kigali Statement. National Public Health Institutes Commit to Advancing Public Health, Resilience and Sustainability. ; Health system resilience indicators: an integrated package for measuring and monitoring health system resilience in countries.

25	Process of validation	Expert review and consultation across the three levels of WHO; Ministry of Health review. WHO HQ and ROs will work with health policy advisers and other WHO country offices' focal points and global and regional partners and networks (e.g., IANPHI) to validate the data by cross-checking countries' relevant documents (e.g., national health policies, strategies and plans, terms of reference for national public health institutes), in collaboration with national counterparts (e.g., MoH, NPHIs).
26	Limitations	Countries' resources and capacities for data collection and reporting might be limited. This can be addressed by leveraging or further strengthening existing data collection tools and mechanisms that Member States are already involved.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Sohel SAIKAT< <a href="mailto:saikats@who.int">saikats@who.int</a> >; Redda Seifeldin<seifeldinr@who.int>

**3.1.2.IND2\_UID 1389: Number of countries that have incorporated the service-oriented essential public health functions within their universal health coverage package of health services (or equivalent)**

#	Metadata field	Summary
1	GPW14 Output	3.1.2. WHO strengthens national institutional capacities for essential public health functions and improve the resilience of health systems
2	GPW14 Output indicator code	3.1.2.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have incorporated the service-oriented essential public health functions within their universal health coverage package of health services (or equivalent)
4	Output/Leading Indicator (Country Level Formulation)	Country has incorporated the service-oriented Essential Public Health Functions (EPHFs) within the UHC package of health services (or equivalent)
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Institutional capacity for essential public health functions (meeting criteria) (D); Integrated services and models of care composite indicator (D); Coverage of essential health services (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	Country's UHC package of health services or equivalent has integrated public health services (encompassing health promotion, disease prevention,

		health protection, public health emergency management, and public health monitoring and surveillance), to meet population health needs. Examples of equivalent to UHC package of health services include: essential package of health services; package of intersectoral interventions; health benefit packages; nutrition services package; package of essential non-communicable interventions; ToRs/plans of District Health Management Team; ToRs/plans subnational disease control unit; etc. Public health services are actions with a primary focus on improving population-level health outcomes, including promoting health equity, while reducing risks and promoting health at the individual level. Public health services reflect a wide range of actions that seek to positively impact the broader determinants of health and wider issues in the promotion and protection of health, including those across various sectors, such as health, agriculture, environment, commercial, education, transport and housing. The EPHFs include five areas of services-oriented functions: health promotion (e.g., health education), disease prevention (e.g., screening program), health protection (e.g., occupational and environmental health program), public health emergency management (e.g., dissemination of alert on public health events), and public health monitoring and surveillance (e.g., integrated diseases and events monitoring and surveillance).
12	Criteria	<p>Countries are considered to have met the criteria for this indicator if they have demonstrated up to date assessments that capture <b>attributes</b> of integration of service-oriented EPHFs within UHC package of health services as follows:</p> <p>Public health services are</p> <ol style="list-style-type: none"> <li>1. defined for service delivery levels (as applicable to the country)</li> <li>2. routinely provided in primary care (or equivalent front line service delivery setting, including those from district level health management units).</li> </ol>
13	Numerator	Number of countries that have achieved the criteria mentioned in Field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country meets the criteria as outlined in Field 12, meaning it is assessed at Level 4 (Established) or Level 5 (Advanced) on the progress matrix, meaning a score of at least 60</p> <p><b>Partially achieved:</b> The country has made measurable progress and is assessed at Level 3 (Moderate) or Level 2 (Progress), meaning a score between 20–59 on the progress matrix</p> <p><b>Not achieved:</b> The country is assessed at Level 1 (Emerging) (score: 0–19), indicating minimal or no foundational elements in place</p>
17	Rationale	Public health functions and services are delivered within and across health and allied sectors. Package of essential health services is a key instrument in countries. Integrating Essential Public Health Functions (EPHFs) and public health services in the package and defining the roles of actors from national, subnational, local, district to primary care levels in the package can support



		strengthening institutional capacity for comprehensive delivery of EPHFs and public health services. WHO has a unique added value as the lead UN agency for public health and can facilitate convening and coordination of responsible authorities at country level (including ministries of health, national public health institutions, allied public health sectors) for essential public health functions. WHO's leadership role will be key driving global efforts for adapting and applying the EPHFs for building health systems resilience in various contexts including fragile, conflict and violence-affected contexts. WHO has the body of knowledge and technical expertise to support national health policies, strategies and plans, and develop capacity for EPHFs and public health services delivery from national to subnational to primary care levels. Routine delivery at primary care level is prioritised as the first point of contact and link between health systems and communities recognising that primary care can be provided in different settings including community-based services, primary care facilities, primary care settings in hospitals etc. This indicator is related to the World Health Assembly and Regional Committee resolutions WHA 69.1, WHA 72.2, AFR/RC73/5, CD61.R11, EM/RC69/R.2, EUR/RC74(5), SEA/RC76/R3, WPR/RC74/R6, etc
18	Measurement method	<p>Data is collected through assessment tool "Assessing health systems for UHC: A rapid review of policies, plans and practices, including PHC</p> <p>At the country level, the indicator score is calculated as follows:</p> <ul style="list-style-type: none"> <li>A preliminary score is calculated by adding up the score for the 2 attributes mentioned in Field 12.  <math display="block">\text{Preliminary score} = \sum_{n=1}^2 \text{Attribute score } n</math> </li> <li>The preliminary score is then <b>normalized to a scale of 0 to 100</b> to determine the overall score for comparison and further aggregation, where necessary:  <math display="block">\text{Overall score} = [\text{Preliminary score}] / 2 * 100</math> </li> <li>Overall score is rounded to the nearest integer (whole number) before being matched to the corresponding level in the progress matrix. <ul style="list-style-type: none"> <li>Level 1 – Emerging: 0–19</li> <li>Level 2 – Progressing: 20–39</li> <li>Level 3 – Moderate: 40–59</li> <li>Level 4 – Established: 60–79</li> <li>Level 5 – Advanced: 80–100</li> </ul> </li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that have achieved this indicator
21	Calculation type	Cumulative
22	Target setting methodology	Target countries for 2026 were selected based on baseline score within 20% of the lower end of the Level 4 (Established - 60 - 79), that is those with a score of at least 48 but less than 60. Target countries for 2027 were selected based on baseline score within the next 20% of the lower end of the Level 4 (Established - 60 - 79), that is, those with a score of at least 36 but less than 48. This approach was decided based on the available data and consideration of the demonstrated moderate and progressing capacity as

		indicating potentially higher feasibility of establishing and advancing capacities in countries with scores of 36 and above - nearest range of scores to the target.
23	How target is realistic for PB2026-2027	Factors that would contribute to achieving targets for 2026 and 2027 include country demonstration of some foundational capacities (e.g., in Levels 3 and 2) for attaining established and advanced capacities. There are also established technical tools to guide countries, ongoing joint working with the International Association of National Public Health Institutes, and continued advocacy to national authorities and donors on strengthening institutional capacities for EPHFs.
24	Data sources	Assessing health systems for UHC: A rapid review of policies, plans and practices, including PHC”; Countries’ packages of essential health services or equivalent. UHC compendium. Terms of reference of NPHIs or equivalent; WHA 69.1 Strengthening essential public health functions in support of the achievement of universal health coverage. ; WHA 69.24 Strengthening integrated, people-centred health services ; WHA 72.2 Primary health care. ; Declaration of Astana. Global Conference on Primary Health Care. ; AFR/RC73/5 Framework for sustaining resilient health systems to achieve universal health coverage and promote health security, 2023–2030 in the WHO African Region. ; CD61.R11 Strategy for Strengthening the Essential Public Health Functions to Accelerate Health Systems Transformation 2024–2034. ; EM/RC69/R.2 Building resilient health systems to advance universal health coverage and ensure health security in the Eastern Mediterranean Region. ; EUR/RC74(5) Health emergency preparedness, response and resilience in the WHO European Region 2024–2029. ; SEA/RC76/R3 Delhi Declaration on strengthening primary health care as a key element towards achieving universal health coverage. ; WPR/RC74/R6 Health workforce. ; Building health systems resilience for universal health coverage and health security during the COVID-19 pandemic and beyond: WHO position paper. ; WHO global strategy on integrated people-centred health services 2016-2026. ; Political Declaration of the High-level Meeting on Universal Health Coverage “Universal health coverage: moving together to build a healthier world”. ; Political Declaration of the High-level Meeting on Universal Health Coverage “Universal Health coverage: expanding our ambition for health and well-being in a post-COVID world”. ; Global strategy on human resources for health: Workforce 2030. ; IANPHI Kigali Statement. National Public Health Institutes Commit to Advancing Public Health, Resilience and Sustainability. ; Health system resilience indicators: an integrated package for measuring and monitoring health system resilience in countries. ; Application of the essential public health functions: an integrated and comprehensive approach to public health
25	Process of validation	Expert review and consultation across the three levels of WHO; Ministry of Health review. WHO HQ and ROs will work with health policy advisers and other WHO country offices’ focal points and global and regional partners and networks (e.g., IANPHI) to validate the data by cross-checking countries’ relevant documents (e.g., national health policies, strategies and plans, terms of reference for national public health institutes), terms of reference of

		District Health Management Team or equivalent) in collaboration with national counterparts (e.g., MoH, NPHIs).
26	Limitations	Countries' resources and capacities for data collection and reporting might be limited. This can be addressed by leveraging or further strengthening existing data collection tools and mechanisms that Member States are already involved.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Sohel SAIKAT< <a href="mailto:saikats@who.int">saikats@who.int</a> >; Redda Seifeldin<seifeldinr@who.int>

### 3.1.2.IND3\_UID 1390: Number of countries reporting on key public health occupations across health and allied sectors through the National Health Workforce Accounts (NHWA)

#	Metadata field	Summary
1	GPW14 Output	3.1.2. WHO strengthens national institutional capacities for essential public health functions and improve the resilience of health systems
2	GPW14 Output indicator code	3.1.2.IND3
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries reporting on key public health occupations across health and allied sectors through the National Health Workforce Accounts (NHWA)
4	Output/Leading Indicator (Country Level Formulation)	Country has reported on key public health occupations across health and allied sectors
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Institutional capacity for essential public health functions (meeting criteria) (D); Coverage of essential health services (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	The indicator tracks the number of countries reporting, through NHWA, data from the past five years on workforce stock for at least three out of five occupational groups relevant to essential public health functions.
12	Criteria	A country is counted under this indicator if it has reported data in the past five years on workforce stock for <b>at least three</b> of the following five occupational groups across the health and allied sectors:

		<ul style="list-style-type: none"> <li>• environmental and occupational health personnel (includes professionals and inspectors/associates),</li> <li>• medical and pathology laboratory personnel (includes scientists and technicians),</li> <li>• epidemiologists (includes field epidemiologists),</li> <li>• veterinarians (animal health)</li> <li>• environmental protection personnel (includes personnel working to address air pollution, water pollution, climate change).</li> </ul>
13	Numerator	Number of countries that meet the criteria specified in field 12 for NHWA reporting
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets the criteria as outlined in Field 12, meaning it has reported data within the last five years on workforce stock for at least three of the five defined public health occupational groups through the NHWA.</p> <p><b>Partially achieved:</b> The country has reported data within the last five years for either one or two of the five defined public health occupational groups, indicating initial or partial progress toward full reporting.</p> <p><b>Not achieved:</b> The country has not reported any data within the last five years for any of the defined public health occupational groups through the NHWA.</p>
17	Rationale	The purpose of NHWA is to structure the information architecture and interoperability, to define core workforce indicators, to enable strategic workforce planning and to facilitate comparability of the health workforce landscape (within countries and across regions). In the longer-term, the progressive development of the NHWA at the national level will accelerate and support new metrics on measuring workforce availability, accessibility, acceptability, and quality. This includes reporting on key occupations across health and allied sectors that contribute to the delivery of the Essential Public Health Functions (EPHFs). This indicator reflects WHO's support to countries to strengthen national capacity to monitor the public health workforce through the progressive implementation of the NHWA.
18	Measurement method	Data are collected at national level and reported annually through the National Health Workforce Accounts (NHWA) platform, which involves a systematic process of data entry by Member States nominated focal points, integration of health and care workforce data from other official channels to the NHWA (such as the Joint Data Collection on Non-Monetary Healthcare Statistics), triangulation of data with existing national sources, and data mining by the Secretariat for selected countries as and when deemed appropriate. The data validation process involves the three levels of WHO. The Secretariat consolidates the results and determines whether each country meets the technical criteria mentioned in field 12 by reviewing the submitted data.
19	Estimation method (if applicable)	Not applicable

20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria under field 12.
21	Calculation type	Cumulative
22	Target setting methodology	<p><b>The setting of targets is informed by the regular NHWA cycle of reporting to the WHO Secretariat and by the analysis of reporting trends over the last five years. This is driven by the implementation of NHWA and the demand for technical assistance from countries to improve the quality, completeness and timeliness of reporting data on the health and care workforce.</b></p> <p>The NHWA contains a standardized set of indicators that have <b>clear policy relevance</b> across the entire spectrum of HWF priorities and are related to the WHO health labour market framework using the WHO health labour market framework. Thus, <b>regional offices provide direct support</b> to enable countries' activities on workforce.</p> <p>The reporting patterns for each indicator reflect the <b>progressive implementation of NHWA by countries</b>, as per country context and their progress across the different modules of NHWA. Therefore, it is a maturity model that at any point of time describes the state of progress in the implementation of NHWA.</p> <p>Over the last five years, we have observed that <b>more countries are using the NHWA process to generate data</b> to inform their health labour market analysis and planning and policymaking. The bottom-up WHO planning has also listed <b>health workforce among the top five priority areas for countries</b>. Given that the implementation of country support will be informed by data, more countries are expected to report on the NHWA indicators in the coming years.</p> <p>The COVID-19 pandemic exposed critical gaps in the global public health workforce. The Declaration of the G20 Health Ministers (2021) and various <b>World Health Assembly Resolutions have called for investments in building workforce capacity for public health</b>, including emergency preparedness and response. Building on this political consensus, WHO launched the Roadmap to strengthen national workforce capacity to implement the EPHFs (hereafter referred to as "WHO Roadmap"), in partnership with associations, institutions and schools of public health as represented by their respective national, regional and global bodies. The Roadmap has articulated three action areas – defining the functions and services, competency-based education, and mapping and measurement of occupations. There are over 140 countries represented in this global partnership, with an existing mechanism of engagement through a Steering Committee of more than 60 partners and networks. Given that there is now an improved understanding of the scope of the public health workforce and the importance of monitoring this workforce, <b>more countries are expected to report data for these occupations through the NHWA</b> after conducting the mapping and measurement of occupations.</p>
23	How target is realistic for PB2026-2027	<ul style="list-style-type: none"> <li>The 2027 target is realistically achievable, given that the <b>National Health Workforce Accounts is institutionalized in a majority of countries</b>. As of May 2025, focal points have been appointed for 190 out of 194 WHO Member States for either direct reporting to the NHWA or through official</li> </ul>

		<p>channels like the Joint Data Collection on Non-Monetary Healthcare Statistics (JDC). 171 Member States (88%) reported new data during the 2024 NHWA data cycle, compared to 135 in 2023 (27% increase).</p> <ul style="list-style-type: none"> <li>• <b>Data availability has also improved for indicators on various health workforce</b> topics, such as stock, activity level, graduates, and distribution by various parameters such as sex, age group, place of birth, place of training, etc.</li> <li>• <b>There is also the momentum generated by the active involvement of partner organizations, associations and networks in the Roadmap.</b> A Steering Committee has been established, and members meet regularly to review progress and share key learnings from public health workforce strengthening. The Steering Committee has endorsed an ambitious target for Roadmap implementation – to conduct the benchmarking of the national workforce capacity of 100 countries over the next few years. WHO and partners continue to actively mobilize resources to catalyze benchmarking of countries' national public health workforce capacity and support them in developing plans and policies to develop their public health workforce.</li> <li>• The achievement of these targets is contingent on <ul style="list-style-type: none"> <li>○ the continued technical support from WHO to NHWA focal points across the world. This may be in the form of annual global webinars, regional workshops, national trainings, virtual clinics, or email consultations, provided that there is continued recognition of the value of NHWA as a global public good,</li> <li>○ the continued prioritization and implementation of NHWA as a corporate monitoring mechanism for health workforce policy and practice, and continued funding of the team involved in its implementation at all the three levels of WHO.</li> <li>○ the continued recognition of the importance of the Roadmap in strengthening the national public health workforce capacity of countries,</li> <li>○ the continued prioritization and implementation of the Roadmap and provision of technical support to countries,</li> <li>○ the continued funding of the team involved in its implementation at all the three levels of WHO.</li> </ul> </li> </ul>
24	Data sources	National Health Workforce Accounts data platform
25	Process of validation	Country consultation as part of the National Health Workforce Accounts annual data cycle.
26	Limitations	Data reporting with 2-year time lag, and very few countries reporting t-1 data.
27	Expected frequency of reporting	Biennial
28	Date last published	15 June 2025
29	Technical focal point	Jim Campbell <campbellj@who.int>; Khassoum Diallo <kdiallo@who.int>

### 3.1.3. WHO strengthens countries' national capacity to develop implementable national strategies for UHC

#### 3.1.3.IND1\_UID 491: Number of countries that have a national health sector policy/strategy/plan updated within the last five years, with WHO support

#	Metadata field	Summary
1	GPW14 Output	3.1.3. WHO strengthens countries' national capacity to develop implementable national strategies for UHC
2	GPW14 Output indicator code	3.1.3.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have a national health sector policy/strategy/plan updated within the last five years, with WHO support
4	Output/Leading Indicator (Country Level Formulation)	Country has a national health sector policy/strategy/plan updated within the last five years, with WHO support
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Primary healthcare-oriented governance and policy composite (D); Number of countries that improved health information systems, measured by the SCORE Index (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	It tracks the number of countries that have a national health sector policy/strategy/plan updated within the last five years, with WHO support
12	Criteria	<p>A country is considered to have achieved this indicator if it scores at Level 4 (Established) or Level 5 (Advanced) on the WHO progress matrix. The levels on the matrix are defined based on the following <b>attributes</b>:</p> <ol style="list-style-type: none"> <li>1. NHPSP exists</li> <li>2. Stage of development/implementation for NHPSP</li> <li>3. NHPSP established or revised in the last five years</li> <li>4. NHPSP developed with broad participation with key stakeholders (incl communities, civil society)</li> <li>5. Inclusion of PHC-oriented elements</li> <li>6. Geographic scope of plan</li> <li>7. Explicit PHC policy/plan (standalone or part of NHPSP)</li> <li>8. Stage of development/implementation for PHC policy/plan</li> <li>9. PHC policy/plan established or revised in the last five years</li> </ol>

		<p>10. PHC policy/plan developed with broad participation with key stakeholders (incl communities, civil society)</p> <p>11. Dedicated department or unit within the Ministry of Health that is responsible for the implementation of the PHC approach exists</p> <p>12. NHPSP is comprehensive, inclusive of all disease programs as well as private sector participation in health service delivery</p> <p>These attributes reflect the range of package components and sub-components described in the <a href="#">Primary Health Care Measurement Framework and Indicator technical specifications</a></p> <p>While the scoring rubric and attribute framework do not assign a discrete score to the “WHO support” element, it is operationalized at two key stages:</p> <ul style="list-style-type: none"> <li>• The indicator only applies to countries where WHO has provided technical, normative, or operational assistance in the development or revision of the NHPSP. This support may include: <ul style="list-style-type: none"> <li>○ Guidance on strategy formulation aligned with PHC/UHC principles</li> <li>○ Facilitation of stakeholder dialogue</li> <li>○ Technical review or validation of draft policies</li> <li>○ Financial or logistical support for planning processes</li> </ul> </li> <li>• The inclusion of countries in global reporting under this indicator is contingent upon verification that WHO has contributed to the NHPSP update within the last five years. Countries without such support are excluded from the indicator dataset, regardless of policy quality. This operational filter ensures that reported achievements reflect WHO’s added value, per the mandate under WHA 72.2.</li> </ul> <p>See “Measurement method” in Field 18 for more details on the calculation</p>
13	Numerator	Number of countries meeting the criteria defined in the field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets the criteria as outlined in Field 12 and has a score of 60 or above (Level 4– Established , and Level 5 – Advanced).</p> <p><b>Partially achieved:</b> The country has made measurable progress and is assessed at Level 3 (Moderate) or Level 2 (Progress), meaning a score between 20–59 on the progress matrix</p> <p><b>Not achieved:</b> The country does not meet the minimum criteria outlined in Field 12, with an overall score below 20.</p>
17	Rationale	The development of sound national and subnational health policies, strategies and plans (NHPSP) through intersectoral (whole-of-government) and intersectoral inclusive policy dialogue with all health stakeholders (whole-of-society) are necessary to address common challenges to health agendas, including: the under-prioritization of health, funding inconsistency



		and the lack of predictability of both domestic and external resources for health; budget underspending; and misallocation of resources. They must be well prioritized and reflect the needs and the demand for health services, with resource allocation orientated toward PHC and UHC objectives. They need to clearly specify health sector goals and be anchored in strong political agreements to improve consistency and predictability. NHPSPs must be well translated into relevant legal instruments, operational plans and budgets that will allow for full implementation. They also need to be well monitored and transparently evaluated for increased accountability and transparency. Mandate: WHA 72.2
18	Measurement method	<p>At the country level, the indicator score is calculated as follows:</p> <ul style="list-style-type: none"> <li>A preliminary score is calculated by adding up the score for the <b>12</b> attributes mentioned in Field 12.  <math display="block">\text{Preliminary score} = \sum_{n=1}^{12} \text{Attribute score } n</math> </li> <li>The preliminary score is then <b>normalized to a scale of 0 to 100</b> to determine the overall score for comparison and further aggregation, where necessary:  <math display="block">\text{Overall score} = [\text{Preliminary score}] / 12 * 100</math> </li> <li>Overall score is rounded to the nearest integer (whole number) before being matched to the corresponding level in the progress matrix. <ul style="list-style-type: none"> <li>Level 1 – Emerging: 0–19</li> <li>Level 2 – Progressing: 20–39</li> <li>Level 3 – Moderate: 40–59</li> <li>Level 4 – Established: 60–79</li> <li>Level 5 – Advanced: 80–100</li> </ul> </li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria under field 12.
21	Calculation type	Cumulative
22	Target setting methodology	The 2026 and 2027 targets for GPW14 output indicators, such as UID491, are based on verified achievements using the latest year with complete data. Only countries fully meeting all criteria are included in the baseline. UID491 uses a composite scoring rubric across 12 attributes (e.g. policy recency, PHC focus, inclusiveness), normalized on a 0–100 scale. Targets are cumulative: 2026 = baseline + projected achievers by 2026; 2027 = baseline + 2026 + new 2027 achievers. Data are validated via WHO tools, regional review, and country submissions. The rationale aligns with WHA72.2 and the GPW14 Theory of Change.
23	How target is realistic for PB2026-2027	The 2026–2027 targets are realistically achievable due to WHO’s tailored country support, including technical assistance, capacity building, and policy guidance aligned with regional strategies. The UHC Partnership and WHO investment round help secure predictable funding for national health strategy development. The Country Planning Cycle Database supports countries by mapping existing plans, identifying gaps, and informing more effective policy design based on national cycles and legal frameworks. Regional engagement fosters peer learning, accelerates progress, and

		strengthens ownership. Together, these factors enable measurable improvements aligned with Member States' priorities and the GPW14 Theory of Change for systems strengthening and governance reform.
24	Data sources	Assessing Health Systems for UHC: A rapid review of policies, plans, and practices, including PHC; Regional Office inputs; WHA 72.2
25	Process of validation	Indicator reporting includes consultation across all three levels of WHO (country, regional, HQ) and is subject to Ministry of Health review before final scoring and classification
26	Limitations	No significant challenges foreseen related to this indicator aside from the standard constraints encountered when reporting on qualitative indicators in global measurement frameworks.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	MARTEL, Frederic Jean < martelf@who.int>

**3.1.3.IND2\_UID 492: Number of countries that have assessed the progress of their national health policy/strategy/plan based on baseline and targets in the last two years, with WHO support**

#	Metadata field	Summary
1	GPW14 Output	3.1.3. WHO strengthens countries' national capacity to develop implementable national strategies for UHC
2	GPW14 Output indicator code	3.1.3.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have assessed the progress of their national health policy/strategy/plan based on baseline and targets in the last two years, with WHO support
4	Output/Leading Indicator (Country Level Formulation)	Country has assessed the progress of their national health policy/strategy/plan based on baseline and targets in the last two years with WHO support
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Primary healthcare-oriented governance and policy composite (D); Number of countries that improved health information systems, measured by the SCORE Index (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries

11	Indicator definition	The indicator measures the number of countries that have assessed the progress of their national health policy, strategy, or plan (NHPSP) against established baselines and targets, with WHO support, within the last two years.
12	Criteria	<p>A country is considered to have achieved this indicator if it is classified under the “Advanced” category, meaning:</p> <ul style="list-style-type: none"> <li>• It has a national health policy, strategy, or plan (NHPSP) (aligned with UID 491).</li> <li>• It has assessed the progress of their NHPSP within the last 0–2 years with WHO support</li> </ul> <p>Only NHPSP assessments that are explicitly confirmed to have involved WHO support—whether through technical guidance, resource provision, or facilitation—are included in the numerator</p> <p>The “WHO support” qualifier is verified through the following mechanisms:</p> <ul style="list-style-type: none"> <li>• The country’s response is developed with inputs from the WHO Country Office, which is responsible for confirming whether the NHPSP assessment was conducted with WHO’s technical or financial support. This verification happens during the joint data review and validation process involving the Ministry of Health and WHO’s three levels (country, regional, headquarters)</li> <li>• Expert review and triangulation with internal WHO reports, technical assistance records, or formal mission documentation</li> <li>• A prerequisite for UID492 is that the country has an active NHPSP (as measured under UID491). The scoring rubric for UID491 includes direct survey questions on WHO’s involvement in NHPSP development and implementation, which are cross-referenced to confirm ongoing WHO engagement</li> </ul> <p>See “Measurement method” in Field 18 for more details on the calculation</p>
13	Numerator	Number of countries meeting the criteria defined in the field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets the criteria as outlined in Field 12. It has a national health policy, strategy, or plan (NHPSP), and an assessment was completed within the past 0–2 years (classified as Advanced)</p> <p><b>Partially achieved:</b> The country has an NHPSP, and an assessment was completed within the past 3–5 years (classified as Moderate).</p> <p><b>Not achieved:</b> The country either does not have an NHPSP, or has one but no assessment was conducted, or the latest assessment was conducted more than 5 years ago (classified as Needs improvement/targeted for intensified support).</p>
17	Rationale	This indicator is a measure of WHO effectiveness at supporting member states’ implementation of national policies, strategies and plans for UHC and PHC. Mandate: WHA 72.2. It reflects WHO’s effectiveness in strengthening country capacity to implement UHC and PHC strategies. It is designed to ensure that national plans are not only in place but are periodically reviewed

		and aligned with evolving needs, thus directly supporting accountability, adaptive planning, and WHO's added value in national health governance.
18	Measurement method	<p>This indicator is measured by capturing the following:</p> <ol style="list-style-type: none"> <li>1. The country has an NHPSP (corresponds to output indicator UID 491)</li> <li>2. The latest year of assessment.</li> </ol> <p>The country is then assessed according to the following categories:</p> <ul style="list-style-type: none"> <li>• Latest assessment in the past 0 to 2 years = Advanced</li> <li>• Latest assessment in the past 3-5 years = Moderate</li> <li>• Latest assessment &gt;5 years = Needs improvement/targeted for intensified support</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria under field 12.
21	Calculation type	Cumulative
22	Target setting methodology	<ul style="list-style-type: none"> <li>• Derived from WHA 72.2 expectations</li> <li>• Aligned with existing country support mechanisms</li> </ul>
23	How target is realistic for PB2026-2027	The 2026–2027 targets for indicator 492 are achievable due to WHO's integrated support mechanisms, including technical assistance through country and regional offices, and alignment with Member States under WHA 72.2. However, it is mainly dependent on the country M&E cycle.
24	Data sources	Assessing Health Systems for UHC: A rapid review of policies, plans, and practices, including PHC; assessment from Regional and Country Office colleagues; WHA 72.2
25	Process of validation	Data is sourced from WHO Regional and Country Offices and validated through consolidation reviews: Expert review and consultation across the three levels of WHO; Ministry of Health review
26	Limitations	None expected – this is a question that can be easily addressed by the country
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	MARTEL, Frederic Jean < martelf@who.int>

### 3.1.3.IND3\_UID 493: Number of countries that have advanced social participation, with WHO support

#	Metadata field	Summary
1	GPW14 Output	3.1.3. WHO strengthens countries' national capacity to develop implementable national strategies for UHC
2	GPW14 Output indicator code	3.1.3.IND3
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have advanced social participation, with WHO support

4	Output/Leading Indicator (Country Level Formulation)	Country has social participation and civil society engagement mechanisms in health meeting WHO criteria
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Primary healthcare-oriented governance and policy composite (D); People-centredness of primary care (patient experiences, perceptions, trust) (I); Institutional capacity for essential public health functions (meeting criteria) (I); % of population reporting perceived barriers to care (geographical, sociocultural, financial) (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	Tracks the number of countries that have advanced meaningful, institutionalized social participation in health decision-making processes with WHO support.
12	Criteria	<p>A country is considered to have achieved this indicator if it scores at <b>Level 4 (Established)</b> or <b>Level 5 (Advanced)</b> on the WHO progress matrix.</p> <p>The levels on the matrix are defined based on the following <b>attributes</b>:</p> <ol style="list-style-type: none"> <li>1. Social participation mechanisms exist, where local government, health authorities, and/or local network come together with people, communities, and or civil society to seek population views for decision-making processes for health</li> <li>2. The types and scope of participation mechanisms are active, robust and institutionalized</li> <li>3. Local service planning and accountability mechanisms and activities are in place</li> </ol> <p>These attributes reflect the range of package components and sub-components described in the <a href="#">Primary Health Care Measurement Framework and Indicator technical specifications</a></p> <p>See “Measurement method” in Field 18 for more details on the calculation</p>
13	Numerator	Number of countries that score $\geq 60$ (Level 4 or Level 5) on the social participation maturity scale
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if	<b>Achieved:</b> The country meets the criteria as outlined in Field 12, meaning it is assessed at Level 4 (Established) or Level 5 (Advanced) on the progress matrix with a score of at least 60

	benchmarking is applied)	<p><b>Partially achieved:</b> The country has made measurable progress but does not yet fully meet the criteria. This corresponds to Level 2 (score 20–39) or Level 3 (score 40–59) of the progress matrix.</p> <p><b>Not achieved:</b> The country does not meet the minimum progress criteria. This corresponds to Level 1 (score 19 or below) of the progress matrix.</p>
17	Rationale	This indicator provides a measure of WHO effectiveness in supporting Member States to ensure responsive, inclusive, participatory and representative decision-making at all levels of the health system. Mandate: WHA 72.2
18	Measurement method	<p>At the country level, the indicator score is calculated as follows:</p> <ul style="list-style-type: none"> <li>A preliminary score is calculated by adding up the score for the 3 attributes mentioned in Field 12. <math display="block">\text{Preliminary score} = \sum_{n=1}^3 \text{Attribute score } n</math> </li> <li>The preliminary score is then <b>normalized to a scale of 0 to 100</b> to determine the overall score for comparison and further aggregation, where necessary: <math display="block">\text{Overall score} = [\text{Preliminary score}] / 3 * 100</math> </li> <li>Overall score is rounded to the nearest integer (whole number) before being matched to the corresponding level in the progress matrix. <ul style="list-style-type: none"> <li>Level 1 – Emerging: 0–19</li> <li>Level 2 – Progressing: 20–39</li> <li>Level 3 – Moderate: 40–59</li> <li>Level 4 – Established: 60–79</li> <li>Level 5 – Advanced: 80–100</li> </ul> </li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria under field 12.
21	Calculation type	Cumulative
22	Target setting methodology	The 2026–2027 targets for UID493 are derived from validated baselines established through WHO-supported assessments of health systems for UHC, triangulated with regional office inputs. The indicator uses a composite scoring methodology across three core attributes—existence, robustness, and institutionalization of social participation mechanisms—normalized to a 0–100 scale. Countries are classified across a 5-level maturity scale (from Emerging to Advanced). Targets reflect cumulative progress, incorporating countries projected to advance one or more levels annually, in alignment with WHA72.2 and GPW14’s emphasis on participatory governance.
23	How target is realistic for PB2026-2027	Targets are feasible due to WHO’s direct technical assistance, normative guidance, and regional engagement through joint planning and health systems governance initiatives. WHO supports Member States to embed inclusive social participation in national policies using tools aligned with the PHC measurement framework. Funding from the UHC Partnership and GPW14 investment mechanisms should contribute to further support implementation.
24	Data sources	Assessing Health Systems for UHC: A rapid review of policies, plans, and practices, including PHC; Regional Office inputs; WHA 72.2

25	Process of validation	Expert review and consultation across the three levels of WHO; Ministry of Health review
26	Limitations	No significant challenges expected to reporting on this indicator other than the common constraints related to reporting on qualitative indicators at the global level.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Gabriele Pastorino < <a href="mailto:pastorinog@who.int">pastorinog@who.int</a> >; MARTEL, Frederic Jean < <a href="mailto:martelf@who.int">martelf@who.int</a> >

### **3.1.3.IND4\_UID 1391: Proportion of tracer countries with new or revised national health laws, policies, strategies and plans that incorporate gender equality, human rights and equity considerations, in line with WHO guidance and tools**

#	Metadata field	Summary
1	GPW14 Output	3.1.3. WHO strengthens countries' national capacity to develop implementable national strategies for UHC
2	GPW14 Output indicator code	3.1.3.IND4
3	Output/Leading Indicator (Global/Regional Level Formulation)	Proportion of tracer countries with new or revised national health laws, policies, strategies and plans that incorporate gender equality, human rights and equity considerations, in line with WHO guidance and tools
4	Output/Leading Indicator (Country Level Formulation)	Country with new or revised national health law, policy, strategy and/or plan that incorporates gender equality, human rights and/or equity considerations in line with guidance/tools developed by WHO
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Provisional
8	Linked outcome indicators (Direct (D) or indirect (I))	Percentage of countries advancing gender equality in and through health by actions addressing GPW outcomes (index) (D); Coverage of essential health services (I); % of population reporting perceived barriers to care (geographical, sociocultural, financial) (I)
9	Data type	Percentage
10	Unit of measure	Percentage of countries
11	Indicator definition	This indicator measures the proportion of selected tracer countries that have developed or revised national health laws, policies, strategies, or plans to include gender equality, human rights, and/or health equity considerations, using tools and guidance from WHO.
12	Criteria	A country will be considered as having achieved this indicator if:

		<ul style="list-style-type: none"> <li>• It is one of the identified 15 tracer countries; and</li> <li>• At least one of its selected health-related national law, policy, strategy or plan that was finalized during the reporting biennium (or is an advanced draft format by the end of the biennium) meets the following conditions: <ul style="list-style-type: none"> <li>○ Integrate gender equality, human rights, and equity considerations, as defined by a GRE checklist</li> <li>○ Meets or exceeds a required percentage of checklist dimensions</li> </ul> </li> </ul>
13	Numerator	Number of tracer countries with a new or revised national health law, policy, strategy, or plan that meets the GRE integration criteria as detailed in field 12.
14	Denominator	Number of tracer countries (fixed at the same 15 countries throughout the biennium)
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	TBD
17	Rationale	The purpose of this indicator is to assess the extent to which countries are integrating and prioritizing human rights, gender equality, and/or health equity in the development and revision of national health laws, policies, strategies and/or plans through the adoption of tools and/or guidance developed by WHO. It encourages the systematic use of GRE-related tools in health policy-making and strategy development. The indicator enables tracking progress over time in the integration of GRE considerations and approaches into health laws, policies, strategies, plans and programmes providing a global benchmark for national health governance. Measuring integration of gender equality, human rights and health equity is a means of assessing how these issues are being considered and prioritized across the entirety of the health system and across all health topics. The indicator allows WHO to demonstrate progress in supporting Member States to meet their commitments and advance their gender equality, human rights and equity goals and obligations.
18	Measurement method	<p>This indicator measures GRE integration in new or revised health laws, policies, strategies and/or plans in a fixed set of 15 tracer countries identified by the GRE programme across all three levels of the Organization. Tracer countries were selected based on:</p> <ul style="list-style-type: none"> <li>a) existing WHO-Ministry of Health agreements for GRE – as featured in the Country Cooperation Strategy; and</li> <li>b) activities underway with WHO support for advancements on national health laws, policies, strategies or plans.</li> </ul> <p>The same 15 tracer countries are used throughout GPW14 cycle. The GRE programme focus on enabling success in these tracer countries for the entire duration. They were selected across the six WHO regions, with due attention to including at least two countries experiencing humanitarian crises</p>



		<p>The selection process was conducted in close collaboration with the regional leads of the GRE programme, who manage and support country implementation considering the following factors: (1) the policy cycle aligns with the duration of GPW14, (2) there is internal and external appetite, (3) there are sufficient anticipated resources in-country to ensure feasibility, and (4) the results will be transformative rather than merely "checking the box."</p> <p>Data is collected on a biennial basis through the GRE focal points in the relevant WHO Country Offices.</p> <p>For each country,</p> <ul style="list-style-type: none"> <li>• At least one health-related national law, policy, strategy or plan that was finalized during the reporting biennium (or is an advanced draft format by the end of the biennium) will be selected for review.</li> <li>• Regional GRE leads will collate the information for their region and share this information with GRE colleagues in DGO/ HQ, who will then collate the data for global reporting on this indicator. Data sources will include new or revised national health law, policy, planning and programme documents as well as other evidence of GRE integration in national laws, policies, strategies and plans.</li> </ul> <p>Each document will be assessed using the GRE integration checklist developed by WHO HQ.</p>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	$(\text{Number of tracer countries meeting the GRE integration criteria} \div \text{Total number of tracer countries}) \times 100$
21	Calculation type	Cumulative
22	Target setting methodology	Countries have been selected based on feasibility, including alignment of the policy cycle with the duration of GPW14, anticipated resources in-country, and the appetite within WHO and external partners for transformative change
23	How target is realistic for PB2026-2027	Given the uncertainties, particularly regarding resource availability within the Organization, GRE has adopted a cautious approach by selecting 15 tracer countries, assuming limited resources, including human resources, to effect this change. Regional leads are actively involved in selecting the tracer countries and have participated in defining outcome and output indicators from the outset. Based on their experience and regional overview, they have chosen countries where these criteria are met and are likely to be met even as the current restructuring process unfolds.
24	Data sources	WRs and GRE focal points in countries/regional offices
25	Process of validation	Data will be validated by the GRE Network, coordinated by GRE colleagues in DGO/HQ
26	Limitations	The indicator focuses only on a sub-set of countries and does not provide information on progress on GRE across all countries.
27	Expected frequency of reporting	Biennial
28	Date last published	15 June 2025
29	Technical focal point	Alia El-Yassir < elyassira@who.int >; Emilie Di Grazia <edi@who.int>



### 3.2.1. WHO provides technical guidance and operational support to countries to optimize and expand their health and care workforce

#### 3.2.1.IND1\_UID 494: Number of countries implementing the NHWA and reporting data through the NHWA data platform

#	Metadata field	Summary
1	GPW14 Output	3.2.1. WHO provides technical guidance and operational support to countries to optimize and expand their health and care workforce
2	GPW14 Output indicator code	3.2.1.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries implementing the NHWA and reporting data through the NHWA data platform
4	Output/Leading Indicator (Country Level Formulation)	Implementing National Health Workforce Accounts (NHWA) and reporting data through the NHWA data platform
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Coverage of essential health services (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator measures the number of countries implementing National Health Workforce Accounts (NHWA) and reporting data through the NHWA data platform. NHWA is a system that enables countries to improve the availability, quality, and use of health workforce data by monitoring a standardized set of indicators.
12	Criteria	A country is considered as having achieved this indicator if: <ul style="list-style-type: none"> <li>• It reports at least 2 years data (on the stock) within the last 5 years for the five health occupations (dentists, medical doctors, midwives, nurses and pharmacists), and</li> <li>• at least one year data (on age and/or sex distribution) within the last 5 years for at least 3 of the health occupations listed above.</li> </ul>
13	Numerator	Number of countries that meet both criteria specified in field 12 for NHWA reporting
14	Denominator	Not applicable

15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets both technical criteria outlined in Field 12 (i.e. (i) at least 2 years of stock data for 5 occupations within the last 5 years and (ii) at least 1 year of data on age and/or sex distribution for at least 3 occupations within the last 5 years).</p> <p><b>Partially achieved:</b> The country meets only one of the two required criteria described above.</p> <p><b>Not achieved:</b> The country does not meet any criteria.</p>
17	Rationale	<p>The purpose of NHWA is to structure the information architecture and interoperability, to define core workforce indicators, to enable strategic workforce planning and to facilitate comparability of the health workforce landscape (within countries and across regions). In the longer-term, the progressive development of the NHWA at the national level will accelerate and support new metrics on measuring workforce availability, accessibility, acceptability, and quality. as the determinants to attaining UHC.</p> <p>The Secretariat also measures the quality of Member States reporting on their National Health Workforce Accounts based on “progressive implementation”. This measures frequency of reporting and disaggregation by occupation, age, gender and sector of employment at national and subnational levels. This is a proxy to measure the availability and comprehensiveness of data required to inform national evidence-based decision making and the global milestones in the Global Strategy on Human Resources for Health: Workforce 2030, adopted by resolution WHA69.19.</p>
18	Measurement method	<p>Data are collected at national level and reported annually through the National Health Workforce Accounts (NHWA) platform, which involves a systematic process of data entry by Member States nominated focal points , integration of health and care workforce data from other official channels to the NHWA (such as the Joint Data Collection on Non-Monetary Healthcare Statistics), triangulation of data with existing national sources, and data mining by the Secretariat for selected countries as and when deemed appropriate. The data validation process involves the three levels of WHO.</p> <p>The Secretariat consolidates the results and determines whether each country meets the two technical criteria (stock and age/sex distribution) by reviewing the submitted data.</p>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria under field 12
21	Calculation type	Cumulative
22	Target setting methodology	<p>The setting of targets is informed by the regular NHWA cycle of reporting to the WHO Secretariat and by the analysis of reporting trends over the last five years. This is driven by the implementation of NHWA and the demand for technical assistance from countries to improve the quality, completeness and timeliness of reporting data on the health and care workforce. The NHWA contains a standardized set of indicators that have clear policy relevance</p>

		across the entire spectrum of HWF priorities and are related to the WHO health labour market framework using the WHO health labour market framework. Thus, regional offices provide direct support to enable countries' activities on workforce. The reporting patterns for each indicator reflect the progressive implementation of NHWA by countries, as per country context and their progress across the different modules of NHWA. Therefore, it is a maturity model that at any point of time describes the state of progress in the implementation of NHWA. Over the last five years, we have observed that more countries are using the NHWA process to generate data to inform their health labour market analysis and planning and policymaking. The bottom-up WHO planning has also listed health workforce among the top five priority areas for countries. Given that the implementation of country support will be informed by data, more countries are expected to report on the NHWA indicators in the coming years
23	How target is realistic for PB2026-2027	The 2027 target is realistically achievable, given that the National Health Workforce Accounts (NHWA) is institutionalized in a majority of countries. As of May 2025, focal points have been appointed for 190 out of 194 WHO Member States for either direct reporting to the NHWA or through official channels like the Joint Data Collection on Non-Monetary Healthcare Statistics (JDC). 171 Member States (88%) reported new data during the 2024 NHWA data cycle, compared to 135 in 2023 (27% increase). Data availability has also improved for indicators on various health workforce topics, such as stock, activity level, graduates, and distribution by various parameters such as sex, age group, place of birth, place of training, etc. The achievement of these targets is contingent on the continued technical support from WHO to NHWA focal points across the world. This may be in the form of annual global webinars, regional workshops, national trainings, virtual clinics, or email consultations, provided that there is continued recognition of the value of NHWA as a global public good, continued prioritization and implementation of NHWA as a corporate monitoring mechanism for health workforce policy and practice, and continued funding of the team involved in its implementation at all the three levels of WHO.
24	Data sources	National Health Workforce Accounts data platform
25	Process of validation	Country consultation as part of National Health Workforce Accounts annual data cycle.
26	Limitations	Data reporting has a standard 1-year lag (e.g. 2024 data are only reported in 2025). And, very few countries report t-1 data (data from the immediate prior year). However, this does not impact a country's eligibility to be counted, as countries are assessed based on having submitted required data within the last five years, regardless of the lag. This time lag is an inherent feature of NHWA indicator design, not a barrier to inclusion.
27	Expected frequency of reporting	Biennial
28	Date last published	15 June 2025
29	Technical focal point	Jim Campbell <Campbellj@who.int>; Khassoum Diallo <kdiallo@who.int>

### 3.2.1.IND2\_UID 495 : Number of countries reporting on health worker migration through the NHWA

#	Metadata field	Summary
1	GPW14 Output	3.2.1. WHO provides technical guidance and operational support to countries to optimize and expand their health and care workforce
2	GPW14 Output indicator code	3.2.1.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries reporting on health worker migration through the NHWA
4	Output/Leading Indicator (Country Level Formulation)	Country reporting on health worker migration through the NHWA
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Coverage of essential health services (I); Government domestic spending on health (1) as a share of general government expenditure, and (2) per capita (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks the number of countries reporting data on health workforce migration for all five health occupations (dentists, medical doctors, midwives, nurses, and pharmacists)
12	Criteria	A country will be counted if it has reported data on health workforce migration, irrespective of time period. Data must be disaggregated by place of birth or place of training for all five health occupations: Dentists, Medical doctors, Midwives, Nurses, Pharmacists.
13	Numerator	Number of countries that meet the criteria specified in field 12 for NHWA reporting
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<b>Achieved:</b> The country fully meets the criteria as outlined in Field 12. It reported data disaggregated by place of birth or place of training for all five health occupations (dentists, medical doctors, midwives, nurses, and pharmacists).

		<p><b>Partially achieved:</b> The country reported data on health worker migration, only for some occupations.</p> <p><b>Not achieved:</b> The country did not report data on health worker migration for any occupations in the NHWA platform.</p>
17	Rationale	<ul style="list-style-type: none"> <li>• The purpose of NHWA is to structure the information architecture and interoperability, to define core workforce indicators, to enable strategic workforce planning and to facilitate comparability of the health workforce landscape (within countries and across regions). In the longer-term, the progressive development of the NHWA at the national level will accelerate and support new metrics on measuring workforce availability, accessibility, acceptability, and quality as the determinants to attaining UHC.</li> <li>• Monitoring health worker migration, disaggregated by place of birth or place of training, provides countries with critical evidence for addressing workforce shortages, planning training and education investments, and promoting self-reliance in the health sector</li> <li>• This indicator supports WHO's normative role in promoting ethical recruitment practices, aligned with the WHO Global Code of Practice on the International Recruitment of Health Personnel, and in enabling countries to track and manage the reliance on foreign health workers.</li> </ul>
18	Measurement method	<ul style="list-style-type: none"> <li>• Data are collected at national level and reported annually through the National Health Workforce Accounts (NHWA) platform, which involves a systematic process of data entry by Member States nominated focal points, integration of health and care workforce data from other official channels to the NHWA (such as the Joint Data Collection on Non-Monetary Healthcare Statistics), triangulation of data with existing national sources, and data mining by the Secretariat for selected countries as and when deemed appropriate. The data validation process involves the three levels of WHO.</li> <li>• The Secretariat consolidates the results and determines whether each country meets the technical criteria mentioned in field 12 by reviewing the submitted data.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria under field 12.
21	Calculation type	Cumulative
22	Target setting methodology	The setting of targets is informed by the regular NHWA cycle of reporting to the WHO Secretariat and by the analysis of reporting trends over the last five years. This is driven by the implementation of NHWA and the demand for technical assistance from countries to improve the quality, completeness and timeliness of reporting data on the health and care workforce. The NHWA contains a standardized set of indicators that have clear policy relevance across the entire spectrum of HWF priorities and are related to the WHO health labour market framework using the WHO health labour market framework. Thus, regional offices provide direct support to enable countries' activities on workforce. The reporting patterns for each indicator reflect the

		progressive implementation of NHWA by countries, as per country context and their progress across the different modules of NHWA. Therefore, it is a maturity model that at any point of time describes the state of progress in the implementation of NHWA. Over the last five years, we have observed that more countries are using the NHWA process to generate data to inform their health labour market analysis and planning and policymaking. The bottom-up WHO planning has also listed health workforce among the top five priority areas for countries. Given that the implementation of country support will be informed by data, more countries are expected to report on the NHWA indicators in the coming years.
23	How target is realistic for PB2026-2027	The 2027 target is realistically achievable, given that the National Health Workforce Accounts is institutionalized in a majority of countries. As of May 2025, focal points have been appointed for 190 out of 194 WHO Member States for either direct reporting to the NHWA or through official channels like the Joint Data Collection on Non-Monetary Healthcare Statistics (JDC). 171 Member States (88%) reported new data during the 2024 NHWA data cycle, compared to 135 in 2023 (27% increase). Data availability has also improved for indicators on various health workforce topics, such as stock, activity level, graduates, and distribution by various parameters such as sex, age group, place of birth, place of training, etc. The achievement of these targets is contingent on the continued technical support from WHO to NHWA focal points across the world. This may be in the form of annual global webinars, regional workshops, national trainings, virtual clinics, or email consultations, provided that there is continued recognition of the value of NHWA as a global public good, continued prioritization and implementation of NHWA as a corporate monitoring mechanism for health workforce policy and practice, and continued funding of the team involved in its implementation at all the three levels of WHO.
24	Data sources	National Health Workforce Accounts data platform
25	Process of validation	Country consultation as part of the National Health Workforce Accounts annual data cycle.
26	Limitations	There is typically a 2-year time lag in data reporting for this indicator, with very few countries submitting t-1 data. This lag is due to the complexity of collecting and validating data on health worker migration (e.g. by place of birth or training), and is common even among OECD countries. However, this limitation does not impact countries' eligibility to be counted. As per the technical specification, countries are included in the indicator if they have reported any data on health workforce migration — regardless of the reference year.
27	Expected frequency of reporting	Biennial
28	Date last published	15 June 2025
29	Technical focal point	Jim Campbell <Campbellj@who.int>; Khassoum Diallo <kdiallo@who.int>



### 3.2.1.IND3\_UID 496: Number of countries reporting on the production of health and care workers

#	Metadata field	Summary
1	GPW14 Output	3.2.1. WHO provides technical guidance and operational support to countries to optimize and expand their health and care workforce
2	GPW14 Output indicator code	3.2.1.IND3
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries reporting on the production of health and care workers
4	Output/Leading Indicator (Country Level Formulation)	Country is reporting on the production of health and care workers
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Coverage of essential health services (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks the number of countries reporting on health workforce production (number of graduates) through the NHWA platform
12	Criteria	A country is counted as having achieved this indicator if it has reported data within the last five years on health workforce production (mainly the number of graduates from schools of dentistry, medicine, midwifery, nursing, or pharmacy) for <b>at least three of the five health occupations</b> (dentists, medical doctors, midwives, nurses, and pharmacists).
13	Numerator	Number of countries that meet the criteria specified in field 12 for NHWA reporting
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country has reported data within the last five years on health workforce production (number of graduates) for at least three of the five occupations (dentists, medical doctors, midwives, nurses, and pharmacists).</p> <p><b>Partially achieved:</b> The country has reported data on workforce production for only one or two of the five occupations within the last five years.</p>

		<b>Not achieved:</b> The country has not reported data on workforce production for any occupations in the last five years.
17	Rationale	<p>The purpose of NHWA is to structure the information architecture and interoperability, to define core workforce indicators, to enable strategic workforce planning and to facilitate comparability of the health workforce landscape (within countries and across regions). In the longer-term, the progressive development of the NHWA at the national level will accelerate and support new metrics on measuring workforce availability, accessibility, acceptability, and quality as the determinants to attaining UHC.</p> <p>This indicator captures the number of countries reporting on health workforce production through the NHWA platform, reflecting WHO's support in institutionalizing workforce data systems and enabling cross-country comparability.</p>
18	Measurement method	<ul style="list-style-type: none"> <li>• Data are collected at national level and reported annually through the National Health Workforce Accounts (NHWA) platform, which involves a systematic process of data entry by Member States nominated focal points, integration of health and care workforce data from other official channels to the NHWA (such as the Joint Data Collection on Non-Monetary Healthcare Statistics), triangulation of data with existing national sources, and data mining by the Secretariat for selected countries as and when deemed appropriate. The data validation process involves the three levels of WHO.</li> <li>• The Secretariat consolidates the results and determines whether each country meets the technical criteria mentioned in field 12 by reviewing the submitted data.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that meet the defined criteria under field 12.
21	Calculation type	Cumulative
22	Target setting methodology	<p>The setting of targets is informed by the regular NHWA cycle of reporting to the WHO Secretariat and by the analysis of reporting trends over the last five years. This is driven by the implementation of NHWA and the demand for technical assistance from countries to improve the quality, completeness and timeliness of reporting data on the health and care workforce. The NHWA contains a standardized set of indicators that have clear policy relevance across the entire spectrum of HWF priorities and are related to the WHO health labour market framework using the WHO health labour market framework. Thus, regional offices provide direct support to enable countries' activities on workforce. The reporting patterns for each indicator reflect the progressive implementation of NHWA by countries, as per country context and their progress across the different modules of NHWA. Therefore, it is a maturity model that at any point of time describes the state of progress in the implementation of NHWA. Over the last five years, we have observed that more countries are using the NHWA process to generate data to inform their health labour market analysis and planning and policymaking. The bottom-up WHO planning has also listed health workforce among the top five priority</p>

		areas for countries. Given that the implementation of country support will be informed by data, more countries are expected to report on the NHWA indicators in the coming years.
23	How target is realistic for PB2026-2027	The 2027 target is realistically achievable, given that the National Health Workforce Accounts is institutionalized in a majority of countries. As of May 2025, focal points have been appointed for 190 out of 194 WHO Member States for either direct reporting to the NHWA or through official channels like the Joint Data Collection on Non-Monetary Healthcare Statistics (JDC). 171 Member States (88%) reported new data during the 2024 NHWA data cycle, compared to 135 in 2023 (27% increase). Data availability has also improved for indicators on various health workforce topics, such as stock, activity level, graduates, and distribution by various parameters such as sex, age group, place of birth, place of training, etc. The achievement of these targets is contingent on the continued technical support from WHO to NHWA focal points across the world. This may be in the form of annual global webinars, regional workshops, national trainings, virtual clinics, or email consultations, provided that there is continued recognition of the value of NHWA as a global public good, continued prioritization and implementation of NHWA as a corporate monitoring mechanism for health workforce policy and practice, and continued funding of the team involved in its implementation at all the three levels of WHO.
24	Data sources	National Health Workforce Accounts data platform
25	Process of validation	Country consultation as part of the National Health Workforce Accounts annual data cycle.
26	Limitations	There is typically a two-year time lag in countries' reporting of health workforce production data through the NHWA platform. While a few countries report more recent data (t-1), most report based on data from two years prior (t-2), due to the complexity of collecting and validating graduate information. However, this delay does not affect countries' eligibility to be counted under the indicator. A country is included if it has submitted relevant data within the last five years, which accommodates the time lag and aligns with the NHWA measurement approach.
27	Expected frequency of reporting	Biennial
28	Date last published	15 June 2025
29	Technical focal point	Jim Campbell <Campbellj@who.int>; Khassoum Diallo <kdiallo@who.int>

### 3.2.2. WHO generates evidence, guides design and supports health-related macroeconomic policies and practices for sustainable health financing

#### 3.2.2.IND1\_UID 497: Number of countries showing evidence of progress in health financing policies for universal health coverage as a result of WHO support

#	Metadata field	Summary
1	GPW14 Output	3.2.2. WHO generates evidence, guides design and supports health-related macroeconomic policies and practices for sustainable health financing
2	GPW14 Output indicator code	3.2.2.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries showing evidence of progress in health financing policies for universal health coverage as a result of WHO support
4	Output/Leading Indicator (Country Level Formulation)	Evidence of progress in health financing policies for UHC as a result of WHO support
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Government domestic spending on health (1) as a share of general government expenditure, and (2) per capita (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks the number of countries where WHO support has contributed to observable progress in health financing policies aimed at Universal Health Coverage (UHC). Progress is assessed using the Health Financing Progress Matrix (HFPM), a structured qualitative assessment of health financing systems..
12	Criteria	<ul style="list-style-type: none"> <li>A country is counted as having achieved this indicator if it demonstrates measurable progress in health financing policy aligned with one or more areas of the <a href="#">WHO Health Financing Progress Matrix</a> (HFPM). Progress is defined as a positive shift in national health financing arrangements, judged through the HFPM's 33 structured questions covering different dimensions of health financing systems. Each question includes an explanation of why the question is important, along with the observable criteria underpinning progress on each, together with specification of four levels of progress. These shifts must reflect meaningful advancement toward Universal Health Coverage, and are reported through a dedicated WHO submission system established in 2020.</li> </ul>

