13th General Programme of Work (GPW13)
WHO Impact Framework

METADATA

DRAFT 22 March 2019
<table>
<thead>
<tr>
<th>#</th>
<th>Programmatic Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Increase the number of countries which have integrated people-centered quality health care services</td>
</tr>
<tr>
<td>2</td>
<td>Increase public financing to ensure financial protection, efficiency and equity:</td>
</tr>
<tr>
<td></td>
<td>a. Decrease share of health expenditure funded through out-of-pocket payment by 10%.</td>
</tr>
<tr>
<td></td>
<td>b. Increase public financing for Primary Health Care (PHC) by 1% of GDP</td>
</tr>
<tr>
<td></td>
<td>c. Decrease inequality gaps in utilization of outpatient services by 10%</td>
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<tr>
<td></td>
<td>d. Decrease inequality gaps in utilization of inpatient services by 10%</td>
</tr>
<tr>
<td>3</td>
<td>Increase the share of public spending on health by 10%</td>
</tr>
<tr>
<td>4</td>
<td>a. Increase availability of essential medicines for primary health care, including the ones free of charge to 80%</td>
</tr>
<tr>
<td></td>
<td>b. ACCESS group antibiotics at ≥60% of overall antibiotic consumption</td>
</tr>
<tr>
<td>5</td>
<td>Increase coverage of essential health services among women and girls in the poorest wealth quintile</td>
</tr>
<tr>
<td>6</td>
<td>Reduce the number of older adults 65+ years who are care dependent by 15 million</td>
</tr>
<tr>
<td>7</td>
<td>Increase the availability of oral morphine in facilities caring for patients in need of this treatment for palliative care at all levels from 25% to 50%</td>
</tr>
<tr>
<td>8</td>
<td>Increase health workforce density with improved distribution</td>
</tr>
<tr>
<td>9</td>
<td>Increase in member states International Health Regulations capacities</td>
</tr>
<tr>
<td>10</td>
<td>a. Increase the availability of health facilities providing a minimum services package to people in fragile, conflict, or vulnerable settings to at least 80%</td>
</tr>
<tr>
<td></td>
<td>b. Increase immunization coverage for cholera, yellow fever, meningococcal meningitis and pandemic influenza</td>
</tr>
<tr>
<td>11</td>
<td>Reduce number of deaths, missing persons and persons affected by disaster per 100,000 population</td>
</tr>
<tr>
<td>12</td>
<td>Reduce the global maternal mortality ratio by 30%</td>
</tr>
<tr>
<td>13</td>
<td>Reduce the preventable deaths of newborns and children under 5 years of age by 17% and 30% respectively</td>
</tr>
<tr>
<td>14</td>
<td>Reduce the number of stunted children under 5 years of age by 30%</td>
</tr>
<tr>
<td>15</td>
<td>Reduce the prevalence of wasting among children under 5 years of age to less than 5%</td>
</tr>
<tr>
<td>16</td>
<td>Increase the proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being to 80%</td>
</tr>
<tr>
<td>17</td>
<td>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%</td>
</tr>
<tr>
<td>18</td>
<td>Increase the proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods to 66%</td>
</tr>
<tr>
<td>19</td>
<td>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%</td>
</tr>
<tr>
<td>20</td>
<td>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%</td>
</tr>
<tr>
<td>21</td>
<td>20% relative reduction in the premature mortality (age 30-70 years) from NCDs (cardiovascular, cancer, diabetes, or chronic respiratory diseases) through prevention and treatment</td>
</tr>
<tr>
<td>22</td>
<td>25% relative reduction in prevalence of current tobacco use in persons aged 15+ years</td>
</tr>
<tr>
<td>23</td>
<td>7% relative reduction in the harmful use of alcohol as appropriate, within the national context</td>
</tr>
<tr>
<td>#</td>
<td>Programmatic Target</td>
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<tr>
<td>----</td>
<td>------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>24</td>
<td>25% relative reduction in mean population intake of salt/sodium</td>
</tr>
<tr>
<td>25</td>
<td>Halt and begin to reverse the rise in childhood overweight (0-4 years) and obesity (5-19 years)</td>
</tr>
<tr>
<td>26</td>
<td>Eliminate industrially produced trans fats (increase the percentage of people protected by effective regulation)</td>
</tr>
<tr>
<td>27</td>
<td>7% relative reduction in the prevalence of insufficient physical activity in persons aged 18+ years</td>
</tr>
<tr>
<td>28</td>
<td>Reduce suicide mortality rate by 15%</td>
</tr>
<tr>
<td>29</td>
<td>Reduce the number of global deaths and injuries from road traffic accidents by 20%</td>
</tr>
<tr>
<td>30</td>
<td>Increase service coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for severe mental health conditions to 50%</td>
</tr>
<tr>
<td>31</td>
<td>20% relative reduction in the prevalence of raised blood pressure</td>
</tr>
<tr>
<td>32</td>
<td>Increase access to human papilloma virus vaccine among adolescent girls (9-14 years) to 50%</td>
</tr>
<tr>
<td>33</td>
<td>Increase proportion of women between 30-49 years who have been screened for cervical cancer to 25%</td>
</tr>
<tr>
<td>34</td>
<td>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</td>
</tr>
<tr>
<td>35</td>
<td>Eliminate at least one neglected tropical disease in 30 additional endemic member states (cumulative total number of member states)</td>
</tr>
<tr>
<td>36</td>
<td>Reduce tuberculosis deaths (including TB deaths among people with HIV) by 50%</td>
</tr>
<tr>
<td>37</td>
<td>Reduce malaria deaths by 50%</td>
</tr>
<tr>
<td>38</td>
<td>Reduce the number of HBV or HCV related deaths by 40%</td>
</tr>
<tr>
<td>39</td>
<td>Reduce number of new HIV infections per 1000 uninfected population, by sex, age, and key populations by 73%</td>
</tr>
<tr>
<td>40</td>
<td>Increase coverage of 2nd dose of measles containing vaccine (MCV2) to 85%</td>
</tr>
<tr>
<td>41</td>
<td>Increase treatment coverage of Rifampicin-Resistant (RR)-TB to 80%</td>
</tr>
<tr>
<td>42</td>
<td>Reduce the percentage of bloodstream infections due to selected AMR organisms by 10%</td>
</tr>
<tr>
<td>43</td>
<td>Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination</td>
</tr>
<tr>
<td>44</td>
<td>Reduce mortality from climate-sensitive diseases by 10%</td>
</tr>
<tr>
<td>45</td>
<td>Provide access to safely managed drinking water services for 1 billion more people</td>
</tr>
<tr>
<td>46</td>
<td>Provide access to safely managed sanitation services for 800 million more people</td>
</tr>
</tbody>
</table>
### GPW13 WHO Impact Framework: Target #1 Indicator Metadata

