Background

In May 2012, the Sixty-fifth World Health Assembly approved a Comprehensive Implementation Plan on maternal, infant and young child nutrition.¹

The Plan established six global targets to be achieved by 2025:

1. A 40% reduction of the global number of children under five who are stunted
2. A 50% reduction of anaemia in women of reproductive age
3. A 30% reduction of low birth weight
4. No increase in childhood overweight
5. Increase the rate of exclusive breastfeeding in the first six months up to at least 50%
6. Reduce and maintain childhood wasting to less than 5%

These targets, many of which are inter-related, cover different aspects of nutrition, acknowledging the importance of both undernutrition and overweight. By including maternal nutrition, the Plan highlights the intergenerational aspects of malnutrition.

The importance of this plan has been reinforced by the latest joint estimates of child malnutrition published by the World Health Organization (WHO), UNICEF and the World Bank in September 2013 (Figure 1).²

¹ http://www.who.int/nutrition/topics/WHA65.6_annex2_en.pdf
² http://www.who.int/nutgrowthdb/estimates2012/en/index.html
Figure 1 Global child malnutrition trends (1990-2012)

The Plan proposes five actions, with the fifth being to ‘monitor and evaluate the implementation of policies and programmes.’ Paragraph 60 calls for ‘a well-defined monitoring framework … to assess progress made towards the objectives of the comprehensive implementation plan.’

**Purpose of the consultation**

A set of indicators intended to monitor the outcomes and the implementation of programmes was discussed in Regional Consultations. However, further consultations were requested by Member States at the Sixty-fifth WHA.

Thus, a proposed set of indicators for a draft Global Monitoring Framework has been issued for consultation. The purpose of the monitoring framework is:

- to monitor progress towards the achievement of the six global targets – for use at global and national levels
- to track implementation of selected programmes required to achieve the global targets (for use at global and national level)
- to track implementation of all programmes required to achieve national targets (for use at national and at sub-national levels)

A set of 49 indicators has been proposed for discussion and, of these, 29 were proposed as priority indicators. The proposed indicators were selected as being relevant for the achievement of one or more global target and they were also considered to fulfil a number of methodological criteria.

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3. [http://www.who.int/nutrition/events/2013_consultation_indicators_globalmonitoringframework_WHO_MIYNCN.pdf](http://www.who.int/nutrition/events/2013_consultation_indicators_globalmonitoringframework_WHO_MIYNCN.pdf)

4. These can be summarised as: already validated; systems or instruments are in place to set a baseline and monitor changes; currently collected in most countries or can be added at minimal cost; country capacity for monitoring. See the background paper for an explanation of some of the conceptual and methodological issues and questions.
This report is a summary of feedback received during an informal consultation with Member States and UN Agencies from 30 September to 1 October 2013 in Geneva. Separate consultations have been held with representatives of civil society and of the private sector. Furthermore, an on-line consultation, open to anyone, has been carried out until 10 October.5

Thirty-five Member States 6 and two regional intergovernmental organizations 7 participated in the consultation, along with five UN Agencies and coordinating bodies 8 and the UNSG Special Representative on Food Security and Nutrition.

The purpose of the consultation was:

- to review the monitoring framework
- to advise on principles for prioritisation
- to identify gaps in the background paper
- to express expectations on reporting
- to express capacity needs to establish monitoring systems at country level

Review of the draft global monitoring framework: general comments

Many participants indicated their overall support for the monitoring framework and congratulated the Secretariat on the document. The great complexity of the task involved in preparing the monitoring framework was recognised.

Several issues which emerged repeatedly throughout the consultation highlighted some of the key challenges, and tensions, involved in the task of defining indicators.

Consultation with private sector

Concerning the consultation process itself, there was discussion of the terms of the consultation with the private sector. As part of its commitment to transparency, WHO routinely consults with various different sectors. It is important to be clear about the rules of engagement when consulting with the private sector to safeguard public health and to protect WHO against any perceived conflict of interest. A process is currently underway to develop a set of criteria for WHO’s engagement with non-State actors.

Global targets

Some comments related to one or other of the six global targets. The Secretariat reminded participants that the global targets in the Plan had been set by the World Health Assembly and that these are to be achieved by pooling our efforts collectively. The targets, therefore, will not be modified in the Monitoring Framework. This is in no way intended to prevent Member States, however, from setting their own more ambitious national and sub-national targets. It is also important to conduct analyses to


6 Algeria, Brazil, Burkina Faso, Canada, China, Colombia, Congo (the), Czech Republic, El Salvador, Finland, France, Hungary, India, Iran (Islamic Republic of), Iraq, Japan, Malaysia, Mexico, Norway, Pakistan, Panama, Peru, Poland, Portugal, Singapore, South Africa, Spain, Sweden, Syrian Arab Republic (the), Togo, Turkey, United Kingdom of Great Britain and Northern Ireland (the), United Republic of Tanzania (the), United States of America (the), Zimbabwe.

7 European Union and Organization of Islamic Cooperation

8 FAO, IAEA, UNICEF, WFP, UN Standing Committee on Nutrition
understand what level of progress is required by countries to be able to meet the global targets.