		<ul style="list-style-type: none"> <li>The observed progress must be directly attributable to WHO support. This requires validation through consultation between Country Offices and Regional Offices (including MCATs in AFRO), and final review by WHO Headquarters. Submissions must clearly justify WHO's role in enabling the progress and be supported by relevant documentation.</li> <li>Only new countries demonstrating such attributable progress within a given calendar year are counted; countries are not counted more than once across the GPW14 period.</li> </ul>
13	Numerator	Number of countries showing evidence of positive change in health financing policies for UHC attributable to WHO support, as defined in the criteria outlined in Field 12.
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	TBD
17	Rationale	This indicator identifies technical support provided by WHO which results in positive changes in a country's health financing system. Positive developments are identified and mapped against one or more area of health financing in the WHO Health Financing Progress Matrix (HFPM); the HFPM is WHO's structured qualitative assessment which defines the attributes of a high-performing health financing system, and the shifts required to make progress towards these attributes. Linking WHO's technical support to positive change observed in countries allows us to concretely demonstrate the impact of our work.
18	Measurement method	<p>Measurement is conducted annually through a structured reporting and validation process using the Health Financing Progress Matrix (HFPM), which assesses country-level progress in health financing policies for Universal Health Coverage (UHC) that can be directly attributed to WHO support.</p> <ul style="list-style-type: none"> <li>WHO Regional Offices, including MCATs in AFRO, coordinate with Country Offices to identify cases of positive shifts in health financing systems. These shifts are assessed against one or more of the 33 structured HFPM questions, which span key areas such as governance, revenue raising, pooling, purchasing, and benefit design. Regional Offices prepare submissions through a dedicated HFPM reporting platform established and managed by WHO Headquarters since 2020.</li> <li>Progress is defined using the HFPM rubric, which includes four levels: Level 1-Emerging, Level 2- Progressing, Level 3- Established, and Level 4-Advanced. To be counted, a change must reflect meaningful improvement in health financing policy, aligned with HFPM standards.</li> <li>The observed shift must also be directly attributable to WHO support, confirmed through triangulated documentation such as mission reports, technical workplans, or joint reviews.</li> </ul> <p>Attribution is validated through a three-level review process:</p>

		<ul style="list-style-type: none"> <li>○ Country Offices provide inputs and supporting evidence.</li> <li>○ Regional Offices lead the submission and initial review.</li> <li>○ WHO Headquarters conducts final validation to ensure consistency and alignment.</li> </ul> <ul style="list-style-type: none"> <li>• Validated cases are recorded in the centralized HFPM database and dashboard, enabling structured annual tracking.</li> <li>• The indicator is cumulative across the GPW14 period: a country is counted once when progress is first confirmed. Subsequent developments in the same country do not increase the count.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that have achieved this indicator
21	Calculation type	Cumulative
22	Target setting methodology	The targets are based on a) past experience b) correspondence with ROs, and c) adjustments given planned reduction in WHO's capacity to provide technical support
23	How target is realistic for PB2026-2027	The target numbers have been slightly adjusted downward to reflect the anticipated reduction in WHO's capacity for technical support in health financing policy. Nonetheless, the combination of a structured three-level review process and the use of established normative guidance and analytical tools supports the feasibility of the targets.
24	Data sources	Internal WHO reporting system; Health Financing Progress Matrix submissions; documentation from COs/ROs
25	Process of validation	All submissions are reviewed by WHO and must be supported by relevant documentation to strengthen justification of WHO's contribution. They undergo a three-level review process involving Country Offices, Regional Offices, and WHO Headquarters. Where necessary, submissions are further discussed with the submitting parties to ensure clarity of the narrative and completeness of the supporting evidence before final clearance.
26	Limitations	Given the nature of this indicator, it can take some time to collect, review, discuss and verify the data; reference documentation to support submissions is at times lacking.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Matthew Jowett <jowettm@who.int>

**3.2.2.IND2\_UID 500 : Number of countries applying WHO-recommended approaches on economic evidence for planning, decision-making and resource allocation (including priority-setting, economic evaluation, costing, investment cases and plans, defining health benefit packages or health technology assessment) as a result of WHO engagement**

#	Metadata field	Summary
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1	GPW14 Output	3.2.2. WHO generates evidence, guides design and supports health-related macroeconomic policies and practices for sustainable health financing
2	GPW14 Output indicator code	3.2.2.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries applying WHO-recommended approaches on economic evidence for planning, decision-making and resource allocation (including priority-setting, economic evaluation, costing, investment cases and plans, defining health benefit packages or health technology assessment) as a result of WHO engagement
4	Output/Leading Indicator (Country Level Formulation)	Application of WHO-recommended approaches on economic evidence for planning, decision making, and resource allocation (including priority setting, economic evaluation, costing, investment cases and plans, defining health benefit packages or health technology assessment) supported by WHO
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Government domestic spending on health (1) as a share of general government expenditure, and (2) per capita (D); Coverage of essential health services (I); Incidence of financial hardship (defined as large out-of-pocket health spending, impoverishing out-of-pocket health spending, or both, using SDG 3.8.2 and regional indicators where available) (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator counts the number of countries where national planning and budgeting processes applied WHO-recommended approaches to economic evidence for health, such as priority setting, investment cases, health benefit packages, or health technology assessment, as a result of WHO engagement. WHO's contribution may include process guidance, methodological input, or technical assistance that enabled the use of such evidence in decision-making.
12	Criteria	<p>A country is counted as having achieved this indicator if WHO provided support, either in person or remotely, to a country-owned process that applied economic evidence for planning, decision-making, or resource allocation.</p> <ul style="list-style-type: none"> <li>• WHO's technical support is coordinated through a three-level process.</li> <li>• Support may refer to process guidance, data guidance, and methods guidance; and range from dissemination or orientation on suitable methods and tools to direct technical oversight and use of such evidence in decision-making and use of such evidence in decision making</li> </ul>

		<ul style="list-style-type: none"> <li>The application areas include priority setting, economic evaluation, costing, investment cases and plans, defining health benefit packages, or health technology assessment.</li> </ul>
13	Numerator	Number of countries that meet the criteria described in Field 12, where WHO engagement contributed to a country-owned process applying economic evidence for planning, decision-making, or resource allocation.
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country fully meets the criteria outlined in Field 12. WHO engagement clearly contributed to the application of economic evidence in national planning, decision-making, or resource allocation during the reporting year, supported by documented guidance or technical assistance.</p> <p><b>Partially achieved:</b> WHO engaged with the country during the reporting year, but evidence of application of economic analysis or decision-making tools remains limited, not fully embedded in national processes, or lacks sufficient documentation.</p> <p><b>Not achieved:</b> No evidence of country-owned application of economic evidence as a result of WHO engagement during the reporting year.</p>
17	Rationale	<p>This indicator measures the result of WHO's engagement (across the three levels of the Organization) in enabling countries to apply economic evidence within national planning, decision-making and resource allocation. It reflects how WHO contributes to country-owned processes that use economic analysis—such as priority setting, costing, investment cases and plans, defining health benefit packages, or health technology assessments.</p> <p>The use of economic evidence in planning, decision making and priority setting processes is critical to ensure that investments in health consider value for money. Economic evidence needs to be considered continuously through transparent, participatory decision-making processes, and thus this indicator is scored every year to indicate the extent to which WHO supported governments to make efficient investments.</p>
18	Measurement method	<p>Countries are counted based on documented evidence that WHO engagement contributed to a country-owned process applying economic evidence for planning, decision-making, or resource allocation.</p> <ul style="list-style-type: none"> <li>Data is collected through a standardized reporting system coordinated across WHO's three levels.</li> <li>Country offices report cases where WHO provided technical input, such as process guidance, methodological support, or tool dissemination, that enabled the application of economic evidence in national processes.</li> <li>Submissions must describe how WHO's engagement influenced the use of economic evidence and are supported by documentation when possible.</li> <li>Only countries where such application occurred during the reporting year are counted. The indicator is measured annually, but the final biennium total should count each country only once, even if supported in both</li> </ul>



		<p>years or across different economic areas (e.g. HTA in 2026 and costing in 2027).</p> <ul style="list-style-type: none"> <li>Starting in 2025, routine tracking will be implemented to ensure consistency in reporting and validation.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that have achieved this indicator
21	Calculation type	Cumulative
22	Target setting methodology	<p>Targets are based on a review of historical patterns of WHO technical support to countries in applying economic evidence.</p> <p>They also account for anticipated future needs in the context of increasing demand for efficient health financing and prioritization, particularly in low- and middle-income countries.</p> <p>Regional focal points for Health Financing and Economics were contacted to review and provide inputs on the proposed targets for 2026-27, and the target number of countries was updated based on this feedback.</p>
23	How target is realistic for PB2026-2027	In 2025 WHO will update its guidance on priority setting, costing and efficiency analysis. This will be available for countries to use in 26-27. The WHO will continue its efforts to work through networks of trusted technical partners in this area.
24	Data sources	WHO technical support documentation, internal reports, and regional/country office reporting
25	Process of validation	All submissions are backed up by documentation where possible to strengthen justification; submissions are reviewed by WHO and cleared following further discussion with ROs where necessary.
26	Limitations	Given the nature of this indicator, it can take some time to collect, review, discuss and verify the information. The use of economic -data is very context -specific but efforts will be made to standardize the information for reporting
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Anna Vassal< <a href="mailto:Vassala@who.int">Vassala@who.int</a> >; Karin Stenberg< <a href="mailto:Stenbergk@who.int">Stenbergk@who.int</a> >

### 3.2.3. WHO supports countries to implement measures for better access to, and use of, safe, effective and quality-assured health products

**3.2.3.IND1\_UID 190: Number of countries with a list of essential medicines (or reimbursed medicines) developed centrally, updated within the last five years and grounded in the concept of the WHO Model List of Essential Medicines**

#	Metadata field	Summary
1	GPW14 Output	3.2.3. WHO supports countries to implement measures for better access to, and use of, safe, effective and quality-assured health products
2	GPW14 Output indicator code	3.2.3.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries with a list of essential medicines (or reimbursed medicines) developed centrally, updated within the last five years and grounded in the concept of the WHO Model List of Essential Medicines
4	Output/Leading Indicator (Country Level Formulation)	A list of essential medicines (or reimbursed medicines) developed centrally, updated within the last 5 years, and grounded in the concept of the WHO Model List of Essential Medicines
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Access to Health Product Index (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks the number of countries that have a centrally developed (national or regional) list of essential or reimbursed medicines. The list must have been updated within the last five years and should reflect the principles and structure of the WHO Model List of Essential Medicines.
12	Criteria	<p>A country is counted as having achieved this indicator if it has a centrally developed (national or regional) list of essential or reimbursed medicines that meets all the following conditions:</p> <ul style="list-style-type: none"> <li>• The list has been updated within the last five years.</li> <li>• The list is grounded in the concept of the WHO Model List of Essential Medicines. This means the country explicitly bases its national list on the principles outlined in the WHO Model List, namely, a process of selecting medicines based on evidence, public health relevance, cost-effectiveness, and safety. Countries often note this alignment in the acknowledgements or background section of their official documents otherwise the principles are adopted implicitly.</li> </ul>

		<ul style="list-style-type: none"> <li>The list is the result of a central prioritization process used for procurement and/or reimbursement, even if it is not formally called an "essential medicines list".</li> <li>The list may include medicines used for primary or secondary level of care, or both.</li> </ul>
13	Numerator	Number of countries that meet the conditions described in the criteria outlined in Field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> countries that have a national EML and have actively engaged in an update within 5 years</p> <p><b>Partially achieved:</b> countries that have a national EML but did not have actively engaged in an update within 5 years</p> <p><b>Not achieved:</b> countries that do not have a national EMLs.</p>
17	Rationale	Access to medicines and other health products is essential for achieving universal health coverage. The national essential medicines list serves as a proxy for determining if a country is prioritizing medicines for procurement and reimbursement according to the national context and the needs of the population. The national essential medicines list also serves as a proxy for determining if a country is prioritizing other essential health products such as medical devices, including diagnostics, and assistive products. National essential medicines lists are closely connected to the WHO Model List of Essential Medicines, an important public health guidance that is evidence based, transparent and free from conflict of interest. This indicator is also important with a view to future developments, e.g. by measuring the proportion of medicines recommended as essential by the WHO that are partially or totally reimbursed.
18	Measurement method	<p>The measurement process involves identifying and analyzing national essential medicines lists (EMLs) using a combination of systematic web searches and expert validation:</p> <ul style="list-style-type: none"> <li>Search strategy: A structured search protocol is applied across multiple web search engines and in different languages to locate publicly available national EMLs. This strategy was originally used in 2017 and again in 2023 to identify national EMLs globally. It is continuously being refined to improve performance.</li> <li>Verification: When a country's EML cannot be located online, WHO technical officers in Country or Regional Offices, responsible for access to health care are contacted to verify whether a list exists.</li> <li>Scope of inclusion: The search includes both inpatient and outpatient lists, covering all levels of care (primary, secondary, tertiary, and quaternary). Lists that are not formally titled "essential medicines lists" are also included if they reflect a central prioritization process for procurement and/or reimbursement.</li> <li>Data abstraction: For each eligible national EML, the following information is extracted:</li> </ul>

		<ul style="list-style-type: none"> <li>○ Year of publication</li> <li>○ Time interval since last update</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that have achieved this indicator
21	Calculation type	Cumulative
22	Target setting methodology	<ul style="list-style-type: none"> <li>• Based on countries that had updated their lists in 2019 and are now due for an update</li> <li>• Countries generally adopt the WHO concept, and with some support, the target is considered achievable</li> </ul>
23	How target is realistic for PB2026-2027	The regions are highly engaged with WHO on this work.
24	Data sources	Global database of essential medicines
25	Process of validation	The database is populated using a combination of a computer algorithm and manual approaches. Target documents from each country are first identified using a computer run search screened by a computer algorithm. All eligible documents are manually reviewed by one staff member that verifies the accuracy of the computer abstraction process.
26	Limitations	Some countries may have lists that are not publicly available. Some countries might have multiple lists with different update timelines.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Deus Mubangizi < <a href="mailto:mubangizid@who.int">mubangizid@who.int</a> >; Deirdre Dimancesco < <a href="mailto:dimancescod@who.int">dimancescod@who.int</a> >

### **3.2.3.IND2\_UID 507 : Number of in-country registrations of prequalified products and SRA/WLA approved products registered under the Collaborative Registration Procedure or other facilitated reliance pathway in case of emergency**

#	Metadata field	Summary
1	GPW14 Output	3.2.3. WHO supports countries to implement measures for better access to, and use of, safe, effective and quality-assured health products
2	GPW14 Output indicator code	3.2.3.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of in-country registrations of prequalified products and SRA/WLA approved products registered under the Collaborative Registration Procedure or other facilitated reliance pathway in case of emergency
4	Output/Leading Indicator (Country Level Formulation)	Number of in country registrations of prequalified products and SRA/WLA approved products registered under the Collaborative Registration Procedure or other facilitated reliance pathways in case of emergencies
5	Monitoring framework (SDG, GPW, etc)	GPW14

6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Improved regulatory systems for targeted health products (medicines, vaccines, medical devices including diagnostics) (D)
9	Data type	Number
10	Unit of measure	Number
11	Indicator definition	This indicator measures the total number of registrations of health products that have been registered in-country under WHO's Collaborative Registration Procedure (CRP) or other facilitated pathways in emergency contexts. It includes prequalified products and those approved by Stringent Regulatory Authorities (SRA) or WHO Listed Authorities (WLA).
12	Criteria	<p>A registration is counted under this indicator if a product has been registered in-country through one of the following mechanisms:</p> <ul style="list-style-type: none"> <li>• Collaborative Registration Procedure (CRP) using a WHO-prequalified product or SRA/WLA approved</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>• A facilitated reliance pathway during an emergency, where the country relies on a WHO EUL/prequalification.</li> </ul> <p>The registration must be documented with official information (e.g. registration date and number) and entered into WHO's ePQS system or the Emergency Use Authorization tracker.</p>
13	Numerator	Number of product registrations that meet the criteria described in Field 12, specifically those completed in-country through the CRP or facilitated reliance pathways during emergencies.
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	National Regulatory Authorities (NRAs) are the gatekeepers of supply of medicines and other health products, with mechanisms in place to support quality, safety and efficacy/effectiveness. The regulatory process requires significant resources and capacity to conduct scientific evaluations. The WHO Collaborative Registration Procedure (CRP) promotes cooperation and information-sharing amongst participating NRAs and allows countries to reach a robust regulatory decision more efficiently, reducing duplication of effort and fostering capacity building. CRP uses the product assessment from WHO Prequalification) or Stringent Regulatory Authorities/WHO Listed Authorities (SRA/WLA) to facilitate timely registration of quality assured

		products in participating countries. WHO Prequalification is a rigorous science-based assessment process based on WHO global norms and standards for safety, efficacy and quality assurance. This indicator provides information on how both WHO Prequalification and WHO CRP contribute to strengthening the regulatory capacity for ensuring access to safe, effective and quality- assured priority medical products. WHO is uniquely placed to lead efforts to allow NRAs globally to have access to data which supports the safety, quality and efficacy of health products. In case of response to an emergency or outbreak, quick access to key health products is essential and reliance facilitation mechanisms exist to facilitate in-country Emergency Use Authorizations.
18	Measurement method	<ul style="list-style-type: none"> <li>• Data on participating countries is collected through signed agreements with National Regulatory Authorities, while product registrations data is gathered via emails containing details such as the date of registration and the product's registration number.</li> <li>• This information is then entered into the ePQS system in the appropriate fields. The ePQS serves as a platform for record tracking, communication, information sharing, and record management.</li> <li>• In case of emergency or response to an outbreak, facilitation of in-country Emergency Use Authorization (EUA) is facilitated through the provision of the WHO Emergency Use Listing evaluation. Facilitation of EUA is managed through tracker outside of ePQS</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of registrations in countries that have achieved this indicator, as per field 12
21	Calculation type	Cumulative
22	Target setting methodology	The targets have been set based on trends in registration of prequalified products (medicines, vaccines, IVDs) and SRA approved products in CRP participating countries recorded since 2013 with current cumulative number of registrations being 1476 as at December 2024 for all CRP product streams. Number of registrations in country is dependent on number of submissions made under CRP or other facilitated registration pathways and experience in implementation of reliance mechanisms in the participating NRAs. Considering all these factors and the work being undertaken by FPI including enablers listed below, the proposed targets are realistic and achievable.
23	How target is realistic for PB2026-2027	Factors for achievement of the targets: i) Existing national regulatory authorities (NRAs) already participating in the CRP for the three product streams are as follows: CRP for Prequalified medicines and vaccines (69 +1 Regional Economic Community (CARICOM), CRP for SRA approved medicines and vaccines (67 + 1 Regional Economic Community (CARICOM) and CRP for prequalified IVDs (37). ii) Ongoing engagement strategies to increase the number participating NRAs. We anticipate that at least 5 new NRAs will sign agreements to participate in the CRP annually. iii) Ongoing support to NRAs in strengthening their product registration systems including development and adoption of robust and efficient reliance mechanisms to increase efficiencies in CRP implementation. iv) Advocacy meetings and

		workshops with prequalification holders, marketing authorization holders, manufacturers and manufacturer associations to advocate for increased use of CRP as an efficient registration pathway to increase the number of submissions under the procedure, including expanding the scope of submissions. v) Joint efforts, collaboration and engagement of key stakeholders in all three levels of the organization (Headquarters, Regional Offices and Country Offices) vi) Availability of funding to support CRP activities and regional joint assessment initiatives.
24	Data sources	WHO ePQS
25	Process of validation	Data is entered into the ePQS by trained FPI staff, with specific modules assigned to data wardens to minimize errors and prevent duplication. Regular internal meetings are held to ensure alignment, track progress, and address any issues. Additionally, ePQS is integrated into the FPI Standard Operating Procedure for the Management of CRP (FPI-SOP-03).
26	Limitations	Challenges relate to the volume of information that must be entered into the system, and the timeliness of data entry is critical.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	SILLO, Hiiti Baran < <a href="mailto:silloh@who.int">silloh@who.int</a> >; Morris Ebenezer Gargar< <a href="mailto:gargarm@who.int">gargarm@who.int</a> >

### 3.2.3.IND3\_UID 749: Number of Member States with an established institutional development plan to improve regulatory capacity for health products, based on assessment using the WHO global benchmarking tool

#	Metadata field	Summary
1	GPW14 Output	3.2.3. WHO supports countries to implement measures for better access to, and use of, safe, effective and quality-assured health products
2	GPW14 Output indicator code	3.2.3.IND3
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of Member States with an established institutional development plan to improve regulatory capacity for health products, based on assessment using the WHO global benchmarking tool
4	Output/Leading Indicator (Country Level Formulation)	Establishment of an institutional development plan to improve regulatory capacity for health products based on the assessment of the national regulatory system & functions using the Global Benchmarking Tool
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active

8	Linked outcome indicators (Direct (D) or indirect (I))	Improved regulatory systems for targeted health products (medicines, vaccines, medical devices including diagnostics) (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator counts the number of countries that have developed an Institutional Development Plan (IDP) to strengthen their regulatory systems for health products. The IDP must be based on a formal WHO assessment using the Global Benchmarking Tool (GBT), which identifies areas where the country's regulatory system needs improvement.
12	Criteria	<p>A country is counted as having achieved the indicator if:</p> <ul style="list-style-type: none"> <li>• A formal <a href="#">WHO GBT assessment</a> has been conducted in that country.</li> <li>• The assessment identified gaps in the regulatory system (i.e., sub-indicators that did not meet the objective or lacked implementation evidence).</li> <li>• An Institutional Development Plan (IDP) has been developed based on those identified gaps, as per guidance in the GBT factsheet.</li> <li>• The IDP has been formally recorded in the WHO GBT administrative database.</li> </ul>
13	Numerator	Number of countries with an established IDP based on GBT assessment, as per the criteria in field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	<p>National Regulatory Authorities (NRAs) are the gatekeepers of the supply of medicines and other health products, mandated to ensure their quality, safety, and efficacy. The World Health Organization (WHO) uses the Global Benchmarking Tool (GBT) to evaluate national regulatory systems for medical products. The benchmarking process facilitates the formulation of an Institutional Development Plan (IDP) to build on strengths and address identified gaps. This helps prioritize interventions and monitor progress towards maturity level of the NRA. With this, the indicator will ensure that countries can systematically strengthen their regulatory capacity, ultimately leading to improved access to quality, safe and effective health products. WHO is the only institution mandated to conduct a formal assessment in a country (Resolution WHA67.20). The GBT was developed in 2016 after international consultations with member states and partners. There has been a consensus reached among member states and partners that the WHO GBT is the only globally acceptable tool for assessing the regulatory systems for oversight of health products in member states.</p>



18	Measurement method	Data is collected through a computerized global benchmarking tool (cGBT) after formal assessment of the national regulatory system and managed through the GBT administrative database.
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that have achieved this indicator
21	Calculation type	Cumulative
22	Target setting methodology	<ul style="list-style-type: none"> <li>• The target is based on ongoing negotiations with the countries. Before a formal benchmarking process can take place, an advance negotiations and agreement has to be made with the country before the benchmarking process.</li> <li>• Moreover, the regional advisors are consulted.</li> <li>• It is also donor driven depending on the availability of funds</li> </ul>
23	How target is realistic for PB2026-2027	Availability of resources Confirmation from the country after negotiation
24	Data sources	WHO Regulatory System Strengthening Database
25	Process of validation	<ul style="list-style-type: none"> <li>• Data is entered into the GBT admin module only after a formal assessment by the WHO.</li> <li>• Moreover, only RSS trained data managers have access to the database.</li> </ul>
26	Limitations	Several IDPs can be developed for a single country (IDP per products). Moreover, an IDP can be updated following re-assessment. However, only the first IDP developed for a country will be reported. This may underestimate the joint efforts of the member state and WHO. A country cannot be counted more than once despite the number of assessments carried out and IDP established and updated.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	SILLO, Hiiti Baran < <a href="mailto:silloh@who.int">silloh@who.int</a> >; Morris Ebenezer Gargar< <a href="mailto:gargarm@who.int">gargarm@who.int</a> >

### 3.3.1. WHO builds country capacity and develops tools and platforms to support countries in developing and improving their national digital health and health information systems to improve resilience, coverage, equity and impact

#### 3.3.1.IND1\_UID 811 : Number of countries with a digital health strategy and/or a road map

#	Metadata field	Summary
1	GPW14 Output	3.3.1. WHO builds country capacity and develops tools and platforms to support countries in developing and improving their national digital health and health information systems to improve resilience, coverage, equity and impact
2	GPW14 Output indicator code	3.3.1.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries with a digital health strategy and/or a road map
4	Output/Leading Indicator (Country Level Formulation)	Country has a digital health strategy and/or a road map
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Existence of national digital health strategy, costed implementation plan, legal frameworks to support safe, secure and responsible use of digital technologies for health (D); Number of countries that improved health information systems, measured by the SCORE Index (I); % of health facilities using point-of-service digital tools that can exchange data through use of national registry and directory services (by type) (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks the number of countries that have an official digital health strategy or roadmap in place. These documents outline how countries plan, coordinate, and implement digital health initiatives at the national level, to improve health system resilience, equity, and impact.
12	Criteria	A country is counted under this indicator if it has a Digital Health Strategy (DHS) or Roadmap that meets the following conditions: <ul style="list-style-type: none"> <li>• The document serves as a general framework for planning and coordinating various national digital health initiatives</li> <li>• It addresses key elements of regulation, governance, standards, human capacity, funding, policies and regulations</li> </ul>

		<p>Without a strong DHS, resource allocation may not align with steps needed to achieve a country's digital health vision.</p> <ul style="list-style-type: none"> <li>• May exist as a dedicated, standalone DHS document, or it can be integrated into a member state's national health strategy, policy, or broader digital strategy</li> <li>• <b>Must be officially published and endorsed by the country's Ministry of Health</b> or equivalent national health authority, following national regulatory procedures for government document approval.</li> </ul> <p><b>WHO attribution is validated</b> through:</p> <ul style="list-style-type: none"> <li>• Explicit references to the Global Strategy on Digital Health (GSDH) in the DHS document.</li> <li>• Alignment with GSDH strategic objectives.</li> <li>• Documented WHO support in the development of the DHS.</li> <li>• Mention of WHO-supported platforms like Global Initiative on Digital Health, Global Digital Health Certification Network or WHO-developed products like SMART guidelines.</li> </ul>
13	Numerator	Number of countries that have a digital health strategy or roadmap that meets the criteria described in Field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> Country has a DHS/roadmap that meets inclusion conditions in Field 12, including official endorsement and at least one of the criteria for WHO attribution.</p> <p><b>Partially achieved:</b> Country has a DHS/roadmap that is either (a) published but not endorsed by Ministry of Health or equivalent national health authority, (b) endorsed but lacks evidence of WHO attribution (including alignment with GSDH); or c) country has an informal/unofficial planning document.</p> <p><b>Not achieved:</b> Country has no DHS/roadmap</p>
17	Rationale	Reflects the ability for WHO to support countries in establishing an executable plan and roadmap for digital transformation.
18	Measurement method	<ul style="list-style-type: none"> <li>• Data is collected through country-level surveys, coordinated via WHO Regional and Country Offices.</li> <li>• DHS documents are reviewed to ensure they meet the criteria outlined in field 12</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries that have achieved this indicator as confirmed by the WHO Regional Office digital health lead
21	Calculation type	Cumulative
22	Target setting methodology	<ul style="list-style-type: none"> <li>• Targets were set in consultation with WHO Regional Offices and respective Country Offices, considering the baseline, regional priorities as well as Member States' digital health maturity and/or plans to develop a DHS.</li> </ul>

		<ul style="list-style-type: none"> <li>Additional consideration was given to the likelihood of whether or not new funding will be available to support the development of Member States' DHS moving forward.</li> </ul>
23	How target is realistic for PB2026-2027	Many Member States are prioritizing digital health to improve health outcomes amid constraints such as decreasing fiscal space, vastly geographic and socioeconomic distribution of populations combined with a double burden of disease and a need to tackle these challenges creatively. The growing global prioritization of digital health, demonstrated by global governance frameworks such as the Global Digital Compact, provide a strong foundation for countries to develop or renew their DHS. These efforts will be supported by continuous technical consultations with Member States, promotion of WHO normative tools and guidance, while fostering collaboration and knowledge exchange.
24	Data sources	Digital health strategy repository; Global Strategy for Digital Health
25	Process of validation	Request to countries through regional offices.
26	Limitations	Challenges dependent on country responsiveness
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Natschja Nash-Mendez< ratanaprayuln@who.int>

### **3.3.1.IND2\_UID1373 : Number of countries that have demonstrably improved their health information system capacity and increased their country assessment scores using the SCORE for Health Data technical package**

#	Metadata field	Summary
1	GPW14 Output	3.3.1. WHO builds country capacity and develops tools and platforms to support countries in developing and improving their national digital health and health information systems to improve resilience, coverage, equity and impact
2	GPW14 Output indicator code	3.3.1.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have demonstrably improved their health information system capacity and increased their country assessment scores using the SCORE for Health Data technical package
4	Output/Leading Indicator (Country Level Formulation)	Country has demonstrably improved their health information system by applying a WHO intervention, tool, or standard from the SCORE for Health Data technical package
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active

8	Linked outcome indicators (Direct (D) or indirect (I))	Number of countries that improved health information systems, measured by the SCORE Index (D); % of health facilities using point-of-service digital tools that can exchange data through use of national registry and directory services (by type) (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator measures the number of countries that demonstrate an increase in their overall SCORE Index, based on the composite results of five input indicators from the SCORE assessment tool.
12	Criteria	<p>A country is counted as having achieved this indicator if it <b>participated in the SCORE assessment round 2 and shows an increase in its overall SCORE Index</b> compared to the previous round.</p> <ul style="list-style-type: none"> <li>The increase must be in the composite SCORE Index, which is calculated as the weighted average of five normalized input indicators.</li> <li>It is not required that a country improves in all five components; a general increase in the overall score is sufficient.</li> <li>The five components were selected based on criteria including: <ul style="list-style-type: none"> <li>availability of data on an annual or biennial basis,</li> <li>representation of core health information system (HIS) functions,</li> <li>alignment with standards across countries, and</li> <li>ability to reflect the overall performance of national HIS.</li> </ul> </li> <li>There is no fixed percentage threshold for improvement. The focus is on enabling countries to track progress using the SCORE for health technical package, which is a WHO-developed tool managed across all three levels of the organization</li> </ul>
13	Numerator	Number of countries that participated in SCORE assessment round 2 and showed an increase in their composite SCORE Index compared to the previous round
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> Country shows a documented increase in its overall SCORE Index between rounds, with all five components assessed and validated submission supported by documentation.</p> <p><b>Partially achieved:</b> Country shows an increase in its overall SCORE Index, but submission has gaps (e.g. missing documentation, incomplete response to one or more components).</p> <p><b>Not achieved:</b> Country did not show an increase in its SCORE Index, or did not participate/submit a complete SCORE assessment.</p>
17	Rationale	The SCORE Composite Indicator provides a comprehensive measure of the effectiveness and efficiency of a country's health information systems. It integrates multiple aspects of health data systems, from surveillance to collect, analyse and reporting of common program indicators, allowing for a holistic view of health system performance including progress and gaps. It provide a snap shot on country's capacity to monitor health and SDG targets.

18	Measurement method	<ul style="list-style-type: none"> <li>Each country completes the SCORE assessment using an online tool developed and managed by WHO. Countries respond to a set of questions attributed to each of the five selected indicators. These questions are based on the SCORE assessment instrument, a WHO technical product developed and managed by WHO DDI.</li> <li>The SCORE Composite Indicator is calculated as a weighted average of five scaled input indicators, each normalized to a value between 0 and 1 using Min-Max normalization. The five input indicators are: <ol style="list-style-type: none"> <li>Indicator and event-based surveillance systems based on IHR standards (S2.2)</li> <li>Completeness of death registration (C1.2)</li> <li>Availability of selected indicators derived from facility data in the annual statistics (O1.1)</li> <li>Annual report on health sector progress (R1.2)</li> <li>National health plans and budget (E1.1)</li> </ol> </li> <li>The score index is calculated as: Numerator: Sum of the weighted, normalized scores of the five input indicators. Denominator: Number of input indicators (5).</li> <li>For the purpose of this output indicator, a country is counted as achieved if its composite SCORE Index is higher than in the previous round</li> <li>The final value of the indicator is the total number of countries with an increased SCORE Index</li> <li>Data is reviewed and validated by WHO country and regional offices. Responses must be supported by documentation and pass automated quality checks embedded in the tool</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries with an increased SCORE Index as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	The target is based on requests received from WHO regions and countries to participate in and use the SCORE for Health technical package. There has also been interest and engagement from partners to support this initiative. WHO/DDI has received requests from countries to register to access the assessment instruments. Results from the first global assessment round, published in 2021, showed that no country had yet reached the sustainable maturity level, indicating room for improvement.
23	How target is realistic for PB2026-2027	There has been a strong interest from member states who participated in the global assessment round 2. Consultation meetings showed that countries are interested in using the SCORE technical package to develop health information system improvement plan and to monitor their progress. There has also been interest and engagement from the partners to support this initiative. Moving forward, WHO's role will be to facilitate the dialogue in countries and with partners, to use of the SCORE technical package for strengthen HIS to meet the data needs in countries and use the tool to monitor the progress.
24	Data sources	SCORE assessment rounds

25	Process of validation	<p>The design of the questionnaire includes embedded data quality assurance measures, such as validation rules and an automated data quality review process.</p> <p>The data is reviewed by WHO Country Office (WCO) and Regional Office (RCO) focal points who have been trained on the content and methods.</p> <p>All responses are accompanied by supporting documents for validation.</p>
26	Limitations	<ul style="list-style-type: none"> <li>• Data quality and availability may vary between countries including Missing Data.</li> <li>• Inconsistent data collection methodologies can affect comparability.</li> <li>• Dependence on the accuracy and completeness of national health reports.</li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Hong Anh Chu <chuh@who.int>

#### 4.1.1. WHO develops evidence-based policies and supports the implementation, scale-up and measurement of best buys and other actions to strengthen person-centered prevention, control and management of noncommunicable diseases

**4.1.1.IND1\_UID 1000 : Number of countries that have completed a WHO STEPS survey or an equivalent risk factor survey aligned with WHO standards, including physical and biochemical measurements of key behavioural and metabolic risk factors for noncommunicable diseases**

#	Metadata field	Summary
1	GPW14 Output	4.1.1. WHO develops evidence-based policies and supports the implementation, scale-up and measurement of best buys and other actions to strengthen person-centered prevention, control and management of noncommunicable diseases
2	GPW14 Output indicator code	4.1.1.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have completed a WHO STEPS survey or an equivalent risk factor survey aligned with WHO standards, including physical and biochemical measurements of key behavioural and metabolic risk factors for noncommunicable diseases
4	Output/Leading Indicator (Country Level Formulation)	Country has completed a STEPS survey or another risk factor survey which includes physical measurements and biochemical assessments covering the key behavioural and metabolic risk factors for noncommunicable diseases
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Provisional
8	Linked outcome indicators (Direct (D) or indirect (I))	Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator measures whether a country has conducted a national survey, either a WHO STEPS survey or an equivalent, that includes physical and biochemical measurements of key behavioral and metabolic risk factors for noncommunicable diseases (such as tobacco use, physical inactivity, unhealthy diet, obesity, high blood pressure, and raised blood glucose), and that meets WHO standards for data quality and frequency.
12	Criteria	A country is counted as having achieved this indicator if it responds <b>“Yes” to each of the following</b> for adults:



		<ul style="list-style-type: none"> <li>Have surveys of risk factors (may be a single RF or multiple) been conducted in your country for all of the following: <ul style="list-style-type: none"> <li>Harmful alcohol use” (optional for the Member States where there is a ban on alcohol),</li> <li>Physical inactivity</li> <li>Tobacco use</li> <li>Raised blood glucose/diabetes</li> <li>Raised blood pressure/hypertension</li> <li>Overweight and obesity</li> <li>Salt / Sodium intake</li> </ul> For risk factors “Raised blood glucose/diabetes”, “Raised blood pressure/hypertension”, and “Overweight and obesity”, the data must be measured, not self-reported. </li> <li>Additionally, for each risk factor, the country must indicate that the last survey was <b>conducted in the past 5 years</b> (i.e. 2018 or later for the 2023 CCS survey responses)</li> <li>And must respond <b>“Every 1 to 2 years”</b> or <b>“Every 3 to 5 years”</b> to the subquestion “How often is the survey conducted?”</li> </ul>
13	Numerator	Number of countries that have conducted a WHO STEPS survey or an equivalent national risk factor survey aligned with WHO standards, covering all required behavioral and metabolic risk factors with physical and biochemical measurements, and meeting the criteria related to timing (within the last 5 years) and frequency (at least every 1–5 years) as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	TBD
17	Rationale	This indicator is an agreed process indicator for the NCD global plan of action for prevention and control of NCDs, and is used to track whether countries have in place an up to date and comprehensive system for reporting the epidemiological data needed for developing and monitoring NCD interventions and programmatic responses at the country level. It also reflects whether WHO technical assistance and tools are relevant and useful at the country level as countries use WHO guidance and tools to implement.
18	Measurement method	Data are collected through the WHO NCD Country Capacity Survey (CCS), completed by country-level teams. The responses are reviewed against WHO-defined criteria to confirm the completeness, timing, and frequency of national risk factor surveys. WHO verifies responses using supporting documents (e.g., survey reports) and cross-checks them with the STEPS tracking system to ensure reliability and alignment with standards.
19	Estimation method (if applicable)	Not applicable

20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	Targets are based on past responses to the NCD CCS. They take into account the decline in survey activity caused by the COVID-19 pandemic and anticipate a rebound to at least pre-pandemic levels, followed by a continued upward trend in line with pre-pandemic patterns.
23	How target is realistic for PB2026-2027	WHO provides technical support to countries to conduct NCD risk factor surveys and engages with countries looking to collect NCD risk factor data at all levels of the organization. Country interest in conducting surveys remains very high and the value of these data is appreciated by countries as these data will serve broad purposes from policy guidance to programme evaluation to monitoring the health of their population.
24	Data sources	<a href="#">STEPwise approach to NCD risk factor surveillance (STEPS)</a>
25	Process of validation	Countries are asked to submit a copy of their survey report(s) when submitting their response to the NCD CCS. Where discrepancies are noted, these are referred back to the country for clarification and modification. Data are also checked against the STEPS tracking system which records details of STEPS surveys undertaken by countries.
26	Limitations	None
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Leanne Riley < <a href="mailto:rileyl@who.int">rileyl@who.int</a> >; Melanie Cowan < <a href="mailto:cowanm@who.int">cowanm@who.int</a> >

**4.1.1.IND2\_UID 1009 : Number of countries with evidence-based national guidelines/protocols/standards aligned with WHO guidance for the management of major noncommunicable diseases through a primary care approach**

#	Metadata field	Summary
1	GPW14 Output	4.1.1. WHO develops evidence-based policies and supports the implementation, scale-up and measurement of best buys and other actions to strengthen person-centered prevention, control and management of noncommunicable diseases
2	GPW14 Output indicator code	4.1.1.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries with evidence-based national guidelines/protocols/standards aligned with WHO guidance for the management of major noncommunicable diseases through a primary care approach
4	Output/Leading Indicator (Country Level Formulation)	Country has evidence-based national guidelines/protocols/standards aligned with WHO guidance for the management of major NCDs through a primary care approach
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input,	Output

	Process, Output, Outcome)	
7	Indicator status (Active, Retired etc)	Provisional
8	Linked outcome indicators (Direct (D) or indirect (I))	Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease (I); Prevalence of treatment (taking medication) for diabetes, among adults aged 30 years and over with diabetes (I); Prevalence of controlled hypertension, among adults aged 30–79 years (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator measures how many countries have national guidelines, protocols, or standards for managing major noncommunicable diseases (cardiovascular diseases, diabetes, cancer, and chronic respiratory diseases) that are aligned with WHO guidance and implemented through a primary care approach. It reflects whether these documents exist for all four disease areas and are backed by official documentation.
12	Criteria	A country is counted as having achieved this indicator if: <ul style="list-style-type: none"> <li>• National guidelines, protocols, or standards exist for all four major NCDs: cardiovascular diseases, diabetes, cancer, and chronic respiratory diseases; and</li> <li>• The country provides the necessary supporting documentation confirming their existence.</li> </ul>
13	Numerator	Number of countries that have national guidelines, protocols, or standards for all four major NCDs (cardiovascular diseases, diabetes, cancer, and chronic respiratory diseases), and have submitted the required supporting documentation as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country has national guidelines, protocols, or standards for all four major NCDs (cardiovascular diseases, diabetes, cancer, and chronic respiratory diseases), and has submitted the required supporting documentation.</p> <p><b>Partially achieved:</b> The country has national guidelines/protocols/standards for at least two of the four NCDs (cardiovascular diseases, diabetes, cancer and chronic respiratory diseases), but not for all four.</p> <p><b>Not achieved:</b> The country has guidelines for fewer than two of the four major NCDs, or has not submitted the necessary documentation.</p>
17	Rationale	Existence of Government approved evidence-based national guidelines/protocols/ standards for the management (diagnosis and treatment) of the four main NCDs – cardiovascular diseases, diabetes, cancer and chronic respiratory diseases - is critical to improving quality of care and management of major NCDs.

18	Measurement method	Data for this indicator are collected through the WHO NCD Country Capacity Survey (CCS), which is completed by a designated team at the country level to ensure a comprehensive response. Countries are asked to report whether they have government-approved national guidelines, protocols, or standards for the management of the four major NCDs: cardiovascular diseases, diabetes, cancer, and chronic respiratory diseases.
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	Targets were set based on observed trends, where countries have progressively established national guidelines using WHO tools and support. These past patterns suggest continued uptake and alignment with WHO recommendations over time, providing a reasonable basis for expecting additional country uptake during the 2026–2027 period.
23	How target is realistic for PB2026-2027	Given past trends, countries are regularly establishing new guidelines utilizing WHO tools.
24	Data sources	<a href="#">Existence of evidence-based national guidelines/protocols/standards for the management of major NCDs through a primary care approach</a>
25	Process of validation	Countries are asked to submit a copy of the guidelines/protocols/ standards when submitting their response to the NCD CCS. Where discrepancies are noted, these are referred back to the country for clarification and modification.
26	Limitations	None
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Leanne Riley < <a href="mailto:riley.l@who.int">riley.l@who.int</a> >; Melanie Cowan < <a href="mailto:cowanm@who.int">cowanm@who.int</a> >

#### **4.1.1.IND3\_UID 1020 : Number of countries implementing an action plan or strategy aligned with the WHO global strategy to accelerate the elimination of cervical cancer as a public health problem**

#	Metadata field	Summary
1	GPW14 Output	4.1.1. WHO develops evidence-based policies and supports the implementation, scale-up and measurement of best buys and other actions to strengthen person-centered prevention, control and management of noncommunicable diseases
2	GPW14 Output indicator code	4.1.1.IND3
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries implementing an action plan or strategy aligned with the WHO global strategy to accelerate the elimination of cervical cancer as a public health problem

4	Output/Leading Indicator (Country Level Formulation)	Country has implemented a plan or strategy aligned with the WHO global strategy for cervical cancer elimination
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Provisional
8	Linked outcome indicators (Direct (D) or indirect (I))	Cervical cancer screening coverage in women aged 30–49 years, at least once in lifetime (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks the number of countries that have developed and implemented a national action plan or strategy specifically aligned with the WHO global strategy for cervical cancer elimination.
12	Criteria	<p>A country is counted as having achieved this indicator if :</p> <p>Case 1</p> <ul style="list-style-type: none"> <li>• it responds “Yes” to the question “Does your country have a national NCD policy, strategy or action plan which integrates several NCDs and their risk factors?”</li> <li>• It responds “Operational” to the subquestion “Indicate its stage”</li> <li>• It responds “Yes” to the subquestion on Cancer</li> </ul> <p>Case 2</p> <ul style="list-style-type: none"> <li>• It responds “Yes” to the question " Is there a policy, strategy, or action plan for cancer or some particular cancer types in your country?</li> <li>• It responds to the subquestion "yes for all cancers" or “yes, for specific cancer and cervical cancer is specified.”</li> </ul> <p>In both cases, the country must provide the needed supporting documentation</p>
13	Numerator	Number of countries that meet the criteria listed in field 12 and submit supporting documentation
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	TBD
17	Rationale	This indicator supports the WHO-led Cervical Cancer Elimination Initiative (CCEI), a global effort adopted in August 2020, which aims to eliminate cervical cancer as a public health problem. The initiative targets an incidence rate of below 4 per 100,000 women globally.

		<p>Cervical cancer is the fourth most common cancer among women worldwide and reflects deep inequities in access to prevention and care. The CCEI seeks to transform the global strategy into concrete, country-level action by encouraging the development and implementation of national policies, strategies, or action plans aligned with WHO's global approach.</p> <p>This indicator captures whether countries have operationalized these efforts through official documents. It reflects progress toward global commitments by the 194 Member States that endorsed the initiative and supports equitable access to prevention, screening, and treatment services.</p>
18	Measurement method	<p>Data are collected through the WHO Noncommunicable Diseases Country Capacity Survey (NCD CCS), completed by designated country teams. The process includes:</p> <ul style="list-style-type: none"> <li>• Responding to specific questions on national NCD and cancer policies, strategies, or action plans.</li> <li>• Indicating the operational status of these plans.</li> <li>• Identifying whether cervical cancer is specifically included.</li> <li>• Uploading relevant supporting documentation to substantiate the responses.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries achieving the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	Targets are based on past trends in country uptake of cervical cancer policies and assume a modest increase over the biennium. The approach includes retaining all countries currently in the baseline and anticipating a few additional countries based on historical patterns of engagement and policy development.
23	How target is realistic for PB2026-2027	WHO provides regular support to countries to develop cancer-related policies.
24	Data sources	<a href="#">Existence of evidence-based national guidelines/protocols/standards for the management of major NCDs through a primary care approach</a>
25	Process of validation	Countries are asked to submit a copy of their policy/strategy/action plan when submitting their response to the NCD CCS. Where discrepancies are noted, these are referred back to the country for clarification and modification.
26	Limitations	None
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Leanne Riley < <a href="mailto:rileyl@who.int">rileyl@who.int</a> >; Melanie Cowan < <a href="mailto:cowanm@who.int">cowanm@who.int</a> >

#### 4.1.1.IND4\_UID 1207 : Number of countries that have implemented disability inclusion measures in national health programmes and strategies

#	Metadata field	Summary
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1	GPW14 Output	4.1.1. WHO develops evidence-based policies and supports the implementation, scale-up and measurement of best buys and other actions to strengthen person-centered prevention, control and management of noncommunicable diseases
2	GPW14 Output indicator code	4.1.1.IND4
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have implemented disability inclusion measures in national health programmes and strategies
4	Output/Leading Indicator (Country Level Formulation)	Country has implemented disability inclusion measures in national health programmes and strategies
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Coverage of essential health services (D); Service coverage for people with mental health and neurological conditions (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks how many countries have integrated and mainstreamed disability across their programmes and strategies. Integration would mean including disability specific actions into mainstream activities across different health system components .Measures may be taken across any of the 10 strategic entry points for disability inclusion as outlined in the <a href="#">WHO Global report on health equity for persons with disabilities</a> , adapted from the original WHO Primary Health Care Framework. These areas represent all aspects of the health system that should be strengthened, depending on the specific country situation.
12	Criteria	<p>A country is counted as having achieved this indicator if:</p> <ul style="list-style-type: none"> <li>It has integrated disability inclusion into national health programmes and strategies in at least one of the following 10 strategic entry points outlined in the WHO Global Report on Health Equity for Persons with Disabilities: <ol style="list-style-type: none"> <li>1. Political commitment, leadership, and governance</li> <li>2. Health financing</li> <li>3. Engagement of stakeholders and private sector providers</li> <li>4. Models of care</li> <li>5. Health and care workforce</li> <li>6. Physical infrastructure and health communication</li> <li>7. Digital technologies for health</li> <li>8. Systems for improving the quality of care</li> </ol> </li> </ul>

		<p>9. Monitoring and evaluation</p> <p>10. Health policy and systems research</p> <ul style="list-style-type: none"> <li>The country <b>must have received technical support from WHO</b> (HQ, regional, or country level). Only countries where WHO support was requested and provided will be counted as having achieved the indicator</li> </ul>
13	Numerator	Number of countries that implemented disability inclusion measures in national health programmes and strategies (at least one of the ten strategic entry points) with WHO support
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> Disability inclusion is integrated in at least 1 of the 10 strategic entry points.</p> <p><b>Partially achieved:</b> Work is ongoing, but disability inclusion is planned or under development and not yet implemented in any entry point.</p> <p><b>Not achieved:</b> There is no evidence of integration or plans to integrate disability inclusion.</p>
17	Rationale	<p>This indicator will monitor the efforts of WHO to support Member States to integrate and mainstream disability across programmes and strategies. Currently, 1.3 billion people have significant disability and evidence shows that this population group is left behind and excluded from health systems. Persons with disabilities die up to 20 years earlier and have double risk of developing secondary conditions like diabetes, cardiovascular diseases, depression, TB compared to those without disabilities due to barriers in the health system and discrimination at societal level. Countries will achieve SDG3 and UHC, as well as any national health goals, only if persons with disabilities are included in the health system. The indicator is strongly aligned with WHO GPW14 principle to leave no one behind, as well as in WHO's commitment to health equity, gender equality and the right to health for all. This indicator makes it possible to: - monitor progress in Member States in making their strategic and policy frameworks inclusive of persons with disabilities and the impact these changes may have on inequities as mandated in the WHA74.8 Resolution</p>
18	Measurement method	<p>Countries report annually whether they have integrated disability inclusion into national health programmes and strategies in at least one of ten strategic entry points defined in WHO guidance.</p> <p>Data is collected through structured country reporting, compiled by WHO across all three levels (country, regional, and HQ), and submitted through the WHO KPI data tracker. Annual progress reports are coordinated with national health planning units, relevant ministries, and statistical offices. Responses use a binary format ("Yes" or "No") to confirm whether integration has occurred.</p>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries achieving the criteria as per Field 12



21	Calculation type	Cumulative
22	Target setting methodology	<p>The following factors defined the targets for 2026-2027:</p> <ol style="list-style-type: none"> <li>1. Current requests or initial discussions with Member States that are interested to implement actions on health equity for persons with disabilities</li> <li>2. Countries that WHO partners (e.g. NSA in official relations with WHO) have indicated in collaboration plans with WHO or where they are actively advocating before Ministries of Health for the adoption of WHO guidance on health equity for persons with disabilities</li> <li>3. Countries where regional and country offices of WHO have strong connections with disability counterparts in Ministries of Health</li> <li>4. The number of countries indicated also reflects the current capacity of WHO to provide technical support to Member States</li> </ol>
23	How target is realistic for PB2026-2027	<ol style="list-style-type: none"> <li>1. WHO has the necessary normative guidance to support Member States in their requests</li> <li>2. WHO will provide support through the three levels of the organization - regional offices will be strongly engaged in country activities as well</li> <li>3. WHO is launching a global initiative on health equity for persons with disabilities in 2025 which is expected to mobilize resources for country implementation and support to Member States</li> <li>4. WHO has a strong support from partners such as NSA in official relations with WHO</li> </ol>
24	Data sources	WHO reports from country support activities; WHO KPI data tracker; Yearly progress reports from Ministries of Health and statistical offices
25	Process of validation	WHO HQ Disability team, RO advisers and WCO focal persons for disability will check for accuracy, consistency and reliability of the data against the 10 strategic entry points outlined in the Global report on health equity for persons with disabilities.
26	Limitations	Challenges may arise in the definition and understanding of what a 'disability inclusion' measure is, due to conflation with rehabilitation or assistive technology activities.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Kaloyan Kamenov < kamenovk@who.int >

#### 4.1.1.IND5\_UID 1377: Number of countries with patient information systems reporting noncommunicable diseases indicators aligned to WHO guidance

#	Metadata field	Summary
1	GPW14 Output	4.1.1. WHO develops evidence-based policies and supports the implementation, scale-up and measurement of best buys and other actions to strengthen person-centered prevention, control and management of noncommunicable diseases
2	GPW14 Output indicator code	4.1.1.IND5

3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries with patient information systems reporting noncommunicable diseases indicators aligned to WHO guidance
4	Output/Leading Indicator (Country Level Formulation)	Country has a patient information systems reporting NCD indicators aligned to WHO guidance
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Provisional
8	Linked outcome indicators (Direct (D) or indirect (I))	Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks how many countries have a standardized patient information system in public health facilities that records data on noncommunicable diseases (NCDs) and risk factors in alignment with WHO guidance. A standardized system for recording patient-level data has a specified set of data elements that are well-defined and collected consistently.
12	Criteria	A country is counted as having achieved this indicator if : <ul style="list-style-type: none"> <li>• It responds "Yes" to the question "Please indicate the existence of a standardized system for recording patient level data that includes NCD status and risk factors in the following PUBLIC facilities"</li> <li>• and then answers "yes" for either Primary care centres, or secondary and tertiary care facilities/hospitals or yes for both.</li> </ul>
13	Numerator	Number of countries meeting the criteria detailed in field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	TBD
17	Rationale	Existence of a patient information system monitoring NCDs is critical to helping countries optimize their healthcare services to address the needs of people with NCDs and ensure appropriate patient follow up, identify gaps in access, quality and outcomes of service.

18	Measurement method	Data is collected through the WHO NCD Country Capacity Survey (CCS), completed by a multidisciplinary team at the country level. Along with the CCS, countries are asked to provide documentation related to their Routine Health Information System (RHIS) covering NCDs.
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	Targets are set based on past trends and the expectation of continued country demand for WHO support in establishing or improving patient information systems.
23	How target is realistic for PB2026-2027	There are routine requests from MS for support from WHO to establish or improve patient information systems - it is thus expected the number of MS with such systems in place will continue to grow.
24	Data sources	WHO NCD Country Capacity Survey (CCS)
25	Process of validation	Countries are asked to submit a copy of documentation related to their RHIS covering NCDs when submitting their response to the NCD CCS. Where discrepancies are noted, these are referred back to the country for clarification and modification. Data are also checked against the countries responses provided to WHO through the SCORE assessment to check alignment.
26	Limitations	None
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Leanne Riley < <a href="mailto:riley1@who.int">riley1@who.int</a> >; Melanie Cowan < <a href="mailto:cowanm@who.int">cowanm@who.int</a> >

### 4.1.2. WHO supports the design, scale-up, implementation and measurement of the coverage of people-centred, equitable services for key mental health, neurological and substance use conditions

#### 4.1.2.IND1\_UID 114 : Number of countries that have integrated the WHO mental health gap action programme

#	Metadata field	Summary
1	GPW14 Output	4.1.2. WHO supports the design, scale-up, implementation and measurement of the coverage of people-centred, equitable services for key mental health, neurological and substance use conditions
2	GPW14 Output indicator code	4.1.2.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have integrated the WHO mental health gap action programme
4	Output/Leading Indicator (Country Level Formulation)	Uptake of WHO mental health gap action programme (MhGAP)
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Service coverage for people with mental health and neurological conditions (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	The indicator tracks how many countries have integrated the WHO mental health gap action programme (mhGAP) into their health systems.
12	Criteria	A country is counted as having achieved this indicator if it has conducted a (sub-)national mhGAP training workshop (usually 5 days) for either trainers or health providers. The extent and successful rate of roll-out of the programme is ascertained from WHO mental health Atlas questions, specifically looking at the availability of pharmacological and psychosocial treatment at the primary care level.
13	Numerator	Number of countries that have integrated WHO mental health gap action programme (mhGAP) as per the criteria in Field 12
14	Denominator	Not applicable

15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country has met the criteria in Field 12, including conducting an mhGAP training and having services available at the primary care level.</p> <p><b>Partially achieved:</b> The country has initiated mhGAP-related activities (e.g. planning, adaptation of materials, or subnational training), but full integration or service availability is not yet confirmed.</p> <p><b>Not achieved:</b> No evidence of mhGAP training or integration efforts at national or subnational level.</p>
17	Rationale	WHO's mhGAP programme is a well-established and widely welcomed tool for integrating clinical care and treatment of priority mental, neurological and substance use conditions into primary health care and other non-specialized settings. Tracking country integration of mhGAP provides a robust basis for monitoring WHO's support to countries in scaling up mental health services. The indicator reflects WHO's operational reach and contribution to evidence-based service delivery and enables accountability for country-level implementation under UHC. It also helps identify areas where further technical assistance may be needed to strengthen uptake and scale.
18	Measurement method	Data on countries implementing mhGAP is obtained through a periodic survey (mental health Atlas) and annual tracking of programmatic implementation across all Regional Offices.
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	Targets are based on a situational analysis of remaining gaps and opportunities to implement mhGAP as well as existing planned country work (not all countries want or need to use this WHO package as they have developed their own / another program for identification and management of mental, neurological and substance use conditions).
23	How target is realistic for PB2026-2027	The overall increase is attainable as it represents only about one extra country per year per Region, and mhGAP has proven traction and interest as an operational mechanism for improved capacity to identify and manage mental, neurological and substance use conditions
24	Data sources	WHO mental health Atlas and UCN/MSD internal programmatic tracking of the take-up of WHO's technical packages relating to mental health, brain health and substance use in and across WHO Regions.
25	Process of validation	Administration of the WHO mental health Atlas survey in all WHO Member States provides a periodic validation to the more regular internal tracking of programme implementation. The validity and reliability of the data is derived from the personal knowledge (and involvement) of Regional Officers in mhGAP training and other support activities in the countries of their Region, but also from publicly web stories, technical reports, journal articles and other materials documenting the adaptation, uptake and implementation of this technical package.

