13th General Programme of Work (GPW 13)

WHO Impact Framework

METADATA

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Introduction

The 13th General Programme of Work (GPW 13) sets out WHO's strategic direction, outlines how the Organization will proceed with its implementation and provides a framework to measure progress in this effort. It has taken account of the strategic plans of WHO regional offices and has been developed in collaboration with the Regional Directors. GPW 13 will cover the period 2019−2023 and will serve as the basis for resource mobilization and for the programme budgets for the bienniums 2020−2021 and 2022−2023.

At the heart of GPW 13 are the triple billion goals which are to ensure that by 2023:

- A billion more people have universal health coverage
- A billion more people are protected from health emergencies
- A billion more people are living with better health and wellbeing

The GPW 13 WHO Impact Framework makes measurable the triple billion targets of GPW 13. The aims of the Impact Framework are to make a measurable impact on people's health at country level; increase the likelihood that the triple billion targets will be met; accelerate progress towards the Sustainable Development Goals (SDGs); transform how WHO works by anchoring commitments in measurable results; provide a means of tracking the joint efforts of the Secretariat, Member States and partners; and strengthen country data and information systems for health.

The Impact Framework is a three-layer measurement system:

1. The **programmatic milestones** cover a range of health issues and provide a set of measurement indicators that will be used to measure the outcomes in the programme budget.
2. Each of the **triple billion targets** will be measured using composite indices including:
    a. Universal health coverage index;
    b. Health emergencies index;
    c. Healthier populations index.
3. **HALE**, healthy life expectancy, quantifies expected years of life in good health at a particular age and can be considered a summary measure of the overall health of populations. It is proposed to use HALE within GPW 13 as an overarching and comparable measure of the impact of the triple billion targets.

There are 40 programmatic milestones linked to the 46 indicators in the GPW 13 Impact Framework. Each milestone is tracked by a single or multiple indicator and are aligned to SDGs. Thirty-eight of the 46 programmatic indicators are SDG indicators and the remaining 8 are from World Health Assembly resolutions. The programmatic indicators were developed by WHO technical programmes in consultation with Member States. This document presents the metadata for the 46 programmatic indicators linked to the 40 programmatic milestones. The table below maps the SDG indicators to the programmatic indicators and the corresponding programmatic milestones.

Table 1 List of 40 programmatic milestones and 46 programmatic indicators

#	SDG #	Programmatic Indicators	Programmatic Milestones
1.	SDG 1.5.1	Number of deaths, missing persons and directly affected persons attributed to disasters per 100 000 population	Reduce the number of deaths, missing persons and directly affected persons attributed to disasters per 100 000 population
2.	SDG 1.a.2	Proportion of total government spending on essential services (education, health and social protection)	Increase the share of public spending on health by 10%
3.	SDG 2.2.1	Prevalence of stunting (height for age <-2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age	Reduce the number of stunted children under 5 years of age by 30%
4.	SDG 2.2.2	Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age (wasting)	Reduce the prevalence of wasting among children under 5 years of age to less than 5%
5.	SDG 2.2.2	Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age (overweight)	Halt and begin to reverse the rise in childhood overweight (0-4 years)
6.	SDG 3.1.1	Maternal mortality ratio	Reduce the global maternal mortality ratio by 30%
	SDG 3.1.2	Proportion of births attended by skilled health personnel	
7.	SDG 3.2.1	Under-5 mortality rate	Reduce the preventable deaths of newborns and children under 5 years of age by 17% and 30%, respectively
	SDG 3.2.2	Neonatal mortality rate	
8.	SDG 3.3.1	Number of new HIV infections per 1 000 uninfected population, by sex, age and key populations	Reduce number of new HIV infections per 1 000 uninfected population, by sex, age, and key populations by 73%
9.	SDG 3.3.2	Tuberculosis incidence per 100 000 population	Reduce by 27% the number of new TB cases per 100 000 population
10.	SDG 3.3.3	Malaria incidence per 1 000 population	Reduce malaria case incidence by 50%
11.	SDG 3.3.4	Hepatitis B incidence per 100 000 population	Reduce Hepatitis B incidence to 0.5% for children under 5 years
12.	SDG 3.3.5	Number of people requiring interventions against neglected tropical diseases	Reduction of people requiring interventions by 400 million
13.	SDG 3.4.1	Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory diseases	20% relative reduction in the premature mortality (age 30-70 years) from NCDs (cardiovascular, cancer, diabetes, or chronic respiratory diseases) through prevention and treatment
14.	SDG 3.4.2	Suicide mortality rate	Reduce suicide mortality rate by 15%
15.	SDG 3.5.1	Coverage of treatment interventions (pharmacological, psychosocial and	Increase service coverage of treatment interventions (pharmacological, psychosocial and

#	SDG #	Programmatic Indicators	Programmatic Milestones
		rehabilitation and aftercare services) for substance use disorders	rehabilitation and aftercare services) for substance use disorders to xx% *
16.	SDG 3.5.2	Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in liters of pure alcohol	7% relative reduction in the harmful use of alcohol as appropriate, within the national context
17.	SDG 3.6.1	Death rate due to road traffic injuries	Reduce the number of global deaths and injuries from road traffic accidents by 20%
18.	SDG 3.7.1	Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods	Increase the proportion of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods to 66%
19.	SDG 3.8.1	Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access, among the general and the most disadvantaged population)	Increase coverage of essential health services
20.	SDG 3.8.2	Proportion of population with large household expenditures on health as a share of total household expenditures or income	Stop the rise in percent of people suffering financial hardship (defined as out-of-pocket spending exceeding ability to pay) in accessing health services
21.	SDG 3.9.1	Mortality rate attributed to household and ambient air pollution	Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination
	SDG 3.9.2	Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)	
	SDG 3.9.3	Mortality rate attributed to unintentional poisoning	
	SDG 7.1.2	Proportion of population with primary reliance on clean fuels and technology	
	SDG 11.6.2	Annual mean levels of fine particulate matter (e.g. PM2.5 and PM10) in cities (population weighted)	
22.	SDG 3.a.1	Age-standardized prevalence of current tobacco use among persons aged 15 years and older	25% relative reduction in prevalence of current tobacco use in persons 15+ years
23.	SDG 3.b.1	Proportion of the target population covered by all vaccines included in their national programme	Increase coverage of 2nd dose of measles containing vaccine (MCV2) to 85%
24.	SDG 3.b.3	Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis	Increase availability of essential medicines for primary health care, including the ones free of charge to 80%

#	SDG #	Programmatic Indicators	Programmatic Milestones
25.	SDG 3.c.1	Health worker density and distribution	Increase health workforce density with improved distribution
26.	SDG 3.d.1	International Health Regulations (IHR) capacity and health emergency preparedness	Increase in member states International Health Regulations capacities
27.	SDG 4.2.1	Proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by sex	Increase the proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being to 80%
28.	SDG 5.2.1	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age	Decrease the proportion of ever-partnered women and girls aged 15-49 years subjected to physical or sexual violence by a current or former intimate partner in the previous 12 months from 20% to 15%
29.	SDG 5.6.1	Proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care	Increase the proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care to 68%
30.	SDG 6.1.1	Proportion of population using safely managed drinking water services	Provide access to safely managed drinking water services for 1 billion more people
31.	SDG 6.2.1	Proportion of population using (a) safely managed sanitation services and (b) a hand-washing facility with soap and water	Provide access to safely managed sanitation services for 800 million more people
32.	SDG 16.2.1	Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month	Decrease the number of children subjected to violence in the past 12 months, including physical and psychological violence by care givers in the past month, by 20%
33.	Health Emergencies	Vaccine coverage of at-risk groups for epidemic or pandemic prone diseases	Increase immunization coverage for cholera, yellow fever, meningococcal meningitis and pandemic influenza
34.	Health Emergencies	Proportion of vulnerable people in fragile settings provided with essential health services	Increase the availability of health facilities providing a minimum services package to people in fragile, conflict, or vulnerable settings to at least 80%
35.	WHA68.3	Number of cases of poliomyelitis caused by wild poliovirus (WPV)	Eradicate poliomyelitis: zero cases of poliomyelitis caused by wild poliovirus and establish a clear timetable for the global withdrawal of oral polio vaccines in order to stop outbreaks caused by vaccine-derived poliovirus
36.	WHA68.7	Patterns of antibiotic consumption at national level	ACCESS group antibiotics at ≥60% of overall antibiotic consumption
37.	WHA67.25, WHA 68.7	Percentage of bloodstream infections due to antimicrobial resistant organisms	Reduce the percentage of bloodstream infections due to selected antimicrobial resistant organisms by 10%
38.	WHA66.10	Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure of >140	20% relative reduction in the prevalence of raised blood pressure

#	SDG #	Programmatic Indicators	Programmatic Milestones
		mmHg and/or diastolic blood pressure >90 mmHg) and mean systolic blood pressure	
39.	WHA66.10	Percentage of people protected by effective regulation on trans-fats	Eliminate industrially produced trans fats (increase the percentage of people protected by effective regulation)
40.	WHA66.10	Prevalence of obesity	Halt and begin to reverse the rise in obesity

GPW 13 WHO Impact Framework: **Milestone #1** Indicator Metadata

Milestone #1	**Reduce the number of deaths, missing persons and directly affected persons attributed to disasters per 100,000 population**
Indicator	Number of deaths, missing persons and directly affected persons attributed to disasters per 100 000 population
SDG/ Core 100	SDG 1.5.1
Definition	This indicator measures the number of people who died or went missing from disasters per 100,000 population.
Method of estimation/calculation	$\frac{\text{Number of deaths attributed to disasters}}{Global\ population} * 100\ 000$
Numerator	Number of deaths attributed to disasters: The number of people who died during the disaster, or directly after, as a direct result of the hazardous event. The Sendai Framework and SDG 1.5.1 do not include deaths that are conflict-related, or violent deaths.
Denominator	Global population
Preferred data sources	Data are available from the Sendai Framework monitoring platform, overseen by UNISDR (https://sendaimonitor.unisdr.org/). Data provider at national level is appointed Sendai Framework Focal Points. In most countries disaster data are collected by line ministries and national disaster loss databases are established and managed by special purpose agencies including national disaster management agencies, civil protection agencies, and meteorological agencies. The Sendai Framework Focal Points in each country are responsible of data reporting through the Sendai Framework Monitoring System.
Other possible data sources	Disaster loss data for Sustainable Development Goals and Sendai Framework Monitoring System (DesInventar Sendai; https://www.desinventar.net/); Global Health Observatory; International Disaster Database (EM-DAT; https://www.emdat.be/)
WHO GPW13 Framework Disaggregation	Country (country population as denominator); Hazard type
Expected frequency of data collection	Annual
Limitations	Currently data from UNIDSR and UNSD are available for only 73 countries in 2017. Data availability are expected to increase during the period. Data disaggregated by hazard type (e.g., biological, climatological, hydrological) will be available in future years allowing for narrowing the scope to hazards pertinent to health emergencies.
Data type	Rate
Related links	**Official SDG Metadata URL:** https://unstats.un.org/sdgs/metadata/files/Metadata-01-05-01.pdf **<to be updated with new docs>**

GPW 13 WHO Impact Framework: **Milestone #2** Indicator Metadata

Milestone #2	**Increase the share of public spending on health by 10%**
Indicator	Proportion of total government spending on essential services (education, health and social protection)
SDG/Core 100	SDG 1.a.2
Definition	Share of government health expenditures from domestic sources in general government expenditures increase by 10% of the baseline year.
Method of estimation/calculation	The share of domestic general government health expenditures in general government expenditure indicates the priority of health in government budget allocation. It expresses this priority by comparing the size of current government health expenditures relative to the total size of government expenditure. The indicator is calculated as (GGHED%GGE_t+5 - GGHED%GGE_t)/GGHED%GGE_t
Numerator	Domestic General Government Health Expenditure
Denominator	General Government Expenditure
Preferred data sources	Global Health Expenditure Database (GHED)
Other possible data sources	Global Health Observatory (GHO)
WHO GPW13 Framework	
Disaggregation	No
Expected frequency of data collection	Annual
Limitations	As per metadata for each country in GHED
Data type	Percentage
Related links	http://www.who.int/health-accounts/

GPW 13 WHO Impact Framework: **Milestone #3** Indicator Metadata

Milestone #3	**Reduce the number of stunted children under 5 years of age by 30%**
Indicator	Prevalence of stunting (height for age <-2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age
SDG/ Core 100	SDG 2.2.1
Definition	Percentage of stunting (length- or height-for-age less than -2 standard deviations of the WHO Child Growth Standards median) among children aged 0-4 years. Children's length and height are measured using standard technology, training and standardization procedures for anthropometry is essential for accurate measurements. Determination of the exact child's age is the first and most important step in this anthropometric assessment. Recumbent length should be measured for children less than 24 months of age and standing height should be measured for children 24 months and above.
Method of estimation/calculation	Prevalence of stunted children aged <5 years = $\frac{Number\ of\ children\ aged\ 0-4\ years\ that\ fall\ below\ minus\ two\ standard\ deviations\ from\ the\ median\ length-or\ height-for-age\ of\ the\ WHO\ Child\ Growth\ Standards}{Total\ number\ of\ children\ aged\ 0-4\ years\ that\ were\ measured} \times 100\%$
Numerator	Number of children aged 0-4 years that fall below minus two standard deviations from the median length- or height-for-age of the WHO Child Growth Standards.
Denominator	Total number of children aged 0–4 years who were measured.
Preferred data sources	National nutrition surveys, any other nationally-representative population-based surveys with nutrition modules, and national surveillance systems.
Other possible data sources	
WHO GPW13 Framework Disaggregation	By age, sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g. mother's education, wealth quintile).
Expected frequency of data collection	Annual or every 3-5 years based on survey availability in countries
Limitations	Survey estimates come with levels of uncertainty due to both sampling and non-sampling error (e.g. measurement technical error, recording error etc.
Data type	Prevalence
Related links	WHO: http://apps.who.int/gho/data/node.wrapper.imr?x-id=72; http://www.who.int/childgrowth/en/; http://www.who.int/nutgrowthdb/en/; http://apps.who.int/bookorders/anglais/detart1.jsp?sesslan=1&codlan=1&codcol=15&codcch=660.

GPW 13 WHO Impact Framework: **Milestone #4** Indicator Metadata

Milestone #4	**Reduce the prevalence of wasting among children under 5 years of age to less than 5%**
Indicator	Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age (wasting)
SDG/ Core 100	SDG 2.2.2
Definition	Percentage of wasting (weight-for-length or height less than -2 standard deviations of the WHO Child Growth Standards median) among children aged 0-4 years. Children's weight and height are measured using standard technology, e.g. children less than 24 months are measured lying down, while standing height is measured for children 24 months and older.
Method of estimation/calculation	Prevalence of wasted children aged <5 years = $$\frac{Number\ of\ children\ aged\ 0-4\ years\ that\ fall\ below\ minus\ two\ standard\ deviations\ from\ the\ median\ weight-for-length\ or\ height\ of\ the\ WHO\ Child\ Growth\ Standards}{Total\ number\ of\ children\ aged\ 0-4\ years\ that\ were\ measured} \times 100\%$$
Numerator	Number of children aged 0-4 years that fall below minus two standard deviations from the median weight- for-length or height of the WHO Child Growth Standards
Denominator	Total number of children aged 0-4 years that were measured
Preferred data sources	National nutrition surveys, any other nationally-representative population-based surveys with nutrition modules, and national surveillance systems.
Other possible data sources	
WHO GPW13 Framework	
Disaggregation	By age, sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g. mother's education, wealth quintile).
Expected frequency of data collection	Annual or every 3-5 years based on survey availability in countries.
Limitations	Survey estimates come with levels of uncertainty due to both sampling and non-sampling error (e.g. measurement technical error, recording error etc.).
Data type	Prevalence
Related links	WHO: http://apps.who.int/gho/data/node.wrapper.imr?x-id=302; http://www.who.int/childgrowth/en/; http://www.who.int/nutgrowthdb/en/; http://apps.who.int/bookorders/anglais/detart1.jsp?sesslan=1&codlan=1&codcol=15&codcch=660.