**Reporting levels – global, national or sub-national**

The draft Monitoring Framework proposed that—in addition to Member States collecting national data for global reporting—for some indicators data could be disaggregated at the sub-national level. This would help Member States to track progress within countries.

Concern was expressed that the resource requirements for this sub-national reporting might constitute a data collection heavy burden on some Member States. The Secretariat stressed that the Monitoring Framework does not outline mandatory reporting requirements and there remains flexibility for Member States. The paper does highlight, however, where sub-national monitoring could be helpful to improve service delivery (and access to services) towards achieving the targets. It is also worth noting that, for many indicators, data collection at service level will need to take place anyway to be able to provide the national data.

It is clear that this monitoring at the sub-national level is very important for questions of equity. The next version of the Monitoring Framework could identify indicators for which a sub-national breakdown can be provided.

**Global relevance of indicators**

One of the key challenges in choosing a list of indicators is to ensure that the end result does not overburden Member States with a heavy workload of data collection, but neither does it over-simplify, thus diminishing the value of the monitoring. There was some concern that the long list of indicators, which includes some very targeted, context-specific indicators, could dilute or divert efforts to achieve the main targets.

A clear message to emerge from the consultation was that not all indicators are relevant in all countries or contexts. There was strong support for the idea of prioritising the indicators to select a shortlist of core global indicators, which all countries would report on. There would also be a longer list of indicators which countries could then report on where relevant and that could be presented in a WHO Technical Paper.

**Spell out actions for achieving the targets**

The background paper should provide more information and guidance on the various actions and interventions recommended for achieving the targets. There was also need for more explanation of how these actions link to the targets. The next version of the paper could incorporate elements from WHO’s updated Essential Nutrition Actions publication.9

**Indicators influence policy**

It is clear that indicators must be feasible as well as relevant. Feasibility clearly varies from one country to another and the aim is to include indicators where data is already collected and reporting is feasible for the greatest number of countries.

For some countries, however, collection of data on several of the proposed indicators is currently far from feasible. At the same time, however, the Monitoring Framework might act as an incentive to measure that variable and, in turn, to stimulate important

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9 http://apps.who.int/iris/bitstream/10665/84409/1/9789241505550_eng.pdf
changes in surveillance, encourage good practice and also influence policy. Thus, in cases where data collection for an indicator may not be feasible immediately for all countries (e.g. low birth weight), inclusion of that indicator can still be important.

It is desirable to build a system that will evolve, and which can be updated and modified. It is also helpful to remember that indicator setting is more than a technical exercise, it can also help set policy.

Methodological issues
A number of general points on methodology emerged:

- Data sources: more information on available data sources is needed. In order to provide this, an inventory, or mapping, of available data sources may be required. Member States may require further guidance, or an action plan, for surveillance.
- Frequency of data collection: Several of the indicators are affected by seasonal variation. It is important that this issue is considered when decisions on frequency of data collection are taken.
- Data quality: It was noted that even where data is widely collected, there remains a great deal of work to do to assess the quality of records and to improve the quality of data.
- Combining data: Work is needed on methodologies to enable information from administrative records to be combined with that from survey data. There may be lessons to be drawn from the field of immunisation.
- Existing multi-country reports: there are various initiatives already collating data into multi-country reports. It is interesting to explore the advantages or otherwise of using these indicators.

Alignment of data collection systems is important across WHO, as well as at regional and national levels.

Inequity and gender
An important theme to emerge from the consultation was the need to build markers of inequity into the Monitoring Framework. It is also important that data is disaggregated by sex.

There was a strong recommendation that all indicators be reviewed to identify where it is possible and/or desirable to disaggregate data to be able to track equity (e.g. by socio-economic status, geography, educational level, livelihood group, wealth indicator or some other variable). This disaggregation could be done at country level.

There was also a proposal to set specific sub-targets for particularly disadvantaged groups in the population (e.g. the lowest quintiles by socio-economic status). The idea of tracer interventions could be useful, to track improvements in equity within countries.

Multi-sectoral nature of nutrition
Another important issue highlighted was the fact that nutrition is not solely a health sector issue. Policies and practices from many other sectors can have an impact. Until now, the focus of the Monitoring Framework has been on health sector although the Plan did set out clearly the importance of other sectors (e.g. agriculture, education, trade, taxation, social protection).
There was considerable discussion, in general terms, of whether the indicators could do more to capture these multi-sectoral aspects. It is not clear whether enough evidence exists on the impact of particular actions in other sectors to be able to do this. In some countries the exchange of information between different government departments is challenging and WHO would need to work with counterpart UN agencies to facilitate cross-sectoral collaborations and data exchanges, with the purpose of achieving a unified reporting of nutrition relevant information.

Prioritising indicators
As mentioned previously, there was consensus on the need to agree a shortlist of core global indicators. In order to define priority indicators, it is helpful to consider which indicators:

- have global relevance to the comprehensive implementation Plan,
- are relevant to more than one target,
- have a strong, clearly-documented evidence base,
- are immediately available (although those not available because of data limitations may be highlighted for future development).