26	Limitations	The level of intelligence on use of mhGAP is solid, so there are no significant limitations. The challenge is keeping an up-to-date picture of the extent of implementation / roll-out / impact once initial training activities have been completed, which is only done periodically via the Atlas survey
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Dan Chisholm <chisholmd@who.int>

#### **4.1.2.IND2\_UID 122 : Number of countries that have updated or developed a national strategy and/or action plan for mental health or the prevention of suicide**

#	Metadata field	Summary
1	GPW14 Output	4.1.2. WHO supports the design, scale-up, implementation and measurement of the coverage of people-centred, equitable services for key mental health, neurological and substance use conditions
2	GPW14 Output indicator code	4.1.2.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have updated or developed a national strategy and/or action plan for mental health or the prevention of suicide
4	Output/Leading Indicator (Country Level Formulation)	Development or update of a national strategy and/or action plan for mental health or prevention of suicide
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Suicide mortality rate (D); Service coverage for people with mental health and neurological conditions (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator measures whether countries have developed or updated a national mental health strategy and/or suicide prevention action plan. It tracks the number of countries that report having such a policy document in place, either newly developed or recently revised, in line with WHO's technical guidance.
12	Criteria	A country is counted as having achieved this indicator if <ul style="list-style-type: none"> <li>it reports, through the WHO Mental Health Atlas survey or validated internal WHO records, that a national mental health strategy and/or suicide prevention policy has been developed or updated.</li> </ul>

		<ul style="list-style-type: none"> <li>• Countries must confirm the presence of the plan or strategy and provide a hyperlink to the document.</li> <li>• WHO's contribution is verified through its internal tracking of technical support provided (e.g. guidance, review, input) and the inclusion of newly published strategies in the WHO MINDBANK repository. This ensures the result is attributable to WHO's normative and technical assistance, as requested by Member States.</li> </ul>
13	Numerator	The number of countries that meet the criteria outlined in Field 12, specifically, countries that have developed or updated a national strategy and/or action plan for mental health or suicide prevention, as reported through the Mental Health Atlas or verified via WHO internal tracking and document review.
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> Country has developed or updated a national mental health strategy and/or suicide prevention policy AND provided a hyperlink to the document, as verified through WHO's Mental Health Atlas survey or internal tracking.</p> <p><b>Partially achieved:</b> Country reports having a plan or strategy in place, but it has not been updated in the last 10 years, or no hyperlink/documentation is available for verification. WHO support may be ongoing or planned.</p> <p><b>Not achieved:</b> Country does not currently have a national mental health or suicide prevention strategy, or no report or evidence has been submitted through the Mental Health Atlas or WHO records.</p>
17	Rationale	WHO advocates for and supports a rights-based approach to treatment and care of people with mental health, neurological and substance use conditions, grounded in sound national policies and laws. Each year WHO is requested by many countries worldwide to provide technical support to the development, revision or review of mental health and suicide prevention policies and laws, in line with WHO guidance and tools. Suicide is an SDG indicator / target, and the development and implementation of a national mental health and/or suicide plan is expected to reduce the rate of suicide over time. National strategies for mental health and suicide prevention extend beyond but include provisions to enhance mental health service access, thereby indirectly contributing to higher service coverage.
18	Measurement method	<ul style="list-style-type: none"> <li>• 2025 and 2028 data respectively will be obtained from the WHO Mental health Atlas survey, which is administered periodically to all WHO Member States. There are specific sections of this survey that ask about the existence and nature of both a national mental health policy and a suicide prevention policy or strategy (stand-alone or integrated). There are also questions regarding levels of implementation and the extent to which policies adhere to international standards or include essential components that form part of WHO's technical guidance on mental health policy and suicide prevention.</li> </ul>

		<ul style="list-style-type: none"> <li>Data on the incremental number of new countries updating or developing policies in the interim period will be gathered from WHO internal programme implementation tracking at Regional and HQ levels.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	The targets were established by reviewing existing gaps in the availability of stand-alone mental health or suicide prevention policies or plans in countries, and by mapping these gaps to countries identified for priority support in each Region for the next biennium
23	How target is realistic for PB2026-2027	<p>Targets are realistically achievable owing to the following:</p> <ul style="list-style-type: none"> <li>increased attention to and interest in mental health by Member States</li> <li>WHO's knowledge of past rates of demand for WHO support to mental health policy development</li> <li>the total increase is equivalent to only 1-2 countries per Region per year.</li> </ul>
24	Data sources	Mental health Atlas survey 2024, which is carried out periodically every 4 years, and in between via UCN/MSD internal programme implementation tracking in and across Regions of countries updating / renewing their national mental health and/or suicide prevention policy.
25	Process of validation	Countries reporting newly updated mental health and suicide prevention policies in mental health Atlas survey are asked to provide a hyper-link to the strategy, thereby providing a means of verification. WHO MINDBANK is a further external reference source containing publicly available policies, laws and other governance documents relating to mental health.
26	Limitations	None anticipated.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Dan Chisholm <chisholmd@who.int>

#### **4.1.2.IND3\_UID 740 : Number of countries with improved availability and reporting of service coverage data for mental, neurological and substance use tracer conditions**

#	Metadata field	Summary
1	GPW14 Output	4.1.2. WHO supports the design, scale-up, implementation and measurement of the coverage of people-centred, equitable services for key mental health, neurological and substance use conditions
2	GPW14 Output indicator code	4.1.2.IND3
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries with improved availability and reporting of service coverage data for mental, neurological and substance use tracer conditions



4	Output/Leading Indicator (Country Level Formulation)	Availability and reporting of service coverage data for mental, neurological, and substance use tracer conditions
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Service coverage for people with mental health and neurological conditions (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks the number of countries that improve the availability and reporting of service coverage data for key mental, neurological, and substance use conditions, using tracer conditions such as psychosis, depression, and epilepsy.
12	Criteria	<p>A country is counted as having achieved this indicator if it has improved the availability and reporting of service coverage data for at least one of the following tracer conditions: psychosis, depression, or epilepsy.</p> <p>This improvement must be demonstrated through one or more of the following mechanisms:</p> <ul style="list-style-type: none"> <li>• Conducting a population or household health survey that includes WHO supported relevant modules (e.g. the depression module of STEPS, the World Health Survey + as well as World MH Surveys and a new ICD-11 survey tool called FLII-11).</li> <li>• Strengthening administrative databases or routine health information systems to include access and coverage metrics for the tracer conditions, with WHO technical and/or financial support.</li> <li>• Producing modelled service coverage estimates, such as new estimates for depression treatment coverage.</li> </ul> <p>WHO's contribution is verified through its role in providing tools, support, and tracking progress. The Secretariat maintains records of countries implementing these efforts, ensuring attribution to WHO-supported activities.</p>
13	Numerator	Number of countries that have improved availability and reporting of service coverage data for psychosis, depression, or epilepsy as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if	<b>Achieved:</b> The country has generated and reported new service coverage data for at least one tracer condition (psychosis, depression, or epilepsy) using a WHO-supported mechanism such as a national survey, strengthened

	benchmarking is applied)	routine health information system, or modelled estimates. As per field 12 <b>Partially achieved:</b> The country has initiated relevant activities, such as planning or piloting a survey, developing health information system components, or producing partial or subnational data, but has not yet reported full service coverage data for the tracer conditions. <b>Not achieved:</b> The country has not undertaken new data collection efforts, implemented HIS improvements, or reported service coverage data for any of the tracer conditions.
17	Rationale	Service coverage is a key 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', and 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'. The following outcome indicator of GPW-14 has been approved: Increased service coverage for mental and neurological conditions. This output indicator directly links to the outcome in terms of supporting countries' capacities to collect and report on service coverage for these conditions, which remains weak.
18	Measurement method	A provisional list of 24 countries spanning all WHO Regions has been drawn up, together with the expected source / basis for new service coverage estimation. <ul style="list-style-type: none"> <li>• Service coverage data is collected via population surveys (e.g., STEPS, World MH Surveys, FLII-11), national mental health surveys, routine HIS, and modelled estimates.</li> <li>• WHO supports countries to generate new data through technical and financial assistance.</li> <li>• Progress is measured by tracking countries using these methods to estimate service coverage for tracer conditions</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	The targets are based on countries already planning or expecting to undertake or use <ol style="list-style-type: none"> <li>1) a national mental health survey using FLII-11,</li> <li>2) the mental health module of a new STEPS survey;</li> <li>3) development of mental health indicators in routine HIS.</li> </ol>
23	How target is realistic for PB2026-2027	The targets are realistically achievable by 2026-2027, owing to the following: <ol style="list-style-type: none"> <li>a) new interest / attention to mental health of Member States, including better understanding of population mental health needs</li> <li>b) availability of funds to support development of routine HIS for mental health in selected countries</li> <li>c) the overall increase is equivalent to about 1 country per Region per year.</li> </ol>
24	Data sources	WHO mental health Atlas survey (service uptake and coverage for psychosis) plus IGAP survey for brain health (epilepsy), as well as UCN/MSD internal

		monitoring of programmatic implementation in countries, in particular national mental health surveys containing service uptake questions and use of depression module of STEPs survey.
25	Process of validation	Number of countries being actively supported to generate new estimates of service coverage is being tracked by Regional Offices and HQ. A description and validation of all countries being supported and enabled to collect and report on service coverage will be reported as part of the GPW-14 milestone for this outcome.
26	Limitations	Since the countries being actively supported to generate new estimates of service coverage will be tracked by Regional Offices and HQ, no challenges anticipated.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Dan Chisholm <chisholmd@who.int>

### 4.1.3. WHO provides leadership, develops evidence-based guidance and standards, and supports Member States to build capacity for delivery of targeted, innovative and integrated people-centred services for communicable diseases

#### 4.1.3.IND1\_UID 487 : Percentage of countries confirmed by WHO to have met WHO criteria for disease elimination for at least one disease

#	Metadata field	Summary
1	GPW14 Output	4.1.3. WHO provides leadership, develops evidence-based guidance and standards, and supports Member States to build capacity for delivery of targeted, innovative and integrated people-centred services for communicable diseases
2	GPW14 Output indicator code	4.1.3.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of countries confirmed by WHO to have met WHO criteria for disease elimination for at least one disease
4	Output/Leading Indicator (Country Level Formulation)	Percentage of countries confirmed by WHO to have met WHO criteria for disease elimination for at least one disease
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Malaria incidence per 1000 population (I); Tuberculosis incidence per 100 000 population (I); Number of new HIV infections per 1000 uninfected population, by sex, age and key populations(I); Hepatitis B incidence per 100 000 population (I)
9	Data type	Percentage of countries
10	Unit of measure	Percentage of countries
11	Indicator definition	<p>This indicator measures the percentage of WHO Member States that have been officially confirmed by WHO as having met the criteria for disease elimination for at least one disease. Elimination is defined based on disease-specific WHO criteria and includes any of the following:</p> <ul style="list-style-type: none"> <li>• Tuberculosis (TB): Countries with a low TB burden (less than 10 cases per 100,000 population and fewer than 5,000 cases annually) that have eliminated TB transmission.</li> <li>• Malaria: Countries that had malaria transmission in 2015 and now meet WHO's certification criteria for elimination.</li> <li>• Hepatitis: Countries validated by WHO for the elimination or path to elimination of either hepatitis B, hepatitis C, or mother-to-child transmission of hepatitis B.</li> </ul>

		<ul style="list-style-type: none"> <li>Sexually Transmitted Infections (STIs): Countries validated by WHO for the elimination of mother-to-child transmission of syphilis.</li> <li>Neglected Tropical Diseases (NTDs): Countries officially acknowledged by WHO for elimination as a public health problem (interruption of transmission) or disease-free status for at least one NTD.</li> </ul>
12	Criteria	<p>A country is counted as having achieved this indicator if</p> <ul style="list-style-type: none"> <li>It has been officially confirmed by WHO for disease elimination</li> <li>This can be for one or more of the following diseases: tuberculosis (TB), malaria, hepatitis B or C, sexually transmitted infections (syphilis), and neglected tropical diseases (NTDs).</li> <li>The elimination status must be validated by WHO following its technical criteria and endorsement protocols</li> </ul>
13	Numerator	Number of countries that have been validated by WHO as having achieved disease elimination for at least one of the included diseases
14	Denominator	WHO Member States generally; individual denominators vary by disease
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	WHO provides essential leadership and technical support to countries towards the elimination of diseases.
18	Measurement method	<ul style="list-style-type: none"> <li>TB: New question added to Global Tuberculosis Report for 54 low-burden countries. The 54 Member states are defined as having an estimated TB incidence of less than 10 cases per 100 000 population per year and fewer than 5000 notified new and relapse cases of TB per year.</li> <li>Malaria: Country data collated via World Malaria Report and burden estimates. More information can be found in Annex 1 <a href="#">here</a> . Denominator is defined at 90 endemic countries as of 2015</li> <li>NTDs: Elimination acknowledged officially by WHO Director-General. Denominator is set at 100 as this is the 2030 target set by the WHO NTD road map</li> <li>Hepatitis: WHO- Global level certification for validation of elimination/path to elimination of HBV, HCV or HBV EMTCT</li> <li>STIs: WHO validation for elimination of mother-to-child transmission of syphilis</li> </ul> <p>Data are collected through program-specific reports or direct validation processes</p>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	TBD
21	Calculation type	Cumulative

22	Target setting methodology	Each programme set targets based on trends in previous years bearing in mind possible resource constraints in LMICs
23	How target is realistic for PB2026-2027	The target is considered realistic based on observed trends in elimination progress. However, achievement depends on available financial and human resources
24	Data sources	TB: Global Tuberculosis Report; HIV & Hepatitis: Global Health Observatory, Global Health Sector Strategies; NTDs: WHO/NTD Databank; Malaria: World Malaria Report; STIs: Global Health Observatory
25	Process of validation	<ul style="list-style-type: none"> <li>• TB: Data reported via the annual data collection for the Global Tuberculosis Report are reviewed for accuracy and plausibility. Feedback is sent to Member States when problems are identified so that they can fix any problems directly within the TB data collection system.</li> <li>• Malaria: submitted case data are reviewed for completeness, consistency over time, and accuracy as they are being collated. Any discrepancy is identified through validation processes (validation algorithm within data collection forms, running validation scripts, and data review through online dashboard) and resolved through contacts with regional and country focal points</li> <li>• NTD: official acknowledgement by the Director-General of WHO</li> <li>• Hepatitis: By the GVAC as described in the Guidance for country validation of viral hepatitis elimination and the path to elimination</li> </ul>
26	Limitations	<ul style="list-style-type: none"> <li>• TB: This is a new indicator so it may be difficult for some Member States to report this in the first year.</li> <li>• Malaria: challenges linked to data completeness and timeliness</li> <li>• Hepatitis: Validation process takes various steps at country, regional and global level. This process may take a long time until certification</li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Adriana De Putter <deputtera@who.int>

**4.1.3.IND2\_UID 1378: Percentage of countries that have adopted policies in line with current WHO norms and standards to address endemic communicable diseases (HIV, TB, malaria, neglected tropical diseases (NTDs), hepatitis, sexually transmitted infections (STIs))**

#	Metadata field	Summary
1	GPW14 Output	4.1.3. WHO provides leadership, develops evidence-based guidance and standards, and supports Member States to build capacity for delivery of targeted, innovative and integrated people-centred services for communicable diseases
2	GPW14 Output indicator code	4.1.3.IND2

3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of countries that have adopted policies in line with current WHO norms and standards to address endemic communicable diseases (HIV, TB, malaria, neglected tropical diseases (NTDs), hepatitis, sexually transmitted infections (STIs))
4	Output/Leading Indicator (Country Level Formulation)	Percentage of countries that have adopted policies in line with current WHO norms and standards to address endemic communicable diseases (HIV, TB, malaria, neglected tropical diseases (NTDs), hepatitis, sexually transmitted infections (STIs))
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Malaria incidence per 1000 population (I); Number of new HIV infections per 1000 uninfected population, by sex, age and key populations (I); Tuberculosis incidence per 100 000 population (I); Hepatitis B incidence per 100 000 population (I)
9	Data type	Percentage of countries
10	Unit of measure	Percentage of countries
11	Indicator definition	This indicator measures the proportion of countries that have adopted national policies aligned with WHO norms and standards for six endemic communicable diseases: HIV, tuberculosis (TB), malaria, neglected tropical diseases (NTDs), hepatitis, and sexually transmitted infections (STIs).
12	Criteria	<p>A country is counted as having achieved this indicator if it meets at least one of the following disease-specific criteria:</p> <ul style="list-style-type: none"> <li>• TB: It is included in the WHO list of 30 high MDR-TB burden countries using 6-month regimens for treatment of MDR/RR-TB</li> <li>• HIV: It is a low-and middle-income Member States with DTG introduced as the first line antiretroviral therapy (and procurement has been initiated)</li> <li>• Hepatitis: It has a written a national hepatitis action plan/strategy</li> <li>• STIs: It reports national policy for routinely screening pregnant women for syphilis</li> <li>• NTDs: It is a country eligible for preventive chemotherapy and has submitted a formal request to WHO for donated PC medicines.</li> <li>• Malaria: It has adopted WHO policies for the diagnosis and treatment of malaria.</li> </ul>
13	Numerator	Number of countries that meet at least one of the disease-specific criteria in field 12
14	Denominator	Not applicable (Percentage calculated separately by disease and then summarized)
15	Using benchmarking to qualify the achievements (Yes/No)	No

16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	As the UN specialized agency responsible for global public health, WHO's core mandate is to guide countries, through its leadership and normative functions, towards the achievement of health for all. The adoption of WHO norms and standards is therefore a critical measure of the added value of WHO in countries.
18	Measurement method	<ul style="list-style-type: none"> <li>• TB: Data are collected via the annual data collection exercise for the Global Tuberculosis Report. The denominator for this indicator would be the WHO list of 30 high MDR-TB burden countries in a given year. This list is updated every five years, with the next update due at the end of 2025 and will be valid for the period 2026—2030.</li> <li>• HIV: Data are collected through the annual Global AIDS Monitoring (UNAIDS/WHO/UNICEF) data reporting tool. The denominator for this indicator is low- and middle-income WHO Member States in a given year.</li> <li>• STIs: Data are collected through the annual Global AIDS Monitoring (UNAIDS/WHO/UNICEF) data reporting tool. The denominator for this indicator is all WHO Member States in a given year.</li> <li>• Hepatitis: Data are collected every two years through the Global hepatitis reporting data tool. Policy adoption status are published in the Global hepatitis report and annually as part of the country profiles policy adoption status.</li> <li>• Malaria: data are collected through the World Malaria Report which collate information about policy adoption (more details can be found in Annex 4-A of the World Malaria Report). Denominator – 83 endemic countries as of 2024</li> <li>• NTD: Preventive Chemotherapy is the WHO-recommended strategy against 5 high-burden NTDs, lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminthiasis and trachoma, representing 99% of the global burden of NTDs in terms of population requiring interventions). Requests for donated medicines are submitted by health ministries through dedicated WHO forms; denominator is the number of countries eligible for preventive chemotherapy</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	TBD
21	Calculation type	Cumulative
22	Target setting methodology	Targets were set based on past data trends and newly revised roadmaps, such as the NTD roadmap, taking into account available resources.
23	How target is realistic for PB2026-2027	Targets are considered realistic because of observed past trends, the availability of resources (human and financial) at all levels, and the fact that most programmes already collect data in a



		standardized way. The involvement of EMRO and SEARO in the Output Indicator Working Group further supports feasibility.
24	Data sources	<ul style="list-style-type: none"> <li>• TB: Global Tuberculosis Report; WHO guidelines on the treatment of drug-resistant tuberculosis</li> <li>• HIV: Information sheet on WHO HIV policy adoption and implementation status in countries; 2021 WHO Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring</li> <li>• STIs: WHO policy adoption and implementation status in countries: sexually transmitted infections; Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections (2022–2030)</li> <li>• Hepatitis: Global policy report on the prevention and control of viral hepatitis in WHO Member States; Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections (2022–2030)</li> <li>• Malaria: World Malaria Report</li> <li>• NTDs: WHO/NTD databank; WHO road map for neglected tropical diseases 2021–2030</li> </ul>
25	Process of validation	<ul style="list-style-type: none"> <li>• HIV: submitted policy data are reviewed for completeness, and accuracy as they are being collated. Any discrepancy is identified through a validation processes (data review through GAM reporting tool) and resolved through country GAM teams and/or contacts with regional and country focal points</li> <li>• Malaria: submitted policy data are reviewed for completeness, and accuracy as they are being collated. Any discrepancy is identified through validation processes (data review through online dashboard, and static tables) and resolved through contacts with regional and country focal points</li> <li>• NTD: data are jointly validated by NTD staff at the three levels of WHO (WCO, RO, HQ)</li> <li>• Hepatitis: Data submitted to WHO is reviewed for completeness and accuracy. Discrepancies identified are resolved through contacts with regional and country focal points.</li> <li>• TB: TBD</li> <li>• STIs: TBD</li> <li>• Malaria: TBD</li> </ul>
26	Limitations	<ul style="list-style-type: none"> <li>• TB: None</li> <li>• HIV: Indicator will need to be revised if the WHO recommended first line regimen is no longer dolutegravir (DTG).</li> <li>• STIs: Not all Member States report data through the Global AIDS Monitoring system.</li> <li>• Malaria: challenges linked to data completeness and timeliness</li> <li>• NTD: not all eligible countries may apply to WHO for donated medicines</li> <li>• Hepatitis: Incomplete reporting from member states. National action plans may be drafted but not published or implemented in the countries.</li> </ul>

27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Adriana De Putter <deputtera@who.int>

#### **4.1.3.IND3\_UID 1379: Percentage of countries reporting on WHO-recommended indicators for endemic communicable diseases (HIV, TB, malaria, NTDs, hepatitis, STIs)**

#	Metadata field	Summary
1	GPW14 Output	4.1.3. WHO provides leadership, develops evidence-based guidance and standards, and supports Member States to build capacity for delivery of targeted, innovative and integrated people-centred services for communicable diseases
2	GPW14 Output indicator code	4.1.3.IND3
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of countries reporting on WHO-recommended indicators for endemic communicable diseases (HIV, TB, malaria, NTDs, hepatitis, STIs)
4	Output/Leading Indicator (Country Level Formulation)	Percentage of countries reporting on WHO-recommended indicators for endemic communicable diseases (HIV, TB, malaria, NTDs, hepatitis, STIs)
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Malaria incidence per 1000 population (I); Number of new HIV infections per 1000 uninfected population, by sex, age and key populations (I); Tuberculosis incidence per 100 000 population (I); Hepatitis B incidence per 100 000 population (I)
9	Data type	Percentage of countries
10	Unit of measure	Percentage of countries
11	Indicator definition	This indicator measures the percentage of WHO Member States reporting on selected, WHO-recommended indicators for six major endemic communicable diseases: HIV, TB, malaria, neglected tropical diseases (NTDs), hepatitis, and sexually transmitted infections (STIs).
12	Criteria	<p>A country is counted as having achieved this indicator if it reports data for at least one of the selected, WHO-recommended indicators for each relevant disease area, as defined below:</p> <ul style="list-style-type: none"> <li>• TB: Reports notification data on new and relapse TB cases for at least one of the last three years</li> <li>• HIV: Reports data on testing, treatment, incidence and mortality</li> <li>• Hepatitis: Reports viral hepatitis B &amp; C burden and cascade annually</li> <li>• STIs: Reports women attending antenatal care services who test positive for syphilis</li> </ul>

		<ul style="list-style-type: none"> <li>• Malaria: Reports malaria cases, deaths, testing, treatment, and interventions.</li> <li>• NTDs: For countries eligible for preventive chemotherapy (PC), submits data on epidemiological and programmatic PC indicators</li> </ul>
13	Numerator	Number of countries that meet the criteria described in Field 12 — that is, countries that report on at least one of the selected, WHO-recommended indicators for each relevant disease area (HIV, TB, malaria, NTDs, hepatitis, STIs) in accordance with WHO reporting mechanisms.
14	Denominator	Number of WHO Member States or program-eligible countries per disease area.
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	WHO plays a central and unique role on global data collection on TB, HIV, hepatitis, STIs, malaria, and neglected tropical diseases
18	Measurement method	<ul style="list-style-type: none"> <li>• TB: Data are collected via the annual data collection exercise for the Global Tuberculosis Report. The denominator for this indicator would be all WHO Member States in a given year.</li> <li>• HIV: Data for the numerators are collected through the annual Global AIDS Monitoring reporting tool and/or through HIV estimation statistical models. Data for the denominators are collected through HIV estimation statistical models.</li> <li>• Hepatitis: Data are collected every two years through the Global hepatitis reporting data tool. The denominator for this indicator would be all WHO Member States in a given year</li> <li>• STIs: Data are collected through the annual Global AIDS Monitoring reporting tool. The denominator for this indicator is all WHO Member States in a given year.</li> <li>• Malaria: countries report malaria metrics (case, death, testing, treatment) through the World Malaria Report data collection forms, and data on interventions are supplanted by partners information (more details can be found here). Denominator – 83 endemic countries as of 2024</li> <li>• NTD: PC is the WHO-recommended strategy against 5 high-burden NTDs, lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminthiasis and trachoma, representing 99% of the global burden of NTDs in terms of population requiring interventions). Data are provided by health ministries through dedicated WHO forms; denominator is the number of countries eligible for preventive chemotherapy</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	TBD

21	Calculation type	Cumulative
22	Target setting methodology	Targets were set based on trends from previous biennia and consideration of resource availability, particularly in LMICs. Input from WHO regions was taken into account through standard data collection mechanism
23	How target is realistic for PB2026-2027	<p>Targets are considered realistic based on:</p> <ul style="list-style-type: none"> <li>• Past reporting trends</li> <li>• Standardized data collection in place for most diseases</li> <li>• Previous consultations and inputs from regions like EMRO and SEARO</li> </ul> <p>However, recent reductions in US Government (USG) funding may affect progress for GMP, GTP, and HHS programmes</p>
24	Data sources	<ul style="list-style-type: none"> <li>• TB: Global Tuberculosis Report; The End TB Strategy</li> <li>• HIV: Global Health Observatory; Global Health Sector Strategies on HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030</li> <li>• Hepatitis: Global health sector strategies on HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030 (WHO, 2022)</li> <li>• STIs: Global Health Observatory; Global Health Sector Strategies on HIV, viral hepatitis and sexually transmitted infections for the period 2022–2030 (WHO, 2022)</li> <li>• Malaria: World Malaria Report; Global Technical Strategy for Malaria 2016–2030</li> <li>• NTDs: WHO/NTD databank; WHO road map for neglected tropical diseases 2021–2030</li> </ul>
25	Process of validation	<ul style="list-style-type: none"> <li>• TB: Submitted data are reviewed for completeness and consistency with previous years. Feedback is sent to Member States when problems are identified so that they can fix any problems directly within the TB data collection system.</li> <li>• HIV: Numerators: submitted data are reviewed for completeness, and accuracy as they are being collated. Any discrepancy is identified through a validation processes (data review through GAM reporting tool) and resolved through country GAM teams and/or contacts with regional and country focal points. Denominators: The HIV estimates are created by country teams and are signed off on by ministry of health managers. The focal point in the country is copied on the requests for clearance. UNAIDS reviews the input data and results to ensure quality before requesting clearance and compiling to regional and global values.</li> <li>• Hepatitis: Data submitted to WHO is reviewed for completeness and accuracy. Discrepancies identified are resolved through contacts with regional and country focal points.</li> <li>• Malaria: submitted data are reviewed for completeness, timeliness, consistency, and accuracy as they are being collated. Any discrepancy is identified through validation</li> </ul>

		<p>processes (validation algorithm within data collection forms, validation scripts, data review through online dashboard, and static tables) and resolved through contacts with regional and country focal points</p> <ul style="list-style-type: none"> <li>• NTD: data are jointly validated by NTD staff at the three levels of WHO (WCO, RO, HQ)</li> <li>• <a href="#">STIs:?</a></li> </ul>
26	Limitations	<ul style="list-style-type: none"> <li>• TB: Some Member States are consistently unable to report data in time because of the delays in compiling numbers. This is especially true for countries with a federal structure where TB programmes are decentralised. However, late data are used the following year, so for these countries there is a lag in publishing TB case notification numbers.</li> <li>• HIV: Since the indicator is comprised of four indicators, the availability of data is not the same for each sub-indicator. For reporting on this indicator, the sub-indicator with the highest number of countries for which data are available is used.</li> <li>• Hepatitis: Data completeness is not consistent across the indicators. Reporting frequency is different for the indicator on HBV prevalence among under fives. Indicator include data sourced both from program data and modelled estimates</li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Adriana De Putter <deputtera@who.int>

#### **4.1.4. WHO develops and disseminates guidance and tools to mitigate antimicrobial resistance, collects and reports data for action, raises awareness, guides research and innovation, builds country and regional capacity to implement a core package of interventions, and coordinates global multisectoral action**

##### **4.1.4.IND1\_UID 212 : Number of countries implementing and monitoring government-endorsed multisectoral antimicrobial resistance national action plans based on WHO guidance with necessary financing**

#	Metadata field	Summary
1	GPW14 Output	4.1.4. WHO develops and disseminates guidance and tools to mitigate antimicrobial resistance, collects and reports data for action, raises awareness, guides research and innovation, builds country and regional capacity to implement a core package of interventions, and coordinates global multisectoral action
2	GPW14 Output indicator code	4.1.4.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries implementing and monitoring government-endorsed multisectoral antimicrobial resistance national action plans based on WHO guidance with necessary financing

4	Output/Leading Indicator (Country Level Formulation)	Implementing and monitoring government-endorsed multisectoral antimicrobial resistance national action plan based on WHO guidance with necessary financing
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Percentage of bloodstream infections due to selected antimicrobial-resistant organisms (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator measures how many countries are actively implementing and monitoring a government-endorsed multisectoral national action plan on antimicrobial resistance (AMR), in alignment with WHO guidance and with necessary financing in place.
12	Criteria	<p>A country is counted as having achieved this indicator if it reports Level D or E on Question 2.3.a in the TrACSS survey.</p> <ul style="list-style-type: none"> <li>• Level D: Full implementation and monitoring with necessary financing</li> <li>• Level E: Evaluation of implementation and use of results for policy making</li> </ul> <p>The national action plan must be government-endorsed, and the country must be actively implementing and monitoring it. Even in countries where WHO did not directly support the development of the AMR plan, WHO HQ, Regional Offices, and Country Offices are involved in the implementation and conduct technical reviews to ensure that the plan is aligned with WHO guidance. This ensures that achievement of the indicator reflects WHO's normative and technical contribution.</p>
13	Numerator	Number of countries reporting D or E for implementation of AMR national action plans in the TrACSS survey as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> Country reports full implementation and monitoring with necessary financing, or evaluation and use of results for policy-making. (<i>Level D or E on Question 2.3.a</i>)</p> <p><b>Partially achieved:</b> Country reports partial implementation of the government-endorsed AMR national action plan with limited resources (<i>Level C</i>)</p> <p><b>Not achieved:</b> Country reports no government-endorsed plan in place, or plan exists but not yet being implemented. (<i>Level A or B</i>)</p>
17	Rationale	The UNGA high-level meeting on AMR political declaration (2024) calls on all countries to establish and implement AMR national action plans, and at least 60% of these plans to be funded. The

		overall national response to address antimicrobial resistance (AMR) can be measured through the effective implementation and monitoring of its multisectoral AMR national action plan. Increase in the number of countries implementing and monitoring government-endorsed national action plans with necessary financing highlights national commitment to address AMR in the country, allocation of technical and financial resources, and potential reduction of mortality and morbidity associated with AMR in human health. WHO has developed and provides guidance and technical support to countries for the development, financing, implementation and monitoring of AMR national action plans.
18	Measurement method	Data is collected through the annual "Tracking AMR Country Self-assessment Survey" (TrACSS) administered by WHO on behalf of the Quadripartite. This is a voluntary survey that was started in 2016, and the UNGA HLM on AMR political declaration (2024) sets a global target of 95% of countries to submit responses to TrACSS annually . The indicator will be measured based on the number of countries submitting responses to TrACSS in a particular year and responding to levels A-E for question 2.3.a. Question 2.3.a in the survey measures progress in the implementation of AMR national action plans. There are 5 response categories from A - E. Each response level builds on the previous level. Levels A-B represent the absence of a plan or implementation; Levels C - E represent implementation of the AMR national action plans and monitoring and financing. Level C denotes partial implementation with limited resources; Level D denotes full implementation and monitoring with necessary financing; and Level E denotes evaluation of the full implementation of the national action plans and use of the results for policy making.
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	Targets are based on a review of baseline data from countries that have developed AMR national action plans but are not yet implementing them. Given WHO's current financial and staffing capacity, it is feasible to provide technical support to approximately <b>four countries per year</b> to help them reach implementation levels (Level C -E). This estimate was developed in consultation with Regional Offices, reflecting both demand for support and operational constraints. The final number of countries achieving the indicator may vary, as some countries may progress independently, while others may face challenges such as instability or non-response to the voluntary survey. This methodology supports incremental, demand-driven

		technical engagement aligned with WHO's normative role and resources
23	How target is realistic for PB2026-2027	<ul style="list-style-type: none"> <li>• 6 countries have already requested WHO support.</li> <li>• HQ staffing is limited, and regional funding constraints were considered.</li> <li>• Target of 4 countries per year reflects a realistic scale of WHO-supported implementation, while additional countries may also meet the indicator without support</li> </ul>
24	Data sources	Annual TrACSS data (Question 2.3.a), AMR plan repository on WHO AMR website
25	Process of validation	The data collected through TrACSS is validated through review of the initial submission by the national government, followed by review of the submission by the WHO Country and Regional office. The presence or absence of a national action plans is also verified against the library of AMR national action plans that is available on the WHO AMR website.
26	Limitations	The data collection is through a voluntary survey. Hence it is not feasible to predict accurately the target number of countries annually. In addition, in some instances changes in the Government can result in the national AMR focal point altering the country's specific response category compared to previous years. Reporting can also be impacted by conflicts, instability or natural disasters faced by the country during the data collection period.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Anand Balachandran < balachandrana@who.int>

**4.1.4.IND2\_UID 518: Number of countries with an antimicrobial resistance surveillance system in place and providing data to the WHO Global Antimicrobial Resistance and Use Surveillance System (GLASS), based on WHO guidance and protocols**

#	Metadata field	Summary
1	GPW14 Output	4.1.4. WHO develops and disseminates guidance and tools to mitigate antimicrobial resistance, collects and reports data for action, raises awareness, guides research and innovation, builds country and regional capacity to implement a core package of interventions, and coordinates global multisectoral action
2	GPW14 Output indicator code	4.1.4.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries with an antimicrobial resistance surveillance system in place and providing data to the WHO Global Antimicrobial Resistance and Use Surveillance System (GLASS), based on WHO guidance and protocols
4	Output/Leading Indicator (Country Level Formulation)	Establishment of an antimicrobial resistance surveillance system providing data to WHO Global Antimicrobial Resistance and Use Surveillance System (GLASS) based on WHO guidance and protocols



5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Percentage of bloodstream infections due to selected antimicrobial-resistant organisms (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator measures the number of countries that have an established national antimicrobial resistance (AMR) surveillance system and are submitting AMR data to WHO's Global Antimicrobial Resistance and Use Surveillance System (GLASS) in accordance with WHO guidance and protocols.
12	Criteria	A country is counted as having achieved this indicator if: <ul style="list-style-type: none"> <li>• It has established a national AMR surveillance system aligned with WHO GLASS protocols,</li> <li>• And is actively submitting AMR surveillance data to the WHO Global Antimicrobial Resistance and Use Surveillance System (GLASS) through the designated platform,</li> <li>• Using standardized methods as outlined in WHO guidance, including appropriate microbiological testing (e.g. AST) and data validation at the national level prior to submission.</li> </ul>
13	Numerator	Number of countries reporting AMR data to WHO's GLASS platform based on WHO guidance and protocols as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country has an established AMR surveillance system and has submitted at least one year of validated AMR surveillance data to WHO's GLASS platform within the past three years, following WHO guidance and protocols, as per field 12</p> <p><b>Partially achieved:</b> The country is enrolled in GLASS, but has not submitted at least one year of validated AMR surveillance data to WHO's GLASS platform within the past three years.</p> <p><b>Not achieved:</b> The country has been targeted for engagement but is not enrolled in GLASS</p>
17	Rationale	WHO's Global Action Plan on AMR includes five strategic objectives, with the second focusing on surveillance. In 2024, in the UN General Assembly political declaration on AMR, Member States committed to reporting quality surveillance data on AMR by 2030, through existing global surveillance systems. Additionally, in the WHA 77/5 Resolution of 2024, Member States agreed to accelerate their national responses by adopting WHO's strategic and operational priorities to combat drug-resistant bacterial infections in the human health sector from 2025 to 2035. This includes ensuring access to

		appropriate, quality-assured treatments and obtaining strategic information by monitoring antimicrobial use to guide patient care and actions on AMR. To achieve these goals, countries must establish surveillance systems to monitor AMR. The data generated will help understand the current situation, identify gaps and misuse, and track progress towards the stated objectives.
18	Measurement method	<p>WHO's Global AMR Surveillance System (GLASS) supports countries in implementing standardized surveillance systems for AMR. Data on the establishment of national systems and their core components—such as the National Coordinating Centre (NCC), designated surveillance sites, and the National Reference Laboratory for AMR (NRL)—is <b>generated at the national level and reported to WHO via the GLASS questionnaire on the dedicated IT platform</b>. Cases of AMR infection are identified among patients from whom routine clinical samples have been collected for culture at surveillance sites (health care facilities). Antimicrobial susceptibility tests (AST) are performed on isolated pathogens following international standards* ,**. The microbiological results (bacteria identification and AST) are de-duplicated, combined with patient data, and related to population data from the surveillance sites. This data are then collated and validated at the national level before being reported to GLASS. <b>The number of countries submitting data is counted</b>, and epidemiological statistics and metrics are generated. GLASS has published guidelines on establishing national AMR surveillance systems, and the GLASS methodology implementation manual is available to countries.</p> <p>*EUCAST guidelines for detection of resistance mechanisms and specific resistances of clinical and/or epidemiological importance. Version 2.0. 2017. Both for species identification and antimicrobial susceptibility testing (AST) **Clinical and Laboratory Standards Institute (CLSI). Performance Standards for Antimicrobial Susceptibility Testing. 32nd ed. CLSI supplement M100 (ISBN 978-1-68440-134-5 [Print]; ISBN 978-1-68440-135-2 [Electronic]). Clinical and Laboratory Standards Institute, USA, 2022</p>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	<p>Targets were set based on two main considerations:</p> <ul style="list-style-type: none"> <li>• First, a number of countries are already enrolled in GLASS but have not submitted data in recent years. These countries are being prioritized for targeted support to strengthen their data collection, management, and reporting processes.</li> <li>• Second, there is ongoing outreach to engage countries not yet enrolled in GLASS, with the expectation that new countries will join and begin submitting data. Specifically, it is anticipated that</li> </ul>

		<p>at least <b>two new countries per year</b> will enroll and start reporting.</p> <p>The combined effect of re-engaging existing countries and expanding the network through new enrollments forms the basis for the projected increase in reporting countries over the biennium.</p>
23	How target is realistic for PB2026-2027	WHO has an active GLASS helpdesk which provides ongoing one-on-one support to countries. We also hold an annual series of regional and global webinars on GLASS, supported by ROs. Additionally, we are supported by a network of 36 WHO AMR Collaborating Centres across all regions.
24	Data sources	Data collected from countries through the GLASS IT platform, based on submissions from their national AMR surveillance systems.
25	Process of validation	Data submitted to GLASS undergo automated consistency checks followed by detailed review and validation by a dedicated WHO team (GLASS helpdesk) in consultation with member states.
26	Limitations	There are ongoing constraints in some settings for obtaining nationally representative AMR data. This includes potential bias due to the number and distribution of surveillance sites, low coverage of testing, and suboptimal quality of laboratory analyses.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Anna Dean <deanan@who.int>

#### **4.1.4.IND3\_UID 519 : Number of countries with national systems in place to monitor the use of antimicrobials in human health and reporting to the GLASS, based on WHO guidance and protocols**

#	Metadata field	Summary
1	GPW14 Output	4.1.4. WHO develops and disseminates guidance and tools to mitigate antimicrobial resistance, collects and reports data for action, raises awareness, guides research and innovation, builds country and regional capacity to implement a core package of interventions, and coordinates global multisectoral action
2	GPW14 Output indicator code	4.1.4.IND3
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries with national systems in place to monitor the use of antimicrobials in human health and reporting to the GLASS, based on WHO guidance and protocols
4	Output/Leading Indicator (Country Level Formulation)	Establishment of a national system to monitor the use of antimicrobials in human health, and report to WHO Global Antimicrobial Resistance and Use Surveillance System (GLASS) based on WHO guidance and protocols
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active

8	Linked outcome indicators (Direct (D) or indirect (I))	Percentage of bloodstream infections due to selected antimicrobial resistant organisms (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator measures whether a country has established a national system to monitor the use of antimicrobials in human health, in line with WHO guidance and protocols, and whether it reports antimicrobial use data to WHO's Global Antimicrobial Resistance and Use Surveillance System (GLASS).
12	Criteria	A country is counted as having achieved this indicator if it either: <ul style="list-style-type: none"> <li>• Self-reports LEVEL-C for the NEW TRACSS question 3.2, indicating that it has a functional national surveillance system in place that collects data on antimicrobial use (AMU) regularly; or</li> <li>• Has a functional surveillance system that collects AMU data regularly and has reported this data to WHO GLASS at least once over a 5-year period (including the target year and the four previous years).</li> </ul>
13	Numerator	Number of countries that meet the defined criteria in field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> TrACSS 3.2 Level C - National surveillance system is functional and collects antimicrobial use data regularly OR National surveillance system is functional, collects data regularly, and reports to WHO GLASS (at least once over a 5 year period - the targeted year and previous 4 years) (As per field 12)</p> <p><b>Partially achieved:</b> TrACSS 3.2 Level B - National surveillance system established</p> <p><b>Not achieved:</b> TrACSS 3.2 Level A - No surveillance system in place</p>
17	Rationale	The Global Action Plan on AMR has a strategic objective focusing on the optimal use of antimicrobials. Recently, under the 2024 UNGA HLM on AMR political declaration, Member States committed to ensuring that at least 70% of their antibiotic use consists of "Access" antibiotics. Additionally, in the WHA 77.6 Resolution, Member States agreed to accelerate their national responses by adopting the WHO strategic and operational priorities to combat drug-resistant bacterial infections in the human health sector from 2025 to 2035. This includes ensuring access to appropriate, quality-assured treatments and obtaining strategic information by monitoring antimicrobial use to guide patient care and actions on AMR. To achieve these goals, WHO supports countries by providing guidance for the establishment of national surveillance systems to monitor antimicrobial use, and also by providing assistance for the collection and reporting of data through the WHO GLASS. The data generated will help us understand the current situation in countries and globally, identify gaps and misuse, and track progress towards the

		stated objectives of the Global Action Plan on AMR, as well as the UNGA AMR political declaration commitments and targets.
18	Measurement method	<p>Data is collected through two sources.</p> <ul style="list-style-type: none"> <li>• WHO has set up the annual TrACSS survey to track the progress of Member States' implementation of their AMR national action plans. Specifically, Question 3.2 of TrACSS addresses the implementation of a national surveillance system to monitor antimicrobial use.</li> <li>• Additionally, WHO has established GLASS to gather and report data on antimicrobial use at national, regional, and global levels. Both TRACSS and GLASS conduct annual data calls for countries to report on their NAP implementation and annual antimicrobial use. The data collected by these systems will be utilized to measure the indicator.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	<ul style="list-style-type: none"> <li>• Target setting was based on changes introduced in the 2025 TRACSS questionnaire, which redefined surveillance levels. Countries self-reporting Level B under the previous TRACSS version were reviewed and mapped to the new Level C definition, based on internal estimations and cross-validation.</li> <li>• The target reflects the expected progression of countries from establishing a surveillance system (Level B) to making it functional and regularly collecting antimicrobial use (AMU) data (Level C), or to reporting such data to WHO GLASS. The methodology also accounts for countries currently outside the reporting system that are expected to join and advance through technical support and regional engagement by WHO.</li> <li>• Consultations with regional offices informed the identification of countries likely to progress, and guided assumptions on feasible improvements in AMU surveillance capacity over the biennium.</li> </ul>
23	How target is realistic for PB2026-2027	<p>The target is considered realistic due to the combination of WHO's technical support, regional training efforts, and ongoing engagement with countries to improve AMU surveillance systems.</p> <ul style="list-style-type: none"> <li>• Countries reclassified to "Partially achieved" under the new TRACSS criteria are expected to return to "Achieved"</li> <li>• Regional workshops, such as those conducted in Africa for Central African and Indian Ocean countries, have focused on onboarding new countries and accelerating progress.</li> <li>• WHO headquarters and regional offices are actively tracking country engagement in GLASS and providing support to help them reach the functional surveillance level and begin reporting.</li> </ul>
24	Data sources	TrACSS survey results; WHO GLASS AMU submissions; National AMU surveillance systems

25	Process of validation	Every year, Member States are invited to report on the status of their national surveillance system to monitor national antimicrobial use as part of TrACSS and to report national Antimicrobial Use data to WHO GLASS. Both TrACSS and GLASS have procedures to validate the information/data provided by Member States - including review by national authorities, WHO country/Regional Offices, and by WHO Hq.
26	Limitations	Reporting to WHO, either for TrACSS or GLASS, is only voluntary and is self reporting. It is possible that Member States do not report either that they have a national system in place nor national AMU data. Additionally, some countries may have a functional system which collects AMU data that is incompatible with WHO GLASS. In that case these countries are not able to report AMU data to WHO.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Arno Muller < amuller@who.int>

### 4.2.1. WHO provides guidance and technical assistance to improve sexual, reproductive, maternal, newborn, child, adolescent, adult and older person health

#### 4.2.1.IND1\_UID 728 : Number of countries that have integrated care for older people at the primary care level using the WHO ICOPE package for the assessment and management of impairment in the intrinsic capacity of older people

#	Metadata field	Summary
1	GPW14 Output	4.2.1. WHO provides guidance and technical assistance to improve sexual, reproductive, maternal, newborn, child, adolescent, adult and older person health
2	GPW14 Output indicator code	4.2.1.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have integrated care for older people at the primary care level using the WHO ICOPE package for the assessment and management of impairment in the intrinsic capacity of older people
4	Output/Leading Indicator (Country Level Formulation)	Country has integrated care for older people at the primary care level using the WHO ICOPE package for the assessment and management of impairment in the intrinsic capacity of older people
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Percentage of older people receiving long-term care at a residential care facility and home (D); Effective refractive error coverage (eREC) (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator measures the number of countries that have implemented integrated care for older people (ICOPE) at the primary care level, specifically using the WHO ICOPE package to assess and manage impairments in the intrinsic capacity of older people.
12	Criteria	A country is counted as having achieved this indicator if it has integrated care for older people in primary care using the WHO ICOPE package for the assessment and management of impairments in intrinsic capacity. The determination is based on: <ul style="list-style-type: none"> <li>• Responses to the Decade of Healthy Ageing Process Evaluation Survey</li> <li>• Supplementary data from WHO country support activities coordinated by WHO Headquarters and Regional Offices</li> <li>• Verified evidence that the ICOPE package is being used in practice.</li> </ul>

13	Numerator	Number of countries with integrated care for older people using the ICOPE package as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country has implemented integrated care for older people at both community and primary health care levels using the WHO ICOPE package, with evidence of national policies and operational rollout (e.g. training, service delivery, monitoring) as per field 12.</p> <p><b>Partially achieved:</b> The country has initiated steps to integrate care for older people (e.g. policy in place or pilot sites operational), but implementation of the full ICOPE package is limited or not nationwide.</p> <p><b>Not achieved:</b> The country has no reported implementation of integrated care for older people using the ICOPE package, and no supporting national policy or plans in place.</p>
17	Rationale	<p>When we age, numerous physiological changes occur and the risks of experiencing declines in physical and mental capacities (intrinsic capacity) and having more than one condition (disease) increase. They manifest as cognitive decline, limited mobility, hearing loss, malnutrition, vision impairment, depressive symptoms, urinary incontinence and falls. Integrated care for older people approach (ICOPE) is WHO's approach to provide a continuum of integrated care that helps to reorient health and social services towards more person-centred and coordinated care. ICOPE supports optimizing intrinsic capacity and functional ability in older age. Implementing ICOPE as a part of Universal Health Coverage is one of the action areas of UN Decade of Healthy Ageing (2021-2030). WHO provides guidance <a href="#">Integrated care for older people (ICOPE): guidance for person-centred assessment and pathways in primary care</a>,</p>
18	Measurement method	<ul style="list-style-type: none"> <li>• Data are primarily collected through the UN Decade of Healthy Ageing Process Evaluation Survey, which asks whether countries have national policies supporting comprehensive assessments of health and social care needs of older people.</li> <li>• The current survey question does not explicitly reference WHO ICOPE package, so WHO supplements this with data from country-level technical support activities coordinated by WHO HQ and RO to verify if ICOPE is explicitly being used.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	The targets for 2026–2027 were set through a strategic selection process based on a combination of demographic, political, and operational factors. Countries were prioritized based on the rapid



		growth of their ageing populations, indicating an urgent need for integrated care solutions. Additional considerations included strong national commitment to advancing the integrated care agenda for older persons, the existence of foundational health and social care infrastructure (such as trained health workforces, financing mechanisms, and service delivery systems), and readiness for scale-up based on ongoing policy initiatives. The selection was made in close coordination with WHO Regional and Country Offices to ensure alignment with existing support structures and country priorities
23	How target is realistic for PB2026-2027	Several factors contribute to the realistic achievability of these targets. First, WHO will provide targeted technical assistance, capacity-building support, and implementation tools to accelerate implementation of ICOPE programme at the national and sub-national levels. Second, the selected countries have shown strong political will and have enabling environments conducive to introducing integrated care models. Third, funding and human resources have been considered in the selection process, ensuring that the necessary infrastructure is in place to support rapid rollout, for example availability of trained nurses, doctors and community health workers in primary care. Finally, strong regional engagement through WHO Regional and Country Offices will allow for ongoing technical guidance, monitoring, and troubleshooting, ensuring that implementation remains on track and adaptive to country needs.
24	Data sources	UN Decade of Healthy Ageing Process Evaluation Survey; WHO country support activity data; National policies and implementation documentation
25	Process of validation	<ul style="list-style-type: none"> <li>• Survey conducted online, with one lead respondent designated by each government. using DataForm, a WHO self-service online survey platform based on the open-source product LimeSurvey. This is programmed to include checks and limiting responses in fields to only valid responses.</li> <li>• Responses to the survey are reviewed by WHO regional offices and any discrepancies clarified and corrected.</li> </ul>
26	Limitations	<ul style="list-style-type: none"> <li>• Self-reported data may be subject to bias.</li> <li>• Current survey does not explicitly reference the ICOPE package; verification requires supplementary data</li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Theresa Diaz < <a href="mailto:tdiaz@who.int">tdiaz@who.int</a> >; Jotheeswaran Amuthavalli Thiyagarajan< <a href="mailto:amuthavallithiya@who.int">amuthavallithiya@who.int</a> >

**4.2.1.IND2\_UID 1225: Number of countries that have a strategic plan (whose development was supported by WHO) whose end date has not expired for two or more areas of sexual, reproductive, maternal, newborn, child and adolescent Health**

#	Metadata field	Summary
1	GPW14 Output	4.2.1. WHO provides guidance and technical assistance to improve sexual, reproductive, maternal, newborn, child, adolescent, adult and older person health
2	GPW14 Output indicator code	4.2.1.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have a strategic plan (whose development was supported by WHO) whose end date has not expired for two or more areas of sexual, reproductive, maternal, newborn, child and adolescent Health
4	Output/Leading Indicator (Country Level Formulation)	Country has a strategic plan (whose development was supported by WHO) whose end date has not expired for two or more areas of Sexual, Reproductive, Maternal, Newborn, Child, and Adolescent Health (SRMNCAH)
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive healthcare (I); Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age (I); Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods (estimates) (I); Maternal mortality ratio (I); Proportion of births attended by skilled health personnel (I); Under-5 mortality rate (I); Neonatal mortality rate (I); Proportion of health facilities that provide comprehensive post-rape care as per WHO guidelines (I); Obstetric and gynaecological admissions owing to abortion (I); Stillbirth rate (per 1000 total births) (I); Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1000 women in that age group (I); Treatment of acutely malnourished children (I); Proportion of girls and women aged 15–49 who have undergone female genital mutilation (I); Proportion of children aged 24–59 months who are developmentally on track in health, learning and psychosocial well-being, by sex (I); 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 healthcare, information and education (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries

11	Indicator definition	This indicator measures whether countries that received WHO support have a current national strategic plan covering at least two areas of Sexual, Reproductive, Maternal, Newborn, Child, and Adolescent Health (SRMNCAH). It reflects WHO's role in supporting the development and maintenance of integrated SRMNCAH planning frameworks
12	Criteria	A country is counted as having achieved this indicator if: <ul style="list-style-type: none"> <li>• It reports, through the WHO SRMNCAH Policy Survey, having a <b>current</b> (i.e. Not expired) integrated national strategy or plan that includes <b>at least two areas</b> of sexual, reproductive, maternal, newborn, child, and adolescent health (SRMNCAH).</li> <li>• WHO's support in the development of the plan is verified through collaboration between national respondents (typically from ministries of health) and WHO country and regional offices during completion of the SRMNCAH Policy Survey. Verification is based on joint review and submission of source documents, ensuring attribution to WHO's technical or financial support.</li> </ul>
13	Numerator	Number of countries with a current strategic plan (developed with WHO support) that covers at least two areas of SRMNCAH as per filed 12.
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country has a current (not expired) integrated national strategy or plan covering at least two SRMNCAH areas, developed with WHO support (technical or financial).</p> <p><b>Partially achieved:</b> The country has a current SRMNCAH-related strategy or plan covering at least one area, or a multi-area plan developed without clear WHO support</p> <p><b>Not achieved:</b> The country has no current strategy or plan covering SRMNCAH areas</p>
17	Rationale	WHO, as a leader, provides recommendations on what should be included in RMNCAH strategic plans and offers direct support—either financial or technical—in developing and reviewing these plans. WHO also leads the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), a bold roadmap for ending all preventable maternal, newborn, and child deaths (including stillbirths) by 2030 and improving the overall health and well-being of these populations. The strategy aims to place these groups at the heart of the Sustainable Development Goals (SDG) agenda, unlocking their vast potential for transformative change. It was developed to translate the SDG agenda into concrete guidance for accelerating progress through a multisectoral approach.
18	Measurement method	<ul style="list-style-type: none"> <li>• Data are collected through the WHO SRMNCAH Policy Survey, completed by national health authorities in collaboration with WHO country and regional offices.</li> </ul>

		<ul style="list-style-type: none"> <li>Although the Policy Survey is conducted every five years, interim mechanisms will be used to enable annual updates and ensure alignment with GPW14 measurability standards.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	<p>Using responses from the 2023 WHO SRMNCAH Policy Survey, target countries for 2026 and 2027 were identified through country prioritization exercises coordinated across UHL programmes. Countries were prioritized as follows:</p> <ul style="list-style-type: none"> <li>Target 2026: Countries that do not currently have an integrated SRMNCAH strategy and are priority countries in at least three of the following categories: WHO MNCH support countries, WHO Adolescent Health support countries, WHO SRH support countries, or are target/focus countries of global SRMNCAH-related initiatives (e.g. EWENE, CSA, QoC network, Muskoka).</li> <li>Target 2027: Countries without a current integrated SRMNCAH strategy that fall into at least one of the above prioritization categories.</li> </ul>
23	How target is realistic for PB2026-2027	The targets are realistic because they are based on countries that were prioritized as WHO MNCH support countries, WHO Adolescent health support countries, and/or WHO SRH support countries or are target/focus countries of global initiatives related to SRMNCAH (e.g. EWENE, CSA, QoC network, Muskoka). These countries have an increased level of technical support from WHO.
24	Data sources	<a href="#">WHO SRMNCAH Policy Survey</a> ; National reports of integrated strategies or plans that include at least two areas of sexual, reproductive, maternal, newborn, child, and adolescent health (SRMNCAH)
25	Process of validation	<ul style="list-style-type: none"> <li>Survey was administered using DataForm, a WHO self-service online survey platform based on the open-source product LimeSurvey. This was programmed to include checks and limiting responses in fields to only valid responses.</li> <li>The responses to the survey are reviewed by WHO regional offices and any discrepancies clarified and corrected,</li> <li>Source documents are collected including the actual strategy documents to validate the responses</li> </ul>
26	Limitations	Limited response rate from some regions; Countries can have one strategy (e.g. Maternal/newborn) or combined eg SRMNCAH; Although some strategies may have expired, they may be in the process of being revised and still being followed
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Elizabeth Katwan < <a href="mailto:katwane@who.int">katwane@who.int</a> >; Theresa Diaz < <a href="mailto:tdiaz@who.int">tdiaz@who.int</a> >

**4.2.1.IND3\_UID 1226: Number of countries that have a national sexual, reproductive, maternal, newborn, child and adolescent health coordinating body that includes UN H6 partnership that met at least once in the past year**