GPW 13 WHO Impact Framework: **Milestone #5** Indicator Metadata

Milestone #5	**Halt and begin to reverse the rise in childhood overweight (0-4 years)**
Indicator	Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age (overweight)
SDG/ Core 100	SDG 2.2.2
Definition	For 0-4 years, overweight is defined as weight-for-length or height above two standard deviations of the WHO Child Growth Standards median.
Method of estimation/calculation	Prevalence of overweight = $\frac{Number\ of\ children\ aged\ 0{-}4\ years\ that\ fall\ above\ two\ standard\ deviations\ from\ the\ median\ weight{-}for{-}length\ or\ height\ of\ the\ WHO\ Child\ Growth\ Standards}{Number\ of\ children\ aged\ 0{-}4\ years\ in\ the\ survey\ \ that\ were\ measured} \times 100\%$
Numerator	Number of children aged 0-4 years that fall above two standard deviations from the median weight-for-length or height of the WHO Child Growth Standards.
Denominator	Total number of children aged 0-4 years in the survey that were measured.
Preferred data sources	Nationally representative population-based household or school-based surveys with height and weight measurements of 0-4-year-old children. Other sources of data include national nutrition surveillance systems.
Other possible data sources	Data sets of FAO and UN Statistical office
WHO GPW13 Framework	Risk factor exposure
Disaggregation	By age, sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., mother's education, wealth quintile).
Expected frequency of data collection	Annual or at least every 3-5 years based on survey availability in countries.
Limitations	Survey estimates come with levels of uncertainty due to both sampling and non-sampling error (e.g. measurement technical error, recording error etc.). Another limitation, especially for the school-age children and adolescent age group is the representativeness of the sample.
Data type	Prevalence
Related links	WHO: http://who.int/chp/gshs/en/; http://www.who.int/dietphysicalactivity/childhood/en/

GPW 13 WHO Impact Framework: **Milestone #6** Indicator Metadata

Milestone #6	**Reduce the global maternal mortality ratio by 30%**
Indicator-1	Maternal mortality ratio
SDG/ Core 100	SDG 3.1.1
Definition	**The maternal mortality ratio (MMR)** is the number of maternal deaths during a given time period per 100,000 live births during the same time-period. **Maternal death** refers to the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management (from direct or indirect obstetric death), but not from accidental or incidental causes. **Pregnancy-related death** refers to the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death. **Live birth** refers to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life - e.g. beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles - whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.
Method of estimation/calculation	**MMR** = $\frac{Total\ number\ of\ maternal\ deaths}{Total\ number\ of\ live\ births} \times 100{,}000$
Numerator	Total number of maternal deaths
Denominator	Total number of live births
Preferred data sources	Civil registration vital statistics (CRVS), health service records, household surveys, census.
Other possible data sources	Sample registration systems; verbal autopsy.
WHO GPW13 Framework	Outcome
Disaggregation	By age, parity, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education level, wealth quintile).
Expected frequency of data collection	Annual (for CRVS and health service records).
Limitations	Maternal death is, from an epidemiological perspective, a relatively rare event and mortality is difficult to measure accurately. Many low-income countries have no, incomplete or unusable death registry data. Modelling may be used to obtain a national estimate.
Data type	Ratio
Related links	WHO: http://www.who.int/healthinfo/statistics/indmaternalmortality/en/ WHO: https://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2015/en/. WHO: https://www.who.int/reproductivehealth/publications/monitoring/9789241548458/en/. UNSDG: https://unstats.un.org/sdgs/metadata/files/Metadata-03-01-01.pdf

GPW 13 WHO Impact Framework: **Milestone #6** Indicator Metadata

Milestone #6	**Reduce the global maternal mortality ratio by 30%**
Indicator-2	Proportion of births attended by skilled health personnel
SDG/ Core 100	SDG 3.1.2
Definition	Percentage of live births for women aged 15-49 years attended by skilled health personnel (doctor, nurse or midwife). Skilled health personnel, as referenced by SDG indicator 3.1.2, are competent maternal and newborn health (MNH) professionals educated, trained and regulated to national and international standards. They are competent to: (i) provide and promote evidence-based, human-rights-based, quality, socioculturally sensitive and dignified care to women and newborns; (ii) facilitate physiological processes during labour and delivery to ensure a clean and positive childbirth experience; and (iii) identify and manage or refer women and/or newborns with complications. In addition, as part of an integrated team of MNH professionals (including midwives, nurses, obstetricians, paediatricians and anaesthetists), they perform all signal functions of emergency maternal and newborn care to optimize the health and well-being of women and newborns. Within an enabling environment, midwives trained to International Confederation of Midwives (ICM) standards can provide nearly all of the essential care needed for women and newborns. (In different countries, these competencies are held by professionals with varying occupational titles).
Method of estimation/calculation	The number of women aged 15-49 years with a live birth attended by a skilled health personnel (doctor, nurse or midwife) during childbirth is expressed as a percentage of women aged 15-49 years with a live birth in the same period.
Numerator	Number of births attended by skilled health personnel (doctor, nurse or midwife) trained in providing life-saving obstetric care, including giving the necessary supervision, care and advice to women during pregnancy, childbirth and the postpartum period, to conduct deliveries on their own, and to care for newborns.
Denominator	The total number of live births of women aged 15-49 years in the same period.
Preferred data sources	National population-based surveys.
Other possible data sources	Routine facility information systems.
WHO GPW13 Framework	
Disaggregation	Age, parity, place of residence, socioeconomic status.
Expected frequency of data collection	3-5 years for national population-based surveys, annual for routine facility information systems.
Limitations	Discrepancies possible if national figures are from health facilities rather than household level data. Institutional births may underestimate percentage of births with skilled attendant.
Data type	Percentage
Related links	https://unstats.un.org/sdgs/metadata/files/Metadata-03-01-02.pdf https://data.unicef.org/topic/maternal-health/delivery-care/# https://www.who.int/reproductivehealth/publications/statement-competent-mnh-professionals/en/

GPW 13 WHO Impact Framework: **Milestone #7** Indicator Metadata

Milestone #7	**Reduce the preventable deaths of newborns and children under 5 years of age by 17% and 30% respectively**
Indicator-1	Under-five mortality rate
SDG/ Core 100	SDG 3.2.1
Definition	**The under-5 years mortality rate (U5MR) is** the probability of a child born in a specific year or period dying before reaching the age of five, if subject to the age-specific mortality rates of that period, expressed per 1000 live births. It is, strictly speaking, not a rate (i.e. the number of deaths divided by the number of population at risk during a certain period of time) but a probability of death derived from a life table and expressed as rate per 1000 live births. **Live birth** refers to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life - e.g. beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles - whether or not the umbilical cord has been cut or the placenta is attached. Each product of such a birth is considered live born.
Method of estimation/calculation	The UN Inter-agency Group for Child Mortality Estimation (UN IGME) estimates are derived from national data from censuses, surveys or vital registration systems. The UN IGME does not use any covariates to derive its estimates. It only applies a curve fitting method to good-quality empirical data to derive trend estimates after data quality assessment. In most cases, the UN IGME estimates are close to the underlying data. The UN IGME aims to minimize the errors for each estimate, harmonize trends over time and produce up-to-date and properly assessed estimates. The UN IGME applies the Bayesian B-splines bias-reduction model to empirical data to derive trend estimates of under-five mortality for all countries. See references for details. For the underlying data mentioned above, the most frequently used methods are as follows: Civil registration: The under-five mortality rate can be derived from a standard period abridged life table using the age-specific deaths and mid-year population counts from civil registration data to calculate death rates, which are then converted into age-specific probabilities of dying. Census and surveys: An indirect method is used based on a summary birth history, a series of questions asked of each woman of reproductive age as to how many children she has ever given birth to and how many are still alive. The Brass method and model life tables are then used to obtain an estimate of under-five and infant mortality rates. Censuses often include questions on household deaths in the last 12 months, which can be used to calculate mortality estimates. Surveys: A direct method is used based on a full birth history, a series of detailed questions on each child a woman has given birth to during her lifetime. Neonatal, post-neonatal, infant, child and under-five mortality estimates can be derived from full birth history module.

Numerator	Total number of deaths among children aged 0-4 years (the total number is actually the probability of death derived from a life table)
Denominator	Total number of live births
Preferred data sources	Civil registration and vital statistics,
Other possible data sources	censuses; and household surveys.
WHO GPW13 Framework	Outcome
Disaggregation	By sex, place of residence, wealth quintile and mother's education
Expected frequency of data collection	Annual updates from the UN-IGME revisions
Limitations	The preferred source of data is a civil registration system that records births and deaths on a continuous basis. If registration is complete and the system functions efficiently, the resulting estimates will be accurate and timely. However, many countries do not have well-functioning vital registration systems. In such cases, household surveys, such as the UNICEF-supported Multiple Indicator Cluster Surveys (MICS), the USAID-supported Demographic and Health Surveys (DHS) and periodic population censuses have become the primary sources of data on under-five mortality. These surveys ask women about the survival of their children, and it is these reports that provide the basis of child mortality estimates for a majority of low- and middle- income countries. These data, however, are often subject to sampling or non-sampling errors (such as misreporting of age and survivor selection bias; underreporting of child deaths is also common) These under-five mortality rates have been estimated by applying methods to the available data from all Member States to ensure comparability across countries and time; hence they are not necessarily the same as the official national data.
Data type	Mortality estimate: probability of death derived from a life table and expressed as rate per 1000 live births.
Related links	WHO: http://apps.who.int/gho/data/node.wrapper.imr?x-id=1; http://www.who.int/whosis/whostat2006InfantAndUnder5MortalityRate.pdf?ua=1; http://apps.who.int/gho/data/node.wrapper.imr?x-id=4717 www.cme.org UNICEF: https://www.unicef.org/infobycountry/stats_popup1.html

GPW 13 WHO Impact Framework: **Milestone #7** Indicator Metadata

Milestone #7	**Reduce the preventable deaths of newborns and children under 5 years of age by 17% and 30% respectively**
Indicator-2	Neonatal mortality rate
SDG/ Core 100	SDG 3.2.2
Definition	Probability that a child born in a specific year or period will die in the first 28 days of life (0-27 days), if subject to the age-specific mortality rates of that period, expressed per 1000 live births. Neonatal deaths (deaths among live births during the first 28 days of life)
Method of estimation/calculation	The UN Inter-Agency Group for Child Mortality Estimation (UN IGME) estimates are derived from national data from censuses, surveys or vital registration systems. The UN IGME does not use any covariates to derive its estimates. It only applies a curve fitting method to good-quality empirical data to derive trend estimates after data quality assessment. In most cases, the UN IGME estimates are close to the underlying data. The UN IGME aims to minimize the errors for each estimate, harmonize trends over time and produce up-to-date and properly assessed estimates. The UN IGME produces neonatal mortality rate estimates with a Bayesian spline regression model which models the ratio of neonatal mortality rate / (under-five mortality rate - neonatal mortality rate). Estimates of NMR are obtained by recombining the estimates of the ratio with UN IGME-estimated under-five mortality rate. See the references for details. For the underlying data mentioned above, the most frequently used methods are as follows: Civil registration: Number of children who died during the first 28 days of life and the number of births used to calculate neonatal mortality rates. Census and surveys: Census often includes questions on household deaths in the last 12 months, which can be used to calculate mortality estimates. Surveys: A direct method is used based on a full birth history, a series of detailed questions on each child a woman has given birth to during her lifetime. Neonatal, post-neonatal, infant, child and under-five mortality estimates can be derived from full birth history module.
Numerator	Number of children who died in the first 28 days (0-27) of life (the total number is actually the probability of death derived from a life table)
Denominator	Number of live births
Preferred data sources	Data from civil registration and vital statistics.

Other possible data sources	censuses and household surveys.
WHO GPW13 Framework	Outcome
Disaggregation	By sex, place of residence, wealth quintile and mother's education
Expected frequency of data collection	Annual updates from the UN-IGME revisions
Limitations	The preferred source of data is a civil registration system that records births and deaths on a continuous basis. If registration is complete and the system functions efficiently, the resulting estimates will be accurate and timely. However, many countries do not have well-functioning vital registration systems. In such cases, household surveys, such as the UNICEF-supported Multiple Indicator Cluster Surveys (MICS), the USAID-supported Demographic and Health Surveys (DHS) and periodic population censuses have become the primary sources of data on under-five mortality. These surveys ask women about the survival of their children, and it is these reports that provide the basis of child mortality estimates for a majority of low- and middle- income countries. These data, however, are often subject to sampling or non-sampling errors (such as misreporting of age and survivor selection bias; underreporting of child deaths is also common) These under-five mortality rates have been estimated by applying methods to the available data from all Member States to ensure comparability across countries and time; hence they are not necessarily the same as the official national data.
Data type	Mortality estimate: probability of death derived from a life table and expressed as rate per 1000 live births.
Related links	WHO: http://apps.who.int/gho/data/node.wrapper.imr?x-id=1; http://www.who.int/whosis/whostat2006InfantAndUnder5MortalityRate.pdf?ua=1; http://apps.who.int/gho/data/node.wrapper.imr?x-id=4717 UNICEF: https://www.unicef.org/infobycountry/stats_popup1.html

GPW 13 WHO Impact Framework: **Milestone #8** Indicator Metadata

Milestone #8	**Reduce number of new HIV infections per 1000 uninfected population, by sex, age, and key populations by 73%**
Indicator	Number of new HIV infections per 1000 uninfected population, by sex, age and key populations
SDG/ Core 100	SDG 3.3.1
Definition	The number of new HIV infections per 1,000 uninfected population, by sex, age and key populations as defined as the number of new HIV infections per 1000 person-years among the uninfected population.
Method of estimation/calculation	Longitudinal data on individuals are the best source of data but are rarely available for large populations. Special diagnostic tests in surveys or from health facilities can be used to obtain data on HIV incidence. HIV incidence is thus modelled using the Spectrum software.
Numerator	Number of new HIV infections by sex, age and key populations
Denominator	Total uninfected population by sex, age and key populations
Preferred data sources	Spectrum modelling, household or key population surveys with HIV incidence-testing
Other possible data sources	Other possible data sources: Regular surveillance system among key populations.
WHO GPW13 Framework	
Disaggregation	General population, Key populations (men who have sex with men, sex workers, people who inject drugs, transgender people, prisoners), Age groups (0-14, 15-24, 15-49, 50+ years), for key populations (< 25, 25+ years), mode of transmission (including mother-to-child transmission), place of residence, sex
Expected frequency of data collection	
Limitations	
Data type	Rate
Related links	http://www.unaids.org/en/dataanalysis/datatools/spectrumepp UNAIDS Global AIDS response progress reporting 2015: construction of core indicators for monitoring the 2011 http://www.unaids.org/sites/default/files/media_asset/JC2702_GARPR2015guidelines_en.pdf a2015