This list could, for example, include the six primary outcomes, along with the intermediate and process outcomes for the breastfeeding and overweight targets.

The list of core indicators would be accompanied by a longer list of indicators for countries to use as relevant. For these other areas, there could be defined threshold levels (or other contextual variables) that would trigger the need to report on the further sub-set of indicators.

There was some concern expressed that the list of indicators, even if divided into a core priority list and an optional list for countries, should not be too long. The total number should be reduced.

There was also a proposal to review how the indicators are grouped in the document. The current version lists indicators by target, but does not repeat the cross-cutting indicators where they relate to more than one target. The Plan called for indicators by input, output, outcome and impact. It may be appropriate to re-organise the grouping of indicators in this way. This may highlight some areas (such as inputs) where more work is needed.

Suggestions for new indicators
A number of suggestions emerged from the consultation for potential new indicators. Some of these would be additional to the indicators already proposed, while others would be alternatives. There was agreement that the participants at the informal consultation were not in a position to give any definitive response on proposals for new indicators. These were to be considered, rather, as pointers for development. It is clear that further consultation is required on the next version of the set of indicators.

Revised version of background document
A number of recommendations were made for the next version of the background document. It should:

- include an in-depth description of how indicators relate to targets, the links between indicators and quality of evidence on these relationships,
- provide much greater clarity on sources of data for each indicators,
• outline priorities for further work on indicator development and/or data collection,

• summarise where such work on indicator development is ongoing (along with an indication of how advanced the process is for each),

• incorporate a summary of nutrition actions to help reach targets.

Review of the draft global monitoring framework: specific comments

Stunting (Target: By 2025, a 40% reduction of the global number of children under five who are stunted)

There was some discussion of the stunting target, which relates to prevalence in children under five. The period up until the age of two years is the most important for interventions. There could be value in reporting prevalence data by age group—as well as for under 5s in relation to the target—to track what is happening in this critical period.

Many of the indicators for stunting also relate to other targets, and these relationships have not always been spelled out in the document. Nor have the evidence pathways linking indicators to targets been sufficiently explained.

More detailed comments on the specific indicators are shown in Appendix 1.

There was considerable discussion about the proposed indicators relating to food security (PR6) and dietary diversity (PR8). Information was provided on various initiatives to develop new food security and dietary diversity indicators (e.g. the Food Insecurity Experience Scale, —a threshold for minimum dietary diversity for women), some of which were quite far down the development pipeline. These are areas where further work is needed to explore the scope for using these new indicators which are coming online.

There was discussion of why coverage of vitamin A supplementation had not been included. The Secretariat acknowledged the importance of this issue, but explained that since there is no global target for vitamin A deficiency this had not been included as a primary outcome indicator. Initial analysis had suggested that it was not a high priority to include this as an indicator relating to the stunting or wasting targets.

A number of possible new areas for indicators were put forward:

• Reporting on stunting by age group (in <2s)
• Use of an indicator on water testing (re improved water source)
• Use of an indicator on hand-washing rather than diarrhoea treatment (PR5)

Wasting (Target: By 2025, reduce and maintain childhood wasting to less than 5%)

The Secretariat presented an additional proposed indicator for discussion (Proportion of children with moderate acute malnutrition having access to appropriate supplementary foods) to supplement PR17 on coverage of severe acute malnutrition (SAM) treatment. This is partly in recognition of the fact that the link between an indicator based on coverage of treatment for SAM is clearer with incidence than with prevalence of wasting. The United Nations World Food Programme (WFP) reported ongoing work to combine an indicator of moderate acute malnutrition treatment with other food indicators. This will be tested in some countries next year. Attention was also drawn to a new report being issued by UNICEF on coverage of SAM
management that covers geographic and treatment coverage, along with quality indicators. Further clarification was also needed on the definition of these indicators.

There is a great deal of overlap with many of the indicators discussed in relation to the stunting target. A better explanation of these overlaps and linkages would be welcome. It was suggested to delete those indicators without a strong evidence base to wasting (e.g. prevalence of polio (IO16)).

Because seasonality is particularly important in relation to wasting, this may be an area where more frequent reporting of data is required.

More detailed comments on the specific indicators are described in Appendix I.

Low birth weight (Target: by 2025, a 30% reduction of low birth weight)

A major issue identified with this target was the fact that data on birth weight are missing or poor for many countries, particularly in those where many births are not attended by a health worker. There was agreement, however, that this is such a vital area that inclusion of the indicator is desirable and may stimulate data collection.

This is a particular area where non-nutritional interventions have an important impact (e.g. smoking cessation interventions).

There was considerable discussion about the indicator on maternal age at first child’s birth. It was suggested that an indicator based on a cut-off age for early pregnancy (first child at 18 or younger) would be more sensitive and informative than mean maternal age.

As with the indicators for severe and moderate acute malnutrition treatment coverage (see stunting) questions were raised about the scope and definition of coverage of protein and energy supplementation (PR15). There was a proposal to delete this indicator since it is only relevant to limited countries or contexts.