#	Metadata field	Summary
1	GPW14 Output	4.2.1. WHO provides guidance and technical assistance to improve sexual, reproductive, maternal, newborn, child, adolescent, adult and older person health
2	GPW14 Output indicator code	4.2.1.IND3
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have a national sexual, reproductive, maternal, newborn, child and adolescent health coordinating body that includes UN H6 partnership that met at least once in the past year
4	Output/Leading Indicator (Country Level Formulation)	Country has a national sexual, reproductive, maternal, newborn, child and adolescent health coordinating body that includes UN H6 partnership for sexual, reproductive, maternal, newborn, child, and adolescent health that met at least once in the past year.
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive healthcare (I); Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age (I); Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods (estimates) (I); Maternal mortality ratio (I); Proportion of births attended by skilled health personnel (I); Under-5 mortality rate (I); Neonatal mortality rate (I); Proportion of health facilities that provide comprehensive post-rape care as per WHO guidelines (I); Obstetric and gynaecological admissions owing to abortion (I); Stillbirth rate (per 1000 total births) (I); Adolescent birth rate (aged 10–14 years; aged 15–19 years) per 1000 women in that age group (I); Treatment of acutely malnourished children (I); Proportion of girls and women aged 15–49 who have undergone female genital mutilation (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator measures whether a country has an active UN/H6 partnership for sexual, reproductive, maternal, newborn, child, and adolescent health. A partnership is considered active if the coordinating body, including H6 members, has met at least once in

		the past year, based on responses to the WHO SRMNCAH Policy Survey
12	Criteria	<ul style="list-style-type: none"> <li>• A country is counted as having achieved this indicator if it reports, through the WHO SRMNCAH Policy Survey, the existence of a national coordinating body that includes H6 partnership organizations and has met at least once in the past year.</li> <li>• Survey responses must include the date of the most recent meeting for validation.</li> <li>• WHO is considered to contribute by actively participating in these national coordinating bodies, supporting the development, implementation, and oversight of strategies, policies, and plans</li> </ul>
13	Numerator	Number of countries reporting the existence of an active UN/H6 partnership that met at least once in the past year as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> Country reports the existence of a national SRMNCAH coordinating body that includes UN/H6 partners and has met at least once in the past year.</p> <p><b>Partially Achieved:</b> Country reports a national coordinating body exists for SRMNCAH but it either does not include UN/H6 partners or has not met in the past year.</p> <p><b>Not Achieved:</b> Country reports no national coordinating body for SRMNCAH</p>
17	Rationale	Drawing on the combined strengths of six international organizations – UNFPA, UNICEF, UN Women, WHO, UNAIDS and the World Bank – H6 aims to advance the Sustainable Development Goals and the UN Secretary-General’s Every Woman Every Child strategy by improving sexual, reproductive, maternal, neonatal, child and adolescent health. H6 serves to mobilize technical expertise, investment, advocacy and policy engagement to strengthen countries’ health systems and ensure universal access to an integrated package of essential health services, with a focus on the most vulnerable women and children.
18	Measurement method	<ul style="list-style-type: none"> <li>• The measurement is based on responses by member states to the WHO SRMNCAH policy survey which asks whether there is a national coordinating body responsible for developing, implementing, or oversight of any SRMNCAH strategy, policy, or plan that includes UN/H6</li> <li>• These national coordinating bodies are committees or working groups led by the Ministry of Health and composed of different stakeholders responsible for developing, implementing, and oversight of national strategies, policies, and plans. Thus, by being a member of the coordinating body, WHO actively</li> </ul>

		contributes to development, implementation and oversight of national SRMNCAH strategies, policies and plans.
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	<p>The targets are selected based on country prioritization exercises coordinated across UHL programmes.</p> <ul style="list-style-type: none"> <li>Target 2026: Countries that were identified as a programmatic priority country across one of the following: WHO MNCH support countries, WHO Adolescent health support countries, and/or WHO SRH support countries or are target/focus countries of global initiatives related to SRMNCAH (e.g. EWENE, CSA, QoC network, Muskoka), if they have an existing SMRNCAH coordinating body that includes H6 partnership but is not active</li> <li>Target 2027: Countries with no existing coordinating body, but were identified as a priority support country</li> </ul>
23	How target is realistic for PB2026-2027	Targets are realistically achievable because the countries included are prioritized as WHO MNCH support countries, WHO Adolescent health support countries, and/or WHO SRH support countries or are target/focus countries of global initiatives related to SRMNCAH (e.g. EWENE, CSA, QoC network, Muskoka). These countries receive an increased level of technical support from WHO.
24	Data sources	WHO SRMNCAH policy survey; National SRMNCAH strategies, policies or plans
25	Process of validation	<ul style="list-style-type: none"> <li>Survey is administered using DataForm, a WHO self-service online survey platform based on the open-source product LimeSurvey. This is programmed to include checks and limiting responses in fields to only valid responses.</li> <li>The responses to the survey are reviewed by WHO regional offices and any discrepancies are clarified and corrected,</li> <li>Source documents are collected including the actual strategy documents to validate the responses.</li> </ul>
26	Limitations	Limited response rate from some regions; Countries can have one strategy (e.g. Maternal/newborn) or combined eg SRMNCAH; Although some strategies may have expired, they may be in the process of being revised and still being followed
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Elizabeth Katwan < <a href="mailto:katwane@who.int">katwane@who.int</a> >; Theresa Diaz < <a href="mailto:tdiaz@who.int">tdiaz@who.int</a> >

#### 4.2.2.IND1\_UID 1007: Number of countries submitting immunization coverage data to WHO through the eJRF platform

#	Metadata field	Summary
1	GPW14 Output	4.2.2. WHO provides guidance and technical assistance to strengthen and sustain quality immunization services, including for poliomyelitis, especially for unvaccinated and under-vaccinated persons
2	GPW14 Output indicator code	4.2.2.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries submitting immunization coverage data to WHO through the eJRF platform
4	Output/Leading Indicator (Country Level Formulation)	Country is submitting immunization coverage data to WHO through the eJRF platform
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Provisional
8	Linked outcome indicators (Direct (D) or indirect (I))	Proportion of the target population covered by all vaccines included in their national programme (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks the number of countries that submit immunization coverage data to WHO through the electronic Joint Reporting Form (eJRF) platform. It reflects country participation in standardized immunization data reporting.
12	Criteria	A country is counted as having achieved this indicator if it submits immunization coverage data through the electronic Joint Reporting Form (eJRF) platform during the annual reporting cycle. <ul style="list-style-type: none"> <li>• The data must be submitted by the official deadline to be included in WHO's reporting for that year.</li> <li>• The submission must include the required immunization coverage indicators as outlined in the eJRF.</li> </ul>
13	Numerator	Number of Member States submitting immunization coverage data to WHO through the eJRF platform as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> Country submits complete immunization coverage data through the eJRF platform by the official deadline.</p> <p><b>Partially achieved:</b> Country submits immunization coverage data, but the submission is incomplete or submitted after the official deadline.</p> <p><b>Not achieved:</b> Country does not submit immunization coverage data through the eJRF platform for the reporting year.</p>



17	Rationale	Country reporting of immunization coverage data is critical for tracking needs of immunization programmes and their arising health impact. WHO is uniquely positioned as the gold standard in this area, and is a core remit of WHO's responsibilities to member states.
18	Measurement method	<ul style="list-style-type: none"> <li>• Member States submit annual data via the electronic Joint Reporting Form (eJRF) platform.</li> <li>• WHO counts the number of Member States that successfully submit immunization coverage data.</li> <li>• This count is used to assess global and regional engagement with immunization monitoring systems</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	Targets are aligned with the Immunization Agenda 2030 (IA2030) framework
23	How target is realistic for PB2026-2027	<ul style="list-style-type: none"> <li>• The target is achievable because it builds on existing participation patterns in the eJRF platform.</li> <li>• WHO provides ongoing support and engagement with Member States to maintain and improve reporting consistency.</li> </ul>
24	Data sources	eJRF (electronic Joint Reporting Form); IA2030
25	Process of validation	Extensive validation checks are done with Member States through the eJRF process. Final coverage estimates are achieved through the standardised WUENIC process.
26	Limitations	Member States must report by the closing date for data to be included in each year's reporting cycle
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	BAR-ZEEV, Naor < barzeevn@who.int>

**4.2.2.IND2\_UID 1407 : Number of countries in which the national immunization strategy includes implementation progress reviews of annual operational plans addressing either (a) zero-dose children or (b) measles vaccine coverage or (c) human papillomavirus vaccine coverage**

#	Metadata field	Summary
1	GPW14 Output	4.2.2. WHO provides guidance and technical assistance to strengthen and sustain quality immunization services, including for poliomyelitis, especially for unvaccinated and under-vaccinated persons
2	GPW14 Output indicator code	4.2.2.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries in which the national immunization strategy includes implementation progress reviews of annual operational plans addressing either (a) zero-dose children or (b) measles vaccine coverage or (c) human papillomavirus vaccine coverage
4	Output/Leading Indicator (Country Level Formulation)	National immunization strategy includes implementation progress reviews of annual operational plans addressing either (a) zero-dose children or (b) measles vaccine coverage or (c) human papillomavirus vaccine coverage
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Proportion of the target population covered by all vaccines included in their national programme (D); Proportion of children aged 24–59 months who are developmentally on track in health, learning and psychosocial well-being, by sex (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator measures whether a country's National Immunization Strategy (NIS) includes implementation progress reviews of Annual Operational Plans (AOPs) that focus on at least one of the following: Zero-dose children; Measles vaccination coverage; HPV vaccination coverage
12	Criteria	<p>A country is counted as having achieved this indicator if its National Immunization Strategy (NIS), as reported in the electronic Joint Reporting Form (eJRF), includes implementation progress reviews of Annual Operational Plans (AOPs) that address at least one of the following:</p> <ul style="list-style-type: none"> <li>• Reducing the number of zero-dose children,</li> <li>• Increasing measles vaccine coverage, or</li> <li>• Expanding HPV vaccine coverage</li> </ul> <p>Additional details:</p>

		<ul style="list-style-type: none"> <li>NIS documents are submitted and uploaded to the eJRF annually. NIS cover a 3 to 5 year period and new documents are meant to upload their NIS once done.</li> <li>Information is extracted on whether funded and implemented activities are included for the three target areas.</li> <li>Starting in 2026, countries will also be requested to upload their AOPs to the eJRF platform (currently, they are only asked to confirm whether an AOP exists).</li> </ul> <p>Integration of AOPs as part of the NIS is fully covered in WHO's NIS guidance, which supports countries in developing comprehensive strategies. This confirms WHO's direct contribution to enabling and standardizing this approach.</p>
13	Numerator	Number of countries with NIS that include AOP implementation progress reviews addressing zero-dose children, measles, or HPV as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country's NIS includes implementation progress reviews of AOPs addressing at least one of the three target areas (zero-dose, measles, or HPV), and the AOP is available and verified.</p> <p><b>Partially Achieved:</b> The country confirms the existence of an AOP and includes the three target areas in the NIS, but lacks documented implementation progress reviews or submission of the AOP.</p> <p><b>Not Achieved:</b> The NIS does not include any of the three target areas or there is no confirmation of an AOP.</p>
17	Rationale	National prioritization and funded plans for immunization service delivery is critical for success of immunization programs to achieve coverage targets to reduce zero dose children, increase measles vaccination and human papilloma virus vaccination.
18	Measurement method	<ul style="list-style-type: none"> <li>National Immunization Strategies are reported and uploaded to the eJRF annually.</li> <li>Extraction of NIS data on funded and implemented activities in the three explicit areas of zero dose, measles and HPV are thereby ascertained.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	Targets are selected based on the expected date of completion of their NIS and related AOP and opportunity to review the content of their plans
23	How target is realistic for PB2026-2027	Coordinated support from WHO to member states is planned through regional offices, some countries have integrated funding in their request for support from Gavi , however funding is not fully confirmed for 2027 and some 2026 targets

24	Data sources	Electronic Joint Reporting Form (eJRF); IA2030 strategic framework
25	Process of validation	Extensive validation checks are done with Member States through the eJRF process.
26	Limitations	Member States must report by the closing date for data to be included in each year's reporting cycle, however this reporting process has recently been implemented and not all member States upload their NIS, this is expected to improve over time. Prior to validation some NIS may lack sufficient descriptive detail, but validation can assist in iteratively improving data quality.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Johanna Fihman < fihmanj@who.int>

### 4.3.1. WHO provides guidance and technical assistance and strengthens capacity to track health expenditures at the system level to monitor financial hardship and financial barriers to access and inform decision-making for financial and social health protection

#### 4.3.1.IND1\_UID 498 : Number of countries producing health accounts, based on WHO-supported methodologies

#	Metadata field	Summary
1	GPW14 Output	4.3.1. WHO provides guidance and technical assistance and strengthens capacity to track health expenditures at the system level to monitor financial hardship and financial barriers to access and inform decision-making for financial and social health protection
2	GPW14 Output indicator code	4.3.1.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries producing health accounts, based on WHO-supported methodologies
4	Output/Leading Indicator (Country Level Formulation)	Production of national health accounts, based on WHO-supported methodologies
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Government domestic spending on health (1) as a share of general government expenditure, and (2) per capita (D); Out-of-pocket payment as a share of current health expenditure (D); Incidence of financial hardship (defined as large out-of-pocket health spending, impoverishing out-of-pocket health spending, or both, using SDG 3.8.2 and regional indicators where available) (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks whether a country produces national health accounts using WHO-supported methodologies, specifically the System of Health Accounts 2011 (SHA2011) framework. It counts the number of countries that report disaggregated health expenditure data classified by health financing arrangement, funding source, and health care function, with a focus on primary health care (PHC).
12	Criteria	This is a tracer indicator reflecting the production of health expenditure data based on SHA2011. A country is counted as having achieved this indicator if it reports data according to the SHA2011 framework, that is if it reports total primary health care (PHC) expenditures using detailed health

		<p>financing arrangement (HF) or funding source (FS), and health care function (HC) classifications</p> <p>Total PHC expenditure is computed using the global PHC definition, which includes the following health care functions (HC):</p> <ul style="list-style-type: none"> <li>○ Curative General Outpatient Care (HC.1.3.1)</li> <li>○ Curative Dental Outpatient Care (HC.1.3.2)</li> <li>○ Unclassified Curative Outpatient Care (HC.1.3.nec)</li> <li>○ Curative Home-based Care (HC.1.4)</li> <li>○ Long-term Outpatient Care (HC.3.3)</li> <li>○ Long-term Home-based Care (HC.3.4)</li> <li>○ Preventive Care (HC.6)</li> <li>○ 80% of Medical Goods (HC.5)</li> <li>○ 80% of Health System Administration (HC.7)</li> </ul>
13	Numerator	Number of countries reporting health expenditure data according to SHA2011, including HF, FS, and HC as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> Country reports health expenditure data using the SHA2011 framework, including disaggregated data by HF or FS and HC classifications, allowing calculation of total PHC expenditure as per field 12.</p> <p><b>Partially achieved:</b> Country reports SHA2011 data only on HF and FS classifications, or HC data without sufficient disaggregation for calculating PHC total spending</p> <p><b>Not achieved:</b> Country does not report SHA2011-aligned health expenditure data.</p>
17	Rationale	Health expenditure data is strategic information for monitoring the use of resources, guiding future investment, and promoting transparency and accountability of all stakeholders on health.
18	Measurement method	<ul style="list-style-type: none"> <li>○ Data are collected through country submissions to the Global Health Expenditure Database (GHED), using the System of Health Accounts (SHA2011) framework.</li> <li>○ Countries submit detailed health expenditure data disaggregated by: Health financing arrangement (HF) or funding source (FS), and Health care function (HC).</li> <li>○ Data are reviewed by WHO regional and HQ teams for completeness and classification alignment.</li> <li>○ The indicator is measured by counting the number of countries that meet the criteria as per field 12</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	A consultative process was conducted to establish targets for the indicator for 2026 and 2027. Regional health financing focal points

		from WHO Regional Offices participated in this process to identify target countries for both years, considering recent growth in health accounts production, current financial constraints, HA institutionalization status, ongoing projects, planned support, and regional engagement.
23	How target is realistic for PB2026-2027	<p>The process of establishing targets for 2026 and 2027 considers several factors:</p> <ol style="list-style-type: none"> <li>1. Recent Growth in Health Accounts Production: Regions assess the progress made in producing health accounts, which are essential for tracking health expenditures and financing.</li> <li>2. Current Financial Constraints: The financial limitations faced by each region are taken into account to ensure realistic and achievable targets.</li> <li>3. Ongoing Projects: Existing initiatives and their progress are considered to align new targets with ongoing efforts.</li> <li>4. Planned Support: WHO plans to provide tailored support to regions based on their specific needs and circumstances.</li> <li>5. Regional Engagement: Active involvement and collaboration with regional stakeholders are crucial for setting and achieving these targets.</li> <li>6. Institutionalizing the Production of Health Accounts: Efforts to embed the production of health accounts within national systems are considered to ensure sustainability and consistency in health financing data.</li> </ol>
24	Data sources	<a href="#">Global Health Expenditure Database (GHED)</a>
25	Process of validation	Data is checked for System of Health Accounts (SHA) validity, consistency, and policy alignment by the country and regional office teams as well as HQ. The “ <a href="#">Quality control of SHA-based health accounts data</a> ” document outlines the various elements examined during the validation of countries' health accounts to ensure accuracy, consistency, and reliability.
26	Limitations	There is a 2-year time lag in data reporting, and very few countries provide t-1 data. However, this reporting delay does not affect countries' eligibility to be counted toward the indicator. A country is included if it has produced health accounts data using the SHA2011 framework since 2020, regardless of the reference year. For example, a country submitting 2021 data in 2025 would still be counted in the 2025 reporting cycle.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	ARANGUREN GARCIA, Maria Jackelin <arangurenm@who.int>

#### 4.3.1.IND2\_UID 499 : Number of countries with an updated analysis of financial protection, as a result of WHO engagement

#	Metadata field	Summary
1	GPW14 Output	4.3.1. WHO provides guidance and technical assistance and strengthens capacity to track health expenditures at the system level to monitor financial hardship and financial barriers to access and inform decision-making for financial and social health protection
2	GPW14 Output indicator code	4.3.1.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries with an updated analysis of financial protection, as a result of WHO engagement
4	Output/Leading Indicator (Country Level Formulation)	Updated analysis of financial protection utilized to inform national health policies towards Universal Health Coverage, developed with WHO support
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Incidence of financial hardship (defined as large out-of-pocket health spending, impoverishing out-of-pocket health spending, or both, using SDG 3.8.2 and regional indicators where available) (D); Out-of-pocket payment as a share of current health expenditure (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks the number of countries with an updated financial protection analysis developed with WHO support. The analysis must be used to inform national health policy decisions and planning towards Universal Health Coverage (UHC). WHO's support may be technical, financial, or convening in nature. Updated analyses can include new data, new analysis of old data, expanded scope, or updated methodology, and must be policy-relevant.
12	Criteria	<p>A country is counted as having achieved this indicator if it has conducted and reported an updated financial protection analysis that meets the following conditions:</p> <ul style="list-style-type: none"> <li>• The analysis was developed with WHO support (technical, financial, or convening).</li> <li>• It is used to inform national health policies aimed at achieving Universal Health Coverage (UHC).</li> <li>• The analysis meets criterion #5 (mandatory) and at least one of the criteria below: <ol style="list-style-type: none"> <li>1. It is based on recently collected data.</li> <li>2. It is based on data that has not been recently collected but is analyzed for the first time.</li> </ol> </li> </ul>



		<p>3. It expands the scope by incorporating new or previously un-analyzed data, providing additional interpretation or insights (e.g., disaggregated data analysis or context-specific interpretation).</p> <p>4. It involves re-estimating indicators based on updated methodologies.</p> <p>5. It must be used to support evidence-based policy-making and recommendations at the country, regional, or global level (this is a mandatory criterion and must always be met).</p>
13	Numerator	The number of countries with an updated financial protection analysis as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country has conducted and reported an updated financial protection analysis developed with WHO support, meeting the mandatory policy-use criterion and at least one of the additional methodological criteria (recent data, first-time analysis, expanded scope, or updated methods) as per field 12.</p> <p><b>Partially achieved:</b> The country has conducted a financial protection analysis, but it either does not fully meet the update criteria (e.g., outdated data, no analytical expansion), or was not clearly developed with WHO support, or lacks clear evidence of use in policy discussions at the country, regional or global level.</p> <p><b>Not achieved:</b> The country has not conducted or reported any financial protection analysis since 2015 or there is no evidence of WHO-supported analysis used for policy purposes OR the country has not conducted a relevant household survey. See point 26.</p> <p>The assessment is based on a confirmation of countries capacity to report on the indicator.</p>
17	Rationale	WHO is the only global agency with the mandate and specialized capacity to support all countries, at all income levels, in tracking and analyzing financial protection to inform national health policies towards Universal Health Coverage (SDG target 3.8). This mandate is underpinned by Resolution WHA58.33 (2005) on sustainable health financing, universal coverage and social health insurance; UN General Assembly Resolution 74-2 (2019); World Health Assembly resolution 76-4 (2023); and the Executive Board Report 154/6 (2023). WHO is also the UN custodian agency of SDG indicator 3.8.2. Updated analyses are critical for providing evidence-based policy recommendations on the path to UHC. This indicator reflects WHO's role in ensuring that financial protection assessments are available and used to inform national health policy decisions and planning, reinforcing WHO's contribution to advancing UHC.
18	Measurement method	<ul style="list-style-type: none"> <li>Data is collected through collaboration with national statistical offices, ministries of health, and other relevant institutions.</li> </ul>

		<p>Financial protection indicators are produced by the National Statistical Office and the Ministry of Health, either independently or in collaboration with WHO, or by WHO and/or the World Bank.</p> <ul style="list-style-type: none"> <li>The updated analysis is supported by WHO.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	<p>Only countries for which relevant household surveys exist but have not yet been analyzed are included in the calculation of the target. The list of eligible countries is based on a detailed assessment conducted by WHO in preparation for the 2025 country consultation on Universal Health Coverage (UHC) SDG indicators, including SDG indicator 3.8.2 on financial protection. This mapping was carried out by reviewing the websites of national statistical offices in each country to identify the availability of relevant household surveys. The information was corroborated through the country consultation process, which concluded in most countries on 30 May 2025 but was ongoing in some until June 20, 2025.</p>
23	How target is realistic for PB2026-2027	<p>Several key factors contribute to the realistic achievability of the targets for 2026-2027, taking into account WHO's planned support, funding, and regional engagement:</p> <ol style="list-style-type: none"> <li>1. Ongoing Country Consultation Process: WHO is actively engaging with all Member States through the country consultation on SDG UHC indicators, including SDG indicator 3.8.2 on financial protection</li> <li>2. Technical Support and Capacity Building: WHO is providing robust technical support to Member States to help process and analyze relevant household survey data.</li> <li>3. Policy Relevance and Evidence Use: WHO uses the country consultation as a platform not only to provide technical assistance but also to inform Member States about the relevance of the available evidence.</li> <li>4. Regional Engagement: WHO promotes collaboration and knowledge sharing through regional workshops and peer learning. The scale of these activities will depend on funding availability.</li> </ol> <p>Overall, by leveraging these factors—active country consultation, technical support tools, regional collaboration (subject to financial resources), and strategic funding (currently being assessed)—WHO ensures that the targets for 2026-2027 are both achievable and impactful, driving progress toward UHC and financial protection goals.</p>
24	Data sources	<a href="#">WHO Global Health Observatory</a> ; <a href="#">WHO Indicators Platform</a> ; <a href="#">UN SDG Global Indicator Database</a> ; Executive Board Report 154/6 (2023);

		World Health Assembly Resolution 76-4 (2023); UN General Assembly Resolution 74-2 (2019); World Health Assembly Resolution 58.13 (2005)
25	Process of validation	The principles to check the data for accuracy, consistency and reliability are described in the <a href="#">metadata of SDG 3.8.2 indicator</a>
26	Limitations	Updating financial protection analyses requires data sources that are not typically part of standard health sector reviews. To improve the timeliness and quality of data, close collaboration with national statistical offices, ministries of health, and planning ministries will be essential. While these analyses can be resource-intensive, the proposed flexibility in the rewording at the country level, by not specifying a fixed time period, acknowledges these challenges while encouraging progress.
27	Expected frequency of reporting	Biennial
28	Date last published	15 June 2025
29	Technical focal point	Gabriela Flores Pentzke Saint-Germain <floressg@who.int>

### 5.1.1. WHO collaborates with partners to communicate risks and engage with communities to co-create public health prevention and response interventions for all hazards

#### 5.1.1.IND1\_UID 1139 : Number of countries with formalized all-hazard emergency risk communication mechanisms at the national level with the ability to proactively engage with the public and affected communities in local languages

#	Metadata field	Summary
1	GPW14 Output	5.1.1. WHO collaborates with partners to communicate risks and engage with communities to co-create public health prevention and response interventions for all hazards
2	GPW14 Output indicator code	5.1.1.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries with formalized all-hazard emergency risk communication mechanisms at the national level with the ability to proactively engage with the public and affected communities in local languages
4	Output/Leading Indicator (Country Level Formulation)	Formalization of all-hazard emergency risk communication mechanisms at the national level with the ability to proactively engage with the public and affected communities in local languages
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Trust in government and Social Protection (D); Number of cases of poliomyelitis caused by wild poliovirus (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator measures how many countries have formalized all-hazard emergency risk communication mechanisms at the national level. These mechanisms enable proactive engagement with the public and affected communities, including communication in local languages.
12	Criteria	<p>A country is counted as having achieved this indicator if it has formalized all-hazard emergency risk communication mechanisms at the national level that meet the following criteria:</p> <ul style="list-style-type: none"> <li>• Mechanisms include plans, standard operating procedures (SOPs), guidelines, policies, and procedure, such as multi-hazard and multi-sectoral plans for coordination of Risk Communication and Community Engagement (RCCE) functions;</li> <li>• Formal government arrangements exist for RCCE coordination, including provisions for scale-up during emergencies;</li> <li>• Quality assurance processes are in place for communication products;</li> </ul>

		<ul style="list-style-type: none"> <li>• RCCE is integrated into the emergency operations centre or incident management system.</li> </ul> <p>In addition, achievement is only counted if the result is directly attributable to WHO's contribution.</p> <p>Attribution may be demonstrated through documented WHO support such as:</p> <ul style="list-style-type: none"> <li>• Use of WHO technical products (e.g. global or regional guidance, tools);</li> <li>• Uptake of WHO-recommended SOPs (e.g. for community listening and engagement);</li> <li>• Participation in WHO-supported simulation exercises that strengthen RCCE systems;</li> <li>• Completion of WHO-led capacity development programmes;</li> <li>• Use of RCCE data or evidence provided by WHO for community protection.</li> </ul>
13	Numerator	Number of countries with formalized RCCE mechanisms at national level, meeting the defined criteria and with WHO-attributable support as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> Country has formalized RCCE mechanisms that meet all the defined criteria and has documented WHO-attributable support (e.g. uptake of WHO guidance, SOPs, capacity-building, or technical missions).</p> <p><b>Partially achieved:</b> Country has formalized RCCE mechanisms in place, but documentation of WHO-attributable support is incomplete or unclear.</p> <p><b>Not achieved:</b> Country has no formalized RCCE mechanism in place or does not meet the defined criteria.</p>
17	Rationale	Effective health emergency management achieves protection of those at-risk or directly affected. To achieve these goals, communities must be engaged and involved in emergency preparedness and response. Effective emergency risk communication is essential for timely and accurate information dissemination during public health emergencies. Its purpose is to help individuals make informed decisions about their risks and to take preventive and protective actions. Community engagement ensures that interventions are culturally appropriate and community driven. Dedicated strategies to counter misinformation and disinformation help to ensure communities receive accurate, science-backed information, and counter the harmful narratives that can take hold in a crisis. Together, these approaches build trust, encourage the adoption of public health prevention and response interventions and ultimately save lives. To be effective, these approaches need strengthened systems and mechanisms to coordinate RCCE functions and resources. <b>This indicator is</b>

		<p><b>essential for assessing countries' risk communication and community engagement (RCCE) capacities for community protection during health emergencies and crises. It is a critical measure of preparedness and rapid response in the face of emergencies.</b> Strengthening risk communication capacity enhances preparedness, response, and resilience against health threats, is aligned with International Health Regulations (2005) and is central to the community protection objectives of Health Emergency Preparedness and Response (HEPR). WHO plays a critical role in strengthening emergency risk communication and community engagement systems worldwide by providing technical guidance, capacity-building, and coordination to ensure that countries can proactively engage with the public and affected communities in local languages during health crises.</p>
18	Measurement method	<p>The indicator is measured using data reported through SPAR indicator C10.1. Countries self-assess the presence and operationalization of RCCE systems at the national level. Only countries where progress is directly attributable to WHO support are counted. Attribution is determined based on evidence of WHO's contribution, such as:</p> <ul style="list-style-type: none"> <li>• Use of WHO technical guidance or tools;</li> <li>• Uptake of WHO-supported simulation exercises or training;</li> <li>• Engagement in WHO-led capacity-building activities;</li> <li>• Documented use of WHO-supported data or evidence for RCCE-related improvements.</li> </ul> <p>While some of this information is tracked at headquarters level, additional mechanisms may be needed to systematically capture contributions at regional and country levels.</p>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	<p>Targets are based on expected improvements in countries' 2024 SPAR scores for indicator C10.1 on RCCE systems. WHO will prioritize countries with lower baseline performance, focusing particularly on the AFRO and EMRO regions, which currently have combined scores below the global average. Target countries are identified in collaboration with regional offices by:</p> <ul style="list-style-type: none"> <li>• Reviewing changes in SPAR scores between 2021 and 2024;</li> <li>• Flagging countries with 2024 self-assessment scores below 80;</li> <li>• Considering additional country-level factors to determine where WHO support can have the most impact.</li> </ul> <p>This approach allows for a data-driven and regionally informed method of setting realistic and strategic targets.</p>

23	How target is realistic for PB2026-2027	WHO has a unique role and mandate related to health leadership for RCCE. This area is a requirement for member states as it includes a core component of IHR capacity strengthening (risk communication). WHO has an expert unit to provide this technical support to members states, the Community Protection and Resilience Unit, which has produced guidance and technical products to support member states in their work.
24	Data sources	<a href="#">e-SPAR</a> ; <a href="#">WHO guideline for emergency risk communication (ERC) policy and practice</a> ; <a href="#">International Health Regulations (2005)</a> ; <a href="#">Strengthening the global architecture for health emergency prevention, preparedness, response and resilience (HEPR)</a> ; <a href="#">States Parties Self-Assessment Annual Reporting Tool</a>
25	Process of validation	Self-reported data by countries
26	Limitations	<ul style="list-style-type: none"> <li>• Self-reported data may be biased.</li> <li>• The indicator's broad scope may limit clarity.</li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Kai VON HARBOU < vonharbouk@who.int>

## 5.1.2.WHO provides technical expertise and operational support to strengthen and scale preventive population and environmental public health interventions for all hazards, utilizing a One Health approach

### 5.1.2.IND1\_UID 1374 : Number of countries implementing frameworks, evidence-based guidance or tools to operationalize a One Health approach enhancing prevention, early detection, and containment of emerging zoonotic pathogens with epidemic and pandemic potential

#	Metadata field	Summary
1	GPW14 Output	5.1.2.WHO provides technical expertise and operational support to strengthen and scale preventive population and environmental public health interventions for all hazards, utilizing a One Health approach
2	GPW14 Output indicator code	5.1.2.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries implementing frameworks, evidence-based guidance or tools to operationalize a One Health approach enhancing prevention, early detection, and containment of emerging zoonotic pathogens with epidemic and pandemic potential
4	Output/Leading Indicator (Country Level Formulation)	Implementation of frameworks, evidence-based guidance, or tools to operationalize a One Health approach enhancing prevention, early detection, and containment of emerging zoonotic pathogens with epidemic and pandemic potential
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Probability of spillover of zoonotic diseases (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator counts the number of countries that are operationalizing the One Health approach through the implementation of frameworks, tools, or guidance aimed at preventing, detecting, and containing zoonotic diseases with epidemic or pandemic potential.
12	Criteria	A country is counted as having achieved this indicator if it demonstrates implementation of a One Health approach through at least one of the following: <ul style="list-style-type: none"> <li>Improvement in the IHR SPAR scores for technical areas relevant to One Health (e.g. zoonotic diseases, food safety, antimicrobial resistance);</li> </ul>



		<ul style="list-style-type: none"> <li>• Completion of a National Bridging Workshop (NBW) and development of a related country roadmap to strengthen multisectoral collaboration;</li> <li>• Implementation of one or more Tripartite Zoonoses Guide (TZG) operational tools, such as: <ul style="list-style-type: none"> <li>○ Multisectoral Coordination Mechanism Operational Tool (MCM OT)</li> <li>○ Joint Risk Assessment Operational Tool (JRA OT)</li> <li>○ Surveillance and Information Sharing Operational Tool (SIS OT)</li> <li>○ Coordination and Integration Response Operational Tool (CIR OT)</li> <li>○ Monitoring &amp; Evaluation Operational Tool (M&amp;E OT)</li> <li>○ Workforce Development Operational Tool (WFD OT)</li> </ul> </li> </ul> <p>All national efforts are considered, regardless of the extent of WHO's direct support, given that WHO-developed tools and processes are publicly available. However, countries that implement these tools independently may not always be captured if they do not report back to WHO.</p>
13	Numerator	Number of countries implementing One Health frameworks, tools, or guidance as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	TBD
16	Achievement thresholds (if benchmarking is applied)	TBD
17	Rationale	<p>Emerging zoonotic pathogens with epidemic and pandemic potential pose significant threats to global health security. A One Health approach -which integrates human, animal, and environmental health- is essential for strengthening prevention, early detection, and containment of these threats. This indicator measures the number of countries implementing frameworks, evidence-based guidance, or tools to operationalize One Health strategies. Such implementation reflects national commitment to cross-sectoral collaboration, improved surveillance, and coordinated response efforts.</p> <p>Strengthening these systems enhances global preparedness and aligns with international health security objectives, including the International Health Regulations (IHR 2005), the Quadripartite (WHO, FAO, WOA, UNEP) One Health Joint Plan of Action launched in October 2022 and the Health Emergency Preparedness and Response (HEPR). WHO plays a crucial role in advancing the One Health approach, which integrates human, animal, and environmental health to prevent, detect, and contain zoonotic diseases that have epidemic and pandemic potential. <b>By tracking this indicator, WHO provides strategic leadership, technical</b></p>

		<b>support, and coordination to help countries strengthen their One Health systems and multisectoral plans and strategies.</b>
18	Measurement method	<ul style="list-style-type: none"> <li>• Data are compiled through WHO-supported workshops, self-assessments, and documentation of implementation.</li> <li>• List of zoonotic pathogens covered includes respiratory pathogens (influenza viruses, coronaviruses), arthropod borne viruses (Zika, Chikungunya, Dengue, Yellow Fever), and others (Mpox, Ebola, Marburg).</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	TBD
23	How target is realistic for PB2026-2027	TBD
24	Data sources	<a href="#">International Health Regulations (2005)</a> ; <a href="#">IHR States Parties Self-Assessment Annual Report (SPAR)</a> ; <a href="#">A guide to implementing the One Health Joint Plan of Action at national level</a> ; <a href="#">National Bridging Workshops and related country roadmaps</a> ; <a href="#">WHO Unity Studies 2.0</a> ; <a href="#">One Health Joint Plan of Action (2022–2026)</a> ; <a href="#">Tripartite Zoonoses Guide (2019) and its Operational Tools</a> ; <a href="#">Strengthening the global architecture for health emergency prevention, preparedness, response and resilience (HEPR)</a> ; <a href="#">WHO Preparedness and Resilience for Emerging Threats (PRET) initiative</a>
25	Process of validation	<ul style="list-style-type: none"> <li>• Technical leads in WHO HQ (GRT, EZH) validate using monitoring documents and dashboards</li> <li>• MEP Team (HPM) validates using NBW and roadmaps</li> <li>• PRET validation is performed by the Steering Committee, which includes regional and country office representatives</li> </ul>
26	Limitations	The current funding situation may not allow for implementation of National Bridging Workshops which are an important source of data
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Sophie von Dobschuetz <svondobschuetz@who.int >; Jeff Gilbert<gilbertj@who.int>

### 5.2.1. WHO conducts risk and capacity assessments and supports the development and implementation of national preparedness and readiness plans, including tailored prevention and mitigation strategies for specific hazards

**5.2.1.IND1\_UID 297 : Number of countries with epidemic and pandemic prevention and preparedness plan, as well as prevention and control programme, for at least one pathogen of epidemic and pandemic potential**

#	Metadata field	Summary
1	GPW14 Output	5.2.1. WHO conducts risk and capacity assessments and supports the development and implementation of national preparedness and readiness plans, including tailored prevention and mitigation strategies for specific hazards
2	GPW14 Output indicator code	5.2.1.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries with epidemic and pandemic prevention and preparedness plan, as well as prevention and control programme, for at least one pathogen of epidemic and pandemic potential
4	Output/Leading Indicator (Country Level Formulation)	Developed and/or updated an epidemic and pandemic prevention and preparedness plan, vaccination plan, and prevention and control program for at least one pathogen of epidemic and pandemic potential
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	International Health Regulations (IHR) capacity and health emergency preparedness (D); Vaccine coverage of at-risk groups for high-threat epidemic/pandemic pathogens: yellow fever, cholera, meningitis, polio, and measles (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks the number of countries that have in place an epidemic and pandemic prevention and preparedness plan, which is the primary component used for measurement.
12	Criteria	A country is counted as having achieved this indicator if: <ul style="list-style-type: none"> <li>it has developed/or updated an <b>epidemic and pandemic prevention and preparedness plan</b>. This component is the <b>primary reportable element</b> for the purposes of tracking and aggregating results. The plan may be for epidemics or pandemics caused by either respiratory pathogens or arthropod-borne viruses</li> </ul>

		<ul style="list-style-type: none"> <li>• WHO's contribution is captured through the provision of normative guidance and direct technical support to countries, delivered through global initiative such as the Preparedness and Resilience for Emerging Threats (PRET) framework</li> <li>• In addition, data used to assess achievement is collected, reviewed, and validated through WHO-led monitoring processes involving Regional and Country Office staff.</li> </ul>
13	Numerator	Number of countries with an epidemic and pandemic prevention and preparedness plan as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country has a finalized an epidemic and pandemic prevention and preparedness plan that is aligned with PRET guidance published in April 2023 ; as per field 12.</p> <p><b>Partially achieved:</b> The country has initiated development of a preparedness plan (e.g., in the planning, drafting, or consultation stage), but the plan is not yet finalized. There is documented progress reported through PRET, but the plan is not yet considered complete.</p> <p><b>Not achieved:</b> The country has no preparedness plan that has been updated since April 2023, or no progress has been reported through PRET. This includes cases where no information is available, or where existing plans are outdated or not aligned with current WHO guidance.</p>
17	Rationale	<p>Epidemics and pandemics pose significant threats to global health security, requiring countries to have structured prevention and preparedness measures in place. This indicator tracks the number of countries that have developed and/or updated epidemic and pandemic prevention and preparedness plans, which are critical to ensuring readiness for emerging health threats across the 5 C's of the HEPR Framework.</p> <p>WHO plays a critical leadership role in ensuring countries develop and implement robust epidemic and pandemic preparedness plans to prevent, detect, and respond to health threats. By tracking this indicator, which is aligned with the Preparedness and Resilience for Emerging Threats (PRET) initiative, WHO supports global health security, health workforce capacity building, testing of national and cross-border preparedness and response capacities to mitigate the impact of infectious diseases of epidemic and pandemic potential.</p>
18	Measurement method	<ul style="list-style-type: none"> <li>• The indicator originally included three components: <ul style="list-style-type: none"> <li>○ Epidemic and pandemic prevention and preparedness plan</li> <li>○ National vaccine deployment plan (NDVP)</li> <li>○ Prevention and control programme</li> </ul> </li> </ul> <p>However, based on internal consultation and to simplify reporting, the preparedness plan is prioritized as the core requirement.</p> <p>The other two components (NDVP and pathogen-specific programmes) are treated as proxies and provide contextual or supporting information</p>

		<p>but are not required for a country to be counted as having achieved the indicator.</p> <p>This approach aligns with reporting through the Pandemic Influenza Preparedness Framework High-Level Implementation Plan III (HLIP III). WHO provides normative guidance and direct technical support for countries to develop these plans.</p> <ul style="list-style-type: none"> <li>The indicator is anchored in the structure of the <a href="#">WHO Preparedness and Resilience for Emerging Threats (PRET)</a> initiative, which guides how national preparedness planning is assessed and monitored. PRET organizes preparedness efforts by mode of transmission, using the following modular approach: <ul style="list-style-type: none"> <li>PRET Module 1: Respiratory pathogens (e.g. Influenza, coronaviruses)</li> <li>PRET Module 2: Arthropod-borne viruses (e.g. Zika, Chikungunya, Dengue, Yellow Fever)</li> <li>PRET Module 3 (anticipated): Direct contact transmission (e.g. Mpox, Ebola)</li> </ul> </li> <li>Data are reported by Member States through WHO Regional Offices, compiled by WHO HQ, and validated via the PRET Steering Committee, which includes staff from WHO country, regional, and headquarters levels.</li> <li>WHO's contribution is reflected through: <ul style="list-style-type: none"> <li>The development and dissemination of normative guidance</li> <li>Provision of direct technical support to countries in developing, reviewing, testing and finalizing preparedness plans</li> <li>Monitoring and validation processes coordinated by WHO technical units</li> </ul> </li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12. The primary indicator is reported in aggregate. However disaggregated data may be available showing a breakdown of plans specific to respiratory pathogen pandemics and/or those specific to arthropod-borne virus epidemics and pandemics.
21	Calculation type	Cumulative
22	Target setting methodology	Targets are aligned with the targets contained within the Pandemic Influenza Preparedness Framework Partnership Contribution High Level Implementation Plan III. It includes all the PIP priority countries.
23	How target is realistic for PB2026-2027	<ul style="list-style-type: none"> <li>Countries receive PIP funding for epidemic and pandemic planning.</li> <li>PRET initiative is a WHO priority area of work.</li> </ul>
24	Data sources	<a href="#">Preparedness and Resilience for Emerging Threats (PRET) initiative; Pandemic Influenza Preparedness Framework: High-Level Implementation Plan III (2024–2030)</a>
25	Process of validation	<p>Data used to assess this indicator are collected through WHO-coordinated monitoring systems and validated at multiple levels of the Organization to ensure accuracy and consistency:</p> <ul style="list-style-type: none"> <li><b>For preparedness plans</b> (the primary reportable component):</li> </ul>

		<p>Validation is conducted through the PRET Steering Committee, which includes representatives from WHO Country Offices, Regional Offices, and Headquarters. The process includes review by the PRET Monitoring and Evaluation focal point at WHO HQ.</p> <ul style="list-style-type: none"> <li>For proxy components (e.g. pathogen-specific control programmes): Information is reviewed by relevant WHO technical units based on regional and global monitoring frameworks and dashboards.</li> </ul>
26	Limitations	None
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Sarah HESS < hesss@who.int>; Ioana GHIGA < ghigai@who.int> ; Laurence CIBRELUS < cibrelusl@who.int>

### 5.2.1.IND2\_UID 820 : Number of States Parties completing annual reporting on the International Health Regulations (2005)

#	Metadata field	Summary
1	GPW14 Output	5.2.1. WHO conducts risk and capacity assessments and supports the development and implementation of national preparedness and readiness plans, including tailored prevention and mitigation strategies for specific hazards
2	GPW14 Output indicator code	5.2.1.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of States Parties completing annual reporting on the International Health Regulations (2005)
4	Output/Leading Indicator (Country Level Formulation)	Completion of annual reporting on the International Health Regulations (2005)
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	International Health Regulations (IHR) capacity and health emergency preparedness (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks the number of States Parties that submit their annual report on implementation of the International Health Regulations (2005) using the SPAR (States Parties Self-Assessment Annual Reporting) tool.

12	Criteria	<p>A country is counted as having achieved this indicator if it submits a completed SPAR report through the e-SPAR platform by the annual deadline (March 1). Completion is defined as:</p> <ul style="list-style-type: none"> <li>• Submission of the full SPAR self-assessment for all 15 IHR (2005) core capacities using the online platform or approved offline formats (PDF/Excel);</li> <li>• No blank capacity levels unless explicitly marked as "Not applicable" with an explanation provided in the comment box;</li> <li>• All required fields are filled in and pass the platform's electronic quality checks;</li> <li>• The submission is confirmed and validated by WHO following review for completeness and consistency.</li> </ul> <p>WHO reviews all country submissions and follows up with National Focal Points and relevant WHO offices to correct any omissions or inconsistencies prior to final confirmation.</p> <p>WHO plays a central role by:</p> <ul style="list-style-type: none"> <li>• Creating and maintaining the e-SPAR platform and reporting tools;</li> <li>• Providing technical support and training to national authorities;</li> <li>• Facilitating the annual reporting process;</li> <li>• Conducting quality control on submitted data and following up with countries to ensure accuracy and completeness; and</li> <li>• Supporting countries in meeting their IHR obligations through SPAR reporting to the WHA annually.</li> </ul>
13	Numerator	Number of States Parties submitting completed SPAR reports annually as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The State Party submits a completed SPAR report by the annual deadline (March 1), covering all 15 IHR core capacities, validated by WHO, with no missing capacity levels unless marked "Not applicable" and justified in the comments, as per field 12.</p> <p><b>Partially achieved:</b> The State Party submits the SPAR report, but with missing or incomplete capacity data (e.g. blank scores without justification), requiring follow-up by WHO before validation.</p> <p><b>Not achieved:</b> No SPAR report submitted by the deadline, or submission is too incomplete to allow for meaningful review or validation by WHO.</p>
17	Rationale	<p>The International Health Regulations (IHR 2005) require countries that have legally committed to implementing the regulations ("State Parties") to establish and maintain the capacity to detect, assess, notify and respond to public health risks and acute events, including those at points of entry, (Annex 1 of the Regulations). Article 54 of the IHR states that "States Parties and the Director-General shall report to the Health Assembly on the implementation of these Regulations as decided by the Health Assembly".</p> <p>WHO plays a central role in supporting countries in assessing their progress, identifying gaps, and strengthening their core capacities to prevent, detect,</p>

		and respond to public health threats in compliance with the International Health Regulations (IHR 2005). This is achieved through the provision of processes and tools enabling the assessment, monitoring, planning, costing, and implementation of preparedness and readiness capacities related to public health emergencies. Annual reporting on the International Health Regulations (IHR 2005) core capacities is a critical mechanism for monitoring global progress in public health preparedness and response. This indicator tracks the number of States Parties that complete their IHR reporting each year, demonstrating their commitment to strengthening health security, transparency, and compliance with those international obligations. In addition, it also contributes to various WHA resolutions that Member States adopted.
18	Measurement method	<ul style="list-style-type: none"> <li>• The data is collected annually from State Parties since 2010 and is registered and available on the <a href="#">e-SPAR platform</a>. There are 196 States Parties that are signatories to the International Health Regulations and are mandated to annual reporting to the World Health Assembly, through the Secretariat of the WHO. An interactive questionnaire in PDF and MS Excel forms for Points of Entry is available in case of limitations in internet connectivity.</li> <li>• A multisectoral engagement for preparedness and One Health approach remains critical to completing the IHR States Parties Self-assessment Annual Report (SPAR). The indicators assessed represent the essential public health capacity that States Parties must have in place throughout their territories under Articles 5 and 12 and Annex 1A of the IHR (2005) requirements.</li> <li>• The SPAR tool consists of 35 indicators detailing the 15 IHR core capacities defined to detect, assess, notify, report, and respond to public health risks and acute events of domestic and international concern. One to five indicators are used to measure the status of each of the 15 capacities. Indicators are further broken down into attributes, which define them at a specific level.</li> <li>• The SPAR questionnaire is launched every year after the World Health Assembly for States Parties to initiate the process of self-assessment and reporting at the subsequent World Health Assembly, using a multisectoral and One Health approach to obtain information from all sectors involved in implementing IHR core capacities.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	<p>Targets for this indicator are based on the obligation of all 196 States Parties to submit annual reports using the SPAR tool, as agreed by Member States through WHA resolutions:</p> <p>Article 54 of the IHR states that “States Parties and the Director-General shall report to the Health Assembly on the implementation of these Regulations as decided by the Health Assembly”. The Health Assembly, through resolutions</p>



		WHA61(2) (2008) and WHA71(15) (2018), confirmed that “States Parties and the Director-General shall continue to report annually to the WHA on the implementation of the International Health Regulations (2005), using the self-assessment annual reporting tool.”
23	How target is realistic for PB2026-2027	Nearly all (195 of 196 States Parties) submitted SPAR results in 2024, thus it is achievable to have 100% submission (196 States Parties) in 2026 and 2027.
24	Data sources	<a href="#">e-SPAR platform</a> ; <a href="#">International Health Regulations (2005)</a> ; <a href="#">WHA71.15 (2018) Resolution</a>
25	Process of validation	The e-SPAR electronic platform has mechanisms and checks to monitor reports received and proceed with quality checks. The e-SPAR platform is also accessible to WHO staff working with the Member States on SPAR (all levels). When the national authority fills in the questionnaire, electronic checks (pop-up alerts) are automatically available to avoid potential mistakes or missing critical information on the report before final submission. All State Parties submissions are reviewed by the WHO secretariat to: <ul style="list-style-type: none"> <li>• Ensure all submitted SPAR data is correct and complete before confirmation.</li> <li>• Identify and address missing information by reviewing submissions and validating against WHO requirements.</li> <li>• As needed a follow up is made with National Focal Points (NFPs), Country Offices (COs), and Regional Offices (ROs) via formal emails to request missing information and necessary corrections. Additionally, regular announcements and reminders for submission deadlines are sent, ensuring clarity and alignment with WHO guidelines. Seminars are promoted, tutorials are available (under revision) and consultation with national authorities can be made in coordination with all levels of WHO. Potentially needed adjustments to reflect WHA77 (2024) amendments of the IHR are currently being discussed. More details with references, short videos and links in several languages at: <a href="https://extranet.who.int/e-spar/">https://extranet.who.int/e-spar/</a></li> </ul>
26	Limitations	It is based on a self-assessment and reporting by the State Party
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Stella Chungong <chungongs@who.int>, Nirmal Kandel <kandel@who.int>, Peter Mala <malap@who.int>, Cynthia Bell <bellc@who.int>

#### 5.2.1.IND3\_UID 824 : Number of countries that have completed an action review or simulation exercise to review national system capacities and inform national action plans

#	Metadata field	Summary
1	GPW14 Output	5.2.1. WHO conducts risk and capacity assessments and supports the development and implementation of national preparedness and readiness plans, including tailored prevention and mitigation strategies for specific hazards
2	GPW14 Output indicator code	5.2.1.IND3

3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have completed an action review or simulation exercise to review national system capacities and inform national action plans
4	Output/Leading Indicator (Country Level Formulation)	Completion of an action review or a simulation exercise to review national system capacities and inform national action plans
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Provisional
8	Linked outcome indicators (Direct (D) or indirect (I))	Functional capability assessment for health emergency preparedness and response using simulation exercises (SimEx) and action reviews (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks the number of countries that have conducted a simulation exercise or action review to evaluate and improve their national health emergency preparedness and response systems.
12	Criteria	<p>A country is counted as having achieved this indicator if it has completed a simulation exercise or action review to evaluate national system capacities and officially reported it to WHO.</p> <p>To be counted:</p> <ul style="list-style-type: none"> <li>• The simulation exercise or action review must be a component of the International Health Regulations Monitoring and Evaluation Framework (IHRMEF).</li> <li>• Completion must be reported by the State Party to WHO through the eSPAR portal during annual SPAR reporting, or on an ongoing basis via email (ihrmonitoring@who.int).</li> <li>• Only reports that are vetted and appear on the <a href="#">Strategic Partnership for IHR (2005) and Health Security portal</a> or submitted via the IHR Country Capacity Assessment Weekly Update process are considered valid.</li> </ul> <p>The WHO Secretariat plays a critical role by:</p> <ul style="list-style-type: none"> <li>• Providing standardized tools and guidance (e.g. AAR, IAR, SimEx manuals) to support countries in conducting effective evaluations;</li> <li>• Promoting a science- and evidence-based approach to assessing real-world emergency preparedness capacities;</li> <li>• Encouraging cross-country learning through regional reviews and the integration of simulation and action reviews into broader IHR monitoring mechanisms.</li> </ul>
13	Numerator	Number of countries that report completion of at least one simulation exercise or action review as per field 12

14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country has completed a simulation exercise or action review and officially reported it to WHO through recognized mechanisms, such as the eSPAR portal or the IHR Country Capacity Assessment email process as per field 12</p> <p><b>Partially achieved:</b> The country has completed a simulation exercise or action review but has not formally reported it to WHO, or reporting was incomplete or informal.</p> <p><b>Not achieved:</b> The country has not conducted a simulation exercise or action review, or has conducted one but no evidence has been submitted to WHO through any reporting channel.</p>
17	Rationale	<p>The rationale behind this indicator is to assess the extent to which countries actively evaluate and strengthen their national public health emergency preparedness and response systems. By conducting simulation exercises or action reviews, countries can identify gaps, test response mechanisms, and refine national action plans based on real-time learnings. Simulation exercises are also incorporated into various analysis and capacity-building tools and initiatives, including those for multisectoral coordination for preparedness such as civil military collaboration for health security preparedness, health emergencies in cities and urban setting, and parliamentary engagement. This indicator provides valuable insights into global efforts to enhance resilience and readiness for health emergencies under the International Health Regulations (IHR 2005). WHO plays a critical role in ensuring that countries assess, test, and strengthen the efficiency and effectiveness of their health emergency and multisectoral preparedness capacities through action reviews and simulation exercises. These activities help countries identify strengths, gaps, and areas for improvement in their national health security systems. In addition, it also contributes to various WHA resolutions that Member States adopted <a href="http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_22Add1-en.pdf">http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_22Add1-en.pdf</a></p>
18	Measurement method	<ul style="list-style-type: none"> <li>• The purpose of simulation exercises and action review are: <ul style="list-style-type: none"> <li>○ To assess the level of engagement, preparedness, learning, functional capacities, and capabilities of countries through simulation exercises and structured reviews.</li> <li>○ To identify gaps and areas for improvement in health emergency preparedness and response systems.</li> </ul> </li> <li>• Simulation exercises and action reviews are: <ul style="list-style-type: none"> <li>○ components of the IHRMEF process by which States Parties can monitor and evaluate the implementation of IHR capacities in accordance with the requirements for capacity development outlined in Annex 1 of the IHR.</li> <li>○ contributing to Article 54 of the IHR, which calls on States Parties and WHO to report to the WHA on the implementation of the IHR.</li> </ul> </li> </ul>

		<p>This framework encourages the use of existing available information from other monitoring and evaluation tools, including multisectoral engagement with non-traditional partners such as defence, transportation, foreign affairs, trade, tourism, relevant to public health security, as stipulated under the IHR, to avoid duplication and to help ensure countries are not overburdened.</p> <p>The Review Committee report recommended an action-oriented and multisectoral approach to the periodic evaluation of functional capacities (Implementation of the International Health Regulations (2005) – <a href="#">Report of the Review Committee on Second Extensions for Establishing National Public Health Capacities and on IHR Implementation</a></p> <ul style="list-style-type: none"> <li>• Completion of SimEx and action reviews are submitted by States Parties to the WHO on an ongoing basis throughout the year and are reported on the <a href="#">Strategic Partnership for International Health Regulations (2005) and Health Security portal</a> and IHR Country Capacity Assessment, Monitoring, Evaluation and Planning Weekly Update email list (ihrmonitoring@who.int).</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Number of countries
22	Target setting methodology	Targets are set based on the expectation that inclusion of this indicator in GPW14 will lead to improved reporting by Member States. The current levels of reporting may underestimate actual activity due to underreporting, as simulation exercises and action reviews are often completed but not always submitted to WHO.
23	How target is realistic for PB2026-2027	Inclusion of this indicator in GPW14 is expected to incentivize more countries to report completed simulation exercises and action reviews, improving both visibility and consistency in reporting
24	Data sources	<a href="#">WHO eSPAR portal</a> ; <a href="#">WHO Health Security portal</a> ; IHRMEF reports; Weekly update emails from “ihrmonitoring@who.int”
25	Process of validation	<p>States Parties report completion of these events are voluntarily through country and regional offices.</p> <p>Event reports using scenarios for the evaluation of more specific technical capacities—for instance, in the areas of coordination at the human-animal-environment interface for zoonotic disease control—are available on the relevant WHO webpages, following validation by the respective countries.</p>
26	Limitations	<p>Self-reported completion of simulation exercises and action reviews by States Parties is not always reported to WHO, thus current baseline levels may reflect a variability in reporting to WHO rather than completion of simulation exercises and action reviews. Inclusion of this indicator in the GPW14 will promote assessment of functional capabilities as well data reporting to WHO.</p> <p>We recommend use of the standardized scoring of evaluated functions and capabilities using the exercise evaluation guides: <a href="#">WHO Simulation Exercise</a></p>

		<a href="#">Manual; Guidance and tools for conducting an early action review (EAR): rapid performance improvement for outbreak detection and response; Country COVID-19 intra-action review (IAR): facilitator's manual; Guidance for After Action Review (AAR).</a> These standardized scores could be used along with other IHRMEF assessment results to adjust capacity level scores (e.g. SPAR) for functional capability assessments.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Stella Chungong <chungongs@who.int>, Nirmal Kandel <kandeln@who.int>, Peter Mala <malap@who.int>, Cynthia Bell <bellc@who.int>

## 5.2.2. WHO establishes and manages collaborative research networks for fast-track research and development, scalable manufacturing and resilient supply chain systems to enable timely and equitable access to medical countermeasures during health emergencies

**5.2.2.IND1\_UID 1375 : Percentage of medical countermeasures for high-threat pathogens delivered through an internationally agreed and equitable access allocation mechanism (e.g. the Access and Allocation Mechanism or the International Coordinating Group on Vaccine Provision)**

#	Metadata field	Summary
1	GPW14 Output	5.2.2. WHO establishes and manages collaborative research networks for fast-track research and development, scalable manufacturing and resilient supply chain systems to enable timely and equitable access to medical countermeasures during health emergencies
2	GPW14 Output indicator code	5.2.2.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of medical countermeasures for high-threat pathogens delivered through an internationally agreed and equitable access allocation mechanism (e.g. the Access and Allocation Mechanism or the International Coordinating Group on Vaccine Provision)
4	Output/Leading Indicator (Country Level Formulation)	MCM allocations for high-threat pathogens delivered during health emergencies
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	International Health Regulations (IHR) capacity and health emergency preparedness (D); Vaccine coverage of at-risk groups for high-threat epidemic/pandemic pathogens: yellow fever, cholera, meningitis, polio, and measles (I)
9	Data type	Percentage
10	Unit of measure	Percentage of medical countermeasures
11	Indicator definition	This indicator measures the percentage of medical countermeasure (MCM) allocations, such as vaccines, therapeutics, diagnostics, and protective equipment, for high-threat pathogens that are delivered through internationally agreed and equitable access mechanisms (e.g. the Access and Allocation Mechanism (AAM) or the International Coordinating Group (ICG) on Vaccine Provision) during health emergencies. It reflects WHO's ability to respond quickly and equitably to country requests for MCMs during outbreaks or pandemics.