GPW 13 WHO Impact Framework: **Milestone #9** Indicator Metadata

Milestone #9	**Reduce by 27% the number of new TB cases per 100 000 population**
Indicator	Tuberculosis incidence per 100 000 population
SDG/ Core 100	SDG 3.3.2
Definition	Tuberculosis incidence is defined as the estimated number of new and relapse TB cases (all forms of TB, including cases in people living with HIV) arising in a given year, expressed as a rate per 100 000 population.
Method of estimation/calculation	Estimates of incidence for each country are derived using one or more of the following approaches, depending on available data: (i) incidence = case notifications/estimated proportion of cases detected; (ii) capture-recapture modelling; (iii) incidence = prevalence/duration of condition.
Numerator	Estimated number of new and relapse TB cases (all forms of TB, including cases in people living with HIV) arising in a given year
Denominator	Total population
Preferred data sources	High-quality surveillance systems in which underreporting is negligible, and strong health systems so that under-diagnosis is also negligible
Other possible data sources	Annual case notifications, assessments of the quality and coverage of TB notification data, national surveys of the prevalence of TB disease and information from death (vital) registration systems
WHO GPW13 Framework	Outcome
Disaggregation	By country, sex, age (children vs adults).
Expected frequency of data collection	Annual
Limitations	Uncertainty in indicator values
Data type	Rate
Related links	https://unstats.un.org/sdgs/metadata/files/Metadata-03-03-02.pdf

GPW 13 WHO Impact Framework: **Milestone #10** Indicator Metadata

Milestone #10	**Reduce malaria case incidence by 50%**
Indicator	Malaria incidence per 1 000 population
SDG/ Core 100	SDG 3.3.3
Definition	The number of new cases of malaria per 1,000 people at risk each year.
Method of estimation/calculation	Three main methods are used to estimate the number of malaria cases and incidence. *Category 1 method – adjusted routine data*. This method usually applies to countries outside sub-Saharan Africa and to Botswana, Ethiopia, Namibia and Rwanda, where the public health sector surveillance system is good but some clinical diagnosis of cases still occurs and a substantial proportion of patients use the private sector or do not seek treatment. For such countries, case data reported by the NMCPs are adjusted for test positivity rate (where clinical cases are also reported), public health sector reporting rates, fever treatment-seeking rates in the private sector and the rates of not seeking treatment. *Category 2 method – parasite rate-to-incidence modelling*. Used for many countries in sub-Saharan Africa where the routine data is unreliable: surveillance systems do not capture all malaria cases, and data often come from the public health sector only and may not be reported consistently or may not be parasitologically confirmed. A method developed by the Malaria Atlas Project is used, which estimates cases by employing an epidemiological model of the relationship between parasite prevalence and case incidence within a geospatial framework. *Category 3 method – unadjusted routine data*. This approach involves use of routine data reported by NMCPs without any adjustments. Countries for which this approach was used were Algeria, Argentina, Belize, Bhutan, Cabo Verde, China, Comoros, Costa Rica, Democratic People's Republic of Korea, Ecuador, El Salvador, Iran (Islamic Republic of), Iraq, Malaysia, Mexico, Paraguay, Republic of Korea, Sao Tome and Principe, Saudi Arabia, South Africa, Suriname, Swaziland and Thailand. These are countries that have high-quality surveillance systems and are near elimination, having reported few malaria cases (<10 000 cases) in most of the years since 2010. For more details see SDG metadata file as referenced below.
Numerator	Total estimated number of new cases of malaria
Denominator	Total population
Preferred data sources	Country surveillance systems (number of suspected cases, number of tested cases, number of positive cases by method of detection and by species as well as number of health facilities that report those cases)
Other possible data sources	Representative household surveys
WHO GPW13 Framework	Outcome
Disaggregation	Country
Expected frequency of data collection	Annual
Limitations	The estimated incidence can differ from the incidence reported by a Ministry of Health which can be affected by (1) completeness of reporting (2) extent of malaria diagnostic testing, (3) use of private health facilities not included in reporting systems, and (4) estimation only where malaria transmission occurs.
Data type	Rate
Related links	https://unstats.un.org/sdgs/metadata/files/Metadata-03-03-03.pdf

GPW 13 WHO Impact Framework: **Milestone #11** Indicator Metadata

Milestone #11	**Reduce Hepatitis B incidence to 0.5% for children under 5 years**
Indicator	Hepatitis B incidence per 100 000 population
SDG/ Core 100	SDG 3.3.4 (Cumulated incidence of chronic HBV infection in children 5 years of age)
Definition	The number of new hepatitis B infections per 100,000 population in a given year is estimated from the prevalence of total antibodies against hepatitis B core antigen (Total anti-HBc) and hepatitis B surface antigen (HBsAg) positive among children 5 years of age, adjusted for sampling design.
Method of estimation/calculation	$\frac{\text{Number of survey participants with Total anti} - \text{HBc and HBsAg positive test}}{\text{Number in survey with Total anti} - \text{Hc/HBsAg result}}$
Numerator	Number of survey participants with Total anti-HBc and HBsAg positive test
Denominator	Number in survey with Total anti-Hc/HBsAg result
Preferred data sources	Serosurvey
Other possible data sources	Routinely collected hepatitis B vaccine administrative coverage data including the proportion newborn infants given the first dose within 24 hours of birth (HepB0%) and the percentage of infants having received three doses of hepatitis B vaccine (HepB3 %)
WHO GPW13 Framework	Outcome
Disaggregation	By sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education, wealth quintile).
Expected frequency of data collection	Intermittent, dependent on population seroprevalence of HBsAg before hepatitis B immunization and infant hepatitis B vaccination coverage.
Limitations	
Data type	Rate
Related links	Hepatitis B Control Through Immunization: a Reference Guide http://iris.wpro.who.int/bitstream/10665.1/10820/3/9789290616696_eng.pdf Documenting the Impact of Hepatitis B Immunization: best practices for conducting a serosurvey http://whqlibdoc.who.int/hq/2011/WHO_IVB_11.08_eng.pdf Sample design and procedures for Hepatitis B immunization surveys: A companion to the WHO cluster survey reference manual http://whqlibdoc.who.int/hq/2011/WHO_IVB_11.12_eng.pdf

GPW 13 WHO Impact Framework: **Milestone #12** Indicator Metadata

Milestone #12	**Reduction of people requiring interventions for NTDs by 400 million**
Indicator	Number of people requiring interventions against neglected tropical diseases
SDG/ Core 100	SDG 3.3.5
Definition	Number of people requiring treatment and care for any one of the neglected tropical diseases (NTDs) targeted by the WHO NTD Roadmap, World Health Assembly resolutions and reported to WHO
Method of estimation/calculation	Some estimation is required to aggregate data across interventions and diseases. There is an established methodology that has been tested and an agreed international standard. [http://www.who.int/wer/2012/wer8702.pdf?ua=1] 1) Average annual number of people requiring mass treatment known as preventive care (PC) for at least one PC-NTD: People may require PC for more than one PC-NTD. The number of people requiring PC is compared across the PC-NTDs, by age group and implementation unit (e.g. district). The largest number of people requiring PC is retained for each age group in each implementation unit. The total is considered to be a conservative estimate of the number of people requiring PC for at least one PC-NTD. Prevalence surveys determine when an NTD has been eliminated or controlled and PC can be stopped or reduced in frequency, such that the average annual number of people requiring PC is reduced. 2) Number of new cases requiring individual treatment and care for other NTDs: The number of new cases is based on country reports, whenever available, of new and known cases of Buruli ulcer, Chagas disease, cysticercosis, dengue, guinea-worm disease, echinococcosis, human African trypanosomiasis (HAT), leprosy, the leishmaniases, rabies and yaws. Where the number of people requiring and requesting surgery for PC-NTDs (e.g. trichiasis or hydrocele surgery) is reported, it can be added here. Similarly, new cases requiring and requesting rehabilitation (e.g. leprosy or lymphoedema) can be added whenever available. Populations referred to under 1) and 2) may overlap; the sum would overestimate the total number of people requiring treatment and care. The maximum of 1) or 2) is therefore retained at the lowest common implementation unit and summed to get conservative country, regional and global aggregates. By 2030, improved co-endemicity data and models will validate the trends obtained using this simplified approach. A reduction of 400 million is calculated by subtracting current year numerator by baseline year numerator (2017)
Numerator	Number of people requiring interventions against neglected tropical diseases
Denominator	NA
Preferred data sources	The number of people requiring treatment and care for NTDs is measured by existing country systems, and reported through joint request and reporting forms for donated medicines, the integrated NTD database, and other reports to WHO.
Other possible data sources	Develop a standard protocol for systematic data collection for NTDs through World Health Survey Plus (WHS+)._

WHO GPW13 Framework	Impact
Disaggregation	Disaggregation by age is required for PC: pre-school-aged children (1-4 years), school-aged (5-14 years) and adults (= 15 years).
Expected frequency of data collection	Annual
Limitations	Country reports may not be perfectly comparable over time. Improved surveillance and case-finding may lead to an apparent increase in the number of people known to require treatment and care. Some further estimation may be required to adjust for changes in surveillance and case-finding. Missing country reports may need to be imputed for some diseases in some years.
Data type	Absolute number
Related links	https://unstats.un.org/sdgs/metadata/?Text=&Goal=3&Target=3.3 http://www.who.int/neglected_diseases/mediacentre/resolutions/en/ http://www.who.int/neglected_diseases/resources/NTD_Generic_Framework_2015.pdf

GPW 13 WHO Impact Framework: **Milestone #13** Indicator Metadata

Milestone #13	**20% relative reduction in the premature mortality (age 30-70 years) from NCDs (cardiovascular, cancer, diabetes, or chronic respiratory diseases) through prevention and treatment**
Indicator	Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory diseases
SDG/ Core 100	SDG 3.4.1
Definition	Probability of dying between the exact ages 30 and 70 years from cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases. Deaths from these four causes will be based on the following ICD-10 codes: I00-I99, C00-C97, E10-E14, and J30-J98.
Method of estimation/calculation	Age-specific death rates for the combined four cause categories (typically in terms of 5-year age groups30-34, 65-69). A life table method allows calculation of the risk of death between exact ages30 and70 from any of these causes, in the absence of other causes of death. The ICD codes to be included in the calculation are: cardiovascular disease: I00-I99, Cancer: C00-C97, Diabetes: E10-E14, or Chronic respiratory diseases: J30-J98. To calculate age-specific mortality rate for each 5-year age group and country, for each 5-year age range between 30 and 70: $${}^{*}_{5}M_x = \frac{Total\ deaths\ from\ four\ major\ NCD\ causes\ between\ exact\ age\ x\ and\ exact\ age\ x+5}{Total\ population\ between\ exact\ age\ x\ and\ exact\ age\ x+5}$$ Then translate the 5-year death rate to the probability of death in each 5-year age range: $${}^{*}_{5}q_x = \frac{{}^{*}_{5}M_x * 5}{1 + {}^{*}_{5}M_x * 2.5}$$ The probability of death from age 30 to 70 years, independent of other causes of death can be calculated as: $${}^{*}_{40}q_{30} = 1 - \prod_{x=30}^{65}(1 - {}^{*}_{5}q_x)$$
Numerator	See above
Denominator	See above
Preferred data sources	Vital registration systems which record deaths with sufficient completeness to allow estimation of all-cause death rates.
Other possible data sources	Sample registration systems; verbal autopsy.
WHO GPW13 Framework	Outcome
Disaggregation	By sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education, wealth quintile).
Expected frequency of data collection	Annual
Limitations	- incomplete or unusable death registration data

Data type	Probability
Related links	WHO: http://www.who.int/gho/ncd/mortality_morbidity/ncd_premature_text/en/; http://www.who.int/healthinfo/statistics/LT_method.pdf.

GPW 13 WHO Impact Framework: **Milestone #14** Indicator Metadata

Milestone #14	**Reduce suicide mortality rate by 15%**
Indicator	Suicide mortality rate
SDG/ Core 100	SDG 3.4.2
Definition	Number of suicide deaths divided by the population and multiplied by 100,000 in a country in a given period of time. Suicide deaths will be based on the following ICD-10 codes: X60-X84, Y87.0.
Method of estimation/calculation	Suicide mortality rate = $\frac{Number\ of\ deaths\ from\ suicide}{Total\ population} \times 100{,}000$
Numerator	Number of suicide deaths in a given period of time
Denominator	Total population in a given period of time
Preferred data sources	Vital registration systems which record deaths with sufficient completeness to allow estimation of cause-specific death rates.
Other possible data sources	Sample registration systems; verbal autopsy.
WHO GPW13 Framework	Outcome
Disaggregation	By sex, age.
Expected frequency of data collection	Annual
Limitations	- incomplete or unusable death registration data
Data type	Rate
Related links	WHO: http://www.who.int/gho/mental_health/mental_health_indicatorbook.pdf?ua=1.