More detailed comments on specific indicators are given in Appendix I.

A number of possible areas for additional or alternative new indicators were put forward:

- multiple micronutrient supplementation was mentioned as a possible process indicator. The Secretariat pointed out that currently, WHO does not recommend multiple micronutrient supplementation for prevention of low birth weight,
- Intermittent Preventive Treatment (IPT) for malaria,
- proportion of women with access to antenatal care,
- an indicator that captures data on birth spacing.

Anaemia (Target: by 2025, a 50% reduction of anaemia in women of reproductive age)

Once again, there was considerable overlap with the indicators for stunting (e.g. malaria prevalence).

There was agreement that it is important to monitor data in the population of women of reproductive age, but also in pregnant women and non-pregnant women within this population. A small change was proposed, therefore, to amend the primary outcome (PO2) to specify ‘women of reproductive age’ and two further intermediate outcome indicators were proposed: one for ‘pregnant women’, another for ‘non-pregnant
women of reproductive age.’ It was proposed to delete the indicator on proportion of under 5s with anaemia (IO5) or that, if the indicator remains it be limited to children under two years.

In relation to the indicators measuring supplementation it was felt that there was more methodological work to be done, especially on iron supplementation for children (PR14) and supplementation in pregnant women (PR11). This latter indicator could be made more relevant for some regions, such as Europe, if it incorporated data on specific marginalized groups. It was also noted that the indicators for iron supplementation (PR14) and use of micronutrient powders (PR13) were relevant to particular contexts.

There was considerable discussion about the appropriateness of the indicator on consumption of iron-fortified wheat flour. This indicator is not global in relevance, since wheat flour is not a staple in all countries. Proposals were made to either delete this indicator or to amend it to refer to ‘iron-fortified staple foods’ which would also capture fortified rice etc.

It was noted that dietary diversity would also be an area relevant to anaemia, but there are difficulties in identifying a dietary diversity indicator which is sensitive enough to changes in iron intake.

Some other areas to explore for possible additional indicators were suggested:

- additional process or policy indicators focused on prevention (e.g. provision of information to population, dietary interventions),
- deworming (UNICEF already has some data on this).

**Breastfeeding (Target: by 2025, increase the rate of exclusive breastfeeding in the first six months up to at least 50%)**

This is one area where results are worse in high-income countries than in many low- or middle-income countries. The indicators for this target are, therefore, vital to highlight gaps in progress and encourage change in these countries.

There are a number of methodological issues around measurement of exclusive breastfeeding and there was a proposal to provide Member States with more guidance on monitoring this issue to enable better quality data collection, standardisation and comparability. An indicator on exclusive breastfeeding of infants of women living with HIV/AIDS was also suggested.

Evidence on the link between timely or early initiation of breastfeeding and exclusive breastfeeding should be clearly articulated. The intermediate outcome indicator on ‘timely initiation of breastfeeding’ should be changed to ‘early initiation of breastfeeding’ which is already well understood.

One problem with the measurement of baby-friendly maternity care (PR16) is that baby-friendly status is often given on the basis of a one-off certification and, in the absence of reassessment, may not reflect the current situation. Future work on developing this indicator should link to the work that WHO and UNICEF are currently doing to improve assessments of baby-friendly maternity care and should include community-based maternity care.

More detailed comments on the indicators are given in Appendix 1. See the section on Policy and Health System Capacity for discussion of other highly relevant indicators.
Overweight *(Target: by 2025, no increase in childhood overweight)*

One issue with data collection for this indicator is that, in some regions, there is better availability of data for school-age children and for babies from birth to 24 months. There may be gaps in data for three to five year olds. It is also important to be aware of the limitations of school-based surveys, which are usually self-reported, and the cultural differences which may affect them.

Three new proposals for possible indicators were put forward for discussion:

- Continued breastfeeding for 2 years and beyond
- Soft drink consumption in children
- Marketing regulations

In general, there was broad support for these indicators, and they may be relatively easy to incorporate into existing surveys/measures. The second indicator, on soft drink consumption should be amended to refer to *‘sugar-sweetened beverage consumption’*.

More detailed comments on the proposed indicators are given in Appendix I.

A proposal for one additional indicator emerged from the discussion: proportion of pregnant women overweight or obese (maternal BMI).

**Policy and health system capacity**

The indicators proposed relate mainly to health sector actions, but it is clear that actions or inaction by other sectors (e.g. agriculture, trade, education, taxation) also have an impact. Policies to tackle the underlying causes of malnutrition (on access and availability of food, access to healthcare etc.) are fundamental.

Inclusion of some indicators which measure access to health services was proposed. One possible such indicator would be access to antenatal care.

There was general support for the indicators proposed, although there was recognition that there are numerous methodological issues to be resolved. WHO and the SUN Movement Secretariat should align nutrition governance indicators. More detailed comments are given in Appendix I.

The indicators relating to legal instruments such as the Code and the ILO maternity protection convention need to measure *implementation* as well as adoption. Further guidance for Member States on monitoring implementation of the Code would be welcome.