12	Criteria	<p>An MCM allocation is counted toward this indicator if:</p> <ul style="list-style-type: none"> <li>• It is a formal request submitted by a country or territory during a health emergency involving high-threat pathogens;</li> <li>• The request is fully or partially approved;</li> <li>• Delivery of medical countermeasures (e.g. vaccines, therapeutics, diagnostics, or protective equipment) occurs through an internationally agreed equitable access allocation mechanism (e.g. Access and Allocation Mechanism [AAM], International Coordinating Group [ICG]).</li> </ul> <p>Each qualifying request contributes to the numerator of the indicator calculation.</p>
13	Numerator	Number of vaccine (or MCM) requests fully or partially approved and vaccine delivered through an internationally agreed equitable access allocation mechanism (for example the Access and Allocation Mechanism (AAM) or the International Coordinating Group (ICG) on Vaccine as per field 12
14	Denominator	Total number of vaccine (or MCM) requests submitted during health emergencies
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	<p>Medical Countermeasures (MCMs) are crucial in controlling health emergencies caused by high-threat pathogens, such as viruses, bacteria, and other infectious agents that pose significant risks to public health. The timely and efficient delivery of MCMs can significantly reduce mortality and morbidity during public health crises. This indicator measures the proportion of MCMs allocation by countries, such as vaccines, therapeutics, diagnostics, protective equipment and other relevant health products, that are successfully delivered by WHO at the request of affected countries. Areas and territories during a health emergency involving high-threat pathogens. This indicator helps measure WHO's ability to facilitate rapid deployment of life-saving products, reducing the burden and impact of outbreaks and pandemics.</p>
18	Measurement method	<ul style="list-style-type: none"> <li>• Collection by the <a href="#">i-MCM-Net Secretariat</a> : Data is collected through the formal submission of countries requesting any form of MCM during an outbreak or pandemic and the decision to allocate MCM to the requesting country. In addition, the timeliness of the decision-making is captured in terms of days to decision-making, days from allocation decision to shipment, days from arrival of MCM in country to implementation of services. <ul style="list-style-type: none"> <li>○ The mpox access and allocation mechanism (AAM) is designed to ensure timely and equitable access to medical countermeasures (MCMs) during the Public Health Emergency of International concern declared in August 2024. WHO plays a pivotal role in</li> </ul> </li> </ul>

		<p>facilitating the rapid allocation and deployment of life-saving products, such as vaccines, and diagnostics. The AAM involves collaboration between various stakeholders to manage the supply chain systems and ensure that MCMs are delivered to countries in need. The process includes formal submission of requests from countries, decision-making on allocation, and tracking the timeliness of delivery and implementation. This approach helps to control outbreaks by providing essential resources to affected areas promptly.</p> <ul style="list-style-type: none"> <li>○ The International Coordinating Group (ICG) on Vaccine Provision plays a crucial role in ensuring the timely and equitable delivery of vaccines during health emergencies (Yellow fever, Ebola, meningitis and cholera). The ICG collaborates with various stakeholders to manage the supply chain systems and facilitate the rapid allocation and deployment of vaccines to countries in need. The process involves formal submission of requests from countries, decision-making on allocation, and tracking the timeliness of delivery and implementation. The ICG's impact is validated through annual expert meetings, where specialists review and verify the data to ensure its accuracy, consistency, and reliability.</li> </ul> <p>An example of data collection and reporting can be found here: <a href="#">Weekly epidemiological record, No 10, 2018, 93, 105–116, Delivering at the country level: the International Coordinating Group on Vaccine Provision and its impact in 2016 and 2017</a></p>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	Aggregate estimation is performed by calculating the total number of MCM requests that were fully or partially approved and delivered through an internationally agreed equitable access allocation mechanism, divided by the total number of MCM requests submitted during health emergencies. This proportion is then expressed as a percentage.
21	Calculation type	Cumulative
22	Target setting methodology	The WHO secretariat will work with countries that submit vaccine requests during outbreaks to increase their receivability of requests and chances to be approved by the equitable allocation mechanism
23	How target is realistic for PB2026-2027	The factors that will increase this indicator are: (i) the restructuring and increase in personal of the ICG secretariat, (ii) the establishment of allocation frameworks, e.g. pandemic influenza and (iii) the continuation of the i-MCM-net initiative, as well as the implementation of the pandemic agreement
24	Data sources	i-MCM-Net Secretariat; AAM documentation for mpox; ICG records; <a href="#">Landscape report</a> ; HEPR report; WHO WHE IHM 16.1
25	Process of validation	Data validation is conducted through annual expert meetings of the technical steering committees, such as the annual meeting of the ICG. These meetings bring together specialists who review and verify the data to ensure its accuracy, consistency, and reliability. This collaborative approach helps



		maintain the integrity of the data and ensures it meets the highest standards for analysis and decision-making.
26	Limitations	None
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Tim NGUYEN < nguyent@who.int>

**5.2.2.IND2\_UID 1410 : Number of research and development and innovation road maps for product and medical countermeasures developed for high-priority viral families using collaborative open research consortia**

#	Metadata field	Summary
1	GPW14 Output	5.2.2. WHO establishes and manages collaborative research networks for fast-track research and development, scalable manufacturing and resilient supply chain systems to enable timely and equitable access to medical countermeasures during health emergencies
2	GPW14 Output indicator code	5.2.2.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of research and development and innovation road maps for product and medical countermeasures developed for high-priority viral families using collaborative open research consortia
4	Output/Leading Indicator (Country Level Formulation)	Number of research and development and innovation road maps for product and medical countermeasures developed for high-priority viral families using collaborative open research consortia
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	International Health Regulations (IHR) capacity and health emergency preparedness (I)
9	Data type	Number
10	Unit of measure	Number of roadmaps
11	Indicator definition	This indicator measures the number of R&D and Innovation Roadmaps that have been developed and published for high-priority viral families. Each roadmap focuses on one of three medical countermeasures, vaccines, treatments, or diagnostics, and is produced through WHO-supported Collaborative Open Research Consortia (CORCs). These documents are publicly available and provide structured research and innovation plans to address emerging and epidemic-prone viruses.

12	Criteria	<p>A roadmap is counted under this indicator if it meets all the following conditions:</p> <ul style="list-style-type: none"> <li>• It is developed for one of the 10 highest-risk viral families of epidemic or pandemic concern: These are based on the 10 highest-risk viral families of epidemic and pandemic concern: 1. Arenaviridae 2. Hantaviridae 3. Nairoviridae 4. Peribunyaviridae 5. Phenuiviridae 6. Coronavirus 7. Filovirus 8. Flavivirus 9. Paramyxovirus 10. Poxvirus.</li> <li>• The number will vary over time based on emerging data and new knowledge</li> <li>• It focuses on one of the three medical countermeasures: vaccines, treatments, or diagnostics.</li> <li>• It is developed through a WHO-supported Collaborative Open Research Consortium (CORC).</li> <li>• It is finalized, published, and made publicly available on the WHO website.</li> </ul> <p>While the indicator does not track country-level implementation, WHO facilitates dissemination of the Roadmaps through its regional and country offices to promote awareness and encourage potential alignment with national emergency response or preparedness planning. To better reflect WHO's support role, the following criteria are proposed to assess the facilitation and enabling of access to Roadmaps by countries:</p> <ol style="list-style-type: none"> <li>1. Active dissemination: Roadmaps are proactively shared with REDs and regional R&amp;D focal through official communications, technical briefings, or webinars organized.</li> <li>2. Participation in CORC meetings: REDs and regional R&amp;D focal points are encouraged to actively participate in CORC meetings when the Roadmaps are being developed</li> <li>3. Stakeholder engagement: Participation in regional and national-level dialogues or workshops that introduce and contextualize the Roadmaps for government and technical partners.</li> <li>4. Integration into guidance: Roadmaps are referenced or incorporated into regional guidance and planning tools for emergency preparedness and response.</li> <li>5. Monitoring uptake: Collecting anecdotal or in formal feedback from countries indicating awareness of and potential use of the Roadmaps in national planning efforts.</li> </ol>
13	Numerator	Number of published Roadmaps for each high-priority viral family and medical countermeasure as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable

17	Rationale	Global R&D and Innovation Roadmaps for high-risk viral families and medical countermeasures (vaccines, therapeutics, and diagnostics) serve as critical tools for identifying knowledge gaps and defining research priorities. These Roadmaps encompass all aspects of epidemic and pandemic preparedness, including fundamental scientific research, translational studies, clinical development, and implementation strategies. By providing a structured approach, they help streamline efforts, avoid duplication, and optimize resources for maximum impact. Developed through independent and decentralized research consortiums (CORCs), these Roadmaps focus on specific viral families. CORCs serve as coordination hubs, fostering collaboration among scientists, researchers, public health experts, and policymakers from diverse geographical and disciplinary backgrounds. These platforms facilitate peer-reviewed research, promote data sharing, and accelerate the development of medical countermeasures. A strong emphasis is placed on inclusivity, particularly engaging expertise from the Global South to ensure that research and innovation efforts address the needs of all regions equitably. Each R&D Roadmap undergoes an open and transparent review process, incorporating feedback from multiple stakeholders, including governments, regulatory agencies, academia, industry, and civil society organizations. This iterative approach ensures that research priorities remain relevant, scientifically robust, and aligned with evolving public health needs. By serving as dynamic strategic blueprints, these Roadmaps enable a more coordinated and effective global response to emerging and re-emerging infectious disease threats.
18	Measurement method	The indicator is measured by counting the number of R&D and Innovation Roadmaps that meet the criteria outlined in Field 12. Specifically, only those roadmaps that are developed through WHO-supported Collaborative Open Research Consortia (CORCs), finalized, and published in the public domain (including on the WHO website) are included in the count. WHO monitors and verifies publication status through coordination with CORCs and the R&D Blueprint platform.
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of roadmaps meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	<ul style="list-style-type: none"> <li>• Each priority viral family and bacterial group is expected to have one R&amp;D Roadmap developed for each medical countermeasure, vaccines, treatments, and diagnostics.</li> <li>• These roadmaps are intended to remain valid for five years and do not require updates during the 2026–2027 biennium.</li> <li>• Development will be phased, with approximately half of the roadmaps produced before the end of 2026 and the remainder in 2027.</li> <li>• All roadmaps will be developed by CORCs.</li> </ul>
23	How target is realistic for PB2026-2027	<ul style="list-style-type: none"> <li>• These are short strategic documents that should not take very long to develop. These can be produced online without the need for face-to-face meetings.</li> </ul>

		<ul style="list-style-type: none"> <li>• Each CORC will have sub-groups by vaccines, treatment and diagnostics to develop the different roadmaps by MCM.</li> <li>• The funds required to develop a roadmap are minimal.</li> </ul>
24	Data sources	<a href="#">Pathogens prioritization: a scientific framework for epidemic and pandemic research preparedness; R&amp;D Blueprint website</a>
25	Process of validation	R&D and Innovation Roadmaps are developed by viral family CORCs and undergo an open and transparent review process, incorporating feedback from multiple stakeholders, including governments, regulatory agencies, academia, industry, and civil society organizations. The iterative approach to developing the R&D Roadmap ensures that research priorities remain relevant, scientifically robust, and aligned with evolving public health needs. Each CORC is anchored as a WHO Collaborative Center ensuring an additional level of proofing for accuracy, consistency and reliability.
26	Limitations	No specific challenges and constraints are expected in tracking the number of R&D and Innovation Roadmaps produced. A limitation may be that additional Roadmaps may be developed beyond the ones for each of the 10 high-risk viral families. Some may be produced for specific priority or prototype pathogens within a family of viruses.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Ana Maria Henao Restrepo <henaorestrepoa@who.int>

### 5.2.3. WHO provides technical expertise and operational support to strengthen and scale clinical care for emergencies, including infection prevention and control measures to protect health workers and patients

#### 5.2.3.IND1\_UID 1152 : Number of countries with multisectoral, multidisciplinary national costing oxygen system plans being evaluated

#	Metadata field	Summary
1	GPW14 Output	5.2.3. WHO provides technical expertise and operational support to strengthen and scale clinical care for emergencies, including infection prevention and control measures to protect health workers and patients
2	GPW14 Output indicator code	5.2.3.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries with multisectoral, multidisciplinary national costing oxygen system plans being evaluated
4	Output/Leading Indicator (Country Level Formulation)	Assessment of national oxygen ecosystems reported at baseline and periodically reassessed according to WHA76.3 reporting timelines
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Provisional
8	Linked outcome indicators (Direct (D) or indirect (I))	International Health Regulations (IHR) capacity and health emergency preparedness (I)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks the number of countries that have conducted an assessment of their national oxygen ecosystem, aligned with WHA76.3. It serves to monitor evaluation of systems supporting access to medical oxygen.
12	Criteria	<p>A country is counted as having achieved this indicator if:</p> <ul style="list-style-type: none"> <li>• It has conducted a national-level assessment of its oxygen ecosystem, aligned with WHA76.3 commitments.</li> <li>• WHO has developed the ATMOS tool to support this process, provides technical support for its use, and facilitates capacity-building through regional workshops and country briefings.</li> <li>• The evaluation process is nationally owned, but WHO plays a key facilitative role through the dissemination of the ATMOS tool and technical support.</li> </ul>

13	Numerator	Number of countries conducting a national-level oxygen ecosystem assessment as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	TBD
17	Rationale	Oxygen is an essential component of clinical care for many life-threatening conditions, including pneumonia, respiratory distress, and critical illnesses such as COVID-19. Despite its importance, access remains limited in many countries, particularly in low-resource settings. This indicator measures the assessment of capacity and capability of the oxygen ecosystem. The indicator links to the structured, funded national medical oxygen system plans which are being developed by WHO's collaboration with GO2AL, but the indicator assesses the high-level assessment aspects which drive progress, rather than the specifics of implementation.
18	Measurement method	<ul style="list-style-type: none"> <li>• A bespoke tool has been developed that enables rapid national assessment of the oxygen ecosystem, and which maps directly to commitments and requests within WHA76/3 (currently known as the ATMOS scorecard, with 19 high-level questions with semi-quantitative assessment of capacity and capability across these domains).</li> <li>• Ministry of Health oxygen system point person coordinates the completion of the online tool based on ongoing assessments and multisectoral discussion.</li> <li>• Support for completion of the tool will be available from the WHO HQ technical team, but the ownership of the process for evaluation and the data remains with the Member State, allowing a maximal degree of autonomy within the required WHA76.3 reporting requests.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of roadmaps meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	TBD
23	How target is realistic for PB2026-2027	TBD
24	Data sources	Ministry of Health responses via ATMOS tool or other national assessment methods; WHA76.3 reporting; GO2AL Global Oxygen Investment Case
25	Process of validation	Data collected and validated by technical team
26	Limitations	None
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025

29	Technical focal point	Janet DIAZ < diazj@who.int>
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### 5.2.3.IND2\_UID 1154 : Number of countries having standards available for IPC, WASH and waste in healthcare facilities

#	Metadata field	Summary
1	GPW14 Output	5.2.3. WHO provides technical expertise and operational support to strengthen and scale clinical care for emergencies, including infection prevention and control measures to protect health workers and patients
2	GPW14 Output indicator code	5.2.3.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries having standards available for IPC, WASH and waste in healthcare facilities
4	Output/Leading Indicator (Country Level Formulation)	Availability of standards for IPC, WASH and waste in health care facilities
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Coverage of WASH in healthcare facilities (D); Percentage of WHO's minimum requirements for IPC met at the national level, particularly to support outbreak preparedness, readiness, and response (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator measures the number of countries having standards available for Infection Prevention and Control (IPC), based on WHO minimum requirements, Water, Sanitation and Hygiene (WASH) and Waste standards that have been implemented at health care facility level.
12	Criteria	<p>A country is counted as having achieved this indicator if it has reached Level 4 (demonstrated capacity) or Level 5 (sustainable capacity) in Capacity 9 of the e-SPAR report.</p> <p>Capacity 9 includes the following components:</p> <ul style="list-style-type: none"> <li>• C9.1: IPC programme</li> <li>• C9.2: Health care-associated infection (HAI) surveillance</li> <li>• C9.3: Environmental infrastructure and staffing</li> </ul> <p><i>Level 4 in overall C9: the country has demonstrated IPC capacities in the following components: IPC program, HAI surveillance and environmental infrastructure and staffing: (Attributes are in place and sustainable for a few years and can be measured by the inclusion of attributes or IHR core capacities in the national health sector plan and a secure funding source)</i></p>

		<i>Level 5 in overall C9: the country has sustainable IPC capacities in the following components: IPC program, HAI surveillance and environmental infrastructure and staffing (All attributes are functional and sustainable, and the country is supporting one or more other countries in their implementation. This is the highest level of the achievement of implementation of IHR core capacities)</i>
13	Numerator	Number of countries that meet the criteria as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	TBD
17	Rationale	<p>Infection Prevention and Control (IPC) and Water, Sanitation, and Hygiene (WASH), including health care waste management, are foundational to ensuring the safety of patients, health workers, and visitors in health care settings. Strong IPC and WASH standards enable the provision of safe, scalable, and resilient care, particularly during public health emergencies. This output indicator tracks the number of countries that have established national standards for IPC, WASH, and health care waste management, and that have implemented these standards at the health facility level. It reflects progress toward achieving safe, quality, and resilient health systems.</p> <p><b>1. Foundational Role of IPC and WASH in Health Emergency Preparedness</b>  Robust IPC and WASH programs in health facilities—encompassing national guidelines, training, monitoring and feedback systems, health care-associated infection (HAI) surveillance, safe environments (e.g. improved WASH infrastructure, reduction of overcrowding, and adequate staffing)—are essential to:</p> <ul style="list-style-type: none"> <li>• Preventing and controlling infections, including health care-associated infections.</li> <li>• Ensuring continuity of essential health services during health emergencies.</li> <li>• Reducing the risk of disease amplification in health facilities.</li> </ul> <p><b>2. Alignment with WHO's Strategic Role and Global Standards</b>  WHO plays a central role in <b>setting and promoting global standards</b> for IPC, WASH, and health care waste management in health facilities. Through tools such as the <b>Country Progress Tracker on WASH in Health Care Facilities</b>, WHO supports countries in tracking implementation and identifying progress gaps. Incorporating an IPC output indicator into GPW14 directly supports WHO's <b>Protect Pillar</b> under the <b>Health Emergency Preparedness and Response (HEPR)</b> framework and contributes to global health security.</p> <p><b>3. IPC as a Cornerstone of Outbreak Preparedness and Response</b>  Strengthening IPC capacities contributes to:</p> <ul style="list-style-type: none"> <li>• Reducing health care-associated infections and controlling emerging/re-emerging infectious disease outbreaks.</li> </ul>



		<ul style="list-style-type: none"> <li>Minimizing secondary transmission of epidemic-prone diseases such as <b>Ebola, Marburg, cholera, and COVID-19.</b></li> <li>Protecting health care workers and patients, ensuring uninterrupted delivery of health services during crises.</li> </ul> <p><b>4. Supporting WHO's Core Health Emergency Frameworks</b> Including an IPC and WASH output indicator enhances compliance with key WHO and global health frameworks:</p> <ul style="list-style-type: none"> <li><b>International Health Regulations (IHR 2005)</b> – IPC is a core requirement under <b>Core Capacities 8 &amp; 9.</b></li> <li><b>WHO Global IPC Strategy 2023–2030</b> – Recognizes IPC as fundamental to health threat prevention.</li> <li><b>Joint External Evaluation (JEE) and State Party Annual Reporting (SPAR)</b> – Require countries to assess and report on IPC capacity.</li> </ul> <p><b>5. Promoting Data-Driven Decision-Making and Accountability</b> A results-oriented IPC and WASH indicator will:</p> <ul style="list-style-type: none"> <li>Enable <b>evidence-based prioritization</b> of resources for IPC and WASH infrastructure, workforce training, PPE, and surveillance systems.</li> <li>Support <b>timely corrective actions</b> through national monitoring and gap identification.</li> </ul> <p>Foster <b>political commitment and accountability</b> by integrating IPC into broader national health security agendas.</p>
18	Measurement method	<p>The data are collected via WHO's electronic IHR State Parties self-assessment Annual reporting tool (e-SPAR):  <a href="#">States Party self-assessment annual reporting tool second edition</a> <i>"IHR-SPAR annual report"</i>.</p> <p><b>Level 1:</b> No capacity  <b>Level 2:</b> Limited capacity  <b>Level 3:</b> Developed capacity  <b>Level 4:</b> Demonstrated capacity  <b>Level 5:</b> Sustainable capacity</p> <p>Please refer to the detailed descriptions of each level for Capacity 9 <a href="#">here</a></p>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The final number will represent countries having both IPC, WASH and waste standards, which are implemented at health care facilities, as reported in IHR-SPAR annual report.
21	Calculation type	Cumulative
22	Target setting methodology	<p>Targets were set based on a stepwise increase from the baseline of 39.5% that had reached Level 4 or 5 in SPAR Capacity 9. The progression anticipates a gradual but accelerating improvement, supported by WHO's technical guidance, country-level support, and the implementation of the Global IPC Strategy 2023 and its Monitoring Framework for 2024–2030.</p> <p>The proposed targets are: 50% of countries by 2026, 60% by 2027, 75% of countries by 2028; 90% of countries by 2030</p>
23	How target is realistic for PB2026-2027	<ul style="list-style-type: none"> <li>Many countries have already reached Level 3, so reaching Level 4 or 5 is a natural progression.</li> </ul>

		<ul style="list-style-type: none"> <li>The Global Strategy on IPC (2023) and its Monitoring Framework and Action Plan (2024–2030), endorsed by the WHA, support this goal</li> </ul>
24	Data sources	<a href="#">WHO e-SPAR portal</a>
25	Process of validation	<p>Data for this indicator are validated through multiple mechanisms to ensure consistency, accuracy, and government ownership:</p> <ul style="list-style-type: none"> <li>The e-SPAR platform includes automated quality checks (e.g. pop-up alerts) that flag incomplete or inconsistent entries when national authorities complete the questionnaire. WHO staff at all levels (country, regional, HQ) have access to the platform to support validation and follow up with Member States. Additional support includes seminars, tutorials (under revision), and technical consultations.</li> <li>For the WASH and health care waste components, WHO and UNICEF apply a structured eight-step framework. Each step is scored using a four-point scale, visualized through a traffic light system (green, yellow, orange, red). Initial ratings are sent to country offices for review and validation by government counterparts. Where possible, countries submit supporting documents to the WHO/UNICEF portal, <a href="#">WASH country tracker</a>, WHO/UNICEF Joint Monitoring Programme, UN-Water and GLAAS datasets, Online submission forms and country self-assessments</li> <li>For IPC global survey : Follow-up interviews and email exchanges with ministries and WHO/UNICEF country offices</li> <li>Countries were also invited to update their data through a standardized submission form. Additional information was collected from WASHdata.org, global datasets (e.g. JMP, GLAAS), regional events, and direct follow-up with ministries of health and WHO/UNICEF country offices.</li> </ul> <p>This multi-source validation approach supports reliable reporting and enables trend analysis and investment prioritization.</p>
26	Limitations	None
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	April BALLER < ballera@who.int>

### 6.1.1. WHO strengthens surveillance and alert systems, including diagnostics and laboratory capacities, for the effective monitoring of public health threats and the rapid detection, verification, risk assessment and grading of public health events

#### 6.1.1.IND1\_UID 1156 : Percentage of critical acute public health events for which a formal initial rapid risk assessment and grading are completed within one week

#	Metadata field	Summary
1	GPW14 Output	6.1.1. WHO strengthens surveillance and alert systems, including diagnostics and laboratory capacities, for the effective monitoring of public health threats and the rapid detection, verification, risk assessment and grading of public health events
2	GPW14 Output indicator code	6.1.1.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of critical acute public health events for which a formal initial rapid risk assessment and grading are completed within one week
4	Output/Leading Indicator (Country Level Formulation)	Percentage of critical acute public health events for which a formal initial rapid risk assessment and grading are completed within one week
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Detect, notify, and respond (DNR) (D)
9	Data type	Percentage
10	Unit of measure	Percentage of critical acute public health events
11	Indicator definition	<p>This indicator tracks the percentage of critical acute public health events for which a formal initial rapid risk assessment (RRA) and grading are completed within one week of notification or decision to conduct an RRA.</p> <p><b>Critical acute public health events</b> are urgent health emergencies that require immediate response due to their potential to cause widespread harm to public health.</p> <p><b>Rapid risk assessment (RRA)</b> characterizes the risk to public health from an acute event and informs decision-making for an effective response.</p> <p>The <b>one-week window</b> is triggered by either the date the event was notified to WHO or if not available the date of decision to conduct an RRA.</p>
12	Criteria	To be counted under this indicator:

		<ul style="list-style-type: none"> <li>• The public health event must be classified as a <b>critical acute public health event</b>, as per the definition in field 11.</li> <li>• A formal <b>rapid risk assessment (RRA)</b> must be conducted.</li> <li>• The event must also be <b>graded</b>, which determines the level of WHO operational support and triggers immediate actions.</li> <li>• The RRA and grading must be completed <b>within one week</b>, starting from either: <ul style="list-style-type: none"> <li>○ the date the event was notified to WHO, OR</li> <li>○ if notification is unavailable, the date when the decision was made to conduct the RRA.</li> </ul> </li> </ul>
13	Numerator	Number of critical acute public health events for which a formal initial RRA and grading are completed within one week as per field 12
14	Denominator	Total number of critical acute public health events that received WHO operational support, defined as graded events. This excludes events that WHO only monitored or alerted Member States about but did not actively support operationally.
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	The timely and accurate initial rapid risk assessment and grading of acute public health events is crucial for effective decision-making and response. WHO plays a key role in coordinating global health responses to critical acute public health events, ensuring that risk assessments and grading are conducted rapidly and effectively to guide appropriate responses. This indicator helps measure the speed and quality of the initial risk assessment, which is essential for timely decision-making, resource allocation, and response planning during public health emergencies.
18	Measurement method	<p>Data for this indicator are collected through:</p> <ul style="list-style-type: none"> <li>• the WHO PHI Product Tracker, which records completion of rapid risk assessments (RRAs), and</li> <li>• the Emergency Operations Centre (EOC) dataset, which captures event grading.</li> </ul> <p>Each record includes a timestamp, allowing measurement of whether both the RRA and grading were completed within one week of event notification or the decision to conduct an RRA (whichever is available).</p> <p>The indicator is reported as a percentage based on validated entries meeting the criteria as per field 12.</p>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The global percentage is calculated by dividing the number of critical acute public health events with both a rapid risk assessment and grading completed within one week (numerator) by the total number of critical acute

		events notified to WHO or identified for operational response (denominator). Each event is counted once, and data from all WHO regions are combined.
21	Calculation type	Cumulative
22	Target setting methodology	Targets were set based on a review of the baseline data and expectations of gradual improvement. This improvement is anticipated due to increased awareness across all three levels of the Organization, country offices, regional offices, and headquarters.
23	How target is realistic for PB2026-2027	WHOs decrease in funding and staffing will impact the ability to achieve these targets. Conducting RRAs and grading take substantial staff time across the three levels of the organisation, with less staff time available they will take longer. However this is a priority area for WHO staff that work in emergencies as both are essential in triggering our operational support to member states, thereby reducing the impact of a public health event.
24	Data sources	WHO PHI Product Tracker (for rapid risk assessments); WHO Emergency Operations Centre (EOC) dataset (for event grading); <a href="#">International Health Regulations (2005)</a> ; <a href="#">International Health Regulations</a> ; <a href="#">Emergency Response Framework (ERF), Edition 2.1</a>
25	Process of validation	Data is validated by regions and within the analytics unit in the department
26	Limitations	None
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Esther Hamblion <hamblione@who.int>; Abdi MAHAMUD <mahamuda@who.int>

#### 6.1.1.IND2\_UID 1159: Number of countries that have demonstrated laboratory capabilities to test and sequence for priority pathogens of epidemic and pandemic potential

#	Metadata field	Summary
1	GPW14 Output	6.1.1. WHO strengthens surveillance and alert systems, including diagnostics and laboratory capacities, for the effective monitoring of public health threats and the rapid detection, verification, risk assessment and grading of public health events
2	GPW14 Output indicator code	6.1.1.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have demonstrated laboratory capabilities to test and sequence for priority pathogens of epidemic and pandemic potential
4	Output/Leading Indicator (Country Level Formulation)	Demonstrated national laboratory capabilities to test and sequence for priority pathogens of epidemic and pandemic potential
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input,	Output

	Process, Output, Outcome)	
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Detect, notify, and respond (DNR) (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks the number of countries that have demonstrated the laboratory capacity to test for and sequence high-priority pathogens of epidemic and pandemic potential. Demonstration can be through performance in WHO-supported External Quality Assurance Programmes (EQAPs) or WHO-led laboratory assessments.
12	Criteria	<p>A country is counted as having achieved this indicator if it has demonstrated national laboratory capacity to test and/or sequence at least one priority pathogen of epidemic or pandemic potential. This can be shown through:</p> <ol style="list-style-type: none"> <li><b>Participation in a WHO-supported External Quality Assurance Programme (EQAP):</b> The country has participated in at least one EQAP for priority pathogens coordinated by WHO or where access was facilitated by WHO (e.g. GISRS, Mpox, VHF EQAPs).</li> <li><b>Demonstrated capacity to test or sequence at least one priority pathogen:</b> Either testing or sequencing is sufficient. Countries are not required to conduct sequencing in-country, but must have access to sequencing capacity in line with WHO genomic surveillance strategy. <i>List of priority pathogens: zoonotic influenza (e.g., H5, H7, H9), coronaviruses (e.g., SARS-CoV-2, MERS-CoV), chikungunya virus, bacillus anthracis, crimean-congo haemorrhagic fever virus, dengue virus, francisella tularensis, filoviruses, Neisseria meningitidis, hendra virus, vibrio cholerae, lassa fever virus, yersinia pestis, leptospira spp, monkeypox virus, nipah virus, rift valley fever virus, west nile virus, zika virus</i></li> <li><b>Adequate performance in EQAPs:</b> While no universal pass score applies, countries are assessed qualitatively based on EQAP results. For example, in 2024, for the GISRS EQAP, 90% of Member States that participated were 100% correct for non-seasonal influenza virus identification, and 92% of Member States that participated were 100% correct for seasonal influenza virus identification. For the monkeypox virus EQA, 119/125 Member States that participated (95%) showed adequate performance.</li> <li><b>Recognition through the Global Laboratory Recognition Programme (GLRP):</b> A country is counted if it has a laboratory formally recognized under the GLRP, which requires a minimum score of 80%.</li> </ol>
13	Numerator	Number of countries that meet the criteria as per field 12
14	Denominator	Not applicable

15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> Country has demonstrated laboratory capacity through participation in WHO-supported EQAPs and shown adequate performance and/or is recognized under the Global Laboratory Recognition Programme (score <math>\geq 80\%</math>) as per field 12.</p> <p><b>Partially achieved:</b> Country has participated in an EQAP for priority pathogens but has not yet demonstrated consistent adequate performance</p> <p><b>Not achieved:</b> Country has not participated in any WHO-supported EQAP for priority pathogens and has not been recognized under the Global Laboratory Recognition Programme</p>
17	Rationale	Laboratory capabilities for testing and sequencing priority pathogens of epidemic and pandemic potential are essential for early detection, surveillance, and response during public health emergencies. Laboratory systems are essential for detecting and responding to health emergencies by enabling early outbreak detection and confirmation, supporting patient care through clinical diagnostics, informing implementation of public health measures and strengthening collaborative surveillance. WHO provide global leadership, coordination, and technical assistance to support and strengthen laboratory systems and deliver diagnostic services in health emergencies. WHO plays a critical role in ensuring that countries have the necessary laboratory capacities to detect, identify, and sequence pathogens that could pose a risk to public health. This indicator tracks the number of countries that have demonstrated the laboratory capacity to test for and sequence high-priority pathogens, as demonstrated in EQAPs and WHO led laboratory assessments. It helps to monitor global laboratory quality and preparedness, which is essential for early detection, surveillance, and response to emerging infectious diseases that could lead to epidemics or pandemics.
18	Measurement method	<p>Data is collected from:</p> <ul style="list-style-type: none"> <li>Annual WHO-coordinated or facilitated External Quality Assurance Programmes (EQAPs), including GISRS EQAP, Mpox EQAP, viral haemorrhagic fever (VHF) EQAPs, and others targeting high-threat pathogens</li> <li>WHO Global Laboratory Recognition Programme</li> </ul> <p>A country is considered to have demonstrated laboratory capacity if it meets the criteria as per field 12.</p>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	The targets are based on countries already routinely participating in WHO EQA (or programmes led in collaboration with WHO) and strengthen support to countries that have experienced recent outbreaks with high-threat pathogens for which WHO is facilitating access to EQA.

23	How target is realistic for PB2026-2027	There are several EQA rounds planned, notably for Influenza and respiratory pathogens, MERS-CoV, viral hemorrhagic fevers and strategic discussions on optimized provision of EQA access for 2026 and 2027.
24	Data sources	External quality assurance programmes (EQAP): GISRS EQAP, Mpox EQAP, VHF EQAP, other high-threat pathogen EQAPs; Global Laboratory Recognition Programme; <a href="#">International Health Regulations (2005)</a> ; <a href="#">International Health Regulations</a> ; <a href="#">WHO Global Genomic Surveillance Strategy 2022–2032</a> ; <a href="#">Global Influenza Strategy (WHA 73/4)</a>
25	Process of validation	Formal reports from outcome of WHO EQAPs and WHO led lab assessments
26	Limitations	Global Laboratory recognition programme is in the early stages of establishment, and it will take several years to attain complete global roll out
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Celine Barnadas < <a href="mailto:barnadasc@who.int">barnadasc@who.int</a> >; Josefina Campos < <a href="mailto:jcampos@who.int">jcampos@who.int</a> >; Dmitriy Pereyaslov < <a href="mailto:pereyaslovd@who.int">pereyaslovd@who.int</a> >; Lorenzo Subissi < <a href="mailto:subissil@who.int">subissil@who.int</a> >; Philomena Raftery < <a href="mailto:praftery@who.int">praftery@who.int</a> >



### 6.1.2. WHO coordinates rapid and effective responses to acute public health threats, including deploying multisectoral response capacities, surging emergency supplies and logistics support, providing contingency financing, and implementing strategic and operational response plans

#### 6.1.2.IND1\_UID 547: Percentage of approved requests for prepositioned emergency medical supplies and/or equipment ready to ship within 72 hours of the approval of the emergency request

#	Metadata field	Summary
1	GPW14 Output	6.1.2. WHO coordinates rapid and effective responses to acute public health threats, including deploying multisectoral response capacities, surging emergency supplies and logistics support, providing contingency financing, and implementing strategic and operational response plans
2	GPW14 Output indicator code	6.1.2.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of approved requests for prepositioned emergency medical supplies and/or equipment ready to ship within 72 hours of the approval of the emergency request
4	Output/Leading Indicator (Country Level Formulation)	Percentage of approved requests for prepositioned emergency medical supplies and/or equipment ready to ship within 72 hours of the approval of the emergency request
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Provisional
8	Linked outcome indicators (Direct (D) or indirect (I))	Detect, notify, and respond (DNR) (D)
9	Data type	Percentage
10	Unit of measure	Percentage of approved requests
11	Indicator definition	<p>This indicator measures the percentage of approved requests for prepositioned emergency medical supplies and/or equipment that are ready for shipment within 72 hours of approval. It tracks the timeliness of WHO's logistics and emergency preparedness operations to support countries during acute public health emergencies.</p> <p>Emergency orders are defined as approved emergency requests received by the designated supply manager through the emergency workflow in BMS/GSM.</p> <p>“Ready for shipment” is defined as the point when the consignment is fully packed and handed over to the freight forwarder.</p>

12	Criteria	<ul style="list-style-type: none"> <li>Only approved emergency requests for prepositioned supplies (not supplier purchase orders) are included.</li> <li>Requests must be recorded through the emergency supply workflow in the BMS system.</li> <li>A request is counted as achieved if the shipment is ready to be handed over to the freight forwarder within 72 hours of approval.</li> <li>Performance is determined based on system-generated timestamps from BMS and GSM, where available, measuring elapsed time from approval to shipment readiness.</li> </ul>
13	Numerator	Number of approved emergency requests for prepositioned medical supplies and/or equipment that are ready to ship within 72 hours of approval as per field 12.
14	Denominator	Total number of approved emergency requests for prepositioned medical supplies and/or equipment, regardless of time to shipment.
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	Timely delivery of emergency medical supplies, including medicines, vaccines, oxygen, and other critical health commodities, is essential for effective emergency response. Delays in shipment can result in increased morbidity and mortality, especially during health crises such as disease outbreaks, natural disasters, or mass casualty events. This indicator assesses the efficiency and responsiveness of emergency supply chain systems in ensuring rapid deployment of life-saving resources. WHO's added value lies in its ability to rapidly mobilize essential supplies to affected regions, which is critical for early intervention and effective management of health emergencies.
18	Measurement method	<ul style="list-style-type: none"> <li>Data is captured through the emergency supply workflow in the BMS system, where each approved request is time-stamped at two key points: <ul style="list-style-type: none"> <li>The approval date/time of the emergency request, and</li> <li>The date/time the consignment is marked as ready for shipment (handover to the freight forwarder).</li> </ul> </li> <li>These timestamps will be used to calculate elapsed time and determine compliance with the 72-hour threshold. This aligns with the 72-hour benchmark in WHO's Emergency Response Framework (ERF) and reflects WHO's operational capacity for rapid deployment. Once the full BMS MVP rollout is complete, this process will be automated and linked to GSM shipment data.</li> <li>Until then, measurement may rely on partial system data and manual validation of shipment readiness through operational records.</li> <li>Data will be reported as a percentage of qualifying requests that meet the time threshold as per field 12.</li> </ul>

19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The indicator is calculated by dividing the number of approved emergency requests for prepositioned supplies that are ready to ship within 72 hours (numerator) by the total number of approved emergency requests for prepositioned supplies (denominator), and multiplying the result by 100 to obtain a percentage.
21	Calculation type	Cumulative
22	Target setting methodology	The target was established based on an assessment of the operational capacity of WHO logistics hubs to dispatch prepositioned emergency supplies within 72 hours of request approval. It considers the average time required for internal processing steps, including request validation, packing, and freight forwarding. The 72-hour benchmark is drawn from WHO's Emergency Response Framework (ERF), and the target reflects the level of performance that is feasible under normal emergency deployment conditions, accounting for possible variations in destination, shipment method, and hub readiness
23	How target is realistic for PB2026-2027	The target is considered realistic based on the existing capacity of WHO-managed hubs to process and dispatch prepositioned emergency supplies within the 72-hour benchmark. Operational workflows, infrastructure, and supply readiness procedures are already in place to support timely response. The target also reflects alignment with the Emergency Response Framework and benefits from predictable response protocols, experienced logistics teams, and the use of established systems such as BMS and GSM for request tracking and shipment coordination.
24	Data sources	BMS Emergency Supply Portal; Emergency Supply Workflow System; GSM (Global Supply Management) System; WHO Global Logistics Center Reporting Dashboard (where applicable)
25	Process of validation	Data will be generated by a core system, BMS
26	Limitations	The automated capture of key data points through the BMS system is dependent on the full rollout of the MVP version. The emergency supply portal and workflow have been designed to support this data collection, but functionality must still be tested against early deployments and validated through integration with GSM data systems.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Paul MOLINARO< molinarop@who.int>

**6.1.2.IND2\_UID 1161 : Percentage of newly graded emergencies for which the incident management system is activated at least at country level within 72 hours, with focal points for key functions identified and a contingency fund for emergencies released, where appropriate**

#	Metadata field	Summary
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1	GPW14 Output	6.1.2. WHO coordinates rapid and effective responses to acute public health threats, including deploying multisectoral response capacities, surging emergency supplies and logistics support, providing contingency financing, and implementing strategic and operational response plans
2	GPW14 Output indicator code	6.1.2.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of newly graded emergencies for which the incident management system is activated at least at country level within 72 hours, with focal points for key functions identified and a contingency fund for emergencies released, where appropriate
4	Output/Leading Indicator (Country Level Formulation)	Percentage of newly graded emergencies for which the incident management system is activated at least at country level within 72 hours, with focal points for key functions identified and a contingency fund for emergencies released, where appropriate
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Detect, notify, and respond (DNR) (D)
9	Data type	Percentage
10	Unit of measure	Percentage of newly graded emergencies
11	Indicator definition	This indicator measures the proportion of newly graded G2 and G3 emergencies where the Incident Management System (IMS) is activated at country level within 72 hours of grading, including appointment of focal points for key functions and, where applicable, release of the CFE.
12	Criteria	For a newly graded emergency to count as achieving this indicator, the following must occur within 24–72 hours of emergency grading, in line with the Emergency Response Framework (ERF): <ul style="list-style-type: none"> <li>• The Incident Manager (IM) is appointed</li> <li>• Focal points for key Incident Management System (IMS) functions are identified, or the Incident Management Support Team (IMST) is formalized</li> <li>• The Contingency Fund for Emergencies (CFE), where appropriate, is reviewed, cleared, and released</li> </ul>
13	Numerator	Number of newly graded emergencies meeting the criteria in field 12
14	Denominator	All newly graded G2 and G3 emergencies for which a grading call occurred, and a formal joint 3-level (3L) decision was made to assign a grade during the reporting period
15	Using benchmarking to qualify the achievements (Yes/No)	No

16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	The Incident Management System (IMS) is a critical to effectively manage public health emergencies. This indicator measures the efficiency and speed with which WHO activates the IMS in response to health emergencies. The IMS is a critical tool for organizing and coordinating emergency response efforts and ensuring that the right people are in place to manage key functions (such as logistics, epidemiology, communication, and healthcare) as soon as a health emergency is graded. Tracking the percentage of newly graded emergencies for which the IMS is activated within 72 hours ensures that appropriate response mechanisms are swiftly implemented. It measures the readiness and speed of emergency response in critical situations, which is crucial for mitigating the impact of health emergencies. WHO plays a pivotal role in ensuring that the IMS is activated rapidly and that focal points are identified to lead the response efforts. The activation of the IMS is considered achieved with the appointment of an Incident Manager, repurposing of country office staff to cover critical IMS functions (leadership/IM, partner coordination, information and planning, health operations, operations support and logistics, and finance and administration), and gaps in critical IMS functions communicated to the Regional Office.
18	Measurement method	Measurement is based on the time elapsed between the initial grading date and the date the Country Office (CO) assigns the Incident Manager (IM), as recorded in the EMS2/HEMS system, for all newly graded G2 and G3 emergencies within the reporting period. For example, if an emergency is graded on 1 March 2025 and the Incident Manager (IM) is assigned by 4 March 2025 (i.e. within 72 hours), the case is counted as valid. If the IM is assigned on 5 March 2025 or later, or if no assignment date is recorded, it is not counted as valid.
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The indicator is expressed as a percentage by dividing the number of emergencies that meet the indicator criteria (numerator) by the total number of newly graded G2 and G3 emergencies with a formal 3-level (3L) decision (denominator), then multiplying by 100.
21	Calculation type	Cumulative
22	Target setting methodology	Based on ongoing efforts to strengthen reporting by integrating the Emergency Response Framework (ERF) checklist into the EMS2/HEMS system.
23	How target is realistic for PB2026-2027	The target is realistically achievable by 2026–2027 owing to: <ul style="list-style-type: none"> <li>• capacity building for regional and country offices on ERF requirements,</li> <li>• timeliness in documentation and data inputs,</li> <li>• and strengthened data verification and validation processes.</li> </ul>

24	Data sources	EMS2/HEMS; <a href="#">Emergency response framework (ERF), Edition 2.1</a>
25	Process of validation	The figure is verified with the regional office for review, particularly in cases where data is missing or incomplete
26	Limitations	<ul style="list-style-type: none"> <li>• The reporting process and accountability mechanisms need to be agreed upon with regional office to fulfill reporting requirements on emergencies.</li> <li>• The EMS2/HEMS system is inconsistently used across regions which may result in inaccurate, inconsistent or delayed data input.</li> <li>• The incident management system may be activated on the first day following the grading, but it may take multiple days until it is entered into the system by a focal person (for example, waiting for the entire IMST to be mapped out, or for the grading memo to be approved)</li> <li>• New IMS functions aligned with ERF2.1 and HEPR have not yet been integrated into EMS2/HEMS, so we rely on the current functionalities for reporting.</li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Ding Feng < dingf@who.int> ; Andrianirina Fanomezana< fanomezanaa@who.int>

### 6.1.2.IND3\_UID 1358 : Number of countries with classified or nationally validated emergency medical teams

#	Metadata field	Summary
1	GPW14 Output	6.1.2. WHO coordinates rapid and effective responses to acute public health threats, including deploying multisectoral response capacities, surging emergency supplies and logistics support, providing contingency financing, and implementing strategic and operational response plans
2	GPW14 Output indicator code	6.1.2.IND3
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries with classified or nationally validated emergency medical teams
4	Output/Leading Indicator (Country Level Formulation)	Country has a classified or nationally validated emergency medical team (EMTs)
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active

8	Linked outcome indicators (Direct (D) or indirect (I))	Detect, notify, and respond (DNR) (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	Number of countries with at least one emergency medical team (EMT) that has either been classified globally by WHO or nationally validated in line with WHO minimum standards.
12	Criteria	<p>A country is counted as having achieved this indicator if it has at least one emergency medical team (EMT) that is either:</p> <ul style="list-style-type: none"> <li>Classified through the WHO-led global classification process, or</li> <li>Nationally validated through a nationally led external evaluation process confirming compliance with WHO-established minimum standards.</li> </ul> <p>Additional details:</p> <ul style="list-style-type: none"> <li>Classification and validation are based on an external evaluation mechanism assessing EMT compliance with the principles, standards, and domains outlined in the Emergency Medical Teams 2030 strategy (WHO, 2023).</li> <li>National validation must be conducted by a nationally recognized normative entity and confirm readiness for domestic deployment and provision of quality care during emergencies.</li> <li>EMT types include: Type 1 fixed, Type 1 mobile, Type 2, Type 3, and Specialized Care Teams, as defined by the Classification and Minimum Standards for Emergency Medical Teams (WHO, 2021).</li> </ul>
13	Numerator	Number of countries with at least one Classified or nationally validated EMT as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	TBD
17	Rationale	<p>This indicator reflects a country's commitment to building a robust, well-coordinated emergency response workforce, aligned with the International Health Regulations (IHR 2005), WHO's Global Health Emergency Corps efforts and the Health Emergency Preparedness and Response (HEPR). T</p> <p>The rationale behind this WHO indicator is to measure global progress in strengthening emergency medical response capacities and interoperable surge deployment (HEPR 5.1.3). This is reflected through the presence of classified or nationally validated Emergency Medical Teams (EMTs) which meet WHO's quality standards and are ready to deploy rapidly in health emergencies, providing life-saving medical care.</p>

		<p>By tracking the number of countries with classified or nationally validated EMTs, this indicator helps assess:</p> <ul style="list-style-type: none"> <li>• National and regional readiness to respond to disasters, outbreaks, and other health crises</li> <li>• The expansion and distribution of high-quality emergency medical response capacity worldwide</li> <li>• Progress in implementing WHO's EMT Initiative and strengthening health emergency systems.</li> </ul>
18	Measurement method	<p>The indicator is measured based on the presence of classified or nationally validated Emergency Medical Teams (EMTs), using clearly defined mechanisms to ensure quality of services. These mechanisms include an external evaluation process that assesses EMT compliance with the principles, standards, and domains set out in the Emergency Medical Teams 2030 strategy (Geneva: World Health Organization; 2023). WHO is directly involved in both the global Classification and the national Validation processes. Data is collected through coordination with WHO Headquarters, Regional, and Country Offices. As this indicator is already tracked under the EMT 2030 strategy, no additional reporting burden is placed on WHO or Member States.</p>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	<p>Targets are established based on recent trends in country uptake of Emergency Medical Team (EMT) classification and national validation processes, as well as the strategic directions outlined in the EMT 2030 Strategy. The methodology focuses on estimating the number of new countries expected to meet the indicator criteria within each biennium, informed by the scale-up of national EMT systems, increasing requests for support, and ongoing engagement through WHO regional and global mechanisms.</p> <p>The projection assumes that:</p> <ul style="list-style-type: none"> <li>• A growing number of countries will request support for EMT classification or validation as the methodology becomes more institutionalized;</li> <li>• Multiple teams may originate from a single country, but targets are set at the country level;</li> <li>• WHO and regional offices will continue to provide coordinated technical and strategic assistance to facilitate national EMT system development and evaluation.</li> </ul> <p>Targets are calibrated against the number of countries actively progressing through the pipeline, adjusted for operational feasibility, regional balance, and alignment with EMT 2030 objectives, including widespread adoption and application of the EMT methodology.</p>
23	How target is realistic for PB2026-2027	<ul style="list-style-type: none"> <li>• Regional engagement: All WHO regions have formally endorsed the EMT 2030 Strategy and have developed regional implementation</li> </ul>



		<p>plans for the EMT Initiative. Regions are actively advancing efforts to support EMTs towards achieving Global Classification and/or National Validation.</p> <ul style="list-style-type: none"> <li>• WHO planned support: The EMT Secretariat at HQ and RO provide strategic and technical support to countries. This includes guiding the development and implementation of national EMT systems and facilitating the processes of EMT Classification and Validation.</li> </ul>
24	Data sources	<a href="#">EMT Global Classified Teams</a> ; <a href="#">Classification and Minimum Standards for Emergency Medical Teams</a> ; <a href="#">Global Health Emergency Corps</a> ; <a href="#">Strengthening the Global Architecture for Health Emergency Prevention, Preparedness, Response and Resilience (HEPR)</a> ; <a href="#">Emergency Medical Teams 2030 Strategy</a> . Geneva: World Health Organization; 2023.
25	Process of validation	WHO has oversight of the Classification and provides technical support for national validation
26	Limitations	Timely reporting regarding national validated teams
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Flavio SALIO< saliof@who.int>

## 6.2.1. WHO coordinates and leads the health cluster or sector and partners to assess health needs and develop, fund and monitor humanitarian health emergency response plans in humanitarian emergencies

**6.2.1.IND1\_UID 548 : Percentage of countries facing humanitarian emergencies (with dedicated country appeals within the Global Humanitarian Overview) that have received at least 50% of its funding needs**

#	Metadata field	Summary
1	GPW14 Output	6.2.1. WHO coordinates and leads the health cluster or sector and partners to assess health needs and develop, fund and monitor humanitarian health emergency response plans in humanitarian emergencies
2	GPW14 Output indicator code	6.2.1.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of countries facing humanitarian emergencies (with dedicated country appeals within the Global Humanitarian Overview) that have received at least 50% of its funding needs
4	Output/Leading Indicator (Country Level Formulation)	Development of costed humanitarian plan in countries facing humanitarian emergencies
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	Sustain essential health services during emergencies (D)
9	Data type	Percentage
10	Unit of measure	Percentage of countries
11	Indicator definition	The indicator tracks the share of humanitarian health cluster responses in countries with appeals (within the Global Humanitarian Overview) that have received at least 50% of their funding needs.
12	Criteria	<p>A country is counted as having achieved this indicator if:</p> <ul style="list-style-type: none"> <li>• It is facing a humanitarian emergency with a dedicated country appeal listed in the Global Humanitarian Overview (GHO);</li> <li>• It has an Inter-Agency Standing Committee (IASC)-activated health cluster; and</li> <li>• The health cluster has received at least 50% of its funding needs, as reported in the OCHA Financial Tracking System (FTS).</li> </ul> <p>WHO's contribution is reflected through its role as Cluster Lead Agency, including advocacy for funding and coordination of partner inputs.</p>

13	Numerator	The numerator is the total number of IASC activated country health clusters which receive at least 50% of its funding needs as reported in the OCHA Financial Tracking System (FTS)
14	Denominator	The denominator is the total number of IASC activated country health clusters with dedicated humanitarian response plans as cited in the annual Global Humanitarian Overview
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	WHO has a role in leading and coordinating partners in humanitarian emergencies. As Cluster Lead Agency WHO ensures support to national authorities to coordinate partners to identify needs, develop strategies, prioritize response, ensure advocacy to ensure populations affected by humanitarian crises are able to receive lifesaving services, where international assistance has been requested. It thereby supports health systems not to be overwhelmed through the provision of coordinated, predictable surge support as defined in response plans reflected in the Global Humanitarian Overview. Ensuring health cluster/sector response is adequately resourced is dependent on multiple aspects including proactive advocacy by WHO as sector lead within Humanitarian Country Teams and wider stakeholders, ensuring (where clusters are activated) a full coordination team is in place to generate evidence for advocacy, identification of needs, strategy development, prioritization and monitoring. This indicator measures the effectiveness of WHO and its partners for an adequately resourced health cluster or sector response.
18	Measurement method	<ul style="list-style-type: none"> <li>• This indicator is calculated using data from the Financial Tracking System (FTS), which tracks funding against country-level humanitarian appeals. The Global Humanitarian Overview (GHO), published annually by OCHA, consolidates these appeals, including funding requirements and status.</li> <li>• WHO identifies countries with IASC-activated health clusters listed in the GHO and checks whether each has received at least 50% of its funding needs.</li> <li>• Monitoring of humanitarian response plans occurs throughout the year, including for the health sector where WHO typically serves as the cluster lead. This data informs the GHO and underpins the calculation of this indicator.</li> <li>• WHO's contribution is primarily through coordination, evidence generation, and advocacy to mobilize funding on behalf of the health cluster. While the FTS records all funding sources, WHO's own financial input is only visible when funds are directly mobilized and reported by WHO, an approach that has not been consistently applied.</li> </ul>

		<ul style="list-style-type: none"> <li>Nonetheless, WHO's leadership role is critical: proactive advocacy by WHO representatives, particularly WRs, has proven decisive in securing funding, while lack of advocacy or evidence has contributed to funding shortfalls in some cases.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by dividing the number of IASC-activated country health clusters that received at least 50% of their funding needs (numerator) by the total number of IASC-activated country health clusters with dedicated humanitarian response plans listed in the Global Humanitarian Overview (denominator). The result is expressed as a percentage.
21	Calculation type	Cumulative
22	Target setting methodology	Targets were established using end-of-year funding performance data drawn from the Financial Tracking System (FTS), as summarized in internal WHO briefing materials. The methodology involved analyzing the distribution of funding levels across all IASC-activated health clusters with dedicated humanitarian response plans. Clusters were categorized based on the percentage of their funding needs met, using defined ranges (e.g., <20%, 21–49%, ≥50%). The share of clusters that met or exceeded the 50% funding threshold provided the baseline reference for setting forward-looking targets, using the same calculation approach described under the method of measurement.
23	How target is realistic for PB2026-2027	The target is considered realistic due to the ongoing Humanitarian Reset process led by the IASC Principals, which is expected to reduce the number of countries requiring formal humanitarian coordination. As a result, the total number of health clusters will also decrease, allowing for a more focused allocation of resources and potentially improving funding outcomes for the remaining clusters. It is anticipated that this humanitarian reset will result in better funding for a reduced number of clusters targeting assistance to people with greatest level of need. However, the impact of declining Official Development Assistance (ODA) and shifting donor preferences remains a limiting factor and could affect funding levels despite the more targeted approach.
24	Data sources	<a href="#">Financial Tracking Service</a> ; <a href="#">Global Humanitarian Overview</a> ; <a href="#">Health Cluster</a> ; <a href="#">Health Cluster Guide</a>
25	Process of validation	Data is independently collected through global agreed reporting mechanisms into Financial Tracking Service (FTS by UNOCHA) Where WHO is cluster/sector lead there may be additional mechanisms to collate directly from partners and triangulate funding status.
26	Limitations	Delays in reporting to the FTS can lead to underestimation of the total funding received. Similarly, the categorization of funding for the health sector may be inaccurate in cases where funding is integrated or spans multiple sectors.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025

29	Technical focal point	Linda DOULL< doulll@who.int > (until 30 June 2025, with replacement GHC Coordinator thereafter)
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## 6.2.2. WHO ensures the provision of life-saving care and maintains essential health services and systems in emergencies and vulnerable settings, addressing barriers to access and inequity

**6.2.2.IND1\_UID 1171 : Number of countries facing humanitarian emergencies (with a humanitarian response plan as per the Global Humanitarian Overview) with a context-adapted service package for a humanitarian response that meets WHO criteria**

#	Metadata field	Summary
1	GPW14 Output	6.2.2. WHO ensures the provision of life-saving care and maintains essential health services and systems in emergencies and vulnerable settings, addressing barriers to access and inequity
2	GPW14 Output indicator code	6.2.2.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries facing humanitarian emergencies (with a humanitarian response plan as per the Global Humanitarian Overview) with a context-adapted service package for a humanitarian response that meets WHO criteria
4	Output/Leading Indicator (Country Level Formulation)	Development of a context-adapted service package for humanitarian response where there is an interagency appeal (Humanitarian Response Plan as per the Global Humanitarian Overview) that meets WHO criteria
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Provisional
8	Linked outcome indicators (Direct (D) or indirect (I))	Sustain essential health services during emergencies (D)
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks the number of countries with a Humanitarian Response Plan (HRP) or Refugee Response Plan (RRP) that have developed and formally adopted a context-adapted health service package for humanitarian response that meets WHO criteria.
12	Criteria	<p>A country is counted as having achieved this indicator if:</p> <ul style="list-style-type: none"> <li>• It has a published Humanitarian Response Plan (HRP) or Refugee Response Plan (RRP) as listed in the Global Humanitarian Overview;</li> <li>• It has developed a context-adapted service package for humanitarian response that is derived from the H3 reference package;</li> <li>• The package is formally adopted, meaning it is signed by the Ministry of Health or relevant health authority and/or formally circulated to humanitarian partners for implementation;</li> </ul>