GPW 13 WHO Impact Framework: **Milestone #15** Indicator Metadata

Milestone #15	**Increase service coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders to xx*%.**
Indicator	Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders
SDG/ Core 100	SDG 3.5.1 (tier 3)
Definition	Substance use disorders include substance dependence and harmful pattern of substance use. Severe substance use disorders include substance dependence only.
Method of estimation/calculation	There are two approaches currently under development and testing towards the indicator report: 1) Estimation based on actual service utilization: $\text{Treatment coverage} = \frac{\text{Treatment demands (Number of people in contact with treatment services)}}{\text{Treatment needs (Number of people with substance use disorders)}} \times 100\%$ 2) Estimation based on composite indicator of service development: proxy-data reflecting major components of treatment systems for substance use disorders.
Numerator	Number of people with substance use disorders/substance dependence in contact with treatment services in a given year
Denominator	Total number of people with substance use disorders/substance dependence in the population in a given year
Preferred data sources	WHO ATLAS on Substance Use (ATLAS-SU) and associated data collection activities; WHO Global Information System on Alcohol and Health (GISAH) and associated data collection activities; UNODC data generated through Annual Report Questionnaire (ARQ) surveys; WHO-UNODC Facility surveys; data collected through National statistical systems and health system data; population-based household surveys; GBD data. for substance use dosor availability and utilization.
Other possible data sources	Other sources of information available from different international organizations and member states, such as administrative, project data, expert opinions, country-level targeted activities to generate and impute data.
WHO GPW13 Framework	
Disaggregation	By type of substances, substance use disorders and treatment modalities
Expected frequency of data collection	The frequency of data collection will remain the same: -annual data collection for illicit drugs component; -annual or at least biennial for alcohol and other substance use component;
Limitations	Effective coverage estimation may not feasible or limited to few predominantly high-income countries; In case of poor or unavailable data, country estimations may be limited to the level of availability coverage.
Data type	Percentage
Related links	ATLAS-SU: http://www.who.int/gho/substance_abuse/en/ GISAH: http://www.who.int/gho/alcohol/en/ UNODC World Drug Report: https://www.unodc.org/wdr2018/ http://www.who.int/mental_health/publications/action_plan/en/ http://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2017/en/

*exact milestone to be finalized

GPW 13 WHO Impact Framework: **Milestone #16** Indicator Metadata

Milestone #16	**7% relative reduction in the harmful use of alcohol as appropriate, within the national context**
Indicator	Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in liters of pure alcohol
SDG/ Core 100	SDG 3.5.2
Definition	Consumption of pure alcohol (ethanol) in litres per person aged 15+ years during one calendar year.
Method of estimation/calculation	Recorded alcohol per capita (15+) consumption of pure alcohol is calculated as the sum of beverage-specific alcohol consumption of pure alcohol (beer, wine, spirits, other) based on data collection by WHO from different sources. The first priority in the decision tree is given to government statistics ; second are country-specific data in the public domain from data providers supported by the alcohol industry based on results of the field work at country level or data from the International Organisation of Vine and Wine (OIV); third is the Food and Agriculture Organization of the United Nations' statistical database (FAOSTAT); and fourth is data from industry-supported data in the public domain based on desk reviews. To make the conversion into litres of pure alcohol, the alcohol content (% alcohol by volume) is as follows: Beer (barley beer 5%), Wine (grape wine 12%; must of grape 9%, vermouth 16%), Spirits (distilled spirits 40%; spirit-like 30%), and Other (sorghum, millet, maize beers 5%; cider 5%; fortified wine 17% and 18%; fermented wheat and fermented rice 9%; other fermented beverages 9%). Unrecorded alcohol consumption refers to alcohol which is not taxed and is outside the usual system of governmental control, such as home or informally produced alcohol (legal or illegal), smuggled alcohol, surrogate alcohol (which is alcohol not intended for human consumption), or alcohol obtained through cross-border shopping (which is recorded in a different jurisdiction). Unrecorded alcohol consumption was estimated as a percentage of total alcohol consumption. Country-level proportions of unrecorded alcohol consumption were estimated using a regression analysis with input data collected by WHO from different sources. Data sources included expert judgements from a WHO survey, nominal expert group Delphi surveys, and WHO STEPS surveys. Tourist consumption takes into consideration alcohol purchased and consumed by tourists to a country and alcohol purchased and consumed when people are visiting countries other than their home country. For total alcohol per capita consumption by sex, the proportion of alcohol consumed by men versus women (from surveys) and the demographics (from UN population data) were used. Population data came from the UN World Population Prospects. Total alcohol per capita consumption = $\frac{Sum\ of\ recorded\ and\ unrecorded\ alcohol\ consumed\ in\ a\ population\ during\ a\ calendear\ year}{Midyear\ resident\ population\ aged\ 15{+}years\ in\ the\ same\ calendar\ year}$
Numerator	Sum of recorded and unrecorded alcohol consumed in a population during a calendar year, adjusted for tourist consumption, in litres.
Denominator	Midyear resident population aged 15+ for the same calendar year.
Preferred data sources	Administrative reporting systems for recorded APC and survey data for unrecorded APC. The priority of data sources for recorded alcohol per capita consumption should be given to government statistics on sales/taxation of alcoholic beverages during a calendar year or data on production, export and import of alcohol in different beverage categories. For countries, where the governmental sales or production data is not available, the preferred data source would be country specific and publicly available data from the private sector, including alcohol producers or country specific data from the Food and Agriculture Organization of the United Nations statistical database (FAOSTAT), which may also include the estimates of unrecorded alcohol consumption. Data sources for unrecorded alcohol consumption include survey data, customs or police data, and expert opinions.

Other possible data sources	Data sets of FAO and UN Statistical office
WHO GPW13 Framework	Risk factor exposure
Disaggregation	By age, sex.
Expected frequency of data collection	Annual
Limitations	- gaps in administrative records of sales or production, import, export of alcoholic beverages - surveys may be subject to under-reporting of alcohol consumption, - mis-interpretation of questions and/or size of a standard drink, or associated with validity of the survey instruments
Data type	Volume (litres per capita)
Related links	WHO: http://apps.who.int/gho/data/node.gisah.GISAH?showonly=GISAH

GPW 13 WHO Impact Framework: **Milestone #17** Indicator Metadata

Milestone #17	**Reduce the number of global deaths and injuries from road traffic accidents by 20%**
Indicator	Death rate due to road traffic injuries
SDG/ Core 100	SDG 3.6.1
Definition	Absolute figure indicating the number of people who die as a result of a road traffic crash.
Method of estimation/calculation	Our model is based on the quality of data we received. As a health organization, we rely primarily on the submission of vital registration data from countries' Ministries of Health to WHO (through the official channels). These data, on all causes of death, are then analysed by our colleagues in the Health Information Systems department to decide on how good the data are, that is, determining if there is good completeness and coverage of deaths for all causes. We classified the countries on 4 categories or groups namely, Group1: Countries with death registration data (good vital/ death registration data) Group2: Countries with other sources of information on causes of death Group3: Countries with population less than 150 000 Group4: Countries without eligible death registration data.
Numerator	Number of deaths due to road traffic crashes
Denominator	Total population
Preferred data sources	For the road traffic deaths, we have two sources of data. Data from Global Status Report on Road Safety survey and Vital registration or certificate deaths data that WHO receive every year from member states (ministries of health).
Other possible data sources	
WHO GPW13 Framework Disaggregation	Types of road users, age, sex, income groups and WHO regions
Expected frequency of data collection	Biennial
Limitations	There are no vital registration data for all countries to make comparison against the data received on the survey. We published only confidence intervals for countries that have poor completeness of vital registration data. Also, we cannot collect road traffic data every year using this methodology outlined in the Global status report.
Data type	Rate
Related links	http://www.who.int/violence_injury_prevention http://www.who.int/violence_injury_prevention/road_safety_status/2015/en/

GPW 13 WHO Impact Framework: **Milestone #18** Indicator Metadata

Milestone #18	**Increase the proportion of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods to 66%**
Indicator	Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods
SDG/ Core 100	SDG 3.7.1
Definition	The percentage of women of reproductive age (15-49 years) who desire either to have no (additional) children or to postpone the next child and who are currently using a modern contraceptive method.
Method of estimation/calculation	The numerator is the percentage of women of reproductive age (15-49 years old) who are currently using, or whose sexual partner is currently using, at least one modern contraceptive method. The denominator is the total demand for family planning (the sum of contraceptive prevalence (any method) and the unmet need for family planning). Estimates are with respect to women who are married or in a union.
Numerator	Percentage of women of reproductive age (15-49 years old) who are currently using, or whose sexual partner is currently using, at least one modern contraceptive method.
Denominator	Total demand for family planning (the sum of contraceptive prevalence (any method) and the unmet need for family planning).
Preferred data sources	This indicator is calculated from nationally-representative household survey data. Multi-country survey programmes that include relevant data for this indicator are: Contraceptive Prevalence Surveys (CPS), Demographic and Health Surveys (DHS), Fertility and Family Surveys (FFS), Reproductive Health Surveys (RHS), Multiple Indicator Cluster Surveys (MICS), Performance Monitoring and Accountability 2020 surveys (PMA), World Fertility Surveys (WFS), other international survey programmes and national surveys.
Other possible data sources	
Disaggregation	Age, geographic location, marital status, socioeconomic status and other categories, depending on the data source and number of observations.
Expected frequency of data collection	Annual
Limitations	Differences in the survey design and implementation, as well as differences in the way survey questionnaires are formulated and administered can affect the comparability of the data. The most common differences relate to the range of contraceptive methods included and the characteristics (age, sex, marital or union status) of the persons for whom contraceptive prevalence is estimated (base population). The time frame used to assess contraceptive prevalence can also vary. In most surveys, there is no definition of what is meant by “currently using” a method of contraception. In some surveys, the lack of probing questions, asked to ensure that the respondent understands the meaning of the different contraceptive methods, can result in an underestimation of contraceptive prevalence, for traditional methods. Sampling variability can also be an issue, especially when contraceptive prevalence is measured for a specific subgroup (according to method, age-group, level of educational attainment, place of residence, etc.) or when analyzing trends over time.
Data type	Percentage
Related links	United Nations, Department of Economic and Social Affairs, Population Division (2017). World Contraceptive Use 2017 (POP/DB/CP/Rev2017). World Contraceptive Use 2017 (POP/DB/CP/Rev2017), United Nations Publication, (http://www.un.org/en/development/desa/population/publications/dataset/contraception/wcu2017.shtml)

GPW 13 WHO Impact Framework: **Milestone #19** Indicator Metadata

Milestone #19	**Increase coverage of essential health services**
Indicator	Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population)
SDG/ Core 100	SDG 3.8.1
Definition	Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population). The indicator is an index reported on a unitless scale of 0 to 100, which is computed as the geometric mean of 14 tracer indicators of health service coverage.
Method of estimation/calculation	The index is computed with geometric means, based on the methods used for the Human Development Index. The calculation of the 3.8.1 indicator requires first preparing the 14 tracer indicators so that they can be combined into the index, and then computing the index from those values. The 14 tracer indicators are first all placed on the same scale, with 0 being the lowest value and 100 being the optimal value. For most indicators, this scale is the natural scale of measurement, e.g., the percentage of infants who have been immunized ranges from 0 to 100 percent. However, for a few indicators additional rescaling is required to obtain appropriate values from 0 to 100, as follows: • Rescaling based on a non-zero minimum to obtain finer resolution (this "stretches" the distribution across countries): prevalence of non-raised blood pressure and prevalence of nonuse of tobacco are both rescaled using a minimum value of 50%. rescaled value = (X-50)/(100-50)*100 • Rescaling for a continuous measure: mean fasting plasma glucose, which is a continuous measure (units of mmol/L), is converted to a scale of 0 to 100 using the minimum theoretical biological risk (5.1 mmol/L) and observed maximum across countries (7.1 mmol/L). rescaled value = (7.1 - original value)/(7.1-5.1)*100 Note that in countries with low malaria burden, the tracer indicator for use of insecticide-treated nets is dropped from the calculation. • Maximum thresholds for rate indicators: hospital bed density and health workforce density are both capped at maximum thresholds, and values above this threshold are held constant at 100. These thresholds are based on minimum values observed across OECD
Numerator	This indicator is based on aggregate estimates.
Denominator	This indicator is based on aggregate estimates.
Preferred data sources	Many of the tracer indicators of health service coverage are measured by household surveys. However, administrative data, facility data, facility surveys, and sentinel surveillance systems are utilized for certain indicators.
Other possible data sources	
WHO GPW13 Framework	

Disaggregation	Geographic location, household wealth
Expected frequency of data collection	Data collection varies from every 1 to 5 years across tracer indicators. For example, country data on immunizations and HIV treatment are reported annually, whereas household surveys to collect information on child treatment may occur every 3-5 years, depending on the country.
Limitations	TBD
Data type	Index
Related links	https://unstats.un.org/sdgs/metadata/files/Metadata-03-08-01.pdf. Individual tracer indicators are available here: http://www.who.int/healthinfo/universal_health_coverage/UHC_Tracer_Indicators_Metadata.pdf

GPW 13 WHO Impact Framework: **Milestone #20** Indicator Metadata

Milestone #20	**Stop the rise in percent of people suffering financial hardship (defined as out-of-pocket spending exceeding ability to pay) in accessing health services**
Indicator	Proportion of population with large household expenditures on health as a share of total household expenditures or income
SDG/Core 100	SDG 3.8.2
Definition	Proportion of the population with large household expenditure on health as a share of total household expenditure or income. Two thresholds are used to define "large household expenditure on health": greater than 10% and greater than 25% of total household expenditure or income.
Method of estimation/calculation	Population weighted average number of people with large household expenditure on health as a share of total household expenditure or income $$\frac{\sum_i m_i \omega_i 1\left(\frac{health\ expenditure\ of\ the\ household\ i}{total\ expenditure\ of\ the\ household\ i} > \tau\right)}{\sum_i m_i\ \omega_i}$$ where *i* denotes a household, 1() is the indicator function that takes on the value 1 if the bracketed expression is true, and 0 otherwise, m_i corresponds to the household size (number of household members of *i)*, ω_i corresponds to the sampling weight of household *i.* Household's sample weight ω_i multiplied by the household size m_i is used to obtain representative numbers per person. If the sample is self-weighting t only the household size is used as the weight. τ is a threshold identifying large household expenditure on health as a share of total household consumption or income (i.e. 10% and 25%).
Numerator	Total number of people with large household expenditure on health as a share of total household expenditure or income (i.e. greater than 10% and 25%). Household expenditure on health is defined as any expenditure incurred at the time of service use to get any type of care (promotive, preventive, curative, rehabilitative, palliative or long-term care) including all medicines, vaccines and other pharmaceutical preparations as well as all health products, from any type of provider and for all members of the household. These health expenditures are characterized by ***a direct payment*** that are financed by a household's income (including remittances), savings or loans but do not include any third-party payer reimbursement. They are labelled ***Out-Of-Pocket (OOP) payments*** in the classification of health care financing schemes (HF) of the international Classification for Health Accounts (ICHA). The components of a household expenditure on health so defined should be consistent with division 06 of the UN Classification of Individual Consumption According to Purpose (COICOP-2018) and include expenditures on medicines and medical products (06.1), outpatient care services (06.2) and, inpatient care services (06.3) and other health services (06.4). Expenditure on household consumption and household income are both monetary welfare measures. The former is generally defined as the sum of the monetary values of all items (goods and services) consumed by the household during a reference period. It includes the imputed values of goods and services that are not purchased but procured otherwise for consumption. The most relevant measure of household income is disposable income as it is close to the maximum available to the household for consumption expenditure during the accounting period. Disposable income is defined as total income less direct taxes (net of refunds), compulsory fees and fines. Total income is generally composed of income from employment, property income, income from household production of services for own consumption, transfers received in cash and goods, transfers received as services. Expenditure on household consumption is the recommended monetary welfare measure.
Denominator	Total number of people