We know from countries which have made progress on improving nutrition that key elements include strong leadership, a clear national target and a mechanism for inter-sectoral working. The indicator on nutrition governance is seen to be essential, but is also recognised as challenging methodologically.

**Next steps**

The issues discussed during the consultation highlighted some of the key challenges in developing the Monitoring Framework. One such challenge is that, while there is clearly a need to do further work on the definitions and methodology to produce the desired list of relevant and feasible indicators, it is also important to bear in mind the
timescale. The targets are set for 2025 and the Monitoring Framework needs to be ready to track progress towards these targets.

Nonetheless, it is clear that this process should be a dynamic one. There must be scope for the documents submitted to the Sixty-seventh World Health Assembly (via the Executive Board in January 2014) to evolve.

The reporting to the World Health Assembly next year will have to include three elements:

- the proposed monitoring framework,
- a progress report on the targets,
- a preliminary report on progress against some of the indicators in the monitoring framework (based on data which is already available).

These elements will need to be incorporated into a very short document, which can be accompanied by a more detailed background paper.

There was a proposal to establish an expert and/or interagency group to develop the indicators as part of this dynamic process, working towards a more developed set of indicators by 2016. This was seen as highly relevant, given the complexity of the issues involved and the need for many different inputs.

The next steps in the short term are:

- the web consultation on this draft Monitoring Framework closes 10 October. This is a further opportunity for Member States to feedback their views on specific indicators.
- taking into account the feedback from the consultation, a revised list of indicators and accompanying background paper will be submitted for consideration at January 2014 Executive Board by the end of October.
- there will be a further web consultation on the documents submitted to the Executive Board during November.
- analysis of feedback from the web consultation will take place during December and will be informally incorporated into the reporting to the Executive Board meeting in January. There will not be time to revise the documents before the Executive Board meets.
- following its meeting in January 2014, the Executive Board may request further consultation (formal or informal) before the World Health Assembly in May 2014.

There was a request for flexible and timely communication in the further stages of the consultation.

**Summary of key recommendations from consultation**

- Clarity is needed on the rules of engagement when consulting with the private sector to safeguard public health and to protect WHO against any perceived conflict of interest.
- Prioritise indicators to create two lists of indicators:
  - a short list of core global indicators, which all countries would report on,
• a longer list of indicators with threshold levels which trigger countries to report on this sub-set of indicators.

• Build markers of inequity into the Monitoring Framework by reviewing all indicators to see how data can be disaggregated by socio-economic group and sex. Consider setting sub-targets at national level for particular vulnerable groups.

• Explore how the Monitoring Framework can better capture the multi-sectoral nature of nutrition. Consider indicators relating to underlying causes of malnutrition and broader policies or actions, including access to health services and other policies outside the health sector.

• Revise the background paper to include:
  ▪ more information on data sources,
  ▪ better explanation of links between indicators and targets and strength of the evidence,
  ▪ explanation of ongoing or required indicator development work,
  ▪ details of nutrition actions to achieve targets.

• More methodological work was proposed to develop a number of indicators. In particular those relating to food security, coverage of treatment or supplementation, assessing baby-friendly maternity care and and measurement of implementation of the Code. This development work should link closely with work that is already underway in these areas.

• An equity indicator should be included in the monitoring framework

• Specific amendments were proposed for a number of indicators on maternal age (IO9), consumption of iron-fortified foods (PR12), prevalence of anaemia (PO2), thin women of reproductive age (IO6), and timely initiation of breastfeeding (IO12).

• Various potential areas to explore for new indicators were suggested:
  ▪ water testing
  ▪ hand washing
  ▪ stunting by age group
  ▪ Intermittent Preventive Treatment (IPT) for malaria
  ▪ maternal BMI (for overweight)
  ▪ birth spacing
  ▪ access to antenatal care
  ▪ HIV prevalence in women
  ▪ coverage of antiretroviral therapy for prevention of mother-to-child transmission of HIV
  ▪ proportion of women eligible for benefits under the maternity protection convention
  ▪ nutrition competencies in other sectors
  ▪ access to health services (as part of nutrition governance indicator)

• There was support, in principle, for the new indicators proposed by the Secretariat on:
  ▪ Continued breastfeeding for 2 years and beyond
- Sugar-sweetened beverage consumption in children
- Marketing regulations

- The relevance of indicators for emergency contexts should be considered, as well as impediments to data collection deriving from emergency situations.