		<ul style="list-style-type: none"> <li>The status is reported by the WHO WHE Team Lead, Incident Manager, Health Cluster Coordinator or another assigned individual of the country reporting.</li> </ul>
13	Numerator	Number of countries with a Humanitarian Response Plan (HRP) or Refugee Response Plan (RRP) where a context-adapted service package for humanitarian response (derived from the H3 reference package) is defined and formally adopted as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	TBD
17	Rationale	<p><b>WHO is sector lead agency in humanitarian emergencies where international assistance is requested and inter agency appeals are in place</b> (See <a href="#">Inter Agency Standing Committee</a> and <a href="#">Global Humanitarian Overview</a>). <b>WHO supports national authorities by coordinating the multiple partners involved in humanitarian response to collectively identify needs and develop prioritized responses to ensure populations affected by crisis are provided with urgent and lifesaving health services.</b></p> <p>Commitments given in the <a href="#">World Humanitarian Summit (2016)</a> articulate that a service package should be defined by all sectors so that all partners involved in humanitarian response are accountable and transparent to national authorities and populations affected by crisis as to what response they will deliver in humanitarian response.</p> <p><b>In line with this WHO as Cluster Lead Agency has committed to supporting Ministries of Health, local health authorities and partners to jointly establish a contextualized ‘essential’ package of health services for humanitarian response</b> (see <a href="#">Global Health Cluster Strategy and the Health Cluster Guide: A practical handbook</a>). In tandem WHO supports national authorities to achieve Universal Health Coverage (UHC) and critical to this develop a National Package of Services for which the <a href="#">UHC Compendium</a> is being used as a reference.</p> <p>The UHC Compendium is a database of health services and intersectoral interventions designed to assist countries in making progress towards UHC. (See GPW14 Output, 3.1.1). The H3 Package (<a href="#">High-priority Health Interventions in Humanitarian Response</a>) was finalized in 2023 and is a global reference package based on the UHC Compendium. It refers to a set of high-priority health interventions that are critical for saving lives during humanitarian response depending on health threats, context and resources available. <b>The contextualized service package provides a framework and commitment on the services within and sometimes beyond the national package that can be delivered on through humanitarian funding and resources. It therefore bridges the</b></p>

		<p><b>Humanitarian Development Nexus</b>, and clearly articulates which services can be provided by humanitarian stakeholders and allows to determine investments needed to be made by other stakeholders to support the delivery of the wider national package and Universal Health Coverage. The work to determine a contextualized service package for humanitarian response (derived from H3) is conducted collaboratively across WHO, by WHO Emergency Team Leads or Incident Managers, WHO health service delivery experts and Health Cluster Coordinators (where the Health Cluster is activated) with Ministries of Health, local health authorities and humanitarian partners. Since its launch out of the 29 settings where a cluster is activated, a contextualized H3 has been developed for humanitarian response in 4 settings: Myanmar, Cox's Bazar Bangladesh, Gaza Occupied Palestinian Territories and Ethiopia. It has further been developed and used in humanitarian response in Moldova for Ukrainian refugees.</p>
18	Measurement method	<ul style="list-style-type: none"> <li>The data will be collected directly from countries where international assistance has been requested to respond to a humanitarian crisis (i.e. where an Interagency Appeal launched, and a Humanitarian Response Plan or Refugee Response Plan is published).</li> <li>Source of information may include WHE Team Leads, Incident Managers and / or Health Cluster Coordinators who will report on the status of the development of the service package in their respective countries</li> </ul> <p>Note: Other measurements will be taken to understand advancement on this work such as:</p> <ul style="list-style-type: none"> <li>Number of countries with HRP or RRP where development of a package of services (could be derived from H3 reference package) is currently under discussion;</li> <li>Number of countries with HRP or RRP where the development of a package of services (could be derived from H3 reference package) is currently at advance stage (already convened with partners and drafted);</li> <li>Number of countries with HRP or RRP where development of a contextualized package of services (derived from H3 reference package) defined and formally adopted</li> <li>Number of countries with HRP or RRP where development of a package of services (could be derived from H3 reference package) is implemented and monitored.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	Targets are countries with Humanitarian Response Plan or Refugee Response Plan as per the Global Humanitarian Overview of the year of reporting. As member of the Inter Agency Standing Committee, WHO has the institutional accountability for humanitarian health response in all



		countries facing humanitarian emergencies as per the Global Humanitarian Overview, which is updated multiple times per year
23	How target is realistic for PB2026-2027	WHO possesses core capacities to provide technical support and convene health authorities and humanitarian partners to agree on a contextualized service package per humanitarian setting. The source of information for reporting are WHO personnel at the country, regional and global levels.
24	Data sources	Global Humanitarian Overview; WHE Team Leads, Incident Managers, Health Cluster Coordinators; Published packages on ReliefWeb or official documentation shared with humanitarian partners
25	Process of validation	Validation through the <a href="#">Global Humanitarian Overview</a> of the year f reporting and through the receipt and review of either of published document, e.g. publicly available on <a href="#">Response Relief Web</a> , or shared by Health Sector / Health Cluster Coordinators to humanitarian partners.
26	Limitations	Reporting will require updates from WHE Team Lead / Incident Manager with Health Sector / Health Cluster Coordinator where present. Ensuring there is/are focal point/s assigned at country level will be important
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Teresa ZAKARIA < zakariat@who.int>

#### **6.2.2.IND2\_UID 1174 : Percentage of countries facing humanitarian emergencies with periodic reporting on functionality of health facilities and availability of health services**

#	Metadata field	Summary
1	GPW14 Output	6.2.2. WHO ensures the provision of life-saving care and maintains essential health services and systems in emergencies and vulnerable settings, addressing barriers to access and inequity
2	GPW14 Output indicator code	6.2.2.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of countries facing humanitarian emergencies with periodic reporting on functionality of health facilities and availability of health services
4	Output/Leading Indicator (Country Level Formulation)	Regular monitoring and reporting on the functionality of health facilities and the availability of health services during humanitarian emergencies
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active

8	Linked outcome indicators (Direct (D) or indirect (I))	Sustain essential health services during emergencies (D)
9	Data type	Percentage
10	Unit of measure	Percentage of countries
11	Indicator definition	This indicator tracks the proportion of countries experiencing humanitarian emergencies that have a system for regularly monitoring the functionality of health facilities and the availability of health services.
12	Criteria	<p>A country is counted as having achieved this indicator if it has an existing monitoring system that includes, at a minimum:</p> <ul style="list-style-type: none"> <li>• Functionality of health facilities (e.g. operational status, staffing, ability to deliver services)</li> <li>• Availability of health services</li> </ul> <p>In addition to these two core elements, the system should ideally also:</p> <ul style="list-style-type: none"> <li>• Be updated periodically</li> <li>• Cover a wide range of geographic, population, and thematic areas</li> <li>• Be transparent, with key information (e.g. coverage, frequency) accessible to health actors and affected populations</li> <li>• Allow feedback into the monitoring process</li> </ul> <p>The HeRAMS framework is used as a reference</p>
13	Numerator	Number of countries included in the Global Humanitarian Overview of the year of reporting, with an existing monitoring system for functionality of health facilities and availability of services as per field 12.
14	Denominator	Total number of countries included in the Global Humanitarian Overview of the year of reporting.
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	TBD
17	Rationale	As a member of the Inter Agency Standing Committee, WHO has the institutional accountability to respond to the health needs of people in need of humanitarian assistance in all the countries with a consolidated humanitarian appeal process (referenced and regularly updated multiple times per year in the Global Humanitarian Overview)
18	Measurement method	<p>Step 1: Identify countries facing humanitarian emergencies using the Global Humanitarian Overview (GHO) of the reporting year.</p> <p>Step 2: For each country listed in the GHO, determine whether a monitoring system exists that captures:</p> <ul style="list-style-type: none"> <li>• Functionality of health facilities : Whether the facility is operational, damaged, facing staff shortages, and capable of delivering services.</li> <li>• Availability of health services: Whether essential health services are accessible and being provided, as expected, during a humanitarian emergency.</li> </ul>

		<p>Step 3: Assess the monitoring system against the following dimensions:</p> <ul style="list-style-type: none"> <li>• Comprehensiveness (geographic, population, and thematic coverage)</li> <li>• Functionality (frequency of data updates and reporting)</li> <li>• Quality (process transparency and accountability, including accessibility of system metrics)</li> </ul> <p>Step 4: Periodic reporting is considered present if the system captures the two key elements in step 2 and allows for visibility and feedback by partners and communities.</p> <p>Reference system: HeRAMS is used as a benchmark for defining indicators of functionality, resources, and services, but other systems may be considered.</p>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The percentage is calculated by dividing the number of countries included in the Global Humanitarian Overview (GHO) of the reporting year that have a monitoring system for functionality of health facilities and availability of services (as defined in field 12) (numerator) by the total number of countries in the GHO for that year (denominator) multiplied by 100.
21	Calculation type	Cumulative
22	Target setting methodology	As a member of the Inter Agency Standing Committee, WHO has the institutional accountability to respond to the health needs of people in need of humanitarian assistance in <b>all the countries</b> with a consolidated humanitarian appeal process (referenced and regularly updated multiple times per year in the Global Humanitarian Overview)
23	How target is realistic for PB2026-2027	WHO possesses core capacities to provide technical support and convene health authorities and humanitarian partners to establish a monitoring system for the functionality of health facilities and availability of health services. Internal sources of information are available at the country, regional and global levels.
24	Data sources	<a href="#">HeRAMS (Health Resources Availability Monitoring System) Country Implementation Snapshot</a> ; <a href="#">Global Humanitarian Overview (GHO)</a>
25	Process of validation	Part of the measurement looks at process transparency. This means that to be considered successful, any monitoring system identified will need to have its fundamental metrics (number/dates of update, geographic and thematic coverage, etc.) available to a wide audience, including actors present on the ground and the people accessing the health services. Another critical element will be the possibility to feedback into the monitoring system. These will be referenced alongside the indicator results.
26	Limitations	There may be challenges in the estimation. Such monitoring systems are complex and establishing whether they are available and up to expected standards requires expert judgement. To compensate for those limitations full transparency will be made on the drivers behind the result of each assessment.

27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Teresa ZAKARIA < zakariat@who.int>

### 7.1.1. Convening, advocating and engagement with Member States and key constituencies in support of health governance and to advance health priorities

#### 7.1.1.IND1\_UID 618 : Percentage of United Nations System-wide Action Plan on Gender Equality and the Empowerment of Women and United Nations Disability Inclusion Strategy indicators that WHO met or exceeded in the last reporting period

#	Metadata field	Summary
1	GPW14 Output	7.1.1. Convening, advocating and engagement with Member States and key constituencies in support of health governance and to advance health priorities
2	GPW14 Output indicator code	7.1.1.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of United Nations System-wide Action Plan on Gender Equality and the Empowerment of Women and United Nations Disability Inclusion Strategy indicators that WHO met or exceeded in the last reporting period
4	Output/Leading Indicator (Country Level Formulation)	Percentage of United Nations System-wide Action Plan on Gender Equality and the Empowerment of Women and United Nations Disability Inclusion Strategy indicators that WHO met or exceeded in the last reporting period
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Percentage of indicators
11	Indicator definition	This indicator measures the percentage of all applicable indicators from two UN accountability frameworks , UNSWAP (on gender equality) and UNDIS (on disability inclusion), that WHO has either met or exceeded in the latest annual reporting cycle.
12	Criteria	<p>An indicator from the UNSWAP or UNDIS framework is counted as achieved under this output indicator if it is rated as <b>“met”</b> or <b>“exceeded”</b> based on the official UN system-wide scoring criteria.</p> <ul style="list-style-type: none"> <li>UN Disability Inclusion Strategy (UNDIS): <ul style="list-style-type: none"> <li>WHO currently reports on 16 indicators, covering leadership, planning, programming, and organizational culture.</li> <li>The full list and scoring rubric are available in the <a href="#">UN Disability Inclusion Strategy document</a>.</li> <li>An indicator is rated “met” when all core requirements are fulfilled, and “exceeded” when performance goes beyond</li> </ul> </li> </ul>

		<p>minimum standards, e.g. through innovation, strong results, or institutionalization.</p> <ul style="list-style-type: none"> <li>UN System-wide Action Plan on Gender Equality and the Empowerment of Women (UNSWAP): <ul style="list-style-type: none"> <li>WHO currently reports on 18 indicators under the UNSWAP 3.0 framework, covering strategic planning, oversight, resourcing, and institutional culture.</li> <li>Criteria are available in the <a href="#">UNSWAP 3.0 Performance Indicator Framework</a>.</li> <li>A rating of “met” is awarded when minimum gender equality standards are in place; “exceeded” requires clear leadership, innovation, or results surpassing expectations.</li> </ul> </li> </ul> <p><b>Note:</b> The number of indicators may change during GPW14 as frameworks are updated.</p>
13	Numerator	Number of UNSWAP and UNDIS indicators that WHO has assessed as “met” or “exceeded” during the reporting period, according to the official UN system-wide scoring criteria as per field 12
14	Denominator	Total number of applicable UNSWAP and UNDIS indicators assessed by WHO during the reporting period.
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	<p>The purpose of this indicator is to assess the extent to which WHO is advancing at corporate level towards its WHA 60/25 commitments to ‘Integrating gender analysis and actions into the work of WHO’. This mandates the Organization to ‘include gender analysis and planning in joint strategic, and operational planning, and budget planning across all its functions and programmes’.</p> <p>This indicator reflects WHO’s performance under two key UN accountability frameworks:</p> <ul style="list-style-type: none"> <li>The UN System-wide Action Plan (UN-SWAP) on Gender Equality and the Empowerment of Women (GEEW) provides an accountability framework for monitoring the performance of UN entities on gender mainstreaming, with detailed criteria against which progress can be measured.</li> <li>The United Nations Disability Inclusion Strategy (UNDIS), which includes a policy and an accountability framework, with benchmarks to assess progress and accelerate change on disability inclusion. Reporting on UNDIS measures WHO’s progress towards sustainable and transformative progress on disability inclusion through all pillars of its work, in accordance with the implementation of the Convention on the Rights of Persons with Disabilities and other international human rights instruments</li> </ul>

18	Measurement method	<ul style="list-style-type: none"> <li>• WHO conducts an annual self-assessment against the indicators in the UNSWAP and UNDIS accountability frameworks.</li> <li>• The assessment determines whether each indicator is classified as “not met,” “approaches requirements,” “met,” or “exceeded”, using the official UN system-wide scoring rubrics.</li> <li>• For this output indicator, WHO calculates the percentage of indicators (from both frameworks) that were rated as “met” or “exceeded.”</li> <li>• While the headline indicator value is presented as a single aggregate percentage, WHO will also report disaggregated results by framework (UNSWAP and UNDIS) in the narrative, to provide a clearer picture of progress in each area.</li> <li>• The UNSWAP framework currently includes 18 indicators, and the UNDIS framework includes 16 indicators. The number of indicators may change over the GPW14 period, depending on updates to the frameworks.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The percentage is calculated using the following formula: $= (\text{Number of UNSWAP and UNDIS indicators met or exceeded} / \text{Total number of applicable UNSWAP and UNDIS indicators assessed by WHO during the reporting period}) * 100$
21	Calculation type	Cumulative
22	Target setting methodology	<p>Targets were set based on:</p> <ul style="list-style-type: none"> <li>• Anticipated results for the upcoming 2025 UNDIS report, informed by current progress and implementation plans.</li> <li>• A constructed baseline for UNSWAP 3, developed during the 2024 reporting cycle, incorporating transitional elements from UNSWAP 2.</li> <li>• Consultations with HQ-level business owners to assess what annual progress is feasible, grounded in existing action plans.</li> <li>• Separate baselines and targets were defined for each framework (UNSWAP and UNDIS) to reflect their distinct criteria and scope.</li> <li>• These disaggregated targets were subsequently aggregated to produce the overall corporate-level target for the indicator</li> </ul>
23	How target is realistic for PB2026-2027	Targets are based upon existing action plans as noted above. However, caution is being applied in the current context of WHO's funding and human resources restrictions.
24	Data sources	UNSWAP annual reports (submitted by WHO and validated at UN system level); UNDIS annual reports (submitted by WHO and validated at UN system level)
25	Process of validation	Both UNSWAP and UNDIS reports are externally validated according to UN system wide established criteria
26	Limitations	<ul style="list-style-type: none"> <li>• UNSWAP and UNDIS indicators are based on UN system-wide criteria, some of which may have limited relevance to the specific operational context of WHO.</li> <li>• Because both accountability frameworks are subject to periodic updates, comparability of results across years may be affected.</li> </ul>
27	Expected frequency of reporting	Annual

28	Date last published	15 June 2025
29	Technical focal point	Anna Coates < coatesa@who.int>

**7.1.1.IND2\_UID 1392 : Percentage of WHO offices/departments that have conducted capacity-strengthening activities on gender equality, human rights and health equity for WHO staff and/or external stakeholders in the last calendar year**

#	Metadata field	Summary
1	GPW14 Output	7.1.1. Convening, advocating and engagement with Member States and key constituencies in support of health governance and to advance health priorities
2	GPW14 Output indicator code	7.1.1.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of WHO offices/departments that have conducted capacity-strengthening activities on gender equality, human rights and health equity for WHO staff and/or external stakeholders in the last calendar year
4	Output/Leading Indicator (Country Level Formulation)	Percentage of WHO country offices that have conducted capacity strengthening activities on gender equality, human rights and health equity for WHO staff and/or external stakeholders in the last calendar year
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Percentage of WHO offices/departments
11	Indicator definition	This indicator measures the percentage of WHO offices or departments that conducted at least two capacity-strengthening activities in the last calendar year to build knowledge and skills on gender equality, human rights, and health equity for WHO staff or external stakeholders.
12	Criteria	<p>An office/department is counted as having achieved this indicator if:</p> <ul style="list-style-type: none"> <li>• it conducted <b>more than two skill-building activities</b> during the last calendar year. <ul style="list-style-type: none"> <li>○ A <b>skill building</b> is defined as any activity designed to strengthen the capacity of WHO staff to support Member States to: <ul style="list-style-type: none"> <li>▪ implement gender responsive approaches</li> <li>▪ respect, protect and fulfil the human right to health and health-related rights</li> <li>▪ systematically identify, monitor and address health inequities, and work to prevent them</li> </ul> </li> </ul> </li> </ul>



		<p>Further details on these are included in the <a href="#">GRE Roadmap</a> including on the types of activities that are considered (e.g. online and in-person training courses; workshops for specific programmes and offices, webinars, opportunities for peer-to-peer learning, etc). Key resources and reference materials are made available by GRE to support these activities. References to these tools, as well as to the Roadmap, are indicated within the framework of the ICF survey to enable consistent reporting.</p> <ul style="list-style-type: none"> <li>○ The threshold was informed by a capacity assessment conducted by GRE in December 2022 across all levels of WHO. The assessment showed that: <ul style="list-style-type: none"> <li>▪ 35% of respondents had received introductory training on gender equality, human rights, or health equity.</li> <li>▪ Only 5.1% had received intermediate or advanced training.</li> </ul> <p>Given the broad reporting structure (per budget centre) and the diversity of acceptable activity types, conducting <b>more than two activities</b> was determined to be the minimum threshold needed to maintain and build staff capacity beyond basic awareness.</p> </li> </ul>
13	Numerator	Number of WHO offices or departments that conducted more than two skill-building activities on gender equality, human rights, or health equity during the last calendar year as per field 12.
14	Denominator	Total number of WHO offices and departments globally, as reported in the Internal Control Framework during the calendar year.
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	The purpose of the indicator is to showcase the Organization's leadership in integrating gender equality, human rights, and health equity principles, approaches and considerations throughout all aspects of its work and at all three levels of the Organization. It does so by measuring related activities aimed at strengthening the capacity of the workforce, thus ensuring that the Organization is equipped to advance on these critical areas within all its internal actions and practices and, consequently, within its external support to Member States. As well as ensuring coherence between internal practices and external technical assistance, including county level support, this also indirectly supports the achievement of GPW 14 outcome indicators, including (amongst others) on addressing barriers to care and on advancing gender equality in and through health.
18	Measurement method	<ul style="list-style-type: none"> <li>• The indicator will be measured through assessment of whether an office/department has conducted skill building activities within the last</li> </ul>

		<p>calendar year to strengthen the WHO workforce's capacity in health equity, gender equality and human rights.</p> <ul style="list-style-type: none"> <li>Data will be collected through regular annual reporting on the internal control framework, which includes this information gathering as part of its focus on inclusion in workplans of costed activities that aim to advance gender equality, human rights or health equity.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The indicator is aggregated as a percentage, calculated by dividing the number of WHO offices/departments that conducted more than two qualifying skill-building activities during the calendar year (numerator) by the total number of WHO offices/departments (denominator), and then multiplying by 100
21	Calculation type	Cumulative
22	Target setting methodology	<p>Targets for this indicator are set based on findings from prior capacity assessments and operational constraints across the Organization. Given limitations in human and financial resources, particularly at country and regional levels, a 5% annual increase was identified as a feasible and realistic pace of progress. This incremental target allows for steady advancement in capacity strengthening while accommodating variability in implementation and reporting capacity.</p> <p>Integration of the indicator into the Internal Control Framework (ICF) also informed the target setting by aligning it with an existing reporting mechanism and reducing the administrative burden on technical teams.</p>
23	How target is realistic for PB2026-2027	The target was confirmed as realistic following consultations with regional leads. In light of current financial constraints and limited human resources, especially at regional and country levels, the original GRE Roadmap target was adjusted to reflect what is achievable during this period. The adapted target allows for progress while taking into account the operational realities across all levels of the Organization.
24	Data sources	<ul style="list-style-type: none"> <li>Internal Control Framework (ICF) reports, based on annual self-assessments conducted by WHO offices and departments.</li> </ul> <p>The ICF includes reporting on costed workplan activities related to gender equality, human rights, and health equity.</p>
25	Process of validation	Internal control framework reports are based upon self-assessment according to established criteria. Spot checks will be made to ensure validity.
26	Limitations	<ul style="list-style-type: none"> <li>The internal control framework reporting does not measure the exact number of skill-building activities, rather it assesses only whether a minimum number have been conducted during the calendar year. Measurement of this indicator will not assess the quality, approach or focus of the skill building activities.</li> <li>Whilst it is assumed that conducting capacity strengthening activities will lead to increased knowledge by the WHO workforce and thus improve the quality of technical support provided to Member States for better integration of gender equality, health equity and human rights into health governance structures and mechanisms, this is not directly measured by this indicator.</li> </ul>

27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Anna Coates < coatesa@who.int>

## 7.1.2. Effectively communicating to promote evidence-informed planning for decision-making for interventions and healthy behaviours in countries

### 7.1.2.IND1\_UID 1363 : Number of communication strategies with clear roles and responsibilities across all WHO country offices

#	Metadata field	Summary
1	GPW14 Output	7.1.2. Effectively communicating to promote evidence-informed planning for decision-making for interventions and healthy behaviours in countries
2	GPW14 Output indicator code	7.1.2.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of communication strategies with clear roles and responsibilities across all WHO country office
4	Output/Leading Indicator (Country Level Formulation)	Number of communication strategies with clear roles and responsibilities across all WHO country office
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Number
10	Unit of measure	Number of communication strategies
11	Indicator definition	This indicator measures the number of communication strategies developed and submitted with clearly defined roles and responsibilities, based on the standard WHO template. Each strategy is expected to come from a WHO country office, but the focus is on counting the number of strategies submitted.
12	Criteria	<p>A communication strategy is counted under this indicator if it has been submitted by a WHO country office and meets the minimum content requirements defined in the standard WHO template.</p> <p>These requirements include:</p> <ul style="list-style-type: none"> <li>• An overall strategy, which outlines: <ul style="list-style-type: none"> <li>○ Objectives</li> <li>○ Target audiences</li> <li>○ Communication channels</li> </ul> </li> <li>• A results framework, including expected outcomes and impact</li> <li>• A communications plan, designed to be customized by each office, detailing:</li> </ul>

		<ul style="list-style-type: none"> <li>○ Specific communication activities</li> <li>○ A SWOT analysis</li> <li>○ Who is responsible for implementing and measuring each activity (i.e. clear roles and responsibilities)</li> </ul> <p>Additionally, the strategy must cover the following elements:</p> <ul style="list-style-type: none"> <li>• Inputs: Available resources (e.g. staff, tools, budget) to support communication</li> <li>• Activities: Specific communication actions planned for implementation</li> <li>• Outputs: Expected deliverables and key performance indicators (KPIs) to measure success</li> </ul> <p>This approach promotes consistency across the Organization while allowing adaptation to regional and country contexts.</p> <p>Submission of the strategy is sufficient for the purposes of the indicator. Quality is supported through the use of the template and technical workshops provided by WHO Headquarters. Strategies are considered living documents and can evolve over time.</p>
13	Numerator	Number of communication strategies submitted by WHO country offices that meet the minimum content requirements defined in the standard WHO template, including clear roles and responsibilities as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	This indicator allows WHO to demonstrate a strategic and well-planned approach to communication. It also enables alignment of communication activities across all levels of the Organization
18	Measurement method	<ul style="list-style-type: none"> <li>• Country offices are requested to share their communication strategies with the Department of Communications once a year.</li> <li>• A request for submission will be issued with a deadline of 30 April.</li> <li>• Submission of the strategy is sufficient for it to be counted under the indicator.</li> <li>• The strategy must follow the WHO standard template and include clear roles and responsibilities as described.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The total number of submitted communication strategies that meet the required criteria is summed across all WHO country offices to produce the global indicator value.
21	Calculation type	Cumulative
22	Target setting methodology	The target is set based on consultations with regional and country offices. The Department of Communications uses information from these discussions to identify the number of countries actively developing

		communication strategies and to determine a realistic and evidence-based target..
23	How target is realistic for PB2026-2027	The target may vary depending on the resources available at the country office. A communication strategy is only expected <b>if the office has a communications officer</b> in place. This approach ensures that expectations are aligned with the operational capacity of each office.
24	Data sources	Annual submissions of communication strategies from WHO country offices to the Department of Communications.
25	Process of validation	<ul style="list-style-type: none"> <li>• The Department of Communications reviews the submitted strategies to confirm that they follow the WHO standard template and include clear roles and responsibilities.</li> <li>• Submissions are tracked centrally, and compliance is assessed based on presence and structure rather than detailed content quality.</li> </ul>
26	Limitations	<ul style="list-style-type: none"> <li>• The quality and completeness of submitted communication strategies may vary across countries, especially in the early stages of implementation.</li> <li>• Some country offices may also lack dedicated communications officers, which could limit participation and consistency.</li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Gabby Stern < <a href="mailto:sterng@who.int">sterng@who.int</a> >; Mijail Santos Lujan a.i. Vismita Gupta-Smith < <a href="mailto:msantos@who.int">msantos@who.int</a> >

### 7.1.3. Effective results-based management realized through a sustainably financed programme budget aligned with evidence-informed country, regional and global priorities, supported by transparent resource allocation and robust monitoring and performance assessment

#### 7.1.3.IND1\_UID 609 : Percentage of budget centres that have achieved WHO's performance assessment of the programme budget

#	Metadata field	Summary
1	GPW14 Output	7.1.3. Effective results-based management realized through a sustainably financed programme budget aligned with evidence-informed country, regional and global priorities, supported by transparent resource allocation and robust monitoring and performance assessment
2	GPW14 Output indicator code	7.1.3.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of budget centres that have achieved WHO's performance assessment of the programme budget
4	Output/Leading Indicator (Country Level Formulation)	Percentage of budget centres that have achieved WHO's performance assessment of the programme budget
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Provisional
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Percentage of budget centres
11	Indicator definition	<p>This indicator measures the proportion of WHO Budget Centres that achieved at least 70% of their planned output indicator targets at least once during the reporting period, at the mid-term review (MTR) or end-of-biennium assessment (EOBA). It reflects the extent to which Budget Centres have delivered on their performance commitments under the Programme Budget. An output indicator is considered “achieved” if its target for the reporting period has been met, based on WHO’s internal performance reporting criteria outlined in the output indicator’s metadata.</p> <p>The 70% threshold allows for meaningful recognition of high performance without being overly restrictive. This approach ensures fairness by evaluating each budget centre based on its own output indicator count.</p>

12	Criteria	<p>A Budget Centre is counted as having achieved WHO's performance assessment if:</p> <ul style="list-style-type: none"> <li>• It has an assigned set of output indicators under the Programme Budget.</li> <li>• It has achieved at least 70% of these output indicator targets by the end of the reporting period.</li> </ul> <p>Each output indicator must be marked as 'achieved' based on WHO's corporate performance reporting standards, as specified in the output indicator's metadata.</p>
13	Numerator	Number of Budget Centres that achieved at least 70% of their assigned output indicator targets as per field 12
14	Denominator	Total number of Budget Centres with at least one assigned output indicator
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> Budget Centre has achieved at least 70% of its assigned output indicators as per field 12</p> <p><b>Partially achieved:</b> Budget Centre has achieved 40–69% of its assigned output indicators</p> <p><b>Not achieved:</b> Budget Centre has achieved less than 40% of its assigned output indicators</p>
17	Rationale	<p>This indicator is grounded in WHO's commitment to results-based management, as set out in GPW14 and in multiple WHA resolutions that call for greater accountability and transparency across the Organization. It provides a standardized means to assess whether WHO Budget Centres have delivered on their commitments under the Programme Budget, reinforcing a culture of performance and enabling comparative monitoring across all levels of WHO. Unlike earlier versions that measured procedural compliance (e.g. scorecard submission), this revised measure captures actual performance by assessing the proportion of output indicators achieved.</p> <p>By applying a ≥70% achievement threshold, the indicator promotes a results-oriented culture, encourages accountability, and supports performance-based management across all three levels of the Organization. It also enables meaningful comparisons across Budget Centres by applying a standardized performance threshold, while recognizing inherent differences in mandate and scope. A higher proportion of Budget Centres achieving their targets reflects stronger organizational alignment, better implementation of planned activities, and a more strategic use of resources to advance GPW14 outcomes.</p>
18	Measurement method	<p>This indicator is calculated in three steps:</p> <p><b>1. Calculate the achievement rate for each Budget Centre</b></p> <p>For each Budget Centre, identify the output indicators it is accountable for.</p> <p>Determine which output indicators were marked as “achieved.”</p> <p>Calculate the achievement rate by dividing the number of achieved output indicators by the total number assigned to that Budget Centre, then multiply by 100.</p> <p><i>(Achievement rate = [Number achieved ÷ Total assigned] × 100)</i></p>



		<p><b>2. Apply the performance threshold</b> A Budget Centre is considered to have met this indicator if it achieved at least 70% of its assigned output indicators (as per field 12)</p> <p><b>3. Calculate the final result</b> Count the number of Budget Centres that met the 70% threshold (numerator). Divide this number by the <b>total number of Budget Centres with at least one assigned output indicator (denominator)</b>, then multiply by 100 to obtain the final percentage. (Final result = <math>[Number\ meeting\ threshold \div Total\ eligible\ Budget\ Centres] \times 100</math>)</p>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate is expressed as the percentage of WHO Budget Centres that achieved at least 70% of their assigned output indicator targets. It is calculated by dividing the number of Budget Centres meeting the 70% threshold by the total number of Budget Centres with at least one assigned output indicator, then multiplying by 100.
21	Calculation type	Cumulative
22	Target setting methodology	<p>Targets are set based on historical performance data and realistic expectations for incremental improvement over time, in line with the cumulative nature of the indicator.</p> <p>The target represents the expected cumulative proportion of Budget Centres that will have met the <math>\geq 70\%</math> threshold by the end of the reporting period.</p> <p>This approach assumes that:</p> <ul style="list-style-type: none"> <li>• More Budget Centres will meet the threshold over time as performance monitoring improves and corrective actions are taken.</li> <li>• Once a Budget Centre is counted as having met the threshold in any year, it continues to count toward the cumulative total.</li> <li>• The target accounts for performance trends across previous biennia, internal accountability efforts, and operational capacity across Major Offices.</li> </ul>
23	How target is realistic for PB2026-2027	<p>The target reflects a realistic but ambitious expectation for improved performance across WHO Budget Centres over the reporting period. It is grounded in past reporting cycles and assumes progressive uptake of results-based management practices.</p> <p>Because the indicator is cumulative, the target anticipates that additional Budget Centres will meet the <math>\geq 70\%</math> achievement threshold over time, even if some do not maintain that level in subsequent years. This approach rewards early achievement and supports continued institutional strengthening.</p>
24	Data sources	Output indicator metadata and achievement submissions from technical teams; Consolidated achievement data maintained and validated by PRP; Budget Centre assignments as defined in the Programme Budget operational planning system
25	Process of validation	Each technical team is responsible for reviewing and confirming the achievement status of their assigned output indicators at the end of the reporting period (mid-term and end-of-biennium).

		<p>These achievements are submitted to PRP through the internal performance monitoring system and must align with the criteria and definitions outlined in the approved indicator metadata.</p> <p>PRP consolidates submissions, checks for completeness and consistency, and maps each output indicator to its corresponding Budget Centre.</p> <p>Validation includes internal consistency checks by PRP and feedback loops with technical teams and Major Offices in case of discrepancies or missing data. Final figures are cleared through the corporate performance reporting process.</p>
26	Limitations	<ul style="list-style-type: none"> <li>• Budget Centres with a small number of assigned output indicators may experience greater sensitivity to changes in achievement status, which could influence the overall result.</li> <li>• The indicator does not adjust for differences in the scope, scale, or complexity of assigned output indicators across Budget Centres.</li> <li>• Interim data (e.g. mid-term reporting) may be incomplete or provisional, and results should be interpreted accordingly during those periods.</li> <li>• As with all cumulative output indicators under GPW14, this indicator reflects the cumulative number of Budget Centres meeting the threshold over the reporting period. It does not capture temporary declines in performance after the threshold has been met.</li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Ambinintsoa RALAIDOVY <ralaidovya@who.int>

### 7.1.3.IND2\_UID 714 : Percentage of high priority outputs funded up to 80% of their planned budget

#	Metadata field	Summary
1	GPW14 Output	7.1.3. Effective results-based management realized through a sustainably financed programme budget aligned with evidence-informed country, regional and global priorities, supported by transparent resource allocation and robust monitoring and performance assessment
2	GPW14 Output indicator code	7.1.3.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of high priority outputs funded up to 80% of their planned budget
4	Output/Leading Indicator (Country Level Formulation)	Percentage of high priority outputs funded up to 80% of their planned budget
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input,	Output

	Process, Output, Outcome)	
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Percentage of high priority outputs
11	Indicator definition	<p>This indicator measures the share of high-priority outputs that receive at least 80% of the funding they were planned to get in the Programme Budget (award budget divided by planned cost)</p> <p><b>Planned costs</b> are the estimated financial resources needed to complete specific activities within a project or workplan. Each activity contributes to the achievement of an output. Planned costs are estimated during the operational planning phase to ensure all necessary expenses are accounted for and entered onto the system at activity level.</p> <p><b>Award budget</b> is the total amount of financial resources allocated to a specific project or programme. It is recorded in the system once the funds are approved and distributed to ensure that the project or programme has the necessary resources to achieve its objectives. Applying funds to the top task of a workplan is called award budget.</p> <p><b>High-priority outputs</b> are classified based on consultations led by country offices in collaboration with governments and key partners, ranking each outcome as "high," "medium," or "low" priority to align WHO's support with national contexts and capacities. The priorities for 2024-25 can be found in the <a href="#">PB digital platform dashboard</a>.</p> <p>The <b>80% funding threshold for high-priority outputs</b> is chosen to ensure that these critical areas receive sufficient resources to achieve their objectives. This ambitious benchmark helps WHO aim to secure most of the necessary resources. More details can be found <a href="#">here</a></p>
12	Criteria	<p>An output is counted toward the numerator if:</p> <ul style="list-style-type: none"> <li>• It is designated as a high-priority output, based on official priority-setting processes documented in the Programme Budget digital platform.</li> <li>• It has received award funding equal to or greater than 80% of its planned cost for the biennium.</li> </ul>
13	Numerator	Number of high-priority outputs funded at ≥80% of their planned cost for the biennium as per field 12
14	Denominator	Total number of high-priority outputs
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable

17	Rationale	To ensure WHO can efficiently deliver the results set by Member States, it is crucial that available funds are directed towards high-priority outputs whenever possible to achieve the maximum impact.
18	Measurement method	<ul style="list-style-type: none"> <li>• The organization-wide report, linked to priority setting, serves as the data basis.</li> <li>• The calculation follows two steps: <ul style="list-style-type: none"> <li>○ Step 1: Identify all high-priority outputs where the award budget ÷ planned cost <math>\geq 0.80</math>.</li> <li>○ Step 2: Divide the number of those outputs by the total number of high-priority outputs, then multiply by 100 to obtain a percentage.</li> </ul> </li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The indicator is calculated by dividing the number of high-priority outputs funded at $\geq 80\%$ of their planned cost (numerator) by the total number of high-priority outputs in the Programme Budget (denominator), then multiplying by 100 to obtain a percentage.
21	Calculation type	Cumulative
22	Target setting methodology	The 80% funding threshold for high-priority outputs is chosen to ensure that these critical areas receive sufficient resources to achieve their objectives. This ambitious benchmark helps WHO aim to secure most of the necessary resources. More details can be found <a href="#">here</a>
23	How target is realistic for PB2026-2027	WHO continuously strives to increase the flexibility of funding, for example through the increase in assessed contributions or the investment round. Funding for high-priority outputs is increasingly considered in the allocation of flexible or semi-flexible funds.
24	Data sources	WHO internal financial and planning systems, including data on: <ul style="list-style-type: none"> <li>• Planned costs, entered during the operational planning phase</li> <li>• Award budgets, recorded once funding is allocated</li> <li>• High-priority output classifications, drawn from the Programme Budget digital platform</li> </ul>
25	Process of validation	The indicator is regularly calculated through an automated file
26	Limitations	The indicator measures award budget versus planned cost, ensuring comparability across biennia, provided there are no disruptive changes in funding or budget.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Janna RIISAGER <riisagerj@who.int>

### 7.1.3.IND3\_UID 715 : Percentage of base budget financed by flexible and thematic voluntary contributions

#	Metadata field	Summary
1	GPW14 Output	7.1.3. Effective results-based management realized through a sustainably financed programme budget aligned with evidence-informed country, regional and global priorities, supported by transparent resource allocation and robust monitoring and performance assessment

2	GPW14 Output indicator code	7.1.3.IND3
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of base budget financed by flexible and thematic voluntary contributions
4	Output/Leading Indicator (Country Level Formulation)	Percentage of base budget financed by flexible and thematic voluntary contributions
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Percentage of base budget
11	Indicator definition	<p>The indicator tracks the share of WHO's base budget that is financed through flexible and thematic voluntary contributions.</p> <p><b>Flexible funding</b> in WHO includes assessed contributions, core voluntary contributions, and programme support costs. These funds have specific fund type in WHO's financial system, they are defined as resources that can be allocated and used with high flexibility to support various strategic priorities and operational needs.</p> <p><b>Thematic Voluntary Contributions (VCT)</b> are funds earmarked at the global programme budget outputs or higher, allowing for considerable flexibility in their deployment according to need. This classification is determined by the level of earmarking, where thematic contributions are less restricted compared to specified voluntary contributions, offering greater predictability and flexibility for WHO to allocate resources strategically.</p> <p><b>Base</b> segment represents the core mandate of WHO and constitutes the largest part of a programme budget in terms of strategic priority-setting, detail, budget figures and performance assessment mechanisms. Other segments of the Programme Budget include Emergency Operations and Appeals, Polio Eradication, and Special Programmes.</p> <p>The <b>total available funding</b> includes the entirety of Flexible Funds, Thematic Voluntary Contributions (VCT), and Voluntary Contributions Specified (VCS), which are more earmarked, available to implement Programme budget for a given biennium This comprehensive figure ensures that all potential financial resources are accounted for to support WHO's activities and objectives.</p> <p><b>Funds available</b> refers to both funds already implemented plus the balances available to implement.</p>

12	Criteria	<p>A contribution is counted toward the numerator if:</p> <ul style="list-style-type: none"> <li>• It is classified as Flexible Funding (FF) or Thematic Voluntary Contributions (VCT) according to WHO's financial system.</li> <li>• It is allocated to the Base segment of the Programme Budget for the biennium.</li> </ul> <p>The denominator includes all available funding for the Base segment, regardless of fund type (FF, VCT, VCS).</p>
13	Numerator	Total amount of Flexible Funding (FF) and Thematic Voluntary Contributions (VCT) allocated to the Base segment of the Programme Budget.
14	Denominator	Total available funding for the Base segment of the Programme Budget. This includes all fund types (flexible, thematic, and specified voluntary contributions) that are available for implementation during the biennium.
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	To ensure WHO can efficiently deliver the results set by Member States, it is crucial to increase the proportion of flexible and thematic voluntary contributions, allowing better alignment of Programme budget results and funding, ensuring that funds are channeled where they can have the greatest impact.
18	Measurement method	The data used for the WHO official web portal serves as the basis for calculation. The percentages of funding per fund type are calculated, with FF and VCT being flexible and thematic (following formal definition of fund type). These percentages are then compared to the total available funding for the Programme budget Base segment.
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The indicator is calculated by aggregating financial data from WHO's internal systems across all relevant fund types (FF and VCT) and comparing the total amount of flexible and thematic contributions to the total available funding for the Base segment. The estimation is automated and reflects cumulative contributions organization-wide
21	Calculation type	Cumulative
22	Target setting methodology	The target represents a significant, ambitious yet realistic improvement in the flexibility of the organization's funding compared with the baseline.
23	How target is realistic for PB2026-2027	WHO continuously strives to increase the flexibility of funding, for example through the increase in assessed contributions or the investment round.
24	Data sources	WHO Internal data
25	Process of validation	The indicator is regularly calculated through an automated file.
26	Limitations	None
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025

29	Technical focal point	Janna RIISAGER< riisagerj@who.int>
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### 7.1.3.IND4\_UID 854 Percentage of countries that have conducted a joint assessment to validate the Secretariat's achievements under the WHO results framework

#	Metadata field	Summary
1	GPW14 Output	7.1.3. Effective results-based management realized through a sustainably financed programme budget aligned with evidence-informed country, regional and global priorities, supported by transparent resource allocation and robust monitoring and performance assessment
2	GPW14 Output indicator code	7.1.3.IND4
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of countries that have conducted a joint assessment to validate the Secretariat's achievements under the WHO results framework
4	Output/Leading Indicator (Country Level Formulation)	Country has conducted a joint assessment to validate the Secretariat's achievements under the WHO results framework
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Percentage of countries
11	Indicator definition	This indicator measures the percentage of countries that have conducted a joint assessment with WHO to validate the Secretariat's self-reported achievements under the WHO results framework during the biennium. It is primarily focused on output indicators and related narratives with optional inclusion of other elements of results reports and priorities if feasible.
12	Criteria	To be counted as having achieved this indicator, a country must: <ul style="list-style-type: none"> <li>• Conduct a joint assessment covering at least 50% of eligible and relevant output indicators during the biennium</li> <li>• Provide verifiable documentation (e.g. signed meeting minutes, endorsed forms, joint mission reports)</li> <li>• Ensure upload of documentation to the internal platform by the WHO Country Office</li> <li>• Validate WHO's self-assessment</li> </ul>
13	Numerator	Number of countries that have conducted a joint assessment within the current biennium as per field 12

14	Denominator	Total number of countries with eligible and relevant GPW14 output indicators during the biennium
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> Country has assessed <math>\geq 50\%</math> of eligible and relevant indicators jointly</p> <p><b>Partially achieved:</b> Country has assessed <math>&lt;50\%</math> of eligible and relevant indicators jointly</p> <p><b>Not achieved:</b> No joint assessment conducted by the target country</p>
17	Rationale	<p>The joint assessment is a robust review process of programme budget implementation, whereby WHO Country Offices and national health authorities jointly evaluate the achievements of the Secretariat under the WHO results framework, building on the existing collaboration between Member States and the Country Offices. It is an essential component of results based management, aimed at validating WHO country office's assessments of its achievements by national authorities to enhance collaborative work by addressing bottlenecks, to improve the accuracy of output indicator baselines, targets and progress, and to ensure the reliability of information used to measure and analyse indicator changes. The joint assessment also provides an opportunity to refine the programme budget prioritization, ultimately leading to better-informed and aligned planning and implementation.</p> <p>The Joint assessment of results has been proposed by various parties to:</p> <ul style="list-style-type: none"> <li>• provide an external validation of the output scorecard (item 44 in Secretariat Implementation Plan, and 4.1b in results report audit, 7.1 in RBM evaluation),</li> <li>• provide a mechanism through which reported achievements can be used to make decisions about future planning (item 47 of Secretariat Implementation Plan), and</li> <li>• further improve on the methodology for indicator reporting (4.1b in results report audit, 7.1 and 7.2 in RBM evaluation).</li> </ul>
18	Measurement method	<p>The joint assessment is conducted through the following steps:</p> <p><b>Step 1: Select relevant output indicators</b></p> <p>Countries begin by identifying a subset of relevant GPW14 output indicators for joint assessment. This selection may be based on the following criteria:</p> <ul style="list-style-type: none"> <li>• Priority level of the linked outputs</li> <li>• Strategic importance of the indicators</li> <li>• Budget utilization for the outputs</li> <li>• Performance of the indicators (e.g. exceptionally strong or weak results)</li> <li>• Feasibility based on available data or timing</li> </ul> <p>To be counted as having completed the joint assessment, a country <b>must select and assess at least 50%</b> of its eligible and relevant output indicators during the biennium.</p> <p><b>Step 2: Review and validate WHO's internal assessments</b></p>



		<p>National authorities review WHO's self-assessments of progress on the selected output indicators. This includes reviewing both quantitative results and the accompanying narrative commentaries.</p> <p><b>Step 3: Conduct the joint assessment</b></p> <p>The joint assessment involves a structured process of review and validation between WHO Country Offices and national health authorities. It is conducted at least once per biennium, preferably aligned with the End of Biennium assessment (EOB).</p> <p>To meet the indicator's performance threshold, the joint assessment must cover <math>\geq 50\%</math> of the relevant output indicators selected in Step 1.</p> <p><b>Step 4: Submit verifiable documentation</b></p> <p>Countries must provide verifiable documentation of the joint assessment process (e.g. signed meeting minutes, endorsed forms, or joint mission reports). WHO Country Offices are responsible for uploading this documentation to the designated internal platform.</p> <p><b>Step 5: Ongoing data collection and monitoring</b></p> <p>Although reported biennially, data collection and monitoring are continuous throughout the two-year cycle to allow for flexibility and accommodate countries that may complete the joint assessment at different times.</p>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	The targets were defined based on regional inputs following a structured request sent to our regional focal points. In the request, we asked regions to propose targets for 2026–2027 based on their realistic expectations for rolling out the joint assessment process, considering current capacity, country office engagement, and planned scale-up. We aggregated these regional submissions using Member States as the denominator, to ensure consistency across regions, as most regions reported using Member States rather than Country Offices. Where targets were submitted outside the shared Excel file (e.g. via email), we treated them as cumulative values unless stated otherwise.
23	How target is realistic for PB2026-2027	The targets for 2026–2027 are considered realistically achievable based on regional inputs reflecting current capacities, early pilot experiences, and planned phased implementation. Several regions have already engaged with Country Offices to initiate the joint assessment process, while others have set modest, achievable targets aligned with available resources and institutional readiness. WHO will continue to provide technical guidance, tools, and platforms to support implementation, and flexibility has been built in to allow regions to refine country selections post-WHA. This combined approach balances ambition with feasibility across diverse regional contexts.
24	Data sources	WHO internal documentation and reporting platforms capturing country-level consultations.
25	Process of validation	Joint assessments must be supported by verifiable documentation; offline template such as excel or word document, with or without formal

		endorsement. WHO Country Offices will be responsible for uploading or submitting this documentation to the designated internal reporting platform.
26	Limitations	<ul style="list-style-type: none"> <li>• There is considerable variability in country contexts. Not all countries are equally positioned to conduct meaningful joint assessments due to factors such as political instability, transitions, fragile or conflict-affected settings, and limited government capacity or engagement during the assessment period.</li> <li>• National planning, review, or budget cycles may not align with WHO's results reporting timelines, making it difficult to coordinate joint validation of output indicators with national counterparts. Conducting a joint assessment also requires significant time and staff resources from both WHO and national authorities.</li> <li>• The coordination process may be delayed or hindered by limited staffing, competing priorities, or high staff turnover. Milestones and targets should therefore be set realistically to reflect these operational constraints.</li> <li>• There is also a risk of reporting bias, where country offices may report that a joint assessment was completed—even if national engagement was minimal or rushed. This could lead to overestimation of meaningful joint assessment coverage, particularly where fewer than 50% of relevant indicators were genuinely validated in partnership with national counterparts.</li> </ul>
27	Expected frequency of reporting	Biennial
28	Date last published	15 June 2025
29	Technical focal point	Ambinintsoa RALAIDOVY< <a href="mailto:ralaidovya@who.int">ralaidovya@who.int</a> > (for output indicators and related narrative) ; Case DOWNEY < <a href="mailto:downeyc@who.int">downeyc@who.int</a> > (if other elements of results reports are included)

### 7.1.3.IND5\_UID 1501: Percentage of base budget financed by donors other than the 10 largest donors

#	Metadata field	Summary
1	GPW14 Output	7.1.3. Effective results-based management realized through a sustainably financed programme budget aligned with evidence-informed country, regional and global priorities, supported by transparent resource allocation and robust monitoring and performance assessment
2	GPW14 Output indicator code	7.1.3.IND6
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of base budget financed by donors other than the 10 largest donors
4	Output/Leading Indicator (Country Level Formulation)	Percentage of base budget financed by donors other than the 10 largest donors
5	Monitoring framework (SDG, GPW, etc)	GPW14

6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Percentage of base budget
11	Indicator definition	The indicator measures the percentage of WHO's base budget that is financed by donors other than the 10 largest contributors, based on total contributions recorded for the biennium. The list of the top 10 donors is determined dynamically for each reporting cycle, based on the actual size of their contributions to the base segment. This indicator reflects the share of funding from a broader base of contributors, promoting financial sustainability and reducing reliance on a few major donors.
12	Criteria	<ul style="list-style-type: none"> <li>• A contribution qualifies toward this indicator only if <ul style="list-style-type: none"> <li>○ it is made to the WHO base budget segment, and</li> <li>○ the donor is not among the top 10 contributors to the WHO base segment for the reporting period.</li> </ul> </li> <li>• The top 10 donors are determined based on the total size of their contributions to the base budget during the biennium.</li> </ul>
13	Numerator	Total contributions from donors to the base segment outside the top 10 largest contributors as per field 12
14	Denominator	Total base budget
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	Measures funding diversity to reduce dependency on a small group of donors, ensuring financial sustainability, flexibility, and predictability, and reflecting WHO's capacity to mobilize resources broadly. Enhances resilience against funding fluctuations.
18	Measurement method	<ul style="list-style-type: none"> <li>• Data is collected from PowerBI: WHO Revenue, Base Segment, Lead Donor</li> <li>• Identify the top 10 donors by size of contribution to base segment, aggregate remaining contributions, and calculate the percentage.</li> <li>• Formula: (Numerator (as per Field 13) / Denominator (as per Field 14)) × 100</li> </ul>
19	Estimation method (if applicable)	Not applicable

20	Method of aggregate estimation	Aggregate estimation is done at the Organization-wide level by summing all contributions from donors outside the top 10 (numerator) and dividing by the total WHO base budget (denominator) for the reporting biennium. The result is expressed as a percentage.
21	Calculation type	Cumulative
22	Target setting methodology	<p>Three options were considered for setting the 2026–2027 targets:</p> <p><b>Option 1: Linear Regression (Overall Trends)-Selected option</b></p> <p>First, analyze historical data from PowerBI Revenue Data (Voluntary Contributions, Base Segment, Lead Donor, 2020-2024) to calculate the trends regarding the percentage of base budget financed by donors other than the 10 largest donors.</p> <ul style="list-style-type: none"> <li>2020: 35%   2021: 37%   2022: 35%   2023:41%   2024: 36%</li> </ul> <p>Second, calculate key values and use linear regression to project future values since it prioritizes overall trends over individual years.</p> <ul style="list-style-type: none"> <li>Assigning numerical values to years (2020 = 0, 2021 = 1, ..., 2024 = 4). (X=Year, Y=% of base budget financed by donors other than the 10 largest donors) <ul style="list-style-type: none"> <li>Mean of <math>x = (0+1+2+3+4)/5=2</math></li> <li>Mean of <math>y = (35+37+35+41+36)/5=36.8</math></li> <li>Slope (<math>m</math>)=<math>\sum(x_i - \bar{x})(y_i - \bar{y}) / \sum(x_i - \bar{x})^2</math>, <math>m=0.6</math></li> <li>The y-intercept (<math>b</math>)= <math>b = \bar{y} - m \cdot \bar{x}</math>, <math>b=36.8-(0.6 \cdot 2)=35.6</math></li> <li>The regression formula: <math>y=0.6x+35.6</math></li> </ul> </li> <li>35.6% is the baseline value when <math>x=0x=0</math> (i.e., 2020).</li> <li>0.6% is the annual increase in the % of base budget financed by donors other than the 10 largest donors (excluding the US).</li> </ul> <p>Third, projections:</p> <ul style="list-style-type: none"> <li>2026 (Year 6): <math>y=0.6(6)+35.6=39.2\%</math></li> <li>2027 (Year 7): <math>y=0.6(7)+35.6=39.8\%</math></li> </ul> <p>Rationale: The baseline (35.6) anchors the regression line to the historical data (2020-2024), ensuring projections start from a realistic baseline.</p> <p><b>Option 2: Static Baseline (No Trend) – Not selected</b></p> <p>Use the historical average of 36.8% to serve as the baseline to avoid overestimating.</p> <p>Rationale: This assumes no upward/downward trend and treats volatility as noise. Conservative and stable, but ignores the gradual upward trend observed in the data.</p> <p><b>Option 3: Average + Observed Trend – Not selected</b></p> <ul style="list-style-type: none"> <li>2026: <math>36.8\%+(0.6 \times 2)=36.8+1.2=38.0\%</math></li> <li>2027: <math>36.8\%+(0.6 \times 3)=36.8+1.8=38.6\%</math></li> </ul> <p>Rationale: Acknowledges the historical average as a starting point but retains the observed annual growth rate (+0.6%).</p> <p><b>Interpretation note:</b> To fully reflect its value as an output indicator, this metric should be interpreted with qualitative context on Secretariat-led actions. These include donor engagement strategies, promotion of flexible and multi-year funding through the Investment Case, and targeted outreach to emerging or non-traditional donors. This framing ensures the indicator contributes meaningfully to the performance narrative while transparently</p>

		acknowledging the Secretariat's role and the known limitations of the financial data captured.
23	How target is realistic for PB2026-2027	<p>The target is considered realistic based on WHO's strategic priorities, existing donor trends, and manageable growth expectations. Key enabling factors include:</p> <ol style="list-style-type: none"> <li>1. Diversified Donor Engagement: WHO's strategy to expand partnerships with non-traditional donors (e.g., private sector, foundations) reduces reliance on top contributors.</li> <li>2. Regional Prioritization: Increased funding allocations to high-impact regions (e.g., Africa, Southeast Asia) incentivize donors other than the 10 largest donors to invest in localized outcomes.</li> <li>3. Funding Pipeline Analysis: Existing pledges from donors other than the 10 largest donors (2025) suggest momentum can carry into 2026–2027.</li> <li>4. Baseline Growth: Starting from 35.6%, the annual +0.6% trend requires only modest yearly growth (e.g., securing incremental commitments from donors other than the 10 largest donors).</li> <li>5. Mitigating the Impact of the US Situation: Proactive reallocation of WHO's advocacy efforts to other donors (e.g., private sector, middle-income countries)</li> </ol>
24	Data sources	PowerBI: WHO Revenue, Base Segment, Lead Donor; WHO Investment Case
25	Process of validation	Cross-check the data from different platforms: PowerBI, CEM, GSM and seek guidance from relevant colleagues if needed.
26	Limitations	<ul style="list-style-type: none"> <li>• Data quality: Lead Donor vs. Direct Donor. Due to different ways of recording the contributions, it might take some time to manually clean the data to get accurate results/ranking</li> <li>• Non-monetary support: In-kind contributions or technical assistance (critical for operations) are not captured, underrepresenting true donor diversity.</li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Daniel THORNTON <thorntond@who.int>

### **7.1.3.IND6\_UID 1503: Number of major offices whose funding level for the approved base budget is at least 80%**

#	Metadata field	Summary
1	GPW14 Output	7.1.3. Effective results-based management realized through a sustainably financed programme budget aligned with evidence-informed country, regional and global priorities, supported by transparent resource allocation and robust monitoring and performance assessment
2	GPW14 Output indicator code	7.1.3.IND6
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of major offices whose funding level for the approved base budget is at least 80%

4	Output/Leading Indicator (Country Level Formulation)	Number of major offices whose funding level for the approved base budget is at least 80%
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Number
10	Unit of measure	Number of major offices
11	Indicator definition	<p>This indicator tracks in how many WHO Major Offices at least 80% of their approved Base budget is funded.</p> <p>A given biennial programme budget is presented to Member States for approval in four segments:</p> <ul style="list-style-type: none"> <li>• <b>base programmes;</b></li> <li>• emergency operations and appeals;</li> <li>• polio eradication;</li> <li>• and special programmes.</li> </ul> <p>All budget segments will contribute to and are managed within the results framework agreed with the Member States, while the separation of the budget into segments responds to the different governance mechanisms that define the budget of each segment. World Health Assembly (WHA) considers and approves the programme budget.</p> <p>Therefore the “<b>approved base budget</b>” corresponds to the Base segment of a programme budget, which was approved by WHA. <b>Base budget</b> (also referred to as Base budget segment or <b>Base programmes segment</b>) represents the core mandate of WHO and constitutes the largest part of a programme budget in terms of strategic priority-setting, detail, budget figures and performance assessment mechanisms.</p> <p>The <b>80% funding threshold</b> is a practical guideline rather than a formal benchmark. It was chosen to provide a clear indicator of when funding levels are approaching adequacy. This threshold gives some flexibility, acknowledging natural variation, while still highlighting when funding levels are significantly off target.</p>
12	Criteria	<p>A Major Office is counted toward the achieved threshold of this indicator if:</p> <ul style="list-style-type: none"> <li>• It is one of WHO’s designated Major Offices.</li> <li>• It has received total available funding (including Flexible Funds (FF), Thematic Voluntary Contributions (VCT), and Specified Voluntary Contributions (VCS)) equal to or greater than 80% of its approved Base budget for the biennium.</li> </ul>