Preferred data sources	Key requirements for the selection of a data source is the availability of information on both ***household expenditures on health and household total expenditure or income***, from a population based survey nationally representative; the three most common data sources are household budget surveys (HBS), household income and expenditure surveys (HIES), socio-economic or living standards surveys. These surveys are typically implemented by or in close collaboration with national statistical bureaus.
Other possible data sources	Health surveys with a module collecting expenditure data on *both* household total expenditure (including on food, housing and utilities) and household expenditure on health
WHO GPW13 Framework	Yes
Disaggregation	Subnational variables available in survey data. Information on household location (urban vs rural); the gender, age and education of the head of the household; household characteristics; and other socio-economic variables are useful for equity analysis.
Expected frequency of data collection	Every 1–5 years depending on implementation of population-based household expenditure surveys led by national statistics offices
Limitations	This indicator attempts to identify financial hardship that individuals face when using their income, savings or taking loans to pay for health care. However, most household surveys fail to identify the source of funding used by a household who is reporting health expenditure. In countries where there is no retrospective reimbursement of household spending on health this is not a problem. But in those countries where there is retrospective reimbursement – for example, via a contributory health insurance scheme - the amount reported by a household on health expenditures might be totally or partially reimbursed at some later point, perhaps outside the recall period of the household survey. This indicator relies on a single cut-off point to identify what constitutes 'large health expenditure as a share of total household expenditure or income'. People just below or above such thresholds are not taken into account, which is always the problem with measures based on cut-offs. By plotting the cumulative distribution function of the health expenditure ratio, it is possible to identify the proportion of the population that is devoting any share of its household's budget to health for any threshold. Low values of these indicators can be driven by people's inability to spend anything at all on health. For this reason financial hardship needs to be monitored jointly with indicators of service coverage. There are other indicators used to monitor financial hardship. Within the GPW monitoring framework the definition adopted is consistent with the SDG definition of catastrophic health expenditures based on a budget share metric (indicator 3.8.2). Catastrophic health expenditures can be measured in different ways to enrich the analysis and provide policy advice tailored to individual countries. For an overview of different approaches to monitor catastrophic health expenditures using different versions of capacity-to-pay approaches (deducting for meeting basic needs) based on relevant global and regional resolutions see box 2.2 in chapter 2 of the 2017 WHO/WB Global UHC Monitoring Report as well as Cylus et al 2018 and Xu et al 2003. Financial hardship can also be monitored by estimating the proportion of the population with impoverishing health expenditure to link SDG goal 3.8 on Universal health coverage directly to the first SDG goal on poverty eradication. Different poverty lines can be used for monitoring at global, regional and country level. For more information see chapter 2 of the 2017 WHO/WB Global UHC
Data type	Percentage

Related links	*Metadata* SDG indictor 3.8.2 metadata Global reference list of 100 core indicator list - page 136 *Data portal on financial protection* UHC financial protection data portal *WHO webpages* WHO financial protection WHO-EURO financial protection *Reports* 2018 WHO-EURO country reviews on financial protection 2017 UHC global monitoring report 2017 regional reports on financial protection 2015 PAHO/WB report on UHC *COICOP-2018 division on health* UN Statistics Division. Division 06 of the UN Classification of Individual Consumption According to Purpose (COICOP-2018). New York. Internet site: https://unstats.un.org/unsd/class/revisions/coicop_revision.asp *Scientific papers (by year of publication)* Jonathan Cylus, Sarah Thomson,Tamás Evetovits ,Catastrophic health spending in Europe: equity and policy implications of different calculation methods. WHO bulletin 2018. http://dx.doi.org/10.2471/BLT.18.209031 Hui Wang, Lluis Vinyals Torres, Phyllida Travis. Financial protection analysis in eight countries in the WHO South-East Asia Region. WHO bulletin 2018. http://dx.doi.org/10.2471/BLT.18.209858 Hsu J, Flores G, Evans D et al. Measuring financial protection against catastrophic health expenditures: methodological challenges for global monitoring. 2017. International Journal for Equity in Health 2018, 17:69. https://doi.org/10.1186/s12939-018-0749-5 Wagstaff A, Flores G, Hsu J et al. Progress on catastrophic health spending: results for 133 countries. A retrospective observational study. Lancet Global Health. 2017. http://dx.doi.org/10.1016/S2214-109X(17)30429-1 Wagstaff A, Flores G, Smitz M-F et al. Progress on impoverishing health spending: results for 122 countries. A retrospective observational study. 2017. http://dx.doi.org/10.1016/S2214-109X(17)30486-2 Saksena P, Hsu J, Evans DB. Financial risk protection and universal health coverage: evidence and measurement challenges. PLoS Med. 2014;11(9):e1001701. https://doi.org/10.1371/journal.pmed.1001701 Xu K, Evans DB, Carrin G, Aguilar-Rivera AM, Musgrove P, Evans T. Protecting households from catastrophic health spending. Health Aff (Millwood). 2007;26(4):972-83. https://doi.org/10.1377/hlthaff.26.4.972 Xu K, Evans DB, Kawabata K et al. Household catastrophic health expenditure: a multicountry analysis. Lancet. 2003;362(9378):111-7. https://doi.org/10.1016/S0140-6736(03)13861-5 Wagstaff A, van Doorslaer E. Catastrophe and impoverishment in paying for health care: with applications to Vietnam 1993- 1998. Health Economics. 2003;12(11):921-34. https://doi.org/10.1002/hec.776

GPW 13 WHO Impact Framework: **Milestone #21** Indicator Metadata

Milestone #21	**Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination**
Indicator-1	Mortality rate attributed to household and ambient air pollution
SDG/ Core 100	SDG 3.9.1
Definition	Evidence from epidemiological studies have shown that exposure to ambient air pollution is linked, among others, to the important diseases taken into account in this estimate: acute respiratory infections in young children (estimated under 5 years of age); cerebrovascular diseases in adults (estimated above 25 years); ischemic heart diseases in adults (estimated above 25 years); chronic obstructive pulmonary disease in adults (estimated above 25 years); and lung cancer in adults (estimated above 25 years).
Method of estimation/calculation	Burden of disease attributed to air pollution is calculated by first combining information on the increased (or relative) risk of a disease resulting from exposure, with information on how widespread the exposure is in the population (in this case, the annual mean concentration of particulate matter to which the population is exposed). This allows calculation of the 'population attributable fraction' (PAF), which is the fraction of disease seen in a given population that can be attributed to the exposure, in this case the annual mean concentration of particulate matter. Applying this fraction to the total burden of disease (e.g. cardiopulmonary disease expressed as deaths or DALYs), gives the total number of deaths or DALYs that results from ambient air pollution. Population Attributed Fraction (PAF) = $\frac{\sum_{i=1}^{n} P_i \times RR_i - \sum_{i=1}^{n} P_i' \times RR_i}{\sum_{i=1}^{n} P_i \times RR_i}$ P_i = proportion of population at exposure level *i*, current exposure P_i' = proportion of population at exposure level *i*, counterfactual or ideal level of exposure RR = the relative risk at exposure level *i* *n* = the level of exposure levels Mortality rate attributed to household and ambient air pollution = $\frac{Total\ number\ of\ deaths\ attributed\ to\ household\ and\ ambient\ air\ pollution}{Total\ population} \times 100{,}000$
Numerator	Total number of deaths attributed to household and ambient air pollution
Denominator	Total population
Preferred data sources	Civil registration with complete coverage and medical certification of cause of death; Special studies
Other possible data sources	Sample Registration Systems and Verbal Autopsy
WHO GPW13 Framework	
Disaggregation	By age, sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education, wealth quintile).
Expected frequency of data collection	Annual or every 5 years
Limitations	- incomplete or unusable death registration data - measurement errors
Data type	Rate
Related links	WHO: http://apps.who.int/gho/data/node.wrapper.imr?x-id=2259; http://www.who.int/healthinfo/global_burden_disease/metrics_paf/en/.

GPW 13 WHO Impact Framework: **Milestone #21** Indicator Metadata

Milestone #21	**Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination**
Indicator-2	Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)
SDG/ Core 100	SDG 3.9.2
Definition	Deaths attributable to unsafe water, sanitation and hygiene focusing on inadequate WASH services, expressed per 100,000 population. Death rates are calculated by dividing the number of deaths by the total population. Evidence from epidemiological studies have shown that exposure to unsafe water, sanitation and hygiene habits is, among others, directly linked to diarrhoeal diseases and intestinal nematode infections and other diseases. Repeated diarrhoea episodes are linked to protein-energy malnutrition. In this estimate, only the impact of diarrhoeal diseases, intestinal nematode infections, and protein-energy malnutrition are taken into account. The included diseases are the WASH attributable portions of diarrhoea (ICD-10 code A00, A01, A03, A04, A06-A09), intestinal nematode infections (ICD-10 code B76-B77, B79) and protein-energy malnutrition (ICD-10 code E40-E46).
Method of estimation/calculation	Attributable diarrhoea deaths are calculated by first combining information on the increased (or relative) risk of a disease resulting from exposure, with information on how widespread the exposure is in the population (in this case, the percentage of the population with exposure to unsafe water, sanitation and lack of hygiene). This allows calculation of the 'population attributable fraction' (PAF), which is the fraction of disease seen in a given population that can be attributed to the exposure, in this case lack of access to improved water, sanitation and hygiene. Applying this fraction to the total deaths from diarrhoea results in the number of diarrhoea deaths that results from inadequate water, sanitation and hygiene. Deaths from protein-energy malnutrition attributable to inadequate water, sanitation and hygiene are estimated by evaluating the impacts of repeated infectious diarrhoea episodes on nutritional status (in particular stunting). All deaths from intestinal nematode infections are attributed to inadequate water, sanitation and hygiene due to their transmission pathway.
Numerator	Total number of deaths attributed to unsafe water, unsafe sanitation and lack of hygiene
Denominator	Total population
Preferred data sources	Civil registration with complete coverage and medical certification of cause of death
Other possible data sources	Household surveys, special studies, sample or sentinel registration systems, population census, surveillance systems
WHO GPW13 Framework	Impact
Disaggregation	By age, sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education, wealth quintile).
Expected frequency of data collection	
Limitations	- incomplete or unusable death registration data - measurement errors
Data type	Rate
Related links	http://www.who.int/water_sanitation_health/diseases-risks/gbd_poor_water/en http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4255749/

GPW 13 WHO Impact Framework: **Milestone #21** Indicator Metadata

Milestone #21	**Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination**
Indicator-3	Mortality rate attributed to unintentional poisoning.
SDG/ Core 100	SDG 3.9.3
Definition	The mortality rate attributed to unintentional poisoning is defined as the number of deaths of unintentional poisonings in a year, divided by the population, and multiplied by 100 000.
Method of estimation/calculation	Mortality rate in the country attributed to unintentional poisoning per year is estimated. The ICD-10 codes corresponding to the indicator includes X40, X43-X44, X46-X49. The estimates for number of deaths attributed to unintentional poisoning are derived from the WHO Global Health Estimates (GHE), and the corresponding population estimates are derived from the UN World Population Prospects. Mortality rate attributed to unintentional poisoning = $$\frac{Total\ number\ of\ deaths\ attributed\ to\ \text{unintentional poisoning}}{Total\ population} \times 100{,}000$$
Numerator	Total number of deaths attributed to unintentional poisoning
Denominator	Total population
Preferred data sources	Civil registration with complete coverage and medical certification of cause of death; Special studies
Other possible data sources	Household surveys, special studies, sample or sentinel registration systems, population census, surveillance systems
WHO GPW13 Framework	
Disaggregation	By age, sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education, wealth quintile).
Expected frequency of data collection	Every 2-3 years
Limitations	- incomplete or unusable death registration data - measurement errors
Data type	Rate
Related links	WHO: http://apps.who.int/gho/data/node.wrapper.imr?x-id=2259; http://www.who.int/healthinfo/global_burden_disease/metrics_paf/en/.

GPW 13 WHO Impact Framework: **Milestone #21** Indicator Metadata

Milestone #21	**Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination**
Indicator-4	Proportion of population with primary reliance on clean fuels and technology
SDG/ Core 100	SDG 7.1.2
Definition	The percentage of the population that relies on clean fuels and technologies as the primary source of domestic energy for cooking. "Clean" is defined by the emission rate targets and specific fuel recommendations (i.e. against unprocessed coal and kerosene) included in the normative guidance WHO guidelines for indoor air quality: household fuel combustion.
Method of estimation/calculation	The indicator is calculated as the number of people using clean fuels and technologies divided by total population, expressed as percentage. Household energy use data are routinely collected at the national and sub national levels in most countries using censuses and surveys. Household surveys used include: United States Agency for International Development (USAID)-supported Demographic and Health Surveys (DHS); United Nations Children's Fund (UNICEF)-supported Multiple Indicator Cluster Surveys (MICS); WHO-supported World Health Surveys (WHS); national population and housing censuses and other reliable and nationally representative country surveys.
Numerator	The number of people using clean fuels and technologies for cooking, heating and lighting
Denominator	Total population
Preferred data sources	National survey, population census, household surveys
Other possible data sources	
WHO GPW13 Framework	Outcome
Disaggregation	Location (urban/rural)
Expected frequency of data collection	Annual
Limitations	The indicator uses clean fuels and technologies use as a proxy for indoor air pollution, as it is not currently possible to obtain nationally representative samples of indoor concentrations of criteria pollutants, such as small particles and carbon monoxide. The indicator is based on the main type of fuel used for cooking as cooking occupies the largest share of overall household energy needs. However, many households use more than one type of fuel for cooking and, depending on climatic and geographical conditions, heating with solid fuels can also be a contributor to indoor air pollution levels.
Data type	Percentage
Related links	https://www.who.int/airpollution/data/HAP_exposure_results_final.pdf?ua=1 https://www.who.int/indoorair/publications/burning-opportunities/en/

GPW 13 WHO Impact Framework: **Milestone #21** Indicator Metadata

Milestone #21	**Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination**
Indicator-5	Annual mean levels of fine particulate matter (e.g. PM2.5 and PM10) in cities (population weighted)
SDG/ Core 100	SDG 11.6.2
Definition	The mean annual concentration of fine suspended particles of less than 2.5 microns in diameters (PM2.5) is a common measure of air pollution. The mean is a population-weighted average for urban population in a country, and is expressed in micrograms per cubic meter [µg/m3].
Method of estimation/calculation	Although PM is measured at many thousands of locations throughout the world, the amount of monitors in different geographical areas vary, with some areas having little or no monitoring. In order to produce global estimates at high resolution (0.1° grid-cells), additional data is required. Annual urban mean concentration of PM2.5 is estimated with improved modelling using data integration from satellite remote sensing, population estimates, topography and ground measurements.
Numerator	Sum of levels of fine particulate matter in monitored locations
Denominator	Number of monitored locations
Preferred data sources	Special studies
Other possible data sources	
WHO GPW13 Framework	
Disaggregation	
Expected frequency of data collection	Every 2-3 years
Limitations	Urban/rural data: while the data quality available for urban/rural population is generally good for high-income countries, it can be relatively poor for some low- and middle income areas. Furthermore, the definition of urban/rural may greatly vary by country. Grid-size: The grid size used for the model is 0.1° x 0.1° (10 x 10 km close to the equator, but smaller towards the poles). This resolution may cause limitations when considering local situations. However finer resolutions are planned for future studies. Conversion from PM10: Where measurements of PM2.5 are not available, PM10 measurements are used after conversion to PM2.5 using country or regional conversion factors. Conversion factors range between 0.3-0.8 depending on location. Localized conversion factors are likely to be more accurate but the ability to calculate them relies on localized data being available. The potential for inaccuracies in conversion factors means that model outputs for areas using large numbers of converted values may be less accurate than those based directly on measurements of PM2.5 and extra care should be taken in their interpretation. Model calibration in data-poor areas: The model produces a calibration equation for each country using country level data as a priority, with regional data being used to supplement local information for countries without ground monitoring data. It is acknowledged that the estimates for data-poor countries may be relatively imprecise and this imprecision can result in apparently abrupt changes in air pollution levels at borders with data-poor countries. For enhanced accuracy of modelled data it is important that countries continue and/or improve their ground measurements.
Data type	Mean
Related links	www.who.int/gho/phe

GPW 13 WHO Impact Framework: **Milestone #22** Indicator Metadata

Milestone #22	**25% relative reduction in prevalence of current tobacco use in persons 15+ years**
Indicator	Age-standardized prevalence of current tobacco use among persons aged 15 years and older
SDG/ Core 100	SDG 3.a.1
Definition	"Smoked tobacco products" includes the consumption of cigarettes, bidis, cigars, cheroots, pipes, shisha (water pipes), fine-cut smoking articles (roll-your-own), kreteks, and any other form of smoked tobacco. "Smokeless tobacco" includes moist snuff, plug, creamy snuff, dissolvables, dry snuff, gul, loose leaf, red tooth powder, snus, chimo, gutkha, khaini, gudakhu, zarda, quiwam, dohra, tuibur, nasway, naas/naswar, shammah, betel quid, toombak, pan (betel quid), iq'mik, mishri, tapkeer, tombol and any other tobacco product that is sniffed, held in the mouth, or chewed.
Method of estimation/calculation	Prevalence of current tobacco use = $\frac{Number\ of\ respondents\ aged\ 15+\ years\ currently\ using\ any\ tobacco\ product\ (smoked\ or\ smokeless)}{Number\ of\ survey\ respondents\ aged\ 15+\ years} \times 100\%$
Numerator	Number of current tobacco users aged 15+ years. "Current users" includes both daily and non-daily users and smoked or smokeless tobacco.
Denominator	All respondents of the survey aged 15+ years.
Preferred data sources	Population-based (preferably nationally representative) survey.
Other possible data sources	
WHO GPW13 Framework	Risk factor exposure
Disaggregation	By age, sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education, wealth quintile).
Expected frequency of data collection	Annual or at least every 5 years
Limitations	- bias through self-report, including under-reporting of tobacco use - misunderstanding/ -interpretation of questions - limited validity of survey instruments - representativeness of the sample
Data type	Prevalence
Related links	WHO: http://www.who.int/tobacco/surveillance/survey/gats/en/; http://www.who.int/chp/steps/en/index.html.