- More guidance should be provided to Member States on a number of issues (in addition to the expanded version of the background paper):
  - data collection/surveillance,
  - measuring exclusive breastfeeding,
  - monitoring implementation of the Code.
## Appendix I: Specific comments on proposed indicators (core indicators are in bold)

<table>
<thead>
<tr>
<th>Indicator number</th>
<th>Indicator</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO1</td>
<td>Prevalence of low height-for-age in children &lt;5 years of age defined as &lt;-2 standard deviations of the WHO Child Growth Standards median</td>
<td>Discussion on whether a target for children under two would have been more appropriate, since this is the period that matters most. In fact, the target, agreed by the WHA, reflects the way many surveys are designed. It should, however, be possible to report by age group. Recommendation that the background paper should spell out that the period up to two years is when interventions are most effective.</td>
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</tbody>
</table>
| PO2              | Prevalence of haemoglobin <12g/dL among non-pregnant women age 15-49 adjusted for altitude and smoking | There is a discrepancy between wording of the target in the plan approved by WHA (‘women of reproductive age’) and the wording of PO2 in the monitoring framework, which refers to ‘non-pregnant women of reproductive age’. Agreement to keep the target as worded in the plan (i.e. ‘women of reproductive age’). Wording of primary outcome indicator PO2 to be changed accordingly, by deleting ‘non-pregnant’ before women. Proposal to add two further, more specific, indicators on:  
  • Anaemia in pregnant women of reproductive age  
  • Anaemia in non-pregnant women of reproductive age |
<p>| PO3              | Prevalence of infants born &lt;2500 grams (5.5 pounds)                       | It was acknowledged that there are many countries with missing or poor data on this issue. Particularly in countries where the majority of |</p>
<table>
<thead>
<tr>
<th>PO4</th>
<th><strong>Prevalence of weight-for-height in children &lt;5 years of age defined as &gt;+2 standard deviations of the WHO Child Growth Standards</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>PO5</td>
<td><strong>Prevalence of exclusive breastfeeding among infants &lt;6 months of age</strong></td>
</tr>
</tbody>
</table>

This is one area where the results are worse in high-income countries than in low- or middle-income countries. This is, therefore, an important indicator to encourage countries to make progress.

In most national surveys the confidence intervals on exclusive breastfeeding are sufficiently narrow at the national level and, in some cases, are also adequate at the sub-national level.

There are a number of difficulties with methodology for this indicator. One problem is the measurement of exclusive breastfeeding when more than one carer is involved (i.e. the mother is away from the baby for part of the day). MICS and DHS surveys are using an alternative method which is especially relevant for urban populations where this may be the case. Issues of standardisation, data quality and comparability need to be addressed. In relation to the 24-hour recall methodology, recognition that there are difficulties, but the data are still valuable. The International Atomic Energy Agency (IAEA) is developing stable-isotope methodology to measure breastmilk intake, which may be useful in due course.

Recommendation for more guidance to be provided to Member
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO6</td>
<td>Prevalence of low weight-for-height in children &lt;5 years of age defined as &lt;-2 standard deviations of the WHO Child Growth Standards median</td>
<td>States on monitoring this indicator.</td>
</tr>
<tr>
<td>IO1</td>
<td>Prevalence of malaria</td>
<td></td>
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<tr>
<td>IO2</td>
<td>Incidence of diarrhoea in children under 5</td>
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<tr>
<td>IO3</td>
<td>Median urinary iodine concentration (micrograms/L) in children aged 6-12 years</td>
<td></td>
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<tr>
<td>IO4</td>
<td>Proportion of adolescent girls with Hb concentration of &lt;11g/dL</td>
<td>Adolescence was defined as being 10-19 years. There were questions about access to quality data on this.</td>
</tr>
<tr>
<td>IO5</td>
<td>Proportion of children below five years of age with Hb concentration of &lt;11 g/dL</td>
<td>Recommendation to delete this indicator. If this indicator were to remain, proposal to amend it to restrict to children under two because this would be more sensitive and covers most important period.</td>
</tr>
<tr>
<td>IO6</td>
<td>Proportion of thin women of reproductive age</td>
<td>Clarification that ‘thin’ means a body mass index (BMI) of &lt;18.5 kg/m². Proposal to change the wording of this indicator to be more precise to ‘Proportion of women with low BMI (&lt;18.5kg/m²) of reproductive age’.</td>
</tr>
<tr>
<td>IO7</td>
<td>Proportion of stunted women of reproductive age</td>
<td>There were questions about the availability of data on prevalence of stunted women of reproductive age. The WHO Secretariat indicated the data is available, and this is valuable in highlighting intergenerational effect.</td>
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<tr>
<td>IO8</td>
<td>Prevalence of cigarette smoking in pregnant women</td>
<td></td>
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<tr>
<td>IO9</td>
<td>Mean maternal age of first child’s birth</td>
<td>Proposal to change this indicator to base it on a cut-off age for early pregnancy (proportion of women having first birth at 18 or earlier).</td>
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</tbody>
</table>
This could be more informative than the mean maternal age. UNICEF does have such data, including on women whose first birth was at 18 or earlier, and considers that this is more sensitive than mean age at first birth.

One option for the indicator could be the proportion of children born to women below the cut off age (18 or younger).

<table>
<thead>
<tr>
<th>IO10</th>
<th>Proportion of overweight and obese adults</th>
<th>It was pointed out that maternal BMI is in fact the more important factor. Maternal BMI, therefore, could be included as an indicator.</th>
</tr>
</thead>
<tbody>
<tr>
<td>IO11</td>
<td>Proportion of overweight school-age children and adolescents (5-19 years)</td>
<td></td>
</tr>
</tbody>
</table>
| IO12 | Timely initiation of breastfeeding | The wording ‘early initiation’ of breastfeeding is more widely understood than the wording ‘timely initiation’ currently proposed. It was suggested, therefore, to change this to ‘early initiation of breastfeeding’.