		Only those Major Offices meeting or exceeding this 80% threshold are included in the count.
13	Numerator	Number of WHO Major Offices whose funding level for the approved Base budget is equal to or greater than 80% as per field 12.
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> Major Office's approved Base budget is funded <math>\geq 80\%</math></p> <p><b>Partially achieved:</b> Major Office's approved Base budget is funded 70% to 79%</p> <p><b>Not achieved:</b> Major Office's approved Base budget is funded <math>&lt; 70\%</math></p>
17	Rationale	The organization aims for an equitable distribution of resources among the major offices for the Base budget to ensure better alignment of Programme budget results and funding to deliver results wherever they have an impact.
18	Measurement method	<ul style="list-style-type: none"> <li>• Data is collected from WHO's official financial systems</li> <li>• For each WHO Major Office, the funding level is calculated by dividing the total available funding (including Flexible Funds [FF], Thematic Voluntary Contributions [VCT], and Specified Voluntary Contributions [VCS]) by its approved Base budget.</li> <li>• Each Major Office is then classified into one of the categories in field 16</li> <li>• The indicator counts the number of Major Offices classified as Achieved, while the full classification provides additional benchmarking insight in the narrative.</li> <li>• The calculation is performed annually using an automated internal financial tool.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of major offices meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	The target aims for continuous improvement in equitable funding for major offices. It is realistic and achievable, considering WHO's support, funding, and regional engagement.
23	How target is realistic for PB2026-2027	WHO aims to increase flexible resources through the AC increase and the investment round, enabling the distribution of these resources more equitably. At the same time, continuous efforts are underway to mobilize additional resources in underfunded areas. Level of financing is directly dependent on the approved budget figure.
24	Data sources	WHO official financial systems
25	Process of validation	The indicator is regularly calculated through an automated file.
26	Limitations	<p>While the indicator reflects efforts to ensure equitable funding across WHO Major Offices, its interpretation is limited by the nature of WHO's funding structure:</p> <ul style="list-style-type: none"> <li>• The Secretariat can influence the distribution of Base budget funding only to a certain extent, especially when flexible or semi-flexible funds (e.g. FF and VCT) are available.</li> </ul>

		<ul style="list-style-type: none"> <li>• However, a large share of WHO's funding consists of Voluntary Contributions Specified (VCS), which are earmarked for particular purposes and cannot be reallocated freely.</li> <li>• As a result, the indicator primarily highlights disparities and the need for more equitable funding, rather than measuring direct results of Secretariat decisions.</li> </ul> <p>This structural limitation should be considered when interpreting the indicator's findings.</p>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Janna RIISAGER < riisagerj@who.int >



### 7.2.1. WHO supports Member States in strengthening health information collection, aggregation, analysis and interpretation to monitor trends and progress towards indicators and targets of the Sustainable Development Goals, including inequality monitoring

#### 7.2.1.IND1\_UID 1395: Percentage of WHO guidelines developed or updated using the living approach to evidence, with documented mechanisms that facilitate timely dissemination for country use

#	Metadata field	Summary
1	GPW14 Output	7.2.1. WHO supports Member States in strengthening health information collection, aggregation, analysis and interpretation to monitor trends and progress towards indicators and targets of the Sustainable Development Goals, including inequality monitoring
2	GPW14 Output indicator code	7.2.1.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of WHO guidelines developed or updated using the living approach to evidence, with documented mechanisms that facilitate timely dissemination for country use
4	Output/Leading Indicator (Country Level Formulation)	Percentage of WHO guidelines developed or updated using the living approach to evidence, with documented mechanisms that facilitate timely dissemination for country use
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Percentage of WHO guidelines
11	Indicator definition	<p>This indicator measures the percentage of WHO guidelines that are approved by GRC or WHE, use a living approach to evidence, and are disseminated via digital-first platforms. It reflects WHO's effort to ensure that guidelines are not only evidence-based and adaptable but also made available in a timely manner for country use.</p> <p>Although the main indicator is a percentage, WHO also tracks the time (in calendar days) between guideline approval and publication as a supplementary metric to assess dissemination speed.</p>
12	Criteria	A guideline is counted in the numerator as having achieved this indicator if all of the following criteria are met:

		<ul style="list-style-type: none"> <li>• It has been approved by GRC or WHE;</li> <li>• It has been developed or updated using the living approach to evidence, as defined in the WHO Guideline Development Handbook (3rd edition, 2025) As an extract: <i>“A living guideline is one that is developed using continuous surveillance of relevant new evidence and is updated on an ongoing basis when new evidence has the potential to change existing recommendations.”</i></li> <li>• It has been disseminated using a digitally structured, digital-first dissemination platform (e.g. MAGICapp).</li> </ul>
13	Numerator	Number of guidelines that meet the criteria as detailed in Field 12
14	Denominator	Number of all guidelines approved by GRC or WHE, regardless of whether they follow the living approach or use digital-first dissemination mechanisms.
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	Indicator will assess if there is an increase in the number of digitally structured WHO guidelines that are disseminated via a digital-first publication strategy, and whether using such platforms will decrease the time from guideline approval to making new or updated WHO recommendations available for use by countries, in response to rapidly evolving new or updated evidence.
18	Measurement method	<ul style="list-style-type: none"> <li>• The measurement is conducted by extracting data from GRC and WHE approval records, digital dissemination platforms (e.g. MAGICapp), and metadata tags in internal WHO systems (e.g. TULIP, IRIS).</li> <li>• Each guideline is reviewed to confirm the criteria as detailed in field 12</li> <li>• Data is compiled annually by the responsible team and reviewed for completeness before reporting.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	Simple percentage using counts of qualified guidelines as per Field 12 over total GRC/WHE-approved guidelines (Field 14)
21	Calculation type	Cumulative
22	Target setting methodology	In order to fully implement living guidelines at WHO several significant process and change management strategies will need to be implemented. In discussion with major funders, stakeholders and internal personnel, it is anticipated that full implementation of this approach will take 4-5 years. It is thus a realistic target to achieve an increase of 10% each year for 2026-27 whilst pilot testing the required policy and process changes with early-adopter Technical Units to streamline all the required processes.
23	How target is realistic for PB2026-2027	<ul style="list-style-type: none"> <li>• Several major funders are very interested in supporting WHO to adopt a living approach so significant funding support seems likely (contingent on</li> </ul>

		<p>support senior management being in place following the current re-structure).</p> <ul style="list-style-type: none"> <li>• While the living approach was a high priority under previous leadership, its continued prioritization will depend on strategic direction set by the new Chief Scientist and senior management.</li> <li>• As globally-relevant WHO guidelines are developed by Technical Units at HQ, regional engagement is not a key determining factor in achieving the set targets.</li> </ul>
24	Data sources	GRC tracker spreadsheet, TULIP data, IRIS, digital dissemination platform outputs (e.g., MAGICapp)
25	Process of validation	<ul style="list-style-type: none"> <li>• A 10% random sample of guidelines self-reported as using the living approach is reviewed in depth to verify that the evidence type and update frequency meet the definition outlined in the WHO Handbook.</li> </ul>
26	Limitations	<ul style="list-style-type: none"> <li>• True denominators of all WHO guidelines being not known but assumption is that GRC + WHE approved guidelines represent very close to all WHO guidelines.</li> <li>• Use of a living approach to guidelines is self-reported by RTO but reviewed via GRC process.</li> <li>• The living approach is not appropriate for all WHO guidelines or recommendations, so this indicator cannot measure whether the living approach is being used appropriately for all WHO guidelines that should be using it - only the numbers that actually are using this approach.</li> <li>• Other than the use of a digital dissemination platform, other mechanisms that may facilitate timely dissemination for country use are not routinely collected across all WHO guidelines.</li> <li>• Although timeliness is a key objective of this indicator, the number of calendar days between approval and publication is tracked separately and is not part of the percentage calculation.</li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Lisa Askie < askiel@who.int>

**7.2.1.IND2\_UID 1396: Number of WHO norms, standards and guidelines that support the adoption of digital technologies (including SMART Guidelines and guidance on AI) made accessible to countries**

#	Metadata field	Summary
1	GPW14 Output	7.2.1. WHO supports Member States in strengthening health information collection, aggregation, analysis and interpretation to monitor trends and progress towards indicators and targets of the Sustainable Development Goals, including inequality monitoring
2	GPW14 Output indicator code	7.2.1.IND2

3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of WHO norms, standards and guidelines that support the adoption of digital technologies (including SMART Guidelines and guidance on AI) made accessible to countries
4	Output/Leading Indicator (Country Level Formulation)	Number of WHO norms, standards, and guidelines that support the adoption of digital technologies (including SMART Guidelines and guidance on AI) that have been adapted to the country context.
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Number
10	Unit of measure	Number of WHO norms and standards
11	Indicator definition	<p>This indicator counts the number of WHO norms, standards, and guidelines that include digital health content, such as SMART Guidelines and guidance on artificial intelligence, and that are made accessible to countries. Products are considered to include digital health content when they provide information, tools, or resources designed to help users enhance health and well-being through the use of digital technologies, regardless of the format (e.g. PDF guidance, PDF guideline, application, website, etc.). Digital technologies include mobile applications, eHealth services, telemedicine, virtual care, remote monitoring, and platforms that drive the digital transformation of healthcare. It also relates to technologies like Internet of Things (IoT) (including smart wearables), artificial intelligence (including machine learning and large multi-modal models) , big data analytics, blockchain, and robotics for advanced medical applications. Digital health solutions can focus on demand-side or supply-side aspects of health system performance, including supply chain management, coverage, quality, affordability, etc.</p> <p>In the context of country level formulation, this indicator counts the number of WHO norms, standards, and guidelines that support the adoption of digital technologies that have been adapted to a specific context. Country-level adaptation of guidance would be a refinement of the guidance so that it is relevant to a country's context given governance model, resource constraints and epidemiological situation, for example.</p>
12	Criteria	<p>To be counted under this indicator, WHO norms, standards, and guidelines must:</p> <ul style="list-style-type: none"> <li>• Include digital health content as defined in field 11.</li> <li>• Be listed in TULIP as either a "Guideline", or "Non-guideline norms and standards product (NSP)"</li> </ul>

		<ul style="list-style-type: none"> <li>Be published through WHO Press, except SMART Guidelines machine-readable guidelines which include software code published on WHO's official GitHub page. This would also include rapidly evolving guidance on AI</li> </ul>
13	Numerator	Number of digital-related products approved through TULIP, including SMART Guidelines, guidance on AI, and digital health transformation content as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	This indicator measures WHO's ability to provide technical expertise and guidance in the digital age, by providing WHO's health programme norms, standards, and Guidelines in SMART Guidelines format; as well as norms, standards, and guidelines on digital transformation, including ability to provide latest guidance on AI.
18	Measurement method	<ul style="list-style-type: none"> <li>Data are collected through a structured review of products approved in TULIP and published either on IRIS or WHO's official GitHub (for machine-readable SMART Guidelines). The count includes only those products that meet the eligibility criteria outlined in Field 12.</li> <li>All eligible publications are identified and confirmed through internal tracking systems and cross-referenced with publication platforms to ensure completeness.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	Simple percentage using counts of qualified guidelines as per Field 12 over total GRC/WHE-approved guidelines (Field 14)
21	Calculation type	Cumulative
22	Target setting methodology	Targets were set in consultation with teams at Headquarters and Regional Offices. There are planned norms and standards documents that are already in the publication pipeline, most of which have funding in place to support to the finish line. Additional consideration was given to the past average publication rate and the likelihood of receiving new funding to support the development of norms and standards products in this area moving forward.
23	How target is realistic for PB2026-2027	The COVID-19 pandemic drove demand for guidance on digital health transformation. In 2021, WHO published a record of 18 guidance documents on digital health across headquarters and regional offices. WHO averaged 11 annual publications since 2022 across headquarters and regional offices. Targets provided for 2026–2027 are realistically achievable as most activities are already funded and there continues to be increasing interest and demand from Member States. The targets are slightly higher than the past average annual publication rate. However, this is due to increased demand and focus across all teams within WHO on digital health.

24	Data sources	TULIP (WHO technical product approval platform); IRIS (WHO Institutional Repository for Information Sharing)
25	Process of validation	Review of publications on IRIS and technical products approved through TULIP. For country adapted guidance, review of guidance developed and/or published by the Ministry of Health or equivalent health authority in collaboration with WHO Country Offices through workshops, meetings, asynchronous document review or other means of collaboration.
26	Limitations	WHO norms and standards, including guidelines are not clearly numerated; thus, the translation into SMART Guidelines format is limited to how WHO normative publications are counted. The denominator is not currently possible to measure. Therefore, the indicator is provided as a number, thus requiring multiple meaningful disaggregation and analyses to show progress.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Natschja Nash-Mendez < ratanaprayuln@who.int>

## 7.2.2. Strengthening national and regional science ecosystems to improve health and provide opportunities and equity, active support for the digital health transformation, research, development and innovation, including manufacturing capacities of countries

### 7.2.2.IND1\_UID 589: Number of countries that have established an evidence-to-policy process following WHO facilitation or recommendations

#	Metadata field	Summary
1	GPW14 Output	7.2.2. Strengthening national and regional science ecosystems to improve health and provide opportunities and equity, active support for the digital health transformation, research, development and innovation, including manufacturing capacities of countries
2	GPW14 Output indicator code	7.2.2.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries that have established an evidence-to-policy process following WHO facilitation or recommendations
4	Output/Leading Indicator (Country Level Formulation)	Establishment of an evidence-to-policy process following WHO facilitation or recommendations
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator measures the number of countries that have formally established an evidence-to-policy (E2P) process, such as participation in EVIPNet or an equivalent mechanism, following WHO facilitation or recommendations.
12	Criteria	<p>A country is counted as having achieved this indicator if it has:</p> <ul style="list-style-type: none"> <li>• An operational evidence-to-policy (E2P) system in place, supported by WHO through EVIPNet membership or an equivalent mechanism, with training and capacity-building to promote and institutionalize E2P as an ongoing efforts; <b>OR</b></li> <li>• A fully institutionalized E2P system with recognized and resourced specialist unit(s) and mandatory E2P policy.</li> </ul>

13	Numerator	Number of countries with an operational evidence-to-policy (E2P) process established following WHO facilitation or recommendations OR a fully institutionalized E2P system as per field 12.
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> Number of countries meeting the criteria as per field 12</p> <p><b>Partially achieved:</b> ad hoc/one-off WHO contribution, deliver through EVIPNet or an equivalent mechanism, towards the implementation of E2P activities in the country. This typically reflects limited or short-term support (e.g. a single training or workshop), resulting in some initial E2P activities, but without a sustained or institutionalized process in place.</p> <p><b>Not achieved:</b> no WHO intervention and no noteworthy ongoing E2P activity in place</p>
17	Rationale	<ul style="list-style-type: none"> <li>• <b>Direct link to WHO Facilitation:</b> EVIPNet is a WHO initiative that supports countries in institutionalizing E2P processes. A country's membership signals engagement with WHO-endorsed methods and frameworks for E2P.</li> <li>• <b>Institutional commitment:</b> Joining EVIPNet or an equivalent mechanism reflects a government's formal commitment to integrating evidence into policymaking, aligning with WHO recommendations.</li> <li>• <b>Operationalization of E2P processes:</b> EVIPNet member countries typically adopt structured approaches like policy briefs, stakeholder dialogues, and knowledge translation platforms, demonstrating the establishment of an E2P process.</li> <li>• <b>Trackable and verifiable:</b> Membership status is easily documented and regularly updated, making it a practical and transparent indicator for monitoring country progress.</li> </ul>
18	Measurement method	<p>Data collection will be conducted through the following sources:</p> <ul style="list-style-type: none"> <li>• EVIPNet membership list (primary source)</li> <li>• Direct inquiries with WHO Regional and Country Offices to verify status and engagement</li> <li>• Optional: Short questionnaire sent to WHO Member States to confirm or complement reported information</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	<ul style="list-style-type: none"> <li>• Scenario planning in collaboration with WHO Regional Offices, informed by their engagement with Member States and the anticipated demand for evidence-to-policy technical and policy support.</li> <li>• Expansion of EVIPNet to additional French-speaking and Lusophone countries in the WHO African Region.</li> <li>• Political will and institutional engagement can be mobilized through strategic framing and alignment with national priorities.</li> </ul>



		<ul style="list-style-type: none"> <li>Effective partnerships with WHO technical units and external partnerships can be established to leverage and integrate evidence-informed policymaking mechanisms across health priorities.</li> </ul>
23	How target is realistic for PB2026-2027	<ul style="list-style-type: none"> <li><b>Strategic and conservative target setting:</b> The targets were defined through a conservative assessment of the global and regional landscape, reflecting a realistic ambition grounded in current capacities and trends.</li> <li><b>Alignment with WHO capacity and country priorities:</b> Target setting considered the available technical and human resources at WHO, as well as opportunities to align evidence initiatives with national health priorities and policy cycles.</li> <li><b>Leveraging effective partnerships and cross-sectoral and inclusive collaboration:</b> Collaboration with WHO technical units and external partners is expected to help integrate EIP mechanisms into broader health priorities, facilitating cross-programmatic synergies and avoiding parallel efforts. Stakeholder engagement across sectors, including health, research, civil society, and others, will generate broader buy-in and stronger societal demand for evidence use.</li> <li>Existing working contacts with the countries on evidence-to-policy issues.</li> <li>Extending knowledge translation platforms/evidence-to-policy units is a priority in some of the Regional Offices, making it necessary to achieve targets.</li> </ul>
24	Data sources	EVIPNet membership list; WHO facilitation records; WHO Country Office reports; Country self-reports (Ministry of Health, NIPH, etc.); Published knowledge translation outputs
25	Process of validation	Cross-checking with WHO facilitation records to confirm the link between membership and WHO support; WHO Country office reports; self-reporting by countries (Ministry of Health, National Institute of Public Health, etc.); and published knowledge translation products or events
26	Limitations	<ul style="list-style-type: none"> <li>The indicator does not distinguish between levels of engagement.</li> <li>The indicator may underestimate the actual number of countries implementing E2P.</li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Tanja Kuchenmuller (HQ)< kuchenmullert@who.int>; RO focal points

### 7.2.3. WHO supports Member States in strengthening health information collection, aggregation, analysis and interpretation to monitor trends and progress towards indicators and targets of the Sustainable Development Goals, including inequality monitoring

**7.2.3.IND1\_UID 579: Number of countries in which national health information systems have been strengthened using WHO-provided analytical platforms, leading to improved availability and disaggregation of GPW 14 outcome indicators and better use of indicators included in the Global Health Estimates, World Health Statistics and the Health Inequality Data Repository for decision-making**

#	Metadata field	Summary
1	GPW14 Output	7.2.3. WHO supports Member States in strengthening health information collection, aggregation, analysis and interpretation to monitor trends and progress towards indicators and targets of the Sustainable Development Goals, including inequality monitoring
2	GPW14 Output indicator code	7.2.3.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries in which national health information systems have been strengthened using WHO-provided analytical platforms, leading to improved availability and disaggregation of GPW 14 outcome indicators and better use of indicators included in the Global Health Estimates, World Health Statistics and the Health Inequality Data Repository for decision-making
4	Output/Leading Indicator (Country Level Formulation)	Country where the national health information system has been strengthened using WHO provided analytical platforms, and achieved improved availability and disaggregation of GPW14 outcome indicators and better use of indicators included in Global Health Estimates, World Health Statistics and Health Inequality Data Repository for decision-making
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator measures the number of countries where national health information systems have been strengthened through the use of WHO-provided analytical platforms. These platforms must be used to generate data that improve the availability and disaggregation of GPW14 outcome

		indicators or indicators from Global Health Estimates, World Health Statistics, or the Health Inequality Data Repository.
12	Criteria	<p>A country is counted as having achieved this indicator if:</p> <ul style="list-style-type: none"> <li>• It has used at least one WHO-provided analytical platform to generate data for monitoring or reporting on GPW14 outcome indicators; and</li> <li>• It falls into the <b>High usage</b> category, defined as using WHO-provided platforms to produce data for 67% or more of its GPW14 outcome indicators.</li> </ul> <p>See more details in the “Method of measurement” (Field 18)</p>
13	Numerator	Number of countries using WHO analytical platforms as described in field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p>Countries are classified based on the extent to which they use WHO-provided analytical platforms to generate data for GPW14 outcome indicators:</p> <p><b>Achieved:</b> Countries use WHO-provided analytical platforms to support 67% or more of their GPW14 outcome indicators, as per field 12</p> <p><b>Partially achieved:</b> Countries use WHO platforms for 34%–66% of their GPW14 outcome indicators</p> <p><b>Not achieved:</b> Countries use WHO platforms for 0%–33% of their GPW14 outcome indicators</p>
17	Rationale	To evaluate the use of WHO-provided analytical platforms to strengthen national health information systems. These platforms can help countries improve the availability and quality of disaggregated data for tracking the progress of GPW14 outcome indicators. The analytical platforms also facilitate countries to better use of indicators included in WHO flagship products, including Global Health Estimates, World Health Statistics and Health Inequality Data Repository. Data generated using these platforms can supplement data that are available in countries to identify priorities, setting measurable targets, tracking progress and formulating targeted and data-driven policies and interventions to drive impact at country level.
18	Measurement method	<ul style="list-style-type: none"> <li>• Countries report whether they have used WHO-provided analytical platforms to generate data for monitoring or reporting any of the GPW14 outcome indicators.</li> <li>• Usage is validated through the following means: <ul style="list-style-type: none"> <li>○ For online platforms (e.g. the Health Equity Assessment Toolkit): tracked through enrolment information or access logs.</li> <li>○ For standalone tools: tracked via WHO technical assistance, either in-country or remote.</li> <li>○ In some cases: both usage logs and technical support records are used.</li> </ul> </li> <li>• Use of a single platform for one indicator qualifies as "used."</li> </ul>

		<ul style="list-style-type: none"> <li>Eligible WHO analytical platforms include: <ul style="list-style-type: none"> <li>Mortality data (Global Health Estimates)</li> <li>Inequality data analysis platform and database</li> <li>Purpose-built tools (e.g., small-area estimation for maternal health drivers, UHC index computation tool)</li> </ul> </li> </ul> <p>Usage levels are classified as follows:</p> <ul style="list-style-type: none"> <li>Low usage: 0–33%</li> <li>Medium usage: 34–66%</li> <li>High usage: 67–100%</li> </ul> <p>Only countries in the <b>High usage</b> category are counted as having achieved the indicator for global reporting.</p>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	<p>The target reflects the expectation that all Member States interested in applying WHO’s harmonized analytical methods will benefit from the use of WHO-provided platforms to produce consistent metrics. Target setting takes into account:</p> <ul style="list-style-type: none"> <li>The spread among WHO regions; and</li> <li>The capacity of the WHO HQ team to expand engagement with both new countries and those already receiving support, enabling broader use of WHO analytical platforms.</li> </ul>
23	How target is realistic for PB2026-2027	Given the high baseline and the nature of WHO analytical platforms, the target is realistically achievable through limited/online engagement with Member States
24	Data sources	Country reporting and WHO records of technical assistance or platform usage
25	Process of validation	Review of country data and metadata submissions on GPW14 indicators
26	Limitations	<ul style="list-style-type: none"> <li>The level of data availability and quality vary across countries. Some countries may have national data available for all GPW14 outcome indicators; therefore, not using WHO-provided analytical platforms, or using them for only a limited number of indicators, is not necessarily an indication of inadequate support from the Secretariat.</li> <li>Additionally, the extent to which WHO provided analytical platforms are used across different countries is not comparable, as countries have different levels of preference of using national data even though the quality of the national data may not be sufficient.</li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Haidong Wang <hawang@who.int>

**7.2.3.IND2\_UID 1370: Number of countries using the delivery-for-impact approach to identify priorities, develop acceleration scenarios and allocate resources to achieve national or global targets**

#	Metadata field	Summary
1	GPW14 Output	7.2.3. WHO supports Member States in strengthening health information collection, aggregation, analysis and interpretation to monitor trends and progress towards indicators and targets of the Sustainable Development Goals, including inequality monitoring
2	GPW14 Output indicator code	7.2.3.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries using the delivery-for-impact approach to identify priorities, develop acceleration scenarios and allocate resources to achieve national or global targets
4	Output/Leading Indicator (Country Level Formulation)	Country uses/has integrated the delivery for impact approach to identify priorities, develop acceleration scenarios and allocate resources to achieve national or global targets
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Provisional
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator tracks how many WHO Member States have adopted the Delivery for Impact approach, an integrated cycle of prioritization, planning, monitoring and resource allocation, to drive progress toward agreed targets.
12	Criteria	A country is counted as having achieved this indicator if it meets <b>at least 4 out of 5</b> of the parameters that reflect the core phases of the Delivery for Impact (DFI) approach. (See field 16 for more information on the achievement thresholds) (See field 18 for the full list of parameters)
13	Numerator	Number of countries that met a score of 4 or 5 ("achieved" threshold as per field 16) based on their responses to the five Delivery for Impact parameters in field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes

16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> The country has met at least four out of five DFI parameters. This indicates full integration of the DFI approach (4-5)</p> <p><b>Partially achieved:</b> The country has met two or three DFI parameters. This reflects partial integration of the DFI approach (2-3)</p> <p><b>Not achieved:</b> The country has met none or only one of the five DFI parameters. This indicates that the DFI approach is not yet integrated into the country's planning, monitoring, or resource allocation processes. (0-1)</p>
17	Rationale	To measure the use/integration of the Delivery for Impact approach into policy development and implementation, the question to be asked is: “Is the country effectively using the Delivery for Impact approach?” The integration of the delivery for impact approach at country level establishes a standard framework for policy development and implementation, ensuring a structured process for identifying priority issues, designing targeted solutions, setting measurable targets, assessing the progress and determining actionable steps to achieve those targets and achieve meaningful impact.
18	Measurement method	<ul style="list-style-type: none"> <li>To measure the Delivery for impact (DFI) approach use, the following parameters are used as these are the core stages of the impact cycle: <ol style="list-style-type: none"> <li>A prioritization exercise has been conducted, informed by the best available data and aligned with global health frameworks (i.e. SDG, GPW14, etc.)</li> <li>A results framework and/or a delivery plan (including clear indicators, target, acceleration scenarios, theory of change, and an action plan) have been developed</li> <li>A stakeholders mapping has been conducted, and the respective engagement plan has been established</li> <li>Regular stocktakes are scheduled to track progress, with plans to course correct if necessary</li> <li>Budget is available for the country office for a defined period, with resource allocation planned and clear commitment from government (i.e. priority reflected in national plans and/or budgets)</li> </ol> </li> <li>Countries self-report on these five parameters, each corresponding to a key phase of the Delivery for Impact (DFI) approach.</li> <li>For each parameter, countries respond “Yes” (scored as 1) or “No” (scored as 0).</li> <li>The scores are summed to calculate a country-level index ranging from 0 to 5.</li> <li>The resulting index reflects the extent to which the DFI approach has been integrated into national planning and delivery processes.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	The target was set in the WHO investment case by ADG DDI. As the number of countries participating/using the DFI approach has been increasing year

		on year this was set as a stretch target to ensure that half of WHO MS are using the delivery approach.
23	How target is realistic for PB2026-2027	The targets are realistically achievable owing to the following factors: <ul style="list-style-type: none"> <li>• <b>Country support across multiple areas</b>, delivered in cohorts, enables tailored assistance and peer learning to accelerate adoption of the DFI approach.</li> <li>• <b>Alignment with WHO Investment Case priorities</b>: To operationalize the investment case, countries will need to apply the DFI approach. This includes: <ul style="list-style-type: none"> <li>○ Country offices opting in for an acceleration plan;</li> <li>○ Participation in technical workshops;</li> <li>○ Use of targeted mechanisms such as 100-day sprints to drive rapid planning, coordination, and implementation.</li> </ul> </li> </ul>
24	Data sources	Country self-reported data collected through the DFI workplan/dashboard.
25	Process of validation	values are cross-checked and categorized into integration tiers to ensure consistency in reporting.
26	Limitations	<ul style="list-style-type: none"> <li>• Some countries may already use a similar process to the Delivery for impact approach but may not document or report it to HQ.</li> <li>• Variations in the specific context where the DFI tools are applied, and differences in how the parameters are interpreted or reported across countries could lead to inconsistencies and make cross-country comparisons inaccurate.</li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Melanie Bertram< <a href="mailto:bertramm@who.int">bertramm@who.int</a> >; Diana Estevez <estevezd@who.int>

### 7.2.3.IND3\_UID 1371: Number of countries implementing and utilizing the International Classification of Diseases, 11th Revision (ICD-11) to record accurate and key population health information, with level of implementation

#	Metadata field	Summary
1	GPW14 Output	7.2.3. WHO supports Member States in strengthening health information collection, aggregation, analysis and interpretation to monitor trends and progress towards indicators and targets of the Sustainable Development Goals, including inequality monitoring
2	GPW14 Output indicator code	7.2.3.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries implementing and utilizing the International Classification of Diseases, 11th Revision (ICD-11) to record accurate and key population health information, with level of implementation
4	Output/Leading Indicator (Country Level Formulation)	Country is using and contributing to ICD-11, ranging from initial interest, to producing data coded with ICD-11, and submitting and processing proposals for updates

5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	This indicator measures the number of countries that have adopted and are using ICD-11 to collect key population health information. It includes assessment of the level of implementation, from basic awareness and legal frameworks to data production and engagement in the global ICD-11 update process.
12	Criteria	<p>A country is counted as having achieved this indicator if it reaches the <b>advanced implementation (81–100%)</b>, based on its total score on the 29-point ICD-11 Summary Index. This level means the country has:</p> <ul style="list-style-type: none"> <li>Completed key steps in ICD-11 implementation, including national data reporting and good quality data production, appropriate to country context and capacities</li> <li>Established institutional support including official national focal point and participation in WHO FIC Network</li> <li>Is actively engaged in ICD-11 maintenance through submission and review of proposals</li> </ul>
13	Numerator	Number of countries that achieved the criteria as detailed in field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved (81-100%):</b> The country has reached advanced implementation including national rollout of ICD-11, active data production, and engagement in global maintenance activities (see Field 12).</p> <p><b>Partially achieved (21-80%):</b> The country is progressing through key stages of ICD-11 implementation, such as translation, legal frameworks, pilot testing, national rollout, or routine data collection.</p> <p><b>Not achieved (0-20%):</b> The country has not yet initiated meaningful ICD-11 implementation activities.</p>
17	Rationale	The indicator reflects uptake of ICD-11 as well as level of activity ranging from being interested, up to production of data or submission of proposals for updates. Level and relates speed of implementation indicates on one end uptake of this product of WHO and level of engagement in the process demonstrating the direct investment of countries into ICD at a global level. ICD being a global information standard is a core WHO product, and its



		uptake and countries participation in related updating progress shows directly the relevance of WHO's work for all countries.
18	Measurement method	<p>The level of ICD-11 implementation in countries is assessed using a combination of structured inputs gathered through WHO's Regional Offices, direct country links, and the ICD-11 Proposal Platform. The method includes both implementation progress and maintenance engagement.</p> <ul style="list-style-type: none"> <li>• Data collection: <ul style="list-style-type: none"> <li>○ Data on implementation are gathered from: Regional Offices, Country Offices, National focal points or WHO Collaborating Centres <ul style="list-style-type: none"> <li>▪ Implementation status reflects: Availability of translation, legislation, training of staff, pilot rollout, national rollout, data production,</li> </ul> </li> <li>○ Data on maintenance engagement are drawn from the ICD-11 proposal platform, which captures: Country of origin for each proposal, number of proposals processed and accepted, accepted with modification or rejected.</li> </ul> </li> <li>• Scoring methodology <ul style="list-style-type: none"> <li>○ Components of ICD-11 Implementation Index <ul style="list-style-type: none"> <li>▪ A. Familiarization Scale (0–3) <ul style="list-style-type: none"> <li>• 0: Not familiarized with ICD-11</li> <li>• 1: Basic familiarization achieved</li> <li>• 2: Country has participated in ICD-11 training or revision activities</li> <li>• 3: Established WHO-FIC Collaborating Centre Translation</li> </ul> </li> <li>▪ B. Translation Progress Scale (0–3) <ul style="list-style-type: none"> <li>• 0: No translation activity initiated</li> <li>• 1: Translation prepared</li> <li>• 2: Translation in progress</li> <li>• 3: Translation completed</li> </ul> </li> <li>▪ C. Implementation Scale (0–6) <ul style="list-style-type: none"> <li>• 1: Active preparations for implementation underway</li> <li>• 2: Pilot phase running and/or legal basis established</li> <li>• 3: National rollout commenced</li> <li>• 4: Data collection initiated</li> <li>• 5: Data reporting in place</li> <li>• 6: Data quality established</li> </ul> </li> </ul> </li> <li>○ Calculation of ICD11 Implementation Index  <b>ICD-11 Implementation Index = A+(B*C)= Familiarization Score + (Translation Progress Score × Implementation Score)</b>  This formula reflects both the breadth of awareness and readiness, and the depth of progress toward actual use and reporting with ICD-11.  <b>➔Maximum possible score: 3+(3*6)= 21</b> </li> <li>○ Components of ICD-11 maintenance index</li> </ul> </li></ul>

		<ul style="list-style-type: none"> <li>▪ D. ICD-11 Country focal point Scale (0–1) <ul style="list-style-type: none"> <li>• 0: No designated Focal Point</li> <li>• 1: Designated national Focal Point within or outside of WHO FIC CC</li> </ul> </li> <li>▪ E. Submission of ICD-11 update proposal (0–3) <ul style="list-style-type: none"> <li>• 0: No proposal submitted</li> <li>• 1: Fewer than 10 proposals submitted per year</li> <li>• 2: Fewer than 100 proposal submitted per year</li> <li>• 3: 100+ proposal submitted per year</li> </ul> </li> <li>▪ F. Engagement in ICD-11 Review process (0–2) <ul style="list-style-type: none"> <li>• 0: No engagement</li> <li>• 1: &lt;100 proposals voted per year</li> <li>• 2: ≥100 proposals voted per year</li> </ul> </li> <li>▪ G. Leadership position in WHO FIC Network (0–2) <ul style="list-style-type: none"> <li>• 0: No leadership position</li> <li>• 1: History of single leadership position</li> <li>• 2: Multiple and current leadership position</li> </ul> </li> <li>○ Calculation of ICD-11 maintenance index  <b>ICD-11 Maintenance Index</b> = D+E+F+G= Focal point score + Proposal Submission Score + Review Process Engagement Score + Leadership Score  This index reflects the degree of national involvement in the governance, updating, and maintenance of ICD-11.  → Maximum possible score: <b>1+3+2+2 =8</b> </li> <li>• ICD-11 Summary Score and Achievement Band <ul style="list-style-type: none"> <li>○ Calculation of ICD-11 summary score  <b>ICD-11 Summary Index=ICD-11 Implementation Index+ICD-11 Maintenance Index</b>  This composite index provides an overall measure of a country’s progress in adopting, operationalizing, and contributing to the ongoing development and governance of ICD-11.  → Maximum total score: <b>21+8=29</b> </li> <li>○ <b>Percentage score=(ICD-11 Summary Index/29)*100</b></li> </ul> </li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	A formal target-setting methodology is not defined. As noted in the original metadata: “An estimate may be that the global implementation will progress by 10% compared to the previous years, because there has been already widespread progress globally.”
23	How target is realistic for PB2026-2027	Sustained national commitment, complemented by WHO facilitation at country, regional and headquarters levels, together with remote training, country- and region-led workshops, active user support, and the suite of

		tools and services provided by the Secretariat will accelerate implementation progress.
24	Data sources	Regional office reports, country focal points, ICD-11 proposal platform
25	Process of validation	The data related to country implementation is reviewed with RO and CO, and country technical liaisons or collaborating centers, being the responsible technical agencies, in said countries. The data related to proposals are documented automatically by the proposal platform.
26	Limitations	Limitations relate to no-progress, because one level of implementation takes more time than anticipated, non response regarding level of "activity" for implementation in the country, skipping one level. Regarding the participation in proposals, not all submissions from a country relate to government activity or activities from scientific societies. Some submissions could come from the same individual, increasing numbers, or be highly complex covering a broad area, leading to an underestimate when looking at the numbers.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Robert JAKOB < <a href="mailto:jakobr@who.int">jakobr@who.int</a> >;

### 7.2.3.IND4\_UID 1372: Number of countries accessing data.who.int public data assets in support of evidence-informed decision-making

#	Metadata field	Summary
1	GPW14 Output	7.2.3. WHO supports Member States in strengthening health information collection, aggregation, analysis and interpretation to monitor trends and progress towards indicators and targets of the Sustainable Development Goals, including inequality monitoring
2	GPW14 Output indicator code	7.2.3.IND4
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of countries accessing data.who.int public data assets in support of evidence-informed decision-making
4	Output/Leading Indicator (Country Level Formulation)	Country is accessing data.who.int public data assets in support of evidence-informed decision-making
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active

8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Number of countries
10	Unit of measure	Number of countries
11	Indicator definition	The indicator tracks the number of countries that access and use WHO's public health data through the data.who.int platform. It reflects country-level engagement with WHO's publicly available health data assets to support evidence-informed decision-making.
12	Criteria	<p>A country is counted as having achieved this indicator if it recorded more than 10,000 active users on data.who.int during the previous calendar year. The following conditions apply:</p> <ul style="list-style-type: none"> <li>• Only WHO Member States are included in the count.</li> <li>• An active user is defined as a distinct individual who interacted with the site by spending more than 10 seconds on a page, clicking, scrolling, and/or viewing more than one page.</li> <li>• The 10,000-user threshold is applied uniformly across all countries, without adjustment for population size or internet access.</li> <li>• The reporting period spans from 1 January to 31 December of a given year.</li> <li>• Data is drawn from WHO's standard web analytics platform and validated by the Communications department.</li> </ul>
13	Numerator	Number of WHO Member States with more than 10,000 active users on data.who.int during a given calendar year as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> A country records more than 10000 active users on data.who.int within a calendar year. This indicates strong engagement with WHO's publicly available health data and meets the criteria as per Field 12.</p> <p><b>Partially achieved:</b> A country records between 5000 and 10000 active users. This reflects moderate engagement and signals growing interest, though not yet reaching the target level of interaction.</p> <p><b>Not achieved:</b> A country records fewer than 5000 active users. This suggests limited public use of WHO data assets and may indicate low awareness, accessibility challenges, or other barriers to engagement.</p>
17	Rationale	The World Health Data Hub (WHDH) is the World Health Organization's (WHO) corporate solution for data storage, analytics, and use. It serves as the trusted and timely source for health data and related analytical and exchange platforms, fostering trust and empowering Member States. WHDH's primary goal is to support evidence-informed decision-making by providing reliable, accessible, and timely health data to WHO, partners, Member States, and the public. WHDH offers data infrastructure for Member State data exchange (Country Portal for data collection and consultation), storage (Data Lake and acquisition tools), harmonization (xMart for structured storage, pipelines, and reference data integration), analysis (Data Science Lab with scalable notebooks for statistical analysis), and dissemination (data.who.int for

		publicly sharing WHO data assets). Public data dissemination represents a critical moment in WHO's data and health statistics journey, and while independently a clearly defined output, it is also the visible tip of the iceberg. Web analytics help capture the effectiveness of WHO dissemination efforts by measuring how widely utilized WHO data assets are by partners, Member States, and the public. Additionally, effective data dissemination signals that the preceding collection, storage, harmonization, analysis, and consultation stages have been robustly executed, ensuring that the data shared are valuable, accessible, and actionable. In this way, web analytics becomes a key metric not only for assessing dissemination success but also for understanding how well the preceding WHDH tools and processes have prepared data for this moment.
18	Measurement method	The indicator is measured using standard web analytics for <a href="https://data.who.int">data.who.int</a> , maintained by the WHO Communications department. Data is collected automatically and compiled annually based on user interaction metrics. No additional reporting is required from countries or WHO offices. Results are extracted centrally and reviewed for accuracy using WHO's established analytics tools.
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate value is calculated by counting the total number of countries meeting the criteria as per Field 12
21	Calculation type	Cumulative
22	Target setting methodology	The targets are based on expected growth in usage driven by content expansion. As more data is added to data.who.int, user engagement is projected to rise, providing the rationale for setting incremental targets over time.
23	How target is realistic for PB2026-2027	The targets are considered realistically achievable, as they adhere to a standardized approach for disseminating globally comparable health data. Although investment in data.who.int feature development is expected to remain limited, the continued expansion of high-quality data, aligned with existing statistical clearance processes, will support steady content growth. This in turn should drive user engagement. Furthermore, planned regional engagement and support will help ensure that Member States are both aware of and able to benefit from newly available data.
24	Data sources	Datadot web analytics report; WHO countries, territories, and areas reference data
25	Process of validation	The standard WHO tools & analytical approach for monitoring web presence are being used. This includes accounting for factors like bot traffic, which could distort representation and lead to inaccurate conclusions.
26	Limitations	<p>Web analytics, while valuable, have several limitations when used as a performance indicator.</p> <ul style="list-style-type: none"> <li>• They often provide surface-level insights, which fail to capture the deeper qualitative value of data, such as engagement, interpretation, or long-term impact.</li> <li>• Privacy and data protection laws also restrict the collection of certain user data, which could impact accuracy and completeness.</li> </ul>

		<ul style="list-style-type: none"> <li>• A single indicator risks oversimplifying the more nuanced data journey overlooking the significant efforts involved at each stage and misaligning with broader objectives.</li> <li>• The number of active users may fluctuate from year to year, meaning a country counted as having achieved the indicator in one year may not meet the threshold the next, despite no change in WHO support or interest. This challenges the use of cumulative counting for performance monitoring used with the GPW14 output indicators</li> <li>• WHO activities related to data.who.int are applied across all Member States rather than tailored to individual countries. For example, national-level tools like country profiles are made available uniformly to support evidence-informed decision-making. While WHO does not carry out country-specific targeting for this platform, the indicator reflects the Secretariat's effectiveness in ensuring data products are visible, usable, and taken up at scale. The ability of countries to meet the engagement threshold is therefore influenced by the quality, accessibility, and promotion of these global public goods, all of which are direct results of Secretariat action.</li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Philippe Boucher <boucherp@who.int>

### 8.1.1. Policies, rules and regulations in place to attract, recruit and retain a diverse, empowered and fit-for-purpose workforce, operating in a respectful and inclusive workplace with organizational change fully institutionalized

**8.1.1.IND1\_UID 603: Number of budget centres that have completed the annual prevention of and response to sexual misconduct risk assessment and mitigation exercise**

#	Metadata field	Summary
1	GPW14 Output	8.1.1. Policies, rules and regulations in place to attract, recruit and retain a diverse, empowered and fit-for-purpose workforce, operating in a respectful and inclusive workplace with organizational change fully institutionalized
2	GPW14 Output indicator code	8.1.1.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of budget centres that have completed the annual prevention of and response to sexual misconduct risk assessment and mitigation exercise
4	Output/Leading Indicator (Country Level Formulation)	Number of budget centres that have completed the annual prevention of and response to sexual misconduct risk assessment and mitigation exercise
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Number
10	Unit of measure	Number of budget centres
11	Indicator definition	This indicator measures how many WHO budget centers complete the annual risk assessment and mitigation exercise related to sexual misconduct. It reflects WHO's commitment to proactively identifying and addressing risks across country, regional, and HQ offices.
12	Criteria	<p>A budget center is considered as having achieved this indicator if it has <b>completed</b> the annual Prevention of and Response to Sexual Misconduct (PRS) risk assessment and mitigation exercise (RAM), meeting the following conditions:</p> <ul style="list-style-type: none"> <li>• The assessment was conducted using the standardized risk assessment tool jointly developed by CRE and PRS.</li> <li>• The following elements of the assessment have been completed: <ul style="list-style-type: none"> <li>○ A contextual analysis of sexual misconduct risk specific to the country, region, or organizational setting.</li> </ul> </li> </ul>

		<ul style="list-style-type: none"> <li>○ A risk mitigation plan tailored to WHO's operations in that location or unit.</li> <li>• The assessment and mitigation plan have been formally reviewed and signed off by the Head of Office, Cluster Director, or ADG, as applicable . and a commitment has been made by the signatory to allocate core resources to identified sexual misconduct risk mitigation actions.</li> <li>• Completion includes both technical review and managerial endorsement, in line with PRS guidance.</li> <li>• The requirement applies to the following budget centers: <ul style="list-style-type: none"> <li>○ All Country Offices (COs)</li> <li>○ Regional Office (RO) major units in AFRO, EMRO, EURO, SEARO , WPRO</li> <li>○ HQ organizational units led by an ADG</li> </ul> </li> </ul>
13	Numerator	Number of WHO budget centers that have completed the annual Prevention of and Response to Sexual Misconduct (PRS) risk assessment and mitigation exercise (RAM), as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> Risk assessment and mitigation exercise fully completed, including managerial sign-off, and resourcing of mitigation plans as per the criteria in field 12</p> <p><b>Partially achieved:</b> Assessment exercise was completed, but follow-up is incomplete (e.g. one or more components missing, no formal sign-off by leadership, mitigation plan not resourced).</p> <p><b>Not achieved:</b> No assessment conducted or submitted during the reporting period.</p>
17	Rationale	Assessments of sexual misconduct risk, along with subsequent risk mitigation plans, their financing, and ongoing monitoring across all budget centers, constitute the foundation of WHO's approach to managing this Principal Risk. Monitoring of compliance across all budget centers helps tracking this mission-critical effort.
18	Measurement method	<ul style="list-style-type: none"> <li>• Data is collected through an annual risk assessment and mitigation exercise using a standardized tool developed jointly by the Compliance, Risk Management and Ethics (CRE) and the Prevention of and Response to Sexual Misconduct (PRS) departments. The tool has been in use since 2023 (initially among non-AMRO Country Offices) and was expanded to AMRO during the 2025 exercise. It will be transitioned from an Excel tool to an online platform after further testing of an expanded, all-budget centre Excel tool in 2025/26. Draft Standard Operating Procedure (SOP) exist and are expected to be finalized in Q4 2025.</li> <li>• The sexual misconduct (SM) risk assessment comprises three parts: <ol style="list-style-type: none"> <li>1. An overview of the sexual misconduct risk context relevant to the country or unit, completed annually</li> </ol> </li> </ul>



		<ol style="list-style-type: none"> <li>2. A risk assessment and mitigation plan tailored to WHO's operational context, completed annually.</li> <li>3. An emergency-specific risk assessment component, completed on an ad hoc basis when new emergencies arise or operational conditions change.</li> </ol> <ul style="list-style-type: none"> <li>• Completion is monitored and validated through technical and managerial review: <ol style="list-style-type: none"> <li>○ Country Office submissions are reviewed by Regional PRS Coordinators and Regional Risk Management teams.</li> <li>○ Regional Office and Headquarters assessments are reviewed by PRS HQ and CRE Risk Management.</li> </ol> </li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The total number of budget centers that completed the annual PRS risk assessment and mitigation exercise as per field 12 is summed across all eligible units, including Country Offices, Regional Offices, and HQ departments . Aggregation is done by simple count, without weighting.
21	Calculation type	Cumulative
22	Target setting methodology	<p>Targets are established based on the total number of WHO budget centers expected to conduct the annual PRS risk assessment and mitigation exercise. These include Country Offices, Regional Office units, and HQ departments led by ADGs.</p> <p>The methodology relies on:</p> <ul style="list-style-type: none"> <li>• Mapping all eligible budget centers that fall under the scope of the assessment requirement.</li> <li>• Applying a full coverage expectation, whereby all relevant budget centers are required to complete the assessment annually.</li> <li>• Adjusting targets as needed to reflect any structural or organizational changes across WHO.</li> </ul> <p>Targets are set to reflect full institutionalization of the risk assessment process.</p>
23	How target is realistic for PB2026-2027	<p>The targets are realistically achievable owing to the following factors:</p> <ul style="list-style-type: none"> <li>• Uptake of the sexual misconduct risk assessment/mitigation tool has been strong in 2024/25 (non-compliance below 7%).</li> <li>• Testing is about to start for all other levels of WHO so that the total number of budget centres will expand.</li> <li>• An improved tool (online) by 2026 should also facilitate the exercise roll-out and monitoring in 2026/27.</li> </ul>
24	Data sources	(1) Completed PRS risk assessment and mitigation exercises using the standardized SM risk assessment tool and (2) letters of representation by WRs, RDs, and ADGs to DG confirming compliance with sexual misconduct prevention and response accountabilities
25	Process of validation	<ul style="list-style-type: none"> <li>• Sexual misconduct risk assessments from Country Offices are reviewed by Regional Office Coordinators responsible for the Prevention and Response to Sexual Misconduct (PRS), as well as by Regional Risk Management teams.</li> </ul>

		<ul style="list-style-type: none"> <li>Risk assessments from Regional Offices and Headquarters are reviewed by the PRS team at Headquarters and the Risk Management team within the Compliance, Risk Management and Ethics (CRE) department.</li> </ul>
26	Limitations	<ul style="list-style-type: none"> <li>While Country Offices in the Region of the Americas (AMRO) have adopted the risk assessment tool, the Regional Office itself is still in the process of considering its implementation.</li> <li>Additionally, potential structural or organizational changes within WHO require an annual verification of the numerator</li> <li>Variability in implementation of risk assessment exercises across regions and timeframes will be addressed through SOPs and continuous support and training</li> <li>Transitioning from an Excel-based tool to an online platform may require a training and adaptation phase during roll-out.</li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Gaya Gamhewage < <a href="mailto:gamhewageg@who.int">gamhewageg@who.int</a> >; Oliver Stucke < <a href="mailto:stuckeo@who.int">stuckeo@who.int</a> >

**8.1.1.IND2\_UID 611: Percentage of global workforce responding to annual Organization-wide survey on culture, diversity, equity, inclusion, motivation, work environment, management, accountability, capabilities, innovation and learning**

#	Metadata field	Summary
1	GPW14 Output	8.1.1. Policies, rules and regulations in place to attract, recruit and retain a diverse, empowered and fit-for-purpose workforce, operating in a respectful and inclusive workplace with organizational change fully institutionalized
2	GPW14 Output indicator code	8.1.1.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of global workforce responding to annual Organization-wide survey on culture, diversity, equity, inclusion, motivation, work environment, management, accountability, capabilities, innovation and learning
4	Output/Leading Indicator (Country Level Formulation)	Percentage of global workforce responding to annual Organization-wide survey on culture, diversity, equity, inclusion, motivation, work environment, management, accountability, capabilities, innovation and learning
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output indicator
7	Indicator status (Active, Retired etc)	Provisional

8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Percentage of global workforce
11	Indicator definition	This indicator measures the proportion of WHO's global workforce who respond to the organization-wide annual survey. The survey captures perceptions and experiences related to culture, diversity, equity, inclusion, motivation, the work environment, leadership, accountability, innovation, and learning.
12	Criteria	A workforce member is counted toward achievement under this indicator if they: <ol style="list-style-type: none"> <li>1. Belong to the <b>eligible</b> WHO global workforce as captured through GSM/BMS by having a contract expiring no less than 30 days from launch date of survey, and having either a continued appointment, a fixed-term contract or a temporary contract under staff rule 420.4; and</li> <li>2. Submit a <b>valid response</b> to the annual organization-wide workforce survey within the designated reporting window, as defined by having completed all mandatory questions in the survey by the allocated deadline.</li> </ol>
13	Numerator	Number of eligible WHO global workforce members who submit valid responses to the annual organization-wide survey during the reporting period as per field 12
14	Denominator	Total eligible WHO workforce
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	<p>Workforce surveys are a well-established and widely used practice to identify workplace issues and improvement opportunities, and measure and enhance workforce engagement. They are also often used to capture employee motivation and sentiments, and to understand workplace culture. When using validated instruments, and repeating surveys using same instruments, data can be compared against external benchmarks, and internally over time, to quantify and qualify challenges, changes, effects of interventions etc.</p> <p>Corporate outcome 4 in GPW14 specifically mandates ensuring a motivated, diverse, empowered and fit-for-purpose WHO workforce operating in a respectful and inclusive workplace, with organizational change fully institutionalized, by embracing modern human resources and managerial practices, developing an ambitious people strategy etc.</p> <p>Employing robust workforce surveys is a prerequisite for doing that and represents a generally accepted best practice in the field</p>

18	Measurement method	Data is collected through an electronic questionnaire distributed to all eligible WHO workforce members globally. The survey is: <ul style="list-style-type: none"> <li>• Organization-wide in scope and conducted annually;</li> <li>• Translated into major WHO working languages to ensure accessibility;</li> <li>• Designed to protect respondent anonymity and ensure data confidentiality;</li> <li>• Accompanied by reminders to encourage participation;</li> <li>• Based on standardized instruments, drawing from past WHO surveys (e.g., OHI 2017, EURO 2023) and ongoing UN-wide initiatives (e.g., COPSOQ2, UNHCR pilots).</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The indicator is calculated by dividing the number of eligible WHO global workforce members who submit valid responses to the annual organization-wide survey during the reporting period (numerator) by the total number of eligible WHO workforce members (denominator), multiplied by 100 to express the result as a percentage.
21	Calculation type	Cumulative
22	Target setting methodology	The targets are set based on a review of previous WHO survey response rates and commonly accepted standards for organizational survey validity. The methodology considers what is generally required to ensure that survey results are robust, representative, and suitable for analysis over time. This informs the selection of a response rate threshold that reflects both organizational experience and technical best practice.
23	How target is realistic for PB2026-2027	TBD
24	Data sources	WHO internal survey platforms; historical data from previous WHO surveys (e.g., OHI 2017, EURO 2023); methodologies from UN-wide initiatives such as the COPSOQ2 tool and UNHCR survey pilots; and supporting documentation including <a href="#">Annex IV of the TRF report (010924)</a> and <a href="#">the EURO Committee for Health, Safety, and Well-being webpage</a> .
25	Process of validation	Data will be processed using commercially available and recognized survey software solutions.
26	Limitations	Greatest limitation can be granularity of reporting, especially for smaller organizational entities. A suggested cutoff of at least 10 headcount is suggested, also to preserve anonymity. A low response rate, be it global or local, can limit validity and interpretation of data.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Soeren Brostrom <soren@brostrom.dk>

#### 8.1.1.IND3\_UID 626: Percentage of female staff members at the P4 level and above

#	Metadata field	Summary
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1	GPW14 Output	8.1.1. Policies, rules and regulations in place to attract, recruit and retain a diverse, empowered and fit-for-purpose workforce, operating in a respectful and inclusive workplace with organizational change fully institutionalized
2	GPW14 Output indicator code	8.1.1.IND3
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of female staff members at the P4 level and above
4	Output/Leading Indicator (Country Level Formulation)	Percentage of female staff members at the P4 level and above
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Percentage of female staff members
11	Indicator definition	This indicator tracks the percentage of WHO staff who are female and hold positions at the P4 level and above (P4, P5, P6, D1, D2).
12	Criteria	A workforce member is counted toward the achievement of this indicator if they: <ul style="list-style-type: none"> <li>• Are included in WHO's GSM/ERP staff records with an active staff contract;</li> <li>• Are classified as female in the official HR system;</li> <li>• Hold a professional or higher-level position at P4, P5, P6, D1, or D2.</li> </ul>
13	Numerator	Number of female workforce members as per field 12
14	Denominator	Total number of workforce members (regardless of gender) with an active staff contract in WHO's GSM/ERP system who hold a professional or higher-level position at P4, P5, P6, D1, or D2.
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	This indicator tracks gender parity at senior professional levels within WHO, a key marker of equality and inclusiveness in the Organization. It reflects WHO's commitment to achieving equal representation of women and men,

		particularly in leadership roles. Monitoring this indicator supports strategic workforce planning, transparency in recruitment and promotion, and accountability in meeting organizational goals on diversity and equity. It draws attention to systemic gaps and helps guide targeted actions to improve female representation at senior levels.
18	Measurement method	GSM/ERP data feeds into the WHO HR BI (Business Intelligence) Dashboard, which provides real-time tracking on gender parity. Data is automatically extracted and aggregated by contract type and staff grade. Calculations are fully system-generated based on current staff records.
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The indicator is calculated by dividing the number of female workforce members with an active staff contract at P4, P5, P6, D1, or D2 levels as per field 12 (numerator) by the total number of workforce members (regardless of gender) with an active staff contract at the same grade levels (denominator), using data from WHO's GSM/ERP system.
21	Calculation type	Cumulative
22	Target setting methodology	Targets were set based on the 2022 baseline and an analysis of several organizational factors, including the number of senior-level positions, expected retirements, current trends in appointments and separations, application rates among female candidates, and the pace of progress toward gender parity since 2017. The overall aim is to achieve gender parity at each professional level by the end of 2026.
23	How target is realistic for PB2026-2027	Due to funding uncertainty and a recruitment freeze implemented as a cost-containment measure, setting a definitive target value for end-2026 and 2027 is challenging. These constraints are expected to significantly affect WHO's ability to achieve the initially projected progress toward gender parity at senior levels.
24	Data sources	WHO's GSM/ERP staff records, accessed through the HR Business Intelligence (BI) Dashboard.
25	Process of validation	With the HR BI at their disposal that illustrate impact of selection decisions, Regional Directors are responsible for monitoring gender parity progress in regional centre and country offices and for being cognizant of their respective areas for improvement and strategizing accordingly to make progress towards equal representation of men and women.
26	Limitations	Progress toward the indicator may be constrained by ongoing funding uncertainty and a freeze on recruitment, which limit the Organization's ability to influence staffing composition and achieve planned gender parity targets.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Eric Tagnon <tagnone@who.int>

#### 8.1.1.IND4\_UID 628 : Percentage of staff from unrepresented and under-represented countries

#	Metadata field	Summary
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1	GPW14 Output	8.1.1. Policies, rules and regulations in place to attract, recruit and retain a diverse, empowered and fit-for-purpose workforce, operating in a respectful and inclusive workplace with organizational change fully institutionalized
2	GPW14 Output indicator code	8.1.1.IND4
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of staff from unrepresented and under-represented countries
4	Output/Leading Indicator (Country Level Formulation)	Percentage of staff from unrepresented and under-represented countries
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Percentage of staff members
11	Indicator definition	The indicator measures the percentage of WHO staff from Member States that are currently unrepresented or underrepresented in the Organization's workforce, based on appointments against geographical posts.
12	Criteria	TBD
13	Numerator	Number of WHO staff that meet the criteria as per field 12
14	Denominator	Total number of WHO staff members with fixed-term or continuing appointments appointed against vacant geographical posts in GSM, regardless of nationality.
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	WHO recruitment practices are guided by Article 101 of the United Nations Charter, which calls for securing the highest standards of efficiency,

		<p>competence, and integrity, while giving due regard to wide geographical representation.</p> <p>The goal is to ensure that every unrepresented Member State is represented in WHO, and that as many underrepresented Member States as possible are brought within their desirable range.</p>
18	Measurement method	<ul style="list-style-type: none"> <li>• Data are sourced from WHO's Global Management System (GSM) and Enterprise Resource Planning (ERP) records.</li> <li>• The indicator is monitored through the WHO HR Business Intelligence (BI) Dashboard, which enables real-time tracking of geographic representation.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The indicator is calculated by dividing the number of staff from unrepresented or underrepresented Member States with fixed-term or continuing appointments against geographical posts as per field 12 (numerator) by the total number of staff with fixed-term or continuing appointments against geographical posts (denominator), and expressing the result as a percentage.
21	Calculation type	Cumulative
22	Target setting methodology	<p>The target is set with the aim of achieving representation of all unrepresented Member States and moving underrepresented Member States within their desirable range.</p> <p>The methodology reflects WHO's ongoing commitment to gradual improvement in geographical representation, by counting only new appointments (fixed-term or continuing) to vacant geographical posts.</p> <p>The target level is informed by the current status of representation across Member States and internal planning discussions</p>
23	How target is realistic for PB2026-2027	<p>In the current context of funding uncertainty facing the Organization, it is difficult to set a definitive target value for the end of 2026 and 2027.</p> <p>A freeze on recruitment, implemented as a cost-containment measure, is expected to significantly limit the Organization's ability to make new appointments. This constraint presents a major obstacle to achieving the originally intended progress toward improved geographical representation.</p>
24	Data sources	Global Management System (GSM); WHO Enterprise Resource Planning (ERP) records
25	Process of validation	Regional Directors use the HR Business Intelligence (BI) Dashboard, which illustrates the impact of selection decisions, to monitor progress in geographical diversity across regional centres and country offices. They are responsible for reviewing the data regularly, identifying areas needing improvement, and strategizing accordingly to advance toward equal representation of unrepresented and underrepresented Member States.
26	Limitations	The indicator's implementation is constrained by a freeze on recruitment, which reduces opportunities for new appointments and limits measurable progress toward improved geographic representation. Additionally, funding uncertainty may affect the ability to sustain recruitment efforts consistently, making it difficult to track meaningful year-on-year improvements or interpret slow progress solely as performance issues.