GPW 13 WHO Impact Framework: **Milestone #23** Indicator Metadata

Milestone #23	**Increase coverage of 2nd dose of measles containing vaccine (MCV2) to 85%**
Indicator	Proportion of the target population covered by all vaccines included in their national programme
SDG/ Core 100	SDG 3.b.1
Definition	Percentage of children who received two doses of measles containing vaccine according to nationally recommended schedule through routine immunization services.
Method of estimation/calculation	WHO and UNICEF jointly developed a methodology to estimate national immunization coverage from selected vaccines in 2000. The methodology has been refined and reviewed by expert committees over time. The methodology was published and reference is available under web site. Estimates time series for WHO recommended vaccines produced and published annually since 2001. The methodology uses data reported by national authorities from countries administrative systems as well as data from immunization or multi indicator household surveys.
Numerator	Number of children vaccinated in the target group. (12-23 months or other age group depending on recommended national immunization schedule).
Denominator	Number of 2 years old children globally
Preferred data sources	National Health Information Systems or National Immunization systems National immunization registries
Other possible data sources	High quality household surveys with immunization module (e.g. DHS, MICS, national in-country surveys)
WHO GPW13 Framework	
Disaggregation	Geographical location, i.e. regional and national and potentially subnational estimates
Expected frequency of data collection	Annual data collection Annual data collection March-May each year. Country consultation June each year Data release: 15 July each year for time series 1980 – release year -1. (in July 2018 estimates from 1980-2017)
Limitations	Time series of coverage are subject to change when new data becomes available.
Data type	Percentage
Related links	WHO: http://www.who.int/immunization/monitoring_surveillance/routine/coverage/en/index4.html

GPW 13 WHO Impact Framework: **Milestone #24** Indicator Metadata

Milestone #24	**Increase availability of essential medicines for primary health care, including the ones free of charge to 80%**
Indicator	Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis
SDG/ Core 100	SDG 3.b.3
Definition	Percentage of public and private primary health care facilities who at least have all the following available essential medicines - aspirin, a statin, an angiotensin converting enzyme inhibitor, thiazide diuretic, a long acting calcium channel blocker, metformin, insulin, a bronchodilator and a steroid inhalant.
Method of estimation/calculation	% availability = $\frac{Number\ of\ facilities\ that\ have\ all\ essential\ medicines\ from\ the\ minimum\ list\ available}{Number\ of\ serveyed\ facilities} \times 100\%$
Numerator	Number of facilities that have available during assessment the minimum list of essential medicines. The minimum list is: Medicines - at least aspirin, a statin, an angiotensin converting enzyme inhibitor, thiazide diuretic, a long acting calcium channel blocker, metformin, insulin, a bronchodilator and a steroid inhalant.
Denominator	Number of surveyed facilities.
Preferred data sources	Nationally-representative health facility assessment
Other possible data sources	
WHO GPW13 Framework	
Disaggregation	Public, private
Expected frequency of data collection	Annual or every 5 years
Limitations	
Data type	Percentage
Related links	WHO: http://www.who.int/healthinfo/systems/sara_introduction/en/

GPW 13 WHO Impact Framework: **Milestone #25** Indicator Metadata

Milestone #25	**Increase health workforce density with improved distribution**
Indicator	Health worker density and distribution
SDG/ Core 100	SDG 3.c.1
Definition	**Density of medical doctors**: The density of medical doctors is defined as the number of medical doctors , including generalists and specialist medical practitioners per 10,000 population in the given national and/or subnational area. The International Standard Classification of Occupations (ISCO) unit group codes included in this category are 221, 2211 and 2212 of ISCO-08. **Density of nursing and midwifery personnel**: The density of nursing and midwifery personnel is defined as the number of nursing and midwifery personnel per 10,000 population in the given national and/or subnational area. The ISCO-08 codes included in this category are 2221, 2222, 3221 and 3222. **Density of dentists**: The density of dentists is defined as the number of dentists per 10,000 population in the given national and/or subnational area. The ISCO-08 codes included in this category are 2261. **Density of pharmacists**: The density of pharmacists is defined as the number of pharmacists per 10,000 population in the given national and/or subnational area. The ISCO-08 codes included in this category are 2262.
Method of estimation/calculation	The figures for number of medical doctors (including generalist and specialist medical practitioners) depending on the nature of the original data source may include practising medical doctors only or all registered medical doctors. The figures for number of nursing and midwifery include nursing personnel and midwifery personnel, whenever available. In many countries, nurses trained with midwifery skills are counted and reported as nurses. This makes the distinction between nursing personnel and midwifery personnel difficult to draw. The figures for number of dentists include dentists in the given national and/or subnational area. Depending on the nature of the original data source may include practising (active) only or all registered in the health occupation. The ISCO -08 codes included here are 2261. The figures for number of pharmacists include in the given national and/or subnational area. Depending on the nature of the original data source may include practising (active) only or all registered in the health occupation. The ISCO -08 codes that relate to this occupation is 2262.
Numerator	Numerator is defined as the number of health workers, defined in headcounts.
Denominator	Denominator data for workforce density (i.e. national population estimates) are obtained from the United Nations Population Division's World Population Prospects database.
Preferred data sources	This indicator will be reported by WHO using the National Health Workforce Accounts (NHWA). In response to WHA69.19, an online National Health Workforce Accounts (NHWA) data platform was developed to facilitate national reporting. In addition to the reporting, the platform also serves as an analytical tool at the national/regional and global levels. Since Its launch in November 2017, Member States are called to use the NHWA data platform to report health workforce data. Complementing the national reporting through the NHWA data platform, additional sources such as the National Census, Labour Force Surveys and key administrative national and regional sources are also employed. Most of the data from administrative sources are derived from published national health sector reviews and/or official country reports to WHO offices.

Other possible data sources	
WHO GPW13 Framework	
Disaggregation	National level data, subnational level data
Expected frequency of data collection	Annual
Limitations	Data on health workers tend to be more complete for the public health sector and may underestimate the active workforce in the private, military, nongovernmental organization and faith-based health sectors. In many cases, information maintained at the national regulatory bodies and professional councils are not updated. As data is not always published annually for each country, the latest available data has been used. Due to the differences in data sources, considerable variability remains across countries in the coverage, periodicity, quality and completeness of the original data. Densities are calculated using national population estimates from the United Nations Population Division's World Population Prospects database and may vary from densities produced by the country.
Data type	Rate
Related links	https://www.who.int/hrh/statistics/en/

GPW 13 WHO Impact Framework: **Milestone #26** Indicator Metadata

Milestone #26	**Increase in member states International Health Regulations capacities**
Indicator	International Health Regulations (IHR) capacity and health emergency preparedness.
SDG/ Core 100	SDG 3.d.1: Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks
Definition	States Parties to IHR (2005) submit reporting data to the Secretariat annually, measuring self-reported scores on 24 indicators. These indicators, with defined attributes, are scored from 0–5 (5 step) capacity levels. Each of 13 IHR (2005) capacities can be measured as the average of its indicator scores (range of 1–3 indicators per capacity). The tracer indicator is the average of scores for the 13 capacities. Countries can then be stratified into 5 levels, allowing for prioritization of preparedness efforts can be done. Progress can be measured by the cumulative population moving from one level of preparedness to a higher level.
Method of estimation/calculation	*IHR (2005) Capacity Level (Annual)* = $\frac{Sum\ of\ Self-Reported\ IHR\ Capacity\ Averages}{13}$
Numerator	State Party self-reported average of 13 IHR (2005) capacities, as measured by the SPAR.
Denominator	Total number of reported capacities (i.e., 13).
Preferred data sources	SPAR reports (available on the Global Health Observatory); Strategic Partnership for International Health Regulations (2005) and Health Security (https://extranet.who.int/sph/)
Other possible data sources	Joint external evaluation (JEE; available at https://extranet.who.int/sph/); Current Health Expenditure (CHE; available on Global Health Observatory); previous years' IHR (2005) self-assessment annual reporting data (available on Global Health Observatory).
WHO GPW13 Framework Disaggregation	Country; capacity.
Expected frequency of data collection	Annual
Limitations	Data are self-reported from Member States; analysis of self-report of capacities using the SPAR (2018) identified that there was a strong correlation between self-reported capacities and externally evaluated capacities. Although self-assessment annual reporting is mandated under IHR (2005), it is possible that not all Member States will submit a report in time for calculating the baseline. In this event, which is anticipated to be rare, previous years' annual reporting data, validated against other existing IHR (2005) monitoring and evaluation framework components, will be used to estimate a baseline value.
Data type	Self-reported assessment data, using a standardized tool. Average value (0–100) of indicator capacity levels, each expressed as an integer value from 0–5.
Related links	Global Health Observatory: http://www.who.int/gho/ihr/en/; SPH: https://extranet.who.int/sph/

GPW 13 WHO Impact Framework: **Milestone #27** Indicator Metadata

Milestone #27	**Increase the proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being to 80%**
Indicator	Proportion of children under 5 who are developmentally on track in health, learning and psychosocial well-being, by sex
SDG/ Core 100	SDG 4.2.1
Definition	The proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being is currently being measured by the percentage of children aged 36-59 months who are developmentally on-track in at least three of the following four domains: literacy-numeracy, physical, socio-emotional and learning.
Method of estimation/calculation	The number of children under the age of five who are developmentally on track in health, learning and psychosocial well-being divided by the total number of children under the age of five in the population multiplied by 100.
Numerator	The number of children under the age of five who are developmentally on track in health, learning and psychosocial well-being multiplied by 100
Denominator	Total number of children under the age of five in the population
Preferred data sources	The UNICEF-supported MICS surveys have been collecting data on this indicator and converting it into the the Early Childhood Development Index or ECDI in selected low- and middle-income countries since 2010. Many of the individual items included in the ECDI are collected through other mechanisms in high-income (OECD) countries as well.
Other possible data sources	
WHO GPW13 Framework	
Disaggregation	Age, sex, place of residence, wealth, geographic location, caregiver education and other background characteristics.
Expected frequency of data collection	Annual
Limitations	Comparable data are available for 58 low- and middle-income countries since 2010
Data type	Percentage
Related links	WHO: https://data.unicef.org/topic/early-childhood-development/development-status/

GPW 13 WHO Impact Framework: **Milestone #28** Indicator Metadata

Milestone #28	**Decrease the proportion of ever-partnered women and girls aged 15-49 years subjected to physical or sexual violence by a current or former intimate partner in the previous 12 months from 20% to 15%.**
Indicator	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age
SDG/ Core 100	SDG 5.2.1
Definition	This indicator measures the percentage of ever-partnered women and girls aged 15-49 years who have experienced physical, sexual or psychological violence by a current or former intimate partner, in the previous 12 months. Intimate partner violence is the most common form of violence against women and girls globally. Given prevailing social norms that sanction male dominance over women, violence between intimate partners is often perceived as ordinary, particularly in the context of marriage, cohabitation or any formal or informal union. Violence against women and girls is an extreme form of gender inequality.
Method of estimation/calculation	This indicator calls for breakdown by form of violence and by age group. Countries are encouraged to compute prevalence data for each form of violence, disaggregated by age as detailed below to assist comparability at regional and global levels: 1. Physical violence: Number of ever-partnered women and girls (aged 15-49 years who experience physical violence by a current or former intimate partner in the previous 12 months divided by the number of ever-partnered women and girls (aged 15 years and above) in the population multiplied by 100. 2. Sexual violence: Number of ever-partnered women and girls (aged 15-49 years) who experience sexual violence by a current or former intimate partner in the previous 12 months divided by the number of ever-partnered women and girls (aged 15 years and above) in the population multiplied by 100. 3. Any form of physical and/or sexual violence: Number of ever-partnered women and girls (aged 15-49 years) who experience physical and/or sexual violence by a current or former intimate partner in the previous 12 months divided by the number of ever-partnered women and girls (aged 15-49 years) multiplied by 100.
Numerator	*See method of estimation / calculation*
Denominator	*See method of estimation / calculation*
Preferred data sources	The main sources of intimate partner violence prevalence data for SDG Indicator 5.2.1 comprises data from internationally comparable population-based surveys that are (1) specialized national surveys dedicated to measuring violence against women and (2) international household surveys that include a module on experiences of violence by women, such as the DHS. Where available, other dedicated surveys are included if the data are deemed comparable. Since 2015, around 135 countries had conducted violence against women national prevalence surveys or have included a module on violence against women in a DHS or other national household survey.
Other possible data sources	
WHO GPW13 Framework	
Disaggregation	In addition to form of violence and age, income/wealth, education, ethnicity (including indigenous status), disability status, marital/partnership status, relationship with the perpetrator (i.e. current/former partner), geographic location and frequency of violence are suggested as desired variables for disaggregation for this indicator.