The indicator would benefit from having the definition included in the wording of the indicator.

The background paper should include clearer articulation of link between early initiation and exclusive breastfeeding.

Discussion on the inclusion of both living and deceased children, which had been mentioned as a limitation. But not to include data on dead children could distort findings, so no change was proposed.

| IO13 | Prevalence of measles | In relation to wasting: Since this indicator does not have a strong |
| IO14 | Prevalence of rubella | |
| IO15 | Prevalence of pertussis | |
| IO16 | Prevalence of polio | |
| PR1 | Proportion of children receiving a minimum acceptable diet at 6-23 months of age | In relation to overweight: It was questioned whether this indicator, as it stands, would be able to pick up a diet that is poor quality because it is high in sugar, fat, etc. This is not possible from this indicator as it stands. |
| PR2 | Proportion of population using an improved water source | Water quality: It was pointed out that data on water testing is increasingly included in surveys. This may be useful. |
| PR3 | Proportion of population using improved sanitation facilities |  |
| PR4 | Children sleeping under insecticide-treated nets | There was a suggestion that intermittent preventive treatment (IPT) could be added as an optional process indicator. |
| PR5 | Proportion of children under five years old with diarrhea receiving oral rehydration salts (ORS packets or pre-packaged ORS fluids) | There was a suggestion that an indicator on hand washing might be more appropriate than the indicator for diarrhoea treatment. |
| PR6 | Proportion of population below minimum level of dietary energy consumption | Methodological issues with this and the other indicators relating to food security/insecurity drawing on work which is already ongoing. FAO does have a food security indicator based on analysis of Food Balance Sheets, but probably not ideal for this purpose. FAO and partners are well down the line in a process of developing new indicators of food security e.g. Food Insecurity Experience Scale. |
| PR7 | Proportion of households having access to iodized salt | It was noted that it is valuable to ensure that iodine is included somewhere in the global monitoring framework, to underline its importance even if it does not figure in the global targets. |
| PR8 | Mean dietary diversity scores | Proposal to make this indicator more focused on children by |
replacing it with WHO’s IYCF indicator of dietary diversity based on food groups.

Suggestion to move it up to become an intermediate outcome rather than a process indicator.

Work currently going on to define a threshold for minimum dietary diversity for women (should be on table by mid 2014).

This indicator is also relevant as a process indicator for the anaemia target.

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<table>
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<tbody>
<tr>
<td>PR9</td>
<td>Immunization coverage levels</td>
<td></td>
</tr>
<tr>
<td>PR10</td>
<td>Proportion of average household expenditure on food of the bottom three deciles</td>
<td></td>
</tr>
<tr>
<td>PR11</td>
<td><strong>Proportion of pregnant women receiving iron and folic acid supplements</strong></td>
<td>Although data is available on this indicator, it relates to health system delivery and does not cover all women of reproductive age. A lot of methodological work is needed on this indicator to standardise definitions etc. Inclusion of an indicator specific to marginalised groups would be more relevant for some regions (e.g. EURO).</td>
</tr>
<tr>
<td>PR12</td>
<td><strong>Percentage of households consuming iron-fortified wheat flour products</strong></td>
<td>It was acknowledged that this indicator is not global—since wheat flour is not a staple in all regions or countries. There was discussion as to whether it is appropriate for inclusion, when it is not relevant to all regions. One option would be to delete it. Another would be to amend it to refer to ‘iron-fortified staple foods’ to also capture fortified rice etc.</td>
</tr>
<tr>
<td>PR13</td>
<td>Use of micronutrient powders</td>
<td>This is of limited relevance, not a global indicator.</td>
</tr>
<tr>
<td>PR14</td>
<td>Proportion of children under five of age receiving iron supplements</td>
<td>More methodological work to be done here to refine definitions and standardising indicators. WHO and CDC are currently working on</td>
</tr>
</tbody>
</table>
Operationalizing indicators for micronutrient programmes.
This is not really a global indicator and relates to treatment as well as prevention.