27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Eric Tagnon < tagnone@who.int>

### 8.1.1.IND5\_UID 629 : Percentage of workforce holding different contract types

#	Metadata field	Summary
1	GPW14 Output	8.1.1. Policies, rules and regulations in place to attract, recruit and retain a diverse, empowered and fit-for-purpose workforce, operating in a respectful and inclusive workplace with organizational change fully institutionalized
2	GPW14 Output indicator code	8.1.1.IND5
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of workforce holding different contract types
4	Output/Leading Indicator (Country Level Formulation)	Percentage of workforce holding different contract types
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Provisional
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Percentage of workforce
11	Indicator definition	This indicator measures the proportion of WHO workforce holding temporary appointments, as tracked in the WHO ERP system. It reflects reliance on short-term staffing and helps assess progress toward a more stable and sustainable workforce structure.
12	Criteria	TBD
13	Numerator	Number of WHO workforce members holding a temporary appointment (under Staff Rule 420.4) on the reference date as per field 12.
14	Denominator	Total number of WHO workforce members holding a Continuing Appointment, Fixed-Term Appointment, or Temporary Appointment (under Staff Rule 420.4) on the reference date.

15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	Short-term contracts are time limited appointments of up to two years. If a function is going beyond 2 years, a longer time position should be established and filled to recognize the longer term nature the project. Selection of staff against long-term positions shall be completed in time.
18	Measurement method	<ul style="list-style-type: none"> <li>Data are extracted from the WHO ERP system and monitored through the HR Business Intelligence (BI) Dashboard.</li> <li>Data are captured at a specific point in time, typically 31 December of the reporting year.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The indicator is aggregated as the number of WHO workforce members holding a temporary appointment (numerator), divided by the total number of workforce members employed under the three main contract types (denominator), and multiplied by 100.
21	Calculation type	Cumulative
22	Target setting methodology	TBD
23	How target is realistic for PB2026-2027	TBD
24	Data sources	WHO ERP system
25	Process of validation	The HR BI dashboard retrieves real-time data from the WHO ERP system. Regular cross-checks are conducted between ERP-generated reports and the BI dashboard outputs to ensure consistency, accuracy, and reliability of the data used for reporting.
26	Limitations	<ul style="list-style-type: none"> <li>While data collection and reporting are reliable, estimation is more complex due to uncertainties in the organizational structure and funding.</li> <li>Additionally, the development of the contractual modality framework may impact the interpretation and future comparability of the indicator.</li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Guerreiro Jorge < guerreiroj@who.int>

## 8.1.2. Core capacities of WHO country and regional offices strengthened to drive measurable impact at country level

### 8.1.2.IND1\_UID 613 : Percentage of country offices with 80% of core predictable country presence positions filled

#	Metadata field	Summary
1	GPW14 Output	8.1.2. Core capacities of WHO country and regional offices strengthened to drive measurable impact at country level
2	GPW14 Output indicator code	8.1.2.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of country offices with 80% of core predictable country presence positions filled
4	Output/Leading Indicator (Country Level Formulation)	Percentage of country offices with 80% of core predictable country presence positions filled
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Percentage of country offices
11	Indicator definition	This indicator measures how many WHO country offices have filled at least 80% of the key staff positions that are considered essential for predictable and effective operations. These core positions are defined in WHO's Core Predictable Country Presence (CPCP) model and must be filled by staff on payroll (not including acting roles or secondments).
12	Criteria	A WHO country office is counted towards the achievement of this indicator if: <ul style="list-style-type: none"> <li>It has a defined set of core predictable country presence positions based on the CPCP model (2023 or future iterations), and</li> <li>At least 80% of those positions (regardless of typology) are occupied by <b>staff on payroll</b> (excluding acting staff and secondments)</li> </ul>
13	Numerator	Number of WHO country offices that have 80% or more of their core predictable country presence positions occupied as per field 12
14	Denominator	Total number of WHO country offices with a defined set of core predictable country presence positions (according to the CPCP model).

15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<p><b>Achieved:</b> WHO country offices have filled at least 80% of their core predictable country presence positions as per field 12. Expressed as a percentage of the total number of WHO country offices with a defined set of core predictable country presence positions</p> <p><b>Partially achieved:</b> WHO country offices have filled 50% to 79% of their core predictable country presence positions as per field 12. Expressed as a percentage of the total number of WHO country offices with a defined set of core predictable country presence positions</p> <p><b>Not achieved:</b> WHO country offices have filled less than 50% of their core predictable country presence positions as per field 12. Expressed as a percentage of the total number of WHO country offices with a defined set of core predictable country presence positions</p>
17	Rationale	WHO's presence in countries should be stable and predictable to improve its support and effectiveness. This enhances WHO's capability to offer consistent and relevant assistance by equipping country offices with the required expertise and capacities. It also creates a foundation for advancing strategic priorities and achieving health outcomes with member states and partners
18	Measurement method	<ul style="list-style-type: none"> <li>• This indicator is monitored through the CPCP database. A dedicated dashboard is available internally.</li> <li>• A CPCP model by type of country offices has been established.</li> <li>• The number of occupied positions is tracked via an automatic backend tracking through WHO GSM data.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The global percentage is calculated by dividing the number of WHO country offices with at least 80% of core predictable positions occupied as per field 12 (numerator) by the total number of country offices with a defined CPCP position list (denominator). The result is then expressed as a percentage.
21	Calculation type	Cumulative
22	Target setting methodology	Targets are set based on analysis of data from the CPCP model, HR records, and the CPCP monitoring dashboard. The methodology considers the proportion of country offices that meet the 80% occupancy threshold, trends in position fulfillment, and the current organizational and financial context. Targets are adjusted to reflect operational realities, including staffing constraints and feasibility across different office settings.
23	How target is realistic for PB2026-2027	<ul style="list-style-type: none"> <li>• The CPCP model will be revised to align with the ongoing organizational restructuring process. This alignment aims to ensure that country offices have the necessary capacities to effectively deliver results and impact on the ground.</li> <li>• Maintaining funding for core positions at the country level is essential.</li> <li>• Additionally, improving human resources processes and contractual arrangements will help achieve this goal.</li> </ul>

		<ul style="list-style-type: none"> <li>Although the financial crisis poses a major risk, WHO should prioritize core capacities in country offices for allocation of flexible funds, and country offices are expected to mobilize in-country resources to close capacity gaps. The Action for Results Group (ARG) is undertaking the task of redefining the minimum core capacity to make the model more efficient so that the Organization would be able to finance i</li> </ul>
24	Data sources	Core Predictable Country Presence (CPCP) model; WHO Human Resources (HR) data; CPCP monitoring dashboard
25	Process of validation	Monitoring of the percentage of core predictable country presence is conducted for each WHO country office. Validation is carried out using HR records and the core predictable country presence monitoring dashboard, with oversight and verification by WHO Country Offices (WCOs), Regional Offices, and WHO Headquarters.
26	Limitations	The reprioritization process and review of the core predictable country presence model will affect the data basis.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	TOMAS, Bernard < tomasb@who.int >

#### 8.1.2.IND2\_UID 627 : Ratio of male to female WHO representatives, globally

#	Metadata field	Summary
1	GPW14 Output	8.1.2. Core capacities of WHO country and regional offices strengthened to drive measurable impact at country level
2	GPW14 Output indicator code	8.1.2.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Ratio of male to female WHO representatives, globally
4	Output/Leading Indicator (Country Level Formulation)	Ratio of male to female WHO representatives, globally
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Ratio
10	Unit of measure	Sex distribution of WRs

11	Indicator definition	This indicator measures the gender balance among WHO Representatives (WRs) by calculating the ratio of male to female WRs globally. It helps monitor progress toward gender parity in WHO leadership roles.
12	Criteria	<p>A WHO Representative (WR) position is counted towards this indicator if:</p> <ul style="list-style-type: none"> <li>• It is an officially designated WR post aligned with the list of WHO Country Offices (totalling 153 as of April 2025).</li> <li>• The position is filled and recorded in the official HR records at the time of reporting.</li> <li>• The sex (male/female) of the incumbent is clearly identified in WHO's HR systems.</li> </ul> <p>Only filled WR positions with validated gender information are included in the calculation of the male-to-female ratio.</p>
13	Numerator	Number of WHO Representative (WR) positions held by men as per field 12
14	Denominator	Number of WHO Representative (WR) positions held by women as per field 12
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	It offers a valuable metric for assessing gender representation in leadership roles and will be integrated into a comprehensive framework that monitors gender parity across all staffing levels to ensure alignment with organizational priorities on diversity, equity and inclusion.
18	Measurement method	<ul style="list-style-type: none"> <li>• HR data on the sex of WRs will be aggregated globally.</li> <li>• The indicator is calculated as the ratio of male WRs to female WRs</li> <li>• The data will be drawn from the Head of WHO Offices Dashboard and HR records.</li> <li>• Interpretation: <ul style="list-style-type: none"> <li>○ A ratio of 1 indicates equal numbers of male and female WRs.</li> <li>○ A ratio greater than 1 means there are more male WRs than female.</li> <li>○ A ratio less than 1 means there are more female WRs than male.</li> </ul> </li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	Male-to-female ratio = Number of male WRs (numerator) / Number of female WRs (denominator)
21	Calculation type	Cumulative
22	Target setting methodology	Targets are based on expected progress driven by strategic initiatives, including the implementation of the WR pipeline over the next two years, which is intended to accelerate improvements in gender balance compared to previous years.
23	How target is realistic for PB2026-2027	The planned implementation of the WR pipeline initiative in 2025 is expected to enhance gender diversity in leadership across country offices. Continued

		application of equitable and inclusive selection processes in 2025, 2026, and beyond will contribute to achieving the target.
24	Data sources	HR data and the Head of WHO Offices (HWCO) Dashboard, which records the official status and sex of WHO Representatives.
25	Process of validation	Data is validated through official HR records and the Head of WHO Country Offices (HWCO) information dashboard. The validation process is led by the HR department and CSS, who verify completeness, consistency, and alignment between data sources to ensure accuracy in reporting on WHO Representative positions.
26	Limitations	The number of women applying to the WR roster remains lower than the number of men. There could be inherent bias in the selection of WRs, which could be mitigated by a robust process, including an inclusive selection panel.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	TOMAS, Bernard < tomasb@who.int >

### 8.1.2.IND3\_UID 845 : Percentage of country offices (by typology grouping) with an up-to-date Country Cooperation Strategy

#	Metadata field	Summary
1	GPW14 Output	8.1.2. Core capacities of WHO country and regional offices strengthened to drive measurable impact at country level
2	GPW14 Output indicator code	8.1.2.IND3
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of country offices (by typology grouping) with an up-to-date Country Cooperation Strategy
4	Output/Leading Indicator (Country Level Formulation)	Percentage of country offices (by typology grouping) with an up-to-date Country Cooperation Strategy
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Percentage of country offices
11	Indicator definition	This indicator measures the proportion of WHO Country Offices that have an up-to-date Country Cooperation Strategy (CCS), based on their typology.

		<p>Country offices are grouped into five typologies based on the type and level of support they provide:</p> <ul style="list-style-type: none"> <li>• Typology A: Policy support</li> <li>• Typology B: Targeted technical support</li> <li>• Typology C: Moderate technical support</li> <li>• Typology D: Full technical support with emergency response</li> <li>• Typology E: Full support including field operations</li> </ul>
12	Criteria	<p>A country office is considered as having an up-to-date Country Cooperation Strategy (CCS) if:</p> <ul style="list-style-type: none"> <li>• The CCS has been formally endorsed.</li> <li>• The endorsement has been validated by both the Regional Office (Country Support Unit) and WHO Headquarters.</li> <li>• The CCS is within its usual validity period of 4–5 years, or has been officially extended.</li> </ul>
13	Numerator	Number of WHO country offices with an up-to-date Country Cooperation Strategy (CCS) as per field 12, per typology
14	Denominator	Total number of WHO country offices per typology grouping
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	This indicator is valuable for tracking whether the WCO has an up-to-date Country Cooperation Strategy (CCS) especially that the strategic priorities agreed with the country are still relevant and are being implemented. It is important in monitoring actions and achievements in countries in line with agreed priorities and the results of the cooperation between Member States and WHO Secretariat.
18	Measurement method	CCS monitors the validity of the Country Cooperation Strategies (CCSs) through the CCS tracker and typology data.
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	<p>The aggregate was calculated by summing the total number of up-to-date CCSs across typologies and dividing by the total number WCOs with designated typologies</p> <p>Alternatively, it can also be defined as the average of up-to-date typology-level percentages.</p>
21	Calculation type	Cumulative
22	Target setting methodology	Targets are based on an annual 5% increase in the number of countries with a valid Country Cooperation Strategy (CCS), informed by previous achievement trends and assuming continued support from WHO.
23	How target is realistic for PB2026-2027	The target is considered realistic due to the planned technical support provided by WHO headquarters and regional offices to country offices developing or updating their CCSs.



24	Data sources	CCS tracker; CPCP model
25	Process of validation	Data is validated through the CCS tracker and CPCP model, with additional review by the Country Support Unit (CSU) network and a formal validation process involving WHO Country Offices (WCOs).
26	Limitations	N/A
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	TOMAS, Bernard < tomasb@who.int>

### 8.1.3. Accountability and legal functions enhanced in a transparent, compliant and risk management-driven manner, promoting organizational learning, effective internal justice, safety and impact at country level

#### 8.1.3.IND1\_UID 598 : Percentage of overdue internal audit recommendations

#	Metadata field	Summary
1	GPW14 Output	8.1.3. Accountability and legal functions enhanced in a transparent, compliant and risk management-driven manner, promoting organizational learning, effective internal justice, safety and impact at country level
2	GPW14 Output indicator code	8.1.3.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of overdue internal audit recommendations
4	Output/Leading Indicator (Country Level Formulation)	Percentage of overdue internal audit recommendations
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Percentage of internal audit recommendations
11	Indicator definition	This indicator measures the proportion of internal audit recommendations that were not implemented by their agreed deadline within a calendar year.
12	Criteria	An internal audit recommendation is counted towards the value of this indicator (i.e. considered “ <b>overdue</b> ”) if: <ul style="list-style-type: none"> <li>• It has a target implementation date within the calendar year (i.e. between 1 January and 31 December 20XX); and</li> <li>• It is <b>not implemented</b> on or before its agreed target date, as recorded in the TeamMate audit tracking system.</li> </ul>
13	Numerator	Number of internal audit recommendations with a target implementation date between 1 January and 31 December 20XX that were not implemented by the agreed target date (i.e. overdue recommendations) as per field 12
14	Denominator	Total number of internal audit recommendations with a target implementation date between 1 January and 31 December 20XX.

15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	Internal audit recommendations implemented in a timely manner help to improve the governance, risk management and internal controls of the Organization. It helps to improve the efficiency and effectiveness of the Organization.
18	Measurement method	<ul style="list-style-type: none"> <li>• The data is collected through the internal audit software application called "TeamMate", which tracks the implementation of internal audit recommendations.</li> <li>• Each recommendation includes a target implementation date.</li> <li>• The system logs whether recommendations were implemented on or before their agreed due date.</li> <li>• The indicator captures recommendations that were not implemented by the due date as overdue.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The percentage is calculated by dividing the number of overdue recommendations (not implemented by the agreed date) by the total number of recommendations with a target date in the calendar year, then multiplying by 100.
21	Calculation type	Cumulative
22	Target setting methodology	TBD
23	How target is realistic for PB2026-2027	IOS will continue to engage with audited entities to regularly follow up on the status of each recommendation. This sustained monitoring approach supports timely implementation and increases the likelihood of achieving the target.
24	Data sources	Internal audit software application TeamMate, which tracks the implementation status and target dates of audit recommendations.
25	Process of validation	The data from the TeamMate system is validated for accuracy in a timely manner by the Internal Oversight Services (IOS). This includes reviewing the implementation status and due dates of each recommendation to ensure data consistency and reliability.
26	Limitations	While the TeamMate system functions effectively for tracking data, delays can occur when audited entities are slow to provide updates on implementation status. These delays are often due to competing priorities or limited resources within the audited units.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Elena Sobre <sobree@who.int>

**8.1.3.IND2\_UID 599 : Number of EB-approved biennium evaluation workplan linked to GPW14 strategic objectives and corporate outcomes**

#	Metadata field	Summary
1	GPW14 Output	8.1.3. Accountability and legal functions enhanced in a transparent, compliant and risk management-driven manner, promoting organizational learning, effective internal justice, safety and impact at country level
2	GPW14 Output indicator code	8.1.3.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Number of EB-approved biennium evaluation workplan linked to GPW14 strategic objectives and corporate outcomes
4	Output/Leading Indicator (Country Level Formulation)	Number of EB-approved biennium evaluation workplan linked to GPW14 strategic objectives and corporate outcomes
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Number
10	Unit of measure	Number of evaluations
11	Indicator definition	The total number of finalized evaluations that explicitly demonstrate linkages to at least one of the GPW14 strategic objectives and corporate outcomes, as documented in the evaluation report or ToR.
12	Criteria	An evaluation workplan counts toward this indicator if: <ul style="list-style-type: none"> <li>• It has been formally approved by the Executive Board for the relevant biennium.</li> <li>• It includes one or more evaluations whose Terms of Reference (ToRs) explicitly align with at least one GPW14 outcome, output, or strategic objective.</li> <li>• It is documented in the WHO Evaluation Repository and tagged accordingly.</li> </ul>
13	Numerator	Number of corporate, CPE, decentralized evaluations aligned with GPW14 strategic objectives and corporate outcomes, as per field 12
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	No

16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	Ensures comprehensive assessment of WHO's strategic priorities. This indicator measures WHO's progress in aligning independent evaluations with the strategic direction of the GPW14. Tracking this ensures evaluations are not only conducted systematically but also contribute directly to the achievement of WHO's overarching goals and priorities. The indicator is also relevant to tracking the coverage norms related to GPW14.
18	Measurement method	<ul style="list-style-type: none"> <li>The indicator is measured by counting the number of corporate, Country Programme Evaluations (CPEs), and decentralized evaluations included in the Executive Board-approved biennial evaluation workplan that are formally linked to GPW14 strategic objectives and corporate outcomes.</li> <li>Linkage is determined through a validation process by the WHO Evaluation Office, which reviews each evaluation's Terms of Reference, draft, and final reports to ensure GPW14 outcomes, outputs, and indicators are integrated into the evaluation design and findings. Evaluations that demonstrate alignment with the GPW14 results framework and contribute to WHO's strategic priorities are tagged accordingly in the WHO Evaluation Repository and included in official corporate reporting mechanisms such as the Annual Evaluation Report, Evaluation Synthesis, UN-SWAP, UNDIS, and Governing Body updates</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The indicator is aggregated by summing the total number of corporate, CPE and decentralized evaluations validated as "linked" to GPW14 strategic objectives and corporate outcomes (as per field 12) across the reporting period.
21	Calculation type	Cumulative
22	Target setting methodology	WHO uses baseline data from the previous GPW cycle or most recent evaluation/reporting period as the starting point. Trends are analyzed to determine what level of improvement is realistically achievable over the program cycle, considering past performance. Target setting accounts for organizational capacity, human resources, and financial availability. In addition, target definition is dependent upon the Executive Board approved 2026-2027 evaluation workplan, and subsequent identification of the corporate evaluations that will begin each year
23	How target is realistic for PB2026-2027	<ul style="list-style-type: none"> <li>The total number of EB-approved evaluation workplans in past biennia (baseline).</li> <li>Programmatic priorities and evaluation coverage norms as outlined in the WHO Evaluation Policy (2025).</li> <li>Increased integration of evaluation planning into country, regional, and thematic programme cycles.</li> <li>Feasibility based on available evaluation resources, staffing, and expected demand from donors and internal stakeholders.</li> </ul>

24	Data sources	The data are drawn from the Executive Board-approved biennial evaluation workplan, WHO corporate evaluation reports, the WHO Evaluation Repository, the GPW14 strategic objectives and outcomes list, and WHO workplans that inform evaluation planning.
25	Process of validation	The WHO Evaluation Office validates whether an evaluation qualifies as a evaluation and meets the linkage criteria for GPW14. This includes reviewing the Terms of Reference, draft and final evaluation reports, and confirming alignment with GPW14 outcomes, outputs, and indicators. Evaluations that meet the criteria are formally tagged in the WHO Evaluation Repository and included in corporate reporting.
26	Limitations	Difficulty in accessing comprehensive and up-to-date records of evaluations conducted across different WHO offices and programs.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Mikyias Kotiso <kotisom@who.int>

### 8.1.3.IND3\_UID 600: Percentage of open critical risks with fully implemented risk response actions

#	Metadata field	Summary
1	GPW14 Output	8.1.3. Accountability and legal functions enhanced in a transparent, compliant and risk management-driven manner, promoting organizational learning, effective internal justice, safety and impact at country level
2	GPW14 Output indicator code	8.1.3.IND3
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of open critical risks with fully implemented risk response actions
4	Output/Leading Indicator (Country Level Formulation)	Percentage of open critical risks with fully implemented risk response actions
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Percentage of open critical risks

11	Indicator definition	<p>The indicator is a measure of how many open critical risks have fully implemented mitigation action plans to reduce the negative effects of risks from occurring.</p> <p>A <b>mitigation action</b> is a specific action or set of actions taken, within the proposed implementation date, to prevent, avoid, transfer, or minimize the risk or its consequences. The mitigation action plans apply for all open critical risks identified and assessed.</p>
12	Criteria	<p>A risk is counted toward the achievement of the indicator if all the following conditions are met:</p> <ul style="list-style-type: none"> <li>• The risk is classified as a critical risk, meaning it has a risk criticality rating of ‘Severe’ or ‘Significant’.</li> <li>• The risk is open and fully validated within the review period (e.g., as of 31 December 2024).</li> <li>• The risk has one or more mitigation actions that are: <ul style="list-style-type: none"> <li>– clearly linked to the critical risk,</li> <li>– implemented by the cutoff date,</li> <li>– and recorded in the Risk Management Tool (RMT) with an Implementation Status of “Fully Implemented.”</li> </ul> </li> <li>• The risk owner (usually the Budget Centre Manager) has confirmed that the response action is fully implemented.</li> <li>• This confirmation is subject to review and approval by the relevant Assistant Director-General (ADG) or Regional Office, as per the internal control framework.</li> </ul> <p>These criteria reflect WHO’s internal accountability procedures and help ensure a consistent basis for assessing full implementation of mitigation actions</p>
13	Numerator	Number of open critical risks with fully implemented risk response actions, as per field 12.
14	Denominator	Total number of open critical risks validated during the reporting period. These risks are classified as having a criticality rating of ‘Severe’ or ‘Significant’, and validated by the date of review (e.g., 31 December 2024).
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	<p>The rationale for this indicator is to measure how risk response actions are monitored and implemented to completion, bringing residual risk levels in line with WHO’s established corporate risk appetite.</p> <p>By knowing the percentage of open critical risks with fully implemented response actions, it is possible to assess how many of the identified risks have been adequately addressed and reduced.</p>
18	Measurement method	<ul style="list-style-type: none"> <li>• The indicator is measured using data extracted from the Risk Management Tool (RMT), which tracks the implementation status of risk response actions across WHO.</li> </ul>

		<ul style="list-style-type: none"> <li>Data are entered and updated by risk owners and validated through the risk and compliance process at HQ and regional levels.</li> <li>Only open critical risks and their associated response actions are considered.</li> <li>The implementation status must be updated by the reporting cut-off date and subject to approval by the ADG or relevant Regional Office.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate is calculated as a percentage by dividing the total number of open critical risks with fully implemented risk response actions as per file 12 (numerator) by the total number of open critical risks (denominator), then multiplying by 100:
21	Calculation type	Cumulative
22	Target setting methodology	<p>Targets were determined through simulations on the available data in the Risk Management Tool (RMT) and follow up discussions with the compliance and risk network.</p> <p>This will also be the first instance to measure this indicator with the given parameters and therefore the team agreed to have realistic targets.</p>
23	How target is realistic for PB2026-2027	Risk Management will be linked to operational planning, and this will help ensure a consistent review of risks and how risk responses are being addressed progressively across all budget centres. There will also be focused and more targeted reminders to budget centres to increase their awareness of risk management.
24	Data sources	Risk Management Tool (RMT)
25	Process of validation	<ul style="list-style-type: none"> <li>Data entered into the Risk Management Tool (RMT) are reviewed by risk owners and subject to validation by the relevant Assistant Director-General (ADG) or Regional Office.</li> <li>Oversight is provided by HQ and Regional Compliance and Risk Management Teams to ensure consistency and accuracy of reporting.</li> </ul>
26	Limitations	The concept of “fully implemented” risk response actions may be subject to interpretation, as there is no standardized checklist or decision tree guiding consistent application across all reporting entities.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Fatou Fall < <a href="mailto:fallf@who.int">fallf@who.int</a> >; Anne Njoroge < <a href="mailto:njorogea@who.int">njorogea@who.int</a> >

### 8.1.3.IND4\_UID 601 : Percentage of agreed recommendations implemented within 24 months of evaluation completion

#	Metadata field	Summary
1	GPW14 Output	8.1.3. Accountability and legal functions enhanced in a transparent, compliant and risk management-driven manner, promoting organizational learning, effective internal justice, safety and impact at country level



2	GPW14 Output indicator code	8.1.3.IND4
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of agreed recommendations implemented within 24 months of evaluation completion
4	Output/Leading Indicator (Country Level Formulation)	Percentage of agreed recommendations implemented within 24 months of evaluation completion
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Percentage of agreed recommendations
11	Indicator definition	<p>This indicator tracks the percentage of evaluation recommendations that the Secretariat management has agreed to and that are implemented, within 24 months after the evaluation is completed. It shows whether WHO follows through on its evaluation commitments in a timely manner.</p> <p>The <b>24-month timeframe</b> for assessing the percentage of agreed recommendations implemented is grounded in WHO's internal policy guidance, practical operational considerations, and alignment with global evaluation norms.</p> <ul style="list-style-type: none"> <li>• It provides adequate time for planning, budgeting, and integrating actions into biennial workplans, particularly within WHO's decentralized operational structure.</li> <li>• The timeframe also allows coordination with implementing units and external partners to ensure meaningful execution of recommendations.</li> <li>• Furthermore, this two-year window is consistent with evaluation standards adopted by other UN agencies and endorsed by the United Nations Evaluation Group (UNEG).</li> <li>• Organizational experience within WHO confirms that most actionable recommendations are implemented within two years. Beyond this period, completion rates tend to drop due to shifting priorities, limited resources, or staff turnover—making 24 months a realistic and evidence-based benchmark for effective evaluation follow-up and performance monitoring.</li> </ul>
12	Criteria	A recommendation is considered <b>achieved</b> when all actions outlined in the management response are fully completed within 24 months of the

		evaluation's official completion date. Only agreed recommendations are included in the calculation.
13	Numerator	Number of agreed evaluation recommendations that have been fully implemented within 24 months of the evaluation's completion
14	Denominator	Total number of agreed recommendations from all eligible evaluations during the time period.
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	TBD
17	Rationale	This indicator ensures accountability and measures WHO's commitment to acting on evaluation recommendations.
18	Measurement method	Data on the implementation status of each agreed evaluation recommendation are collected through WHO's consolidated recommendation tracking platform. For each recommendation, implementation progress is assessed routinely based on inputs from responsible units. To note that measurement of follow-up to a completed evaluation's management response will be on a rolling basis (i.e., said MRs start at different times. Output measurement and reporting will be conducted at the PB mid-term point and at the end of biennium for all eligible evaluations. The system records whether the actions outlined in the management response have been fully, partially, or not implemented. The indicator is calculated by dividing the number of recommendations in each category by the total number of agreed recommendations for that evaluation, and for the respective results to be aggregated and to be expressed as a percentage.
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The aggregate percentage is calculated by dividing the total number of agreed evaluation recommendations that are fully implemented within 24 months across all evaluations by the total number of agreed recommendations
21	Calculation type	Cumulative
22	Target setting methodology	The target for the percentage of agreed recommendations implemented within 24 months is set based on a mix of internal performance data, best practices across the UN system, and practical implementation realities within WHO
23	How target is realistic for PB2026-2027	The target for the percentage of agreed evaluation recommendations implemented within 24 months is realistic for PB 2026–2027 because it is based on historical performance trends, increased institutional commitment to results-based management, and strengthened follow-up mechanisms. WHO has progressively improved its management response and follow-up system, including the use of a centralized tracking tool managed by the Evaluation Office. With ongoing efforts to embed evaluation use and accountability across departments and regions, including clearer roles,

		timelines, and responsibilities, achieving a high implementation rate is both feasible and aligned with organizational performance improvement goals. Additionally, increasing donor and governing body expectations around accountability further incentivize timely action on recommendations
24	Data sources	WHO consolidated recommendation tracking platform and associated dashboards
25	Process of validation	Implementation status is validated through the WHO consolidated recommendation tracking platform, with frequent updates provided by responsible units (min: biannual). Data are reviewed by the Evaluation Office and reported to senior management. The process includes verification of progress status, consistency checks, and justification for delays or non-implementation, ensuring accuracy and reliability of reported results.
26	Limitations	<ul style="list-style-type: none"> <li>• Implementing follow-up to actions to recommendations in a given management response may depend on available resources, and in some cases, by the nature of the action and where stated required timeline will take more than 24 months (hence the target can never be 100%).</li> <li>• There may be inconsistencies in how different teams interpret and classify recommendations as “partially” or “fully” implemented.</li> <li>• Additionally, while WHO applies a structured follow-up process, the absence of formal enforcement mechanisms means that non-implementation may go unaddressed unless escalated through internal reporting. Delays or gaps in reporting from responsible units may also affect the timeliness and completeness of data in the tracking platform.</li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Mikyias Kotiso <kotisom@who.int>

#### 8.1.4. Fit-for-purpose, cost-effective, innovative and secure corporate digital platforms and services aligned with the needs of users, corporate functions and technical programmes

##### 8.1.4.IND1\_UID 630: Percentage of locations with harmonized and continuously adapted information technology infrastructure and digital workplace services

#	Metadata field	Summary
1	GPW14 Output	8.1.4. Fit-for-purpose, cost-effective, innovative and secure corporate digital platforms and services aligned with the needs of users, corporate functions and technical programmes
2	GPW14 Output indicator code	8.1.4.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of locations with harmonized and continuously adapted information technology infrastructure and digital workplace services
4	Output/Leading Indicator (Country Level Formulation)	Percentage of locations with harmonized and continuously adapted information technology infrastructure and digital workplace services
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Percentage of WHO office locations
11	Indicator definition	This indicator measures the proportion of WHO office locations where harmonized IT infrastructure and digital workplace services are implemented and kept up to date with organizational and technological changes.
12	Criteria	<p>A WHO office location is counted as a numerator for this indicator if it meets the <b>defined harmonization standards</b> across the four service areas below:</p> <ul style="list-style-type: none"> <li>• Productivity and collaboration tools</li> <li>• Technical infrastructure</li> <li>• Business information systems</li> <li>• IT governance and service management</li> </ul> <p>Achievement is based on whether the location fulfills the required elements within each of these areas according to the harmonized service framework.</p>
13	Numerator	Number of WHO office location that meets the criteria as per field 12

14	Denominator	Total number of WHO offices globally (including HQ, regional, and country offices)
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	<i>Not applicable</i>
17	Rationale	Members of the WHO workforce need access to digital tools to perform for day-to-day functioning, communicating, collaborating and running business processes. A consistent technology-enabled work environment with appropriate access to enterprise applications and systems help staff perform their jobs, increases productivity and promotes collaboration and innovation.
18	Measurement method	<ul style="list-style-type: none"> <li>• A standardized table of harmonized IT services is maintained and used to assess implementation across all WHO office locations.</li> <li>• The table covers four core service areas: <ul style="list-style-type: none"> <li>○ Productivity and collaboration tools</li> <li>○ Technical infrastructure</li> <li>○ Business information systems</li> <li>○ IT governance and service management</li> </ul> </li> <li>• Each office is evaluated against predefined standards within these service areas.</li> <li>• A weighted scoring system is applied to the four areas to calculate a composite value.</li> <li>• The percentage of office locations that meet the defined harmonization standards is then calculated.</li> </ul>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	Each WHO office location is assessed based on defined harmonization standards across four service areas. Offices that meet the required criteria across these areas as per field 12 are counted in the numerator. The denominator is the total number of WHO office locations. The indicator is then expressed as a percentage by dividing the number of compliant office locations by the total number of WHO office locations and multiplying by 100.
21	Calculation type	Cumulative
22	Target setting methodology	The target is based on increased adoption of services where adoptions in the regions have been lagging, e.g., data collection, business workflows, application development. It is expected that there will be increased adoption in these areas as well as completion of rollout of services such as Global Synergy (ongoing deployment in EMR) , mobile device management and cloud services.
23	How target is realistic for PB2026-2027	The global IT network, consisting of IT managers at HQ and the regions, meet regularly and the coordination has been increasing continuously. There is a recognition in the network of the need for harmonization and consolidation

		of IT services. The financial difficulties will also drive consolidation to reduce duplication and local customization.
24	Data sources	Table of harmonized IT services maintained by WHO; Assessment data on implementation of these services across WHO office locations
25	Process of validation	The information is collectively assessed by the IT network.
26	Limitations	The definition of harmonized services evolve with time to keep up with technological evolutions and the Organization's needs.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Biswamber Gurubacharya < gurubacharyab@who.int>

**8.1.4.IND2\_UID 632: Level of implementation of cybersecurity road map, in comparison with baseline established by the information technology security assessment**

#	Metadata field	Summary
1	GPW14 Output	8.1.4. Fit-for-purpose, cost-effective, innovative and secure corporate digital platforms and services aligned with the needs of users, corporate functions and technical programmes
2	GPW14 Output indicator code	8.1.4.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Level of implementation of cybersecurity road map, in comparison with baseline established by the information technology security assessment
4	Output/Leading Indicator (Country Level Formulation)	Level of implementation of cybersecurity road map, in comparison with baseline established by the information technology security assessment
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	TBD
11	Indicator definition	This indicator measures the extent to which WHO has implemented the actions defined in its cybersecurity roadmap. The roadmap, developed following a review of the existing state, outlines an inventory of measures aimed at progressively improving the Organization's cybersecurity posture. The indicator reflects progress compared to the baseline situation identified in the initial security assessment, using a maturity model to assess the level of implementation.
12	Criteria	TBD
13	Numerator	TBD
14	Denominator	TBD
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if	Not applicable

	benchmarking is applied)	
17	Rationale	Cybersecurity is considered a principal risk for the Organization. Cybersecurity attacks can compromise digital services vital to the smooth operation of the Organization. A cybersecurity roadmap, consisting of measures to improve the overall cybersecurity posture of the Organization, helps ensure that vital digital services can be safeguarded and delivered with an acceptable level of risk.
18	Measurement method	TBD
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	TBD
21	Calculation type	Cumulative
22	Target setting methodology	Targets are set based on expected improvements in the maturity of knowledge, processes, and systems over time. The maturity ratings derived from the cybersecurity assessment framework inform the anticipated progression across key domains, guiding realistic target levels for each reporting period.
23	How target is realistic for PB2026-2027	Consistent operational and investments in cybersecurity makes the target realistic. Additionally, all regional offices are involved through monthly Cybersecurity Group meetings where the roadmap and assessment are reviewed regularly.
24	Data sources	Cybersecurity roadmap
25	Process of validation	The implementation is validated by the cybersecurity network and council. It is also presented to the IT Steering Committee.
26	Limitations	The Cybersecurity roadmap will need to be adapted periodically depending on the evolution of global cybersecurity landscape.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Biswamber Gurubacharya <gurubacharyab@who.int>



### 8.1.5. Working environments, infrastructure, support services, supply chains and asset management are fit for purpose, accountable, cost-effective, innovative and secure for optimized operations

#### 8.1.5.IND1\_UID 478: Percentage of compliance with security risk management measures and applicable security protocols and policies

#	Metadata field	Summary
1	GPW14 Output	8.1.5. Working environments, infrastructure, support services, supply chains and asset management are fit for purpose, accountable, cost-effective, innovative and secure for optimized operations
2	GPW14 Output indicator code	8.1.5.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of compliance with security risk management measures and applicable security protocols and policies
4	Output/Leading Indicator (Country Level Formulation)	Percentage of compliance with security risk management measures and applicable security protocols and policies
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Percentage of implemented security measures and policies complied with the assessed office location.
11	Indicator definition	This indicator measures the percentage of required security measures and policies that are fully implemented at each WHO office or sub-office. It shows how compliant each location is with Security Risk Management Measures (SRMMs) and WHO/UN security policies and protocols. Although the specific measures vary by location depending on local risk context, each office's compliance is calculated as a percentage. This allows for consistent comparison across locations, since <b>full implementation of all applicable measures always corresponds to 100% compliance.</b>
12	Criteria	An office location is included in the indicator if: <ul style="list-style-type: none"> <li>• A full security compliance assessment has been conducted using the standard WHO/UN methodology;</li> <li>• All applicable Security Risk Management Measures (SRMMs) and policies have been reviewed at that location;</li> </ul>

		<ul style="list-style-type: none"> <li>The compliance score is based on a complete and validated assessment, not partial or estimated data.</li> </ul> <p>Only offices meeting these criteria are included in the global or regional compliance percentage.</p>
13	Numerator	<p>For each office or sub-office location: the number of applicable Security Risk Management Measures (SRMMs), policies, and protocols that are fully implemented.</p> <p>The final indicator is the average of these office-level compliance percentages.</p>
14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	<p><b>1. Level of Security and Safety Posture:</b> Compliance with Security Risk Management Measures and Security Policies reflects the level of security posture of any assessed office location.</p> <p><b>2. Security Compliance as key ENABLING element of WHO operations:</b> The higher the security compliance level and security posture of any office, the wider area and the more activities it is enabled to access to implement programmes and activities under acceptable risk levels.</p> <p><b>3. Security Compliance is a reflection of the organization's duty of care</b> for the security and safety of personnel, assets and operations at any office location.</p>
18	Measurement method	<ol style="list-style-type: none"> <li>Data collection is done using a standardized WHO security compliance survey template.</li> <li>The survey is conducted by WHO Field Security Officers (FSOs) where available, or by designated Security Focal Points (SFPs) where FSOs are not present.</li> <li>A detailed Guidance Note is shared with all assessors, and webinars are held, especially for SFPs, to ensure consistent understanding of the process.</li> <li>The survey covers all UN and WHO Security Management Policies and the full set of Security Risk Management Measures (SRMMs) that are relevant to the specific location being assessed.</li> <li>The set of applicable SRMMs and policies is tailored to the local context and risk level of each office location.</li> <li>For each office or sub-office location, a compliance percentage is calculated using the following formula:  <b>= Number of applicable measures and policies fully implemented/ Total number of applicable measures and policies at that location</b> </li> <li>This generates a location-specific compliance score (e.g., 100%, 85%, 72%).</li> </ol>

		<b>8. The final indicator value is the average compliance percentage across all assessed WHO office and sub-office locations, globally or regionally, depending on the level of reporting.</b>
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The indicator is calculated by averaging the compliance percentages from all office and sub-office locations that meet the inclusion criteria. Each location contributes equally to the global or regional aggregate, regardless of office size or staffing level.
21	Calculation type	Cumulative
22	Target setting methodology	<ul style="list-style-type: none"> <li>Historical trends from the last five years were used to inform target setting.</li> <li>The projections are considered reasonable based on observed patterns of compliance across office locations.</li> </ul>
23	How target is realistic for PB2026-2027	The target is considered realistic due to the commitment of WHO Heads of Offices at all levels to allocate the necessary resources to meet security compliance requirements.
24	Data sources	<ul style="list-style-type: none"> <li>Annual WHO Security Compliance Survey, conducted using a standardized template</li> <li>Inputs from WHO Field Security Officers (FSOs) or Security Focal Points (SFPs), depending on office availability</li> <li>Assessment is based on applicable Security Risk Management Measures (SRMMs) and UN/WHO security protocols</li> </ul>
25	Process of validation	<ol style="list-style-type: none"> <li>Data is validated at the Regional and Headquarters level: the Regional FSOs at the Regional Level; and the Senior FSO/Policy and Compliance Officer at the HQ level.</li> <li>Director of Global Security (D/SEC) has overall oversight.</li> </ol>
26	Limitations	<ol style="list-style-type: none"> <li>Main challenge is automating the process with an interface between the SRMM source and the WHO security compliance process. This is an ongoing SEC project in collaboration with WHO and UNDSS IMT teams.</li> <li>Another big challenge is the availability of funds to support 100% compliance at each location, especially at the country level.</li> </ol>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	BERMUDEZ, Angelito Francis < bermudezan@who.int>

#### 8.1.5.IND2\_UID 652: Percentage of procured goods and services obtained through competitive means

#	Metadata field	Summary
1	GPW14 Output	8.1.5. Working environments, infrastructure, support services, supply chains and asset management are fit for purpose, accountable, cost-effective, innovative and secure for optimized operations
2	GPW14 Output indicator code	8.1.5.IND2

3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of procured goods and services obtained through competitive means
4	Output/Leading Indicator (Country Level Formulation)	Percentage of procured goods and services obtained through competitive means
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Percentage of procured goods and services
11	Indicator definition	The percentage of total procurement actions reviewed by the Contract Review Committee (CRC) that were conducted through competitive bidding methods (i.e., without requesting a waiver of competition).
12	Criteria	<p>Procured goods and services are qualified as obtained through a competitive procurement if the following conditions are met:</p> <ul style="list-style-type: none"> <li>• WHO uses open or limited competitive methods (e.g., Request for Proposals [RFP], Invitation to Bid [ITB], Request for Quotation [RFQ]).</li> <li>• At least three responsive bids are received.</li> <li>• Value-based thresholds are respected: <ul style="list-style-type: none"> <li>○ Formal competition is required for procurement actions above USD 50,000.</li> <li>○ CRC review is mandatory for actions equal to or greater than USD 300,000.</li> </ul> </li> <li>• The procurement is submitted to the CRC for review as a “non-waiver” case, meaning no request to waive competitive bidding was made (e.g., an award through an open tender).</li> </ul> <p>These requirements apply globally to all WHO HQ and Major Offices under WHO’s procurement policy.</p>
13	Numerator	Number of procurement actions reviewed by the CRC that were conducted through competitive methods without a waiver of competition (i.e., “non-waiver” CRC cases) as per field 12
14	Denominator	Total number of procurement actions reviewed by the Contract Review Committee (CRC).
15	Using benchmarking to qualify the achievements (Yes/No)	No

16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	This indicator is important as it reflects the efficiency and transparency of the procurement process. Competitive procurement methods are generally associated with better value for money and reduced risk of corruption.
18	Measurement method	Data is collected through focal points at all major offices.
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	The percentage is calculated by dividing the number of non-waiver CRC cases as per field 12 by the total number of CRC cases and multiplying by 100.
21	Calculation type	Cumulative
22	Target setting methodology	Targets are set based on historical procurement performance and planned efforts to strengthen competitive procurement practices across WHO. Expected improvements are determined by analyzing trends in past CRC-reviewed cases, procurement reform initiatives, and capacity-building efforts at global and regional levels. While 100% competitive procurement is not feasible due to specific market constraints (e.g. single-source suppliers), the target reflects a realistic and incremental increase over the 2023 baseline.
23	How target is realistic for PB2026-2027	Given the current funding constraints, there is a more emphasis on ensuring efficiency through cost containment while maintaining quality. Competitive procurement is one way to achieve this.
24	Data sources	Procurement and Contract Review Committee (CRC) focal points at each Major Office
25	Process of validation	The data will be compiled and received through procurement and/or Contract Review Committee focal persons of each Major office
26	Limitations	<ul style="list-style-type: none"> <li>• Incomplete data from some offices may affect the reliability of the indicator.</li> <li>• Variations in procurement practices across Major Offices can lead to inconsistencies in how competitive procurement is recorded.</li> <li>• There is a risk of misclassification of procurement methods</li> <li>• Some procurement actions involve single-source or monopoly suppliers, where competition is not feasible (e.g., proprietary software like Microsoft products), limiting the maximum achievable value of the indicator</li> </ul>
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Angela Kastner < kastnera@who.int>; Hassaan Hasan Syed <hasans@who.int>

### 8.1.6. Sound financial practices supported by an effective internal control framework to ensure transparency, accountability, and optimal financial management

#### 8.1.6.IND1\_UID 619 : Receipt of an unmodified audit opinion by the External Auditor on the yearly financial statements, driven by timely adherence to the financial closure processes and finance

#	Metadata field	Summary
1	GPW14 Output	8.1.6. Sound financial practices supported by an effective internal control framework to ensure transparency, accountability, and optimal financial management
2	GPW14 Output indicator code	8.1.6.IND1
3	Output/Leading Indicator (Global/Regional Level Formulation)	Receipt of an unmodified audit opinion by the External Auditor on the yearly financial statements, driven by timely adherence to the financial closure processes and finance policies by WHO country offices/departments
4	Output/Leading Indicator (Country Level Formulation)	Receipt of an unmodified audit opinion by the External Auditor on the yearly financial statements, driven by timely adherence to the financial closure processes and finance policies by WHO country offices/departments
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Binary (Yes=100% or No=0%)
11	Indicator definition	The indicator tracks whether WHO receives an unmodified (clean) audit opinion from the External Auditor on its annual financial statements. This reflects adherence to financial closure processes and compliance with WHO's financial regulations and policies. It is a binary indicator, assessed as either 'Yes' (unmodified opinion received=100%) or 'No' (qualified or adverse opinion).
12	Criteria	To meet the indicator, WHO country offices and departments must: <ul style="list-style-type: none"> <li>Fully comply with financial closure guidelines and related procedures</li> <li>Adhere to WHO financial policies and standard operating procedures</li> <li>Ensure timely, accurate financial recording and reporting across all three levels</li> </ul>
13	Numerator	Not applicable

14	Denominator	Not applicable
15	Using benchmarking to qualify the achievements (Yes/No)	No
16	Achievement thresholds (if benchmarking is applied)	Not applicable
17	Rationale	Maintenance of an unmodified audit opinion gives confidence to Member States, donors and stakeholders of sound financial management and accurate financial reporting.
18	Measurement method	External audit report.
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	Not applicable
21	Calculation type	Cumulative
22	Target setting methodology	Financial Statements are the statutory document and provides confidence about financial health to the external stakeholders. It also confirms WHO's compliance with Financial Regulations and Rules, control environment.
23	How target is realistic for PB2026-2027	The target is realistic due to the presence of a skilled workforce, established tools and systems, and ongoing compliance with WHO's standard operating procedures. Continued support from headquarters and regional office finance teams further reinforces the organization's capacity to maintain strong financial management and meet audit expectations.
24	Data sources	External audit report.
25	Process of validation	Financial statements are prepared by WHO and undergo internal review by the Finance Department (FNM) and the Independent Expert Oversight Advisory Committee (IEOAC). They are then independently audited by the External Auditor to ensure accuracy, consistency, and compliance with financial regulations.
26	Limitations	The indicator relies on consistent and timely adherence to corporate financial recording and reporting procedures throughout the year across all three levels of the Organization (country offices, regional offices, and headquarters). Any delays or inconsistencies in these processes may affect the outcome.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Sushil Kumar Rathi <RATHIS@WHO.INT>

#### **8.1.6.IND2\_UID 1368: Percentage of WHO regional directors and assistant directors-general compliant with the letter of representation, confirming the adequacy of internal controls**

#	Metadata field	Summary
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1	GPW14 Output	8.1.6. Sound financial practices supported by an effective internal control framework to ensure transparency, accountability, and optimal financial management
2	GPW14 Output indicator code	8.1.6.IND2
3	Output/Leading Indicator (Global/Regional Level Formulation)	Percentage of WHO regional directors and assistant directors-general compliant with the letter of representation, confirming the adequacy of internal controls
4	Output/Leading Indicator (Country Level Formulation)	Percentage of WHO regional directors and assistant directors-general compliant with the letter of representation, confirming the adequacy of internal controls
5	Monitoring framework (SDG, GPW, etc)	GPW14
6	Indicator classification (Input, Process, Output, Outcome)	Output
7	Indicator status (Active, Retired etc)	Active
8	Linked outcome indicators (Direct (D) or indirect (I))	N/A
9	Data type	Percentage
10	Unit of measure	Percentage of regional directors and assistant directors-general
11	Indicator definition	The indicator measures the percentage of WHO Regional Directors (RDs) and Assistant Directors-General (ADGs) who are fully compliant with internal control requirements.
12	Criteria	WHO Regional Directors (RDs) and Assistant Directors-General (ADGs) are counted towards the achievement of the indicator if both of the following conditions are met: <ol style="list-style-type: none"> <li>1. <b>Imprest account reconciliation:</b> No unrecorded transactions &gt;7 days</li> <li>2. <b>Timely submission of the letter of representation:</b> No submissions more than 7 days past the deadline</li> </ol>
13	Numerator	Number of RDs/ADGs compliant with the Letter of Representation (i.e., 100% compliance) as per field 12
14	Denominator	Total number of RDs/ADGs
15	Using benchmarking to qualify the achievements (Yes/No)	Yes
16	Achievement thresholds (if benchmarking is applied)	<b>Achieved:</b> RDs/ADGs that met both criteria as per field 12 divided by the Total number of RDs/ADGs <b>Partially achieved:</b> RDs/ADGs that met only one of the two criteria divided by the Total number of RDs/ADGs



		<b>Not achieved:</b> RDs/ADGs that met none of the two criteria divided by the Total number of RDs/ADGs
17	Rationale	Sound internal control environment gives confidence to Member States, donors and stakeholders that funds are being utilised for the purposes received, fiduciary management standards are high and risks of fraud or misappropriation are reduced
18	Measurement method	Performance of each RD/ADG is measured against two operational control criteria (see field 12), each with a defined target. The composite result determines whether the RD/ADG is considered compliant. For each RD/ADG's area of responsibility: - Assign 1 point for each sub-indicator where the target is met; 0 otherwise - Calculate % score = (Sum of points / Total possible) × 100 - RD/ADG is considered compliant only if both sub-indicators are met (i.e., a score of 100%)
19	Estimation method (if applicable)	Not applicable
20	Method of aggregate estimation	$=(\text{Compliant RDs/ADGs} \div \text{Total RDs/ADGs}) \times 100$
21	Calculation type	Cumulative
22	Target setting methodology	The target is set based on the expectation of full compliance, meaning all RDs/ADGs meet the required internal control criteria. Target values are determined by considering historical performance, organizational capacity, and the established processes supporting compliance. The methodology allows for progressive improvement over time, with the goal of reaching and sustaining 100% compliance
23	How target is realistic for PB2026-2027	Each office has established processes to duly complete the Letter of Representation in line with the timeline set out in the annual closure instructions. Lessons learned from prior submissions and necessary corrective measures have been put in place to address any identified deficiencies.
24	Data sources	Data are sourced primarily from the Global Management System (GSM), which records financial transactions and compliance information related to imprest reconciliations and the submission of Letters of Representation.
25	Process of validation	Data are reviewed by the users responsible for entry and approval, with additional oversight provided by Regional Offices and relevant HQ functions. All data are subject to both internal and external audit processes to ensure accuracy, consistency, and reliability.
26	Limitations	The indicator relies on consistent staff adherence to established policies, procedures, and timely completion of recording and closure processes.
27	Expected frequency of reporting	Annual
28	Date last published	15 June 2025
29	Technical focal point	Sushil Kumar Rathi <RATHIS@WHO.INT>

## ANNEX 1: Description of metadata fields

#	Output indicator metadata fields	Description	Mapping with GHO metadata fields
1	GPW14 Output	Which GPW14 output does this indicator contribute to?	
2	GPW14 Output indicator code	What is the code for this indicator?	
3	Output/Leading Indicator (Global/Regional Level Formulation)	How is the indicator formulated at the global/regional level?	Name
4	Output/Leading Indicator (Country Level Formulation)	How is this indicator phrased for country-level use?	Also known as
5	Monitoring framework (SDG, GPW, etc)	Under which global or institutional framework(s) is this indicator tracked? (e.g., SDGs, GPW14, Triple Billion)	Monitoring Framework (SDG, GPW, etc)
6	Indicator classification (Input, Process, Output, Outcome)	What type of indicator is this — does it measure resources (input), actions taken (process), results delivered (output), or change achieved (outcome)?	Indicator Classification (Input, Process, Output, Outcome)
7	Indicator status (Active, Retired etc)	Is this indicator currently active, discontinued, or pending revision?	Indicator Status (Active, Retired etc)
8	Linked outcome indicators (Direct (D) or indirect (I))	Which outcome indicator(s) is this linked to, and is the link direct (D) or indirect (I)?	Related Indicators
9	Data type	What type of data is reported (e.g. number, %, index)?	
10	Unit of measure	What is the unit of measurement (e.g. number of countries, %)?	Unit of Measure
11	Indicator definition	What does this indicator measure in simple terms?	Indicator Definition
12	Criteria	What are the minimum requirements for a country (or unit) to be counted?	
13	Numerator	What is included in the numerator?	Numerator
14	Denominator	What is the denominator, if applicable?	Denominator
15	Using benchmarking to qualify the achievements (Y/N)	Is benchmarking used to define achievement (yes or no)?	
16	Achievement thresholds (if benchmarking is applied)	If yes, what level qualifies as achievement or success?	
17	Rationale	Why is this indicator important, and how does it link to WHO's role?	Rationale (including Institutional Mandates)

<b>18</b>	Measurement method	How is the data collected or calculated in practice?	Measurement Method
<b>19</b>	Estimation method (if applicable)	If estimates are used, how are they produced or modeled?	Estimation Method (if applicable)
<b>20</b>	Method of aggregate estimation	How are data aggregated at regional/global level (e.g. sum, average)?	Method of aggregate estimation
<b>21</b>	Calculation type	Is the indicator value cumulative over time, a snapshot at a point in time, an annual value, or something else?	Calculation Type
<b>22</b>	Target setting methodology	How were the targets determined?	
<b>23</b>	How target is realistic for PB2026-2027	What makes the target feasible for 2026–2027? (e.g. support, capacity, past trends)	
<b>24</b>	Data sources	Where does the data come from (e.g. WHO systems, country reports, surveys)?	
<b>25</b>	Process of validation	How is the data validated (e.g. country review, WHO review, automated checks)?	Process of validation
<b>26</b>	Limitations	What are the main limitations or concerns about this indicator or data?	Limitations
<b>27</b>	Expected frequency of reporting	How often is this indicator expected to be updated (e.g., annually, biennially)?	Expected frequency of reporting
<b>28</b>	Date last published	When was the most recent data for this indicator officially published?	Date last published
<b>29</b>	Technical focal point	Who is the designated WHO technical focal point or contact person for this indicator? (Name, and email)	WHO Focal Point (including email)
		Not applicable	Granularity/Disaggregates
		Not applicable	Short Name
		Not applicable	Themes
		Not applicable	Topics
		Not applicable	Comments (possibly also including notes)
		See 18	Link to additional methodological details
		Not applicable	Link to GATHER/FAIR form
		Not applicable	Methodological Changes
		See 24	Preferred Sources
		See 24	Other data sources
		See 29	Data providers
		See 18	Data collection process
		See 29	Data compilers
		See 18	Data compilation process
		Not applicable	Data completeness
		See 27	Temporal availability
		Not applicable	Geographical Availability
		See 29	Data Custodian

Not applicable	Next expected data publication
Not applicable	Link to publication
Not applicable	Copyright
Not applicable	License
Not applicable	Permission type
Not applicable	Prohibited uses
Not applicable	Disclaimers