Expected frequency of data collection	
Limitations	Comparability: The availability of comparable data remains a challenge in this area as many data collection efforts have relied on different survey methodologies, used different definitions of partner or spousal violence and of the different forms of violence and different survey question formulations. Furthermore, diverse age groups are often utilized. Willingness to discuss experiences of violence and understanding of relevant concepts may also differ according to the cultural context and this can affect reported prevalence levels. Regularity of data production: Since 1995, only some 40 countries have conducted more than one survey on violence against women. Obtaining data on violence against women is a costly and time-consuming exercise, whether they are obtained through stand-alone dedicated surveys or through modules in other surveys. Feasibility: Psychological partner violence—which may be conceptualised differently across cultures and in different contexts—is still a Tear III sub-indicator. Since it is not yet feasible to report on psychological partner violence, this indicator currently reports on *physical and/or sexual intimate partner violence* only. Efforts are underway, led by WHO, to develop a global standard for measuring and reporting on psychological intimate partner violence. Similarly, this indicator calls for global reporting of violence experienced by ever-partnered women aged 15 years and above. However, most data come from DHS, which typically sample only women aged 15-49, and there is a lack of consistency in the age range of sample populations across other country surveys. For those surveys that interview a sample of women from a different age group, the prevalence for the 15-49 age group is often published or can be calculated from available data. The global indicator therefore currently reports violence experienced by ever-partnered women and girls 15-49 years of age. Efforts are underway to address this issue and to better understand and measure partner violence against women aged 50 and above.
Data type	Percentage
Related links	http://evaw-global-database.unwomen.org/en data.unicef.org http://unstats.un.org/unsd/gender/default.html

GPW 13 WHO Impact Framework: **Milestone #29** Indicator Metadata

Milestone #29	**Increase the proportion of women aged 15–49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care to 68%**
Indicator	Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care
SDG/ Core 100	SDG 5.6.1
Definition	Proportion of women aged 15-49 years (married or in union) who make their own decision on all three selected areas i.e. can say no to sexual intercourse with their husband or partner if they do not want; decide on use of contraception; and decide on their own health care. Only women who provide a "yes" answer to all three components are considered as women who "make her own decisions regarding sexual and reproductive".
Method of estimation/calculation	Proportion = Numerator X 100/Denominator [see numerator and denominator]
Numerator	Number of married or in union women aged 15-49 years old: – who can say "no" to sex; and – for whom the decision on contraception is not mainly made by the husband/partner; and – for whom decision on health care for themselves is not usually made by the husband/partner or someone else Only women who satisfy all three empowerment criteria are included in the numerator.
Denominator	Total number women aged 15-49 years old, who are married or in union.
Preferred data sources	Current data on the indicator are derived from nationally representative demographic and surveys (DHS). Plans are underway to broaden the data sources to include MICs and other country specific surveys.
Other possible data sources	
WHO GPW13 Framework	
Disaggregation	Based on available DHS data, disaggregation is possible by age, geographic location, place of residence, education, and wealth quintile.
Expected frequency of data collection	Currently data comes from the DHS which have three to five- year cycles.
Limitations	A key limitation is that current estimates of the indicator are based on currently married or in union women of reproductive age (15-49 years old) who are using any type of contraception. In the current DHS, the question on decision-making on use of contraception is only asked to women who are currently using contraception. Because the questions on decision- making on sexual relations and health care are restricted to women (15-49 years old) currently married or in union, the denominator for Indicator 5.6.1 is women 15-49 years old, who are currently married or in union and currently using contraception.
Data type	Percentage
Related links	

GPW 13 WHO Impact Framework: **Milestone #30** Indicator Metadata

Milestone #30	**Provide access to safely managed drinking water services for 1 billion more people**
Indicator	Proportion of population using safely managed drinking water services
SDG/ Core 100	SDG 6.1.1
Definition	Proportion of population using safely managed drinking water services is currently being measured by the proportion of population using an improved basic drinking water source which is located on premises, available when needed and free of faecal (and priority chemical) contamination. 'Improved' drinking water sources include: piped water into dwelling, yard or plot; public taps or standpipes; boreholes or tubewells; protected dug wells; protected springs; packaged water; delivered water and rainwater.
Method of estimation/calculation	Household surveys and censuses currently provide information on types of basic drinking water sources listed above, and also indicate if sources are on premises. These data sources often have information on the availability of water and increasingly on the quality of water at the household level, through direct testing of drinking water for faecal or chemical contamination. These data will be combined with data on availability and compliance with drinking water quality standards (faecal and chemical) from administrative reporting or regulatory bodies. The WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP) estimates access to basic services for each country, separately in urban and rural areas, by fitting a regression line to a series of data points from household surveys and censuses. This approach was used to report on use of 'improved water' sources for MDG monitoring. The JMP is evaluating the use of alternative statistical estimation methods as more data become available.
Numerator	Total estimated number of people using safely managed drinking water service
Denominator	Total population
Preferred data sources	Nationally representative household surveys, censuses, and administrative data. Currently the JMP database holds over 1,700 censuses and surveys. In high-income countries where household surveys or censuses do not always collect information on basic access, data are drawn from administrative records.
Other possible data sources	
WHO GPW13 Framework	
Disaggregation	Disaggregation by place of residence (urban/rural) and socioeconomic status (wealth, affordability) is possible for all countries. Disaggregation by other stratifiers of inequality (subnational, gender, disadvantaged groups, etc.) will be made where data permit. Drinking water services will be disaggregated by service level (including no services, basic, and safely managed services) following the
Expected frequency of data collection	Biennial
Limitations	
Data type	Percentage
Related links	JMP website: www.washdata.org. JMP 2017 update and SDG baselines https://washdata.org/report/jmp-2017-report-final Safely managed drinking water thematic report https://washdata.org/report/jmp-2017-tr-smdw WHO Guidelines for Drinking Water Quality: http://www.who.int/water_sanitation_health/dwq/guidelines/en/

GPW 13 WHO Impact Framework: **Milestone #31** Indicator Metadata

Milestone #31	**Provide access to safely managed sanitation services for 800 million more people**
Indicator	Proportion of population using (a) safely managed sanitation services and (b) a hand-washing facility with soap and water
SDG/ Core 100	SDG 6.2.1
Definition	The proportion of population using safely managed sanitation services, including a hand-washing facility with soap and water is currently being measured by the proportion of the population using a basic sanitation facility which is not shared with other households and where excreta is safely disposed in situ or treated off-site. 'Improved' sanitation facilities include: flush or pour flush toilets to sewer systems, septic tanks or pit latrines, ventilated improved pit latrines, pit latrines with a slab, and composting toilets. Population with a basic handwashing facility: a device to contain, transport or regulate the flow of water to facilitate handwashing with soap and water in the household.
Method of estimation/calculation	Household surveys and censuses provide data on use of types of basic sanitation facilities listed above, as well as the presence of handwashing materials in the home. The percentage of the population using safely managed sanitation services is calculated by combining data on the proportion of the population using different types of basic sanitation facilities with estimates of the proportion of faecal waste which is safely disposed in situ or treated off-site.
Numerator	Total estimated number of people using safely managed sanitation services
Denominator	Total population
Preferred data sources	Nationally representative household surveys, censuses, and administrative data. Currently the JMP database holds over 1,700 surveys and censuses. In high-income countries where household surveys or censuses do not always collect information on basic access, data are drawn from administrative records. Estimates of excreta management will be collected from countries and used to adjust the data on use of basic sanitation facilities as needed. Administrative, population and environmental data can also be combined to estimate safe disposal or transport of excreta, when no country data are available. Data on disposal or treatment of excreta are limited but estimates for safe management of faecal wastes can be calculated based on faecal waste flows associated with the use of different types of basic sanitation facility. Since the handwashing with soap survey questions were standardized in 2009, over 70 DHS and MICS surveys have included the module. JMP published handwashing estimates for 12 countries in its 2014 update, for 54 countries in its 2015 update, and for 70 countries in its 2017 update. The population data used by JMP, including the proportion of the population living in urban and rural areas, are those established by the UN Population Division.
Other possible data sources	
WHO GPW13 Framework	
Disaggregation	Disaggregation by place of residence (urban/rural) and socioeconomic status (wealth, affordability) is possible for all countries. Disaggregation by other stratifies of inequality (subnational, gender, disadvantaged groups, etc.) will be made where data permit. Sanitation services will be disaggregated by service level (including no services, basic, and safely managed services) following the JMP sanitation ladder.
Expected frequency of data collection	Biennial

Limitations	A framework for measuring faecal waste flows and safety factors has been developed and piloted in 12 countries (World Bank Water and Sanitation Program, 2014), and is being adopted and scaled up within the sanitation sectors. This framework has served as the basis for indicators 6.2.1 and 6.3.1. Data on safe disposal and treatment are not available for all countries. However, sufficient data were available to make global and regional estimates of safely managed sanitation services in 2017. Presence of a handwashing station with soap and water does not guarantee that household members consistently wash hands at key times, but has been accepted as the most suitable proxy. Data were available for 70 countries in 2017.
Data type	Percentage
Related links	www.washdata.org JMP website: www.washdata.org. JMP 2017 update and SDG baselines https://washdata.org/report/jmp-2017-report-final Ram, P., Practical Guidance for Measuring Handwashing Behaviour: 2013 update, World Bank Water Supply and Sanitation Programme, 2013. http://www.wsp.org/sites/wsp.org/files/publications/WSP-Practical-Guidance-Measuring-HandwashingBehavior-2013-Update.pdf"

GPW 13 WHO Impact Framework: **Milestone #32** Indicator Metadata

Milestone #32	**Decrease the number of children subjected to violence in the past 12 months, including physical and psychological violence by care givers in the past month, by 20%**
Indicator	Proportion of children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month
SDG/ Core 100	SDG 16.2.1
Definition	Proportion of children aged 1-17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month is currently being measured by the Proportion of children aged 1-14 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month.
Method of estimation/calculation	Number of children aged 1-17 years who are reported to have experienced any physical punishment and/or psychological aggression by caregivers in the past month divided by the total number of children aged 1-17 in the population multiplied by 100
Numerator	Number of children aged 1-17 years who are reported to have experienced any physical punishment and/or psychological aggression by caregivers in the past month multiplied by 100
Denominator	The total number of children aged 1-17 in the population
Preferred data sources	Household surveys such as UNICEF-supported MICS and DHS that have been collecting data on this indicator in low- and middle-income countries since around 2005. In some countries, such data are also collected through other national household surveys.
Other possible data sources	
WHO GPW13 Framework	
Disaggregation	Sex, age, income, place of residence, geographic location
Expected frequency of data collection	
Limitations	There is an existing, standardized and validated measurement tool (the Parent-Child version of the Conflict Tactics Scale, or CTSPC) that is widely accepted and has been implemented in a large number of countries, including high-income countries. Definitions of both physical punishment and psychological aggression will need to be very clearly defined for countries but this should not be a problem as there is a wealth of available literature and research on the violent punishment of children and General Comment No.13 on the Convention of the Rights of the Child (CRC) also provides a definition for “corporal” or “physical” punishment as well as "mental violence".
Data type	Percentage
Related links	https://data.unicef.org/topic/child-protection/violence/violent-discipline/

GPW 13 WHO Impact Framework: **Milestone #33** Indicator Metadata

Milestone #33	**Increase immunization coverage for cholera, yellow fever, meningococcal meningitis and pandemic influenza**
Indicator	Vaccine coverage of at-risk groups for epidemic or pandemic prone diseases
SDG/ Core 100	
Definition	The Infectious Hazards Management (IHM) department in the Health Emergencies Programme has identified certain countries as at-risk for yellow fever, cholera, and meningococcal meningitis prevention and control. Sixty-six countries are considered at-risk for at least one of these pathogens. An immunization coverage estimate for routine (yellow fever; meningococcal meningitis) and campaign coverage (yellow fever; meningococcal meningitis; cholera) will be generated for each category of country presented, weighted by the relative sizes of the target populations for routine immunization and vaccination campaigns. Because not all Member States are not at-risk for these diseases, routine immunization estimates for first dose measles-containing vaccine (MCV1) will be used in order to develop estimates for all Member States, and to highlight the importance of a functioning immunizations program for disease prevention. Coverage for all antigens will be weighted equally.
Method of estimation/calculation	
Numerator	Vaccination coverage (routine and/or campaign)
Denominator	Target population
Preferred data sources	WHO/UNICEF estimate of immunization coverage (WUENIC) for MCV1 and YF routine immunization estimates; WHO/UNICEF Joint Reporting Form (JRF) for administrative coverage estimates of meningococcal meningitis routine immunization coverage; emergency immunization coverage for cholera, meningococcal meningitis and yellow fever using the International Coordinating Group (ICG) on Vaccine Provision; mass preventive oral cholera vaccination campaign coverage data from the Global Task Force on Cholera Control (GTFCC)
Other possible data sources	Global Health Observatory; pandemic influenza vaccination campaign data in targeted countries, where applicable
WHO GPW13 Framework	
Disaggregation	Country; antigen
Expected frequency of data collection	Annual (routine immunizations); periodic (vaccination campaigns), updated annually
Limitations	Routine immunization data for meningococcal meningitis are not available from WUENIC and are only available (self-reported administrative coverage) from the JRF. Emergency vaccination campaign coverage estimates might require the use of administrative estimates, which could bias (overestimate) campaign coverage as measured using a population-based survey. Because cholera is not part of routine immunization programs, relatively small cholera campaigns can have a disproportionate influence on the mean coverage estimate.
Data type	Percentage
Related links	

GPW 13 WHO Impact Framework: **Milestone #34** Indicator Metadata

Milestone #34	**Increase the availability of health facilities providing a minimum services package to people in fragile, conflict, or vulnerable settings to at least 80%**
Indicator	Proportion of vulnerable people in fragile settings provided with essential health services
SDG/ Core 100	
Definition	The indicator will provide the overall number of functioning health facilities at primary and secondary and tertiary care levels that provide the minimum services packages against the population size. The minimum services package is defined by the country/event context. Fragile, conflict, and vulnerable (FCV) countries are identified by WHO based on criteria including the existing protracted grade, existing acute grade but likely to convert to protracted grade, having a humanitarian response plan (HRP) or other relevant response plans, an INFORM index of at least 4.4, or countries with "risk of very high concern" or "high concern" in the IASC EWEAR. This list is updated periodically by WHO, in consultation with the Regional Emergency Directors. As of January 2019, there were 29 FCV countries.
Method of estimation/calculation	The Health Resources and Services Availability Monitoring System (HeRAMS) aims to guide the standardized, systematic and continuous collection, collation, analysis and dissemination of data on the availability of essential health resources and services in highly constrained, low-resourced and fast changing environments. HeRAMS is a data collection system with standard and country-defined indicators, which is updated on a near-real time basis by service providers. Data on the functioning of health facilities and the availability of context-specific minimum service packages are collected and shared using an online platform. The indicator can be measured using the numerator and denominator described below.
Numerator	Number of fragile, conflict, or vulnerable settings with an average attainment of the Sphere indicators for availability of delivery of a minimum services package at primary and secondary/tertiary levels (i.e., per 50,000 for primary care health facilities; per 250,000 for secondary and tertiary care health facilities).
Denominator	Total number of fragile, conflict, or vulnerable settings.
Preferred data sources	HeRAMS
Other possible data sources	Population-based survey data, where available, can be used to assess access to services among affected populations.
WHO GPW13 Framework	
Disaggregation	By health facility type; by country/setting
Expected frequency of data collection	Data are collected on a near-real time basis. Estimates will be updated annually, the average monthly mid-point.
Limitations	HeRAMS has not yet been rolled-out in all FCV settings. Data quality is difficult to verify given the challenging nature of these environments. Availability of essential health resources and services is a proxy for access to essential health resources and services, which is measurable only by population-based surveys.
Data type	Percentage
Related links	http://www.who.int/hac/herams/en/