<table>
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<tr>
<th>PR15</th>
<th>Proportion of women who have received protein and energy supplements</th>
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<tr>
<td></td>
<td>This indicator, which is linked to programmes, is relevant to specific countries or contexts. Questions were raised about how coverage would be measured for this indicator.</td>
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<tr>
<th>PR16</th>
<th>Proportion of hospitals providing maternity care designated as baby-friendly</th>
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<tbody>
<tr>
<td></td>
<td>It was proposed to develop this indicator, in line with current WHO/UNICEF work on assessing baby-friendly maternity services, so that it better reflects the current situation rather than refer to a historic one-off certification. This should also include community-based baby friendly maternity care. It was suggested that possible links between this indicator and other health system indicators were worth exploring.</td>
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<table>
<thead>
<tr>
<th>PR17</th>
<th>Proportion of children with severe acute malnutrition having access to appropriate treatment including therapeutic foods</th>
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<tbody>
<tr>
<td></td>
<td>This indicator measure changes in mortality rather than in prevalence of wasting itself. It was acknowledged that SAM treatment will impact on incidence of wasting, and not specifically on prevalence. Data on annual incidence, however, are not available. This is why additional indicator on moderate malnutrition treatment coverage is presented as an optional indicator for discussion (see below). Clarification on what is meant by coverage is required. It should be specified whether this is by geographical area, population, health facilities etc.</td>
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<tr>
<th>PR18</th>
<th>Proportion of children born to HIV-positive women who are</th>
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<tbody>
<tr>
<td></td>
<td>There was discussion of whether HIV prevalence in women should</td>
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<tr>
<td>HP1</td>
<td>Ratio of community health workers to total population</td>
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<td>-----</td>
<td>-----------------------------------------------------</td>
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<tr>
<td></td>
<td>There was discussion about whether the indicator should state ‘health workers’ rather than ‘community health workers’. The latter term is usually understood as a particular term which refers only to those at the community level. Measures of physician density and nurse/midwife density, however, also correlate closely with health outcomes and are relevant. There was also discussion of whether there could be an appropriate threshold or cut-off point for the ratio? The suggestion was to identify the cut-off point for ratio which has an impact. It may be worth exploring ways of linking with all the current work on monitoring Universal Health Coverage and strengthening health systems.</td>
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<table>
<thead>
<tr>
<th>HP2</th>
<th>Adoption and implementation of International Code of Marketing of Breast-milk Substitutes</th>
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<tbody>
<tr>
<td></td>
<td>It was recommend that this indicator should be moved up to the level of process indicator. There was considerable discussion of the importance of, as well as difficulties with, measuring implementation of the Code, as well as adoption. There was an initial proposal to remove ‘and implementation’ from the indicator because of these difficulties with measurement.</td>
</tr>
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</table>
Strong support emerged, however, for keeping the concept of implementation and strengthening it if possible. This could draw on ongoing work by UNICEF (on a process for measuring Code implementation) and by IBFAN’s International Code Documentation Centre (assessments of Code adoption).

It was suggested that more guidance be given to countries on monitoring Code implementation and that a consultation on this issue could be useful for further indicator development.

<table>
<thead>
<tr>
<th>HP3</th>
<th>Adoption and implementation of ILO maternity protection convention</th>
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</table>
|     | As with the Code, more clarity is needed on what precisely is meant by ‘adoption and implementation’ of the Maternity Protection Convention.
|     | It would be useful to adapt this indicator to measure the universality of measures that are in place (e.g. what proportion of women are eligible for maternity benefits etc.) It would also be useful to explore how women working in the informal economy could be included. Some data do exist on this issue. |

<table>
<thead>
<tr>
<th>HP4</th>
<th>Number of staff with nutrition skills at each level of service delivery</th>
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<tbody>
<tr>
<td></td>
<td>There was support for this issue as being important to monitor. More clarity, however, was required on how exactly to define the indicator. Further methodological work was recommended to develop better, more objective measures of nutrition skills.</td>
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<tr>
<td></td>
<td>It would be useful if the indicator could capture data on nutrition competencies in other (non-health) sectors.</td>
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<td></td>
<td>It would also be valuable to include skills relevant to prevention of malnutrition in the definition of skills.</td>
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</table>
It may also be useful to measure staff with nutrition skills that are working with the specific *population of interest* (women, infants, young children) for the implementation plan.

<table>
<thead>
<tr>
<th>HP5</th>
<th>Strength of nutrition governance</th>
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<tr>
<td></td>
<td>This indicator was recognised as being very important, but also challenging to operationalise. WHO has used a composite measure of nutrition governance and others have undertaken similar processes. These different processes have come to similar conclusions on the identification of key elements which are meaningful within the concept of nutrition governance. Suggestions for inclusion in nutritional governance indicator:</td>
</tr>
</tbody>
</table>
|     | • something on access to healthcare/services  
|     | • nutrition competencies (or prevention aspects) in related (non-health) sectors |

<table>
<thead>
<tr>
<th>New (i.e. not proposed in draft monitoring framework document)</th>
<th>Proportion of children with moderate acute malnutrition having access to appropriate supplementary foods</th>
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<tbody>
<tr>
<td></td>
<td>WFP is doing some work to combine an indicator of MAM treatment with other food indicators. This will be tested in some countries next year.</td>
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<table>
<thead>
<tr>
<th>New</th>
<th>Continued breastfeeding for 2 years and beyond</th>
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<tbody>
<tr>
<td></td>
<td>There appeared to be broad support for this proposal as an additional indicator.</td>
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<thead>
<tr>
<th>New</th>
<th>Soft drink consumption in children</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>There was considerable support for development of this as an additional new process indicator. It was pointed out, however, that in general this may be of more relevance to school-age children than to infants and young children. The terminology ‘sugar-sweetened’</td>
</tr>
<tr>
<td>New</td>
<td>Marketing regulations</td>
</tr>
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*beverages’ should be used rather than ‘soft drinks’.*