GPW 13 WHO Impact Framework: **Milestone #35** Indicator Metadata

Milestone #35	**Eradicate poliomyelitis: zero cases of poliomyelitis caused by wild poliovirus and establish a clear timetable for the global withdrawal of oral polio vaccines in order to stop outbreaks caused by vaccine-derived poliovirus**
Indicator	Number of cases of poliomyelitis caused by wild poliovirus (WPV)
SDG/ Core 100	WHA68.3
Definition	Reported cases of laboratory-confirmed polio cases. A polio case is confirmed if wild poliovirus is isolated from stool specimens collected from an Acute flaccid paralysis (AFP) case.
Method of estimation/calculation	Sum of reported cases.
Numerator	
Denominator	
Preferred data sources	Surveillance systems
Other possible data sources	
WHO GPW13 Framework	
Disaggregation	
Expected frequency of data collection	Weekly
Limitations	
Data type	Count, absolute number of cases
Related links	WHO: http://www.who.int/immunization/monitoring_surveillance/en/;

GPW 13 WHO Impact Framework: **Milestone #36** Indicator Metadata

Milestone #36	**ACCESS group antibiotics at ≥60% of overall antibiotic consumption**
Indicator	Patterns of antibiotic consumption at national level
SDG/ Core 100	WHA68.7
Definition	Proportion of Access group antibiotics as percentage of overall antibiotic sales. From data on total consumption of antibiotics, the proportion of the total, by DDD that are within the ACCESS group (EML 2017). The term consumption refers to estimates of aggregated data, mainly derived from import, sales or reimbursement databases. In the recent revision of the WHO Model List of Essential Medicines, antibiotics in the list have been grouped into three AWaRe categories: Access, Watch and Reserve. The Access category includes first and second choice antibiotics for the empirical treatment of common infectious syndromes and they should be widely available in health care settings. Antibiotics in the Watch category have a higher potential for resistance to develop and their use as first and second choice treatment should be limited. Finally, the Reserve category includes "*last resort*" antibiotics whose use should be reserved for specialized settings and specific cases where alternative treatments have failed. **Rationale:** Narrow-spectrum beta-lactams of the Access group such as amoxicillin are the preferred treatment option for most RTI and are thought to have a lower ecologic impact regarding the selection and spread of antibiotic resistance than broader-spectrum agents such as cephalosporins, macrolides or fluoroquinolones. Access group antibiotics should therefore constitute the majority of antibiotic use in the outpatient setting and overall (as outpatient use represents the vast majority of AB sales). Broader-spectrum agents classified in the Watch group should be mostly limited to their specific recommended EML uses.
Method of estimation/calculation	Data on overall consumption by AWaRe categories: ACCESS, WATCH, RESERVE, OTHER, are collected and validated at the national level and reported to WHO where epidemiological statistics and metrics are generated. Antibiotic consumption is presented using the following key indicators: • Quantity of antibiotics as DDD per 1000 inhabitants per day for total consumption and by pharmacological subgroup (ATC3) • Quantity of antibiotics as weight in tonnes for total consumption • Relative consumption of antibiotics as a percentage of total consumption by route of administration (oral, parenteral, rectal and inhaled) and AWaRe categories (Access, Watch, and Reserve). To measure the consumption of antimicrobials, the methodology uses the number of defined daily doses (DDDs). The DDD is the assumed average maintenance dose per day of an antimicrobial substance(s) used for its main indication in adults, and is assigned to active ingredients with an existing ATC code. As a rule, the DDDs for antimicrobials are based on treatment for infections of moderate severity. To adjust for population size, the consumption is usually presented as number of DDDs per 1000 inhabitants per day. This metric can be roughly interpreted as the number of individuals per 1000 inhabitants on antibiotic treatment per day. The volume of antibiotics consumed can be presented using two metrics: DDD and the weight of the antibiotic substances in metric tonnes (t). The second metric can be used for comparison with antimicrobial consumption in the animal sector.
Numerator	**Antibiotic consumption of ATC class J01 antibiotics plus oral metronidazole (P01AB01), oral vancomycin (A07AA09) and oral fidaxomicin (A07AA12) in defined daily doses belonging to the ACCCES group.** The number of DDDs consumed for each antibiotic substance can be calculated by dividing the amount consumed in grams of the substance by the DDD value assigned to that substance: Number of DDDs = grams of active substance /substance-specific DDD. The total amount in grams is obtained by multiplying the strength of each tablet or vial by the number of units per package and the number of packages consumed. The DDD value is mostly specified in grams, but can also be defined as MU (million units) for certain substances. For combinations of antibiotics, the DDD value is specified as UD (unit dose). One tablet or vial of a combination product with a specific strength is defined as one UD. To obtain the DDD consumed of a specific combination product, the total number of UDs is divided by the assigned DDD value. For countries that have data at the substance level and by DDD, a reverse calculation can be done using DDD values to obtain the total number of tonnes.

Denominator	**Overall antibiotic consumption/sales of ATC classes: J01 antibiotics plus oral metronidazole (P01AB01), oral vancomycin (A07AA09) and oral fidaxomicin (A07AA12) in defined daily doses** The population size for each country can be obtained from the World Bank population database for all countries, but for Member States of the ESAC-Net, specific populations indicated by the data provider (European Centre for Disease Prevention and Control) is used.
Preferred data sources	National (or sampling of) antibiotic consumption data available at national level through different sources (sales / prescribing / dispensing / …) Consumption data will be collated according to the *WHO methodology for a global programme on surveillance of antimicrobial consumption.* Consumption data collected through a standardized protocol comparable with the WHO methodology will also be utilized, including data collected through the European Surveillance of Antimicrobial Consumption Network (ESAC-Net), the Antimicrobial Medicines Consumption Network managed by the WHO Regional Office for Europe, and the surveillance programmes on antimicrobial consumption in Canada, Japan, New Zealand and the Republic of Korea. According to the WHO protocol, data are collected at the product level (proprietary and generic- products) and comprise information on the active substance(s) of the product, route of administration, strength per unit, number of units per package and total number of packages consumed.
Other possible data sources	Sales should be the main source of data. Other sources could include: • Import records: for example from custom records and declaration forms; • Production records from domestic manufacturers; • Wholesaler records: both procurement data by the wholesaler or sales data from wholesaler to healthcare facilities and pharmacies; • Public sector procurement: from centralized or decentralized purchasing of medicines for the public sector, e.g. records from central medical stores;
WHO GPW13 Framework	Tackling AMR is a GPW13 platform that reduces the risks and contributes to the success of a number of programme targets across the UHC, Health Emergencies, and Healthier population goals. This target can be linked to GPW 13 Output 1.3.5, but also impacts Output 2.2.3, and Output 3.2.1
Disaggregation	Data will be aggregated at the country level – allow disaggregation at regional/district level, by antibiotic category (Access, Watch and Reserve)
Expected frequency of data collection	Yearly
Limitations	• Completeness / representativeness of sales data. Currently, data are collected from official channels and no data explicitly capturing antimicrobials circulating on the informal market have been obtained. Consequently, for countries in which the informal market is significant, only an incomplete picture of antibiotic consumption can be presented. • Data may be available only in certain metrics (e.g. Standard Units instead of DDD) and it is unclear how this will affect the index. • Measurement errors • Antibiotic "Black market" • DDDs are not adequate for children but this will have no impact in this indicator expressed as relative proportion of DDD
Data type	Percentage
Related links	http://www.who.int/antimicrobial-resistance/global-action-plan/optimise-use/surveillance/en/

GPW 13 WHO Impact Framework: **Milestone #37** Indicator Metadata

Milestone #37	**Reduce the percentage of bloodstream infections due to selected AMR organisms by 10%**
Indicator	Percentage of bloodstream infections due to antimicrobial resistant organisms
SDG/ Core 100	WHA67.25, WHA 68.7
Definition	Frequency of bloodstream infection among hospital patients' due to methicillin-resistant *Staphylococcus aureus* (MRSA) and *Escherichia coli* resistant to 3rd-generation cephalosporin (e.g., ESBL- *E. coli*). Rational for selecting these two types of AMR: (i) *E. coli* and *S. aureus* are among the most common human fast-growing bacteria causing acute human infections; (ii) *E. coli* is highly frequent in both humans, animals and environment, being an excellent indicator for monitoring AMR across the sectors in line with the One Health approach; (iii) both MRSA and ESBL- *E. coli* are largely disseminated and frequently in high frequency in hospital settings all over the world. Infections with these types of AMR lead to increase in use of the last resort drugs (e.g., vancomycin for MRSA infections, and carbapenems for ESBL- *E. coli*) against which new types of AMR are emerging. WHO has defined global infection prevention and control standards and strategies. Effective control of these two types of AMR will ultimately preserve the capacity to treat infections with available antimicrobials while new prevention and treatment solutions can be developed.
Method of estimation/calculation	The WHO Global AMR Surveillance System (GLASS) supports countries to implement an AMR standardized surveillance system. At national level cases are found among patients from whom routine clinical samples have been collected for blood culture at surveillance sites according to local clinical practices, and antimicrobial susceptibility tests (AST) are performed for the isolated blood pathogens. The microbiological results (bacteria identification and AST) are combined with the patient data and related to population data from the surveillance sites. GLASS does collect information on the origin of the infection either community origin (less than 2 calendar days in hospital) or hospital origin (patients hospitalized for more than 2 calendar days). Data are collated and validated at national level and reported to GLASS where epidemiological statistics and metrics are generated.
Numerator	Number of patients presenting with blood stream infection due to MRSA and ESBL- *E. coli* among patients seeking hospital care
Denominator	Number of patients seeking hospital care and from whom the blood specimen was taken due to suspected bloodstream infection and from whom blood specimens have been submitted for blood culture and AST.
Preferred data sources	National AMR data collected through the national AMR surveillance system and reported to GLASS.
Other possible data sources	Published and non-published data from national centers and research/academic institutions and from others regional surveillance networks.
WHO GPW13 Framework	
Disaggregation	Data will be aggregated at the country level. Data will be analyzed and reported according to whether specimen is within 2 calendar days of admission (community origin) or after 2 calendar days of admission (hospital origin).
Expected frequency of data collection	Yearly
Limitations	Constraints associated with in national AMR surveillance systems (number and distribution of surveillance sites and representativeness of surveillance data, sampling bias, poor diagnostic capacity, measurements errors, issues with data management).
Data type	Percentage
Related links	http://www.who.int/glass/en/ ; http://www.who.int/gho/glass/en/

GPW 13 WHO Impact Framework: **Milestone #38** Indicator Metadata

Milestone #38	**20% relative reduction in the prevalence of raised blood pressure**
Indicator	Age-standardized prevalence of raised blood pressure among persons aged 18+ years (defined as systolic blood pressure of >140 mmHg and/or diastolic blood pressure >90 mmHg) and mean systolic blood pressure
SDG/ Core 100	Core 100, WHA66.10
Definition	Systolic blood pressure ≥140 and/or diastolic blood pressure ≥90 among persons aged 18+ years.
Method of estimation/calculation	Prevalence of raised blood pressure = $\frac{Number\ of\ respondents\ aged\ 18+\ years\ with\ systolic\ blood\ pressure\ \geq 140\ mmHg\ or\ diastolic\ blood\ pressure\ \geq 90\ mmHg}{Number\ of\ survey\ respondents\ aged\ 18+\ years} \times 100\%$
Numerator	Number of respondents with systolic blood pressure ≥140mmHg or diastolic blood pressure ≥90mmHg. Ideally three blood pressure measurements should be taken and the average systolic and diastolic readings of the second and third measures should be used in this calculation.
Denominator	All respondents of the survey aged 18+ years.
Preferred data sources	Population-based (preferably nationally representative) survey in which blood pressure was measured, not self-reported.
Other possible data sources	
WHO GPW13 Framework	Risk factor exposure
Disaggregation	By age, sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education, wealth quintile).
Expected frequency of data collection	Annual or every 5 years
Limitations	- measurement error - representativeness of the sample
Data type	Prevalence
Related links	WHO: http://www.who.int/chp/steps/en/; http://apps.who.int/gho/data/node.wrapper.imr?x-id=2386.

GPW 13 WHO Impact Framework: **Milestone #39** Indicator Metadata

Milestone #39	**Eliminate industrially produced trans fats (increase the percentage of people protected by effective regulation)**
Indicator	Percentage of people protected by effective regulation on trans-fats
SDG/ Core 100	WHA66.10
Definition	Adoption of a policy to virtually eliminate partially hydrogenated oils (PHOs) in the food supply.
Method of estimation/calculation	Country can respond "yes" to the question “Is your country implementing any national policies or regulations that virtually eliminate industrially produced trans-fats (i.e. partially hydrogenated oils) in the food supply?”
Numerator	Total number of people protected by effective regulation on trans fats
Denominator	Total population
Preferred data sources	WHO NCD Country Capacity Survey
Other possible data sources	National nutrition and health survey
WHO GPW13 Framework	
Disaggregation	
Expected frequency of data collection	Every 2 or 5 years
Limitations	- bias through self-report - misunderstanding/ -interpretation of questions - limited validity of survey instruments
Data type	Qualitative; percentage
Related links	WHO: http://www.who.int/chp/ncd_capacity/en/; http://www.who.int/nmh/publications/best_buys_summary.pdf.

GPW 13 WHO Impact Framework: **Milestone #40** Indicator Metadata

Milestone #40	**Halt and begin to reverse the rise in obesity**
Indicator	Prevalence of obesity
SDG/ Core 100	Core 100, WHA66.10
Definition	For 5-19 years, obesity is defined as body mass index (BMI)-for-age above two standard deviations of the WHO Growth Reference for School-aged Children and Adolescents median. For ages 20 years and older, obesity is defined as BMI of 30 kg/m2 or higher. BMI is calculated by dividing the subject's weight in kilograms by their own height in meters squared.
Method of estimation/calculation	Prevalence of obesity = $\frac{Number\ of\ persons\ who\ are\ obese}{Total\ number\ of\ persons\ in\ the\ survey\ that\ were\ measured} \times 100\%$
Numerator	Number of persons who are obese
Denominator	Total number of persons in the survey that were measured
Preferred data sources	Nationally representative population-based household or school-based surveys with height and weight measurements of adults aged 20 years and older and school-age children and adolescents aged 5–19 years. Other sources of data include national nutrition surveillance systems.
Other possible data sources	Data sets of FAO and UN Statistical office
WHO GPW13 Framework	Risk factor exposure
Disaggregation	By age, sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., mother's education, wealth quintile).
Expected frequency of data collection	Annual or at least every 3-5 years based on survey availability in countries.
Limitations	Survey estimates come with levels of uncertainty due to both sampling and non-sampling error (e.g. measurement technical error, recording error etc.). Another limitation, especially for the school-age children and adolescent age group is the representativeness of the sample.
Data type	Prevalence
Related links	WHO: http://who.int/chp/gshs/en/; http://www.who.int/dietphysicalactivity/childhood/en/