<table>
<thead>
<tr>
<th>Target #1</th>
<th>Increase the number of countries which have integrated people-centered quality health care services</th>
</tr>
</thead>
<tbody>
<tr>
<td>SDG/ Core 100</td>
<td>Core 100 (2015)</td>
</tr>
<tr>
<td>Definition</td>
<td>Percentage of population living within 5 km/1 hour of a primary care health facility (total number of health facilities per 10 000 population).</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
<td>Population within 5 km/1 hour of a primary care health facility</td>
</tr>
<tr>
<td>Denominator</td>
<td>Total population</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>Facility database, geospatial modeling</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td>Population survey: DHS indicator currently - Percentage of women who reported they have big problems in the distance to health facility for treatment for themselves when they are sick. Numerator: N Women who report problems in the distance to health facility for treatment for themselves when they are sick. Denominator: Total number of women interviewed</td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td></td>
</tr>
<tr>
<td>Disaggregation</td>
<td>density of specific services, facility ownership, location (district, province, national), type</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Annual</td>
</tr>
<tr>
<td>Limitations</td>
<td>The indicator collected by facility database, geospatial modelling is not fully comparable with the indicator currently collected through population surveys.</td>
</tr>
<tr>
<td>Data type</td>
<td>Percentage</td>
</tr>
</tbody>
</table>
### GPW13 WHO Impact Framework: Target #1 Indicator Metadata

| Target #1 | Increase the number of countries which have integrated people-centered quality health care services  
| Hospital admissions that can be avoided with appropriate primary care. |
| Indicator-2 |  |
| SDG/ Core 100 | Core 100 (Additional) |
| Definition | Age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care may prevent or reduce the need for admission to hospital, per 100,000 population. Conditions include hypertension, congestive heart failure, diabetes mellitus, asthma and chronic obstructive pulmonary disease |
| Method of estimation/calculation | Number of acute care hospitalizations for ambulatory care sensitive conditions (ACSCs).  
| | Inclusions  
| | • Admission to an acute care hospital for an individual in the denominator  
| | • Admission to an acute care hospital with one of the following as most responsible diagnosis:  
| | − Chronic obstructive pulmonary disease  
| | − Asthma  
| | − Heart failure and pulmonary edema  
| | − Hypertension  
| | − Diabetes  
| | Exclusions  
| | • Individual died before discharge  
| | • Admission category recorded as newborn or stillbirth |
| Numerator |  |
| Denominator | Mid-year population age 75 and younger, per 100,000 (age adjusted).  
| | Inclusions  
| | • Age of individual is younger than 75 years |
| Preferred data sources | Hospital discharge database, census for the denominator |
| Other possible data sources | Facility survey |
| WHO GPW13 Framework |  |
| Disaggregation | Subnational, gender, condition |
| Expected frequency of data collection | Annual |
| Limitations | Limited data availability in LMIC at baseline. |
| Data type | Rate |
| | OECD Health Care Quality Indicators: [https://stats.oecd.org/](https://stats.oecd.org/) |
### Target #1

*Increase the number of countries which have integrated people-centered quality health care services*

#### Indicator-3

*Access to essential surgical services*

#### SDG/ Core 100

**Definition**

Percent of the population that can access, within 2 hours, a facility that can perform emergency caesarean section, laparotomy and open fracture fixation

#### Method of estimation/calculation

**Numerator**

Population within 2 hours of a facility that can perform emergency caesarean section, open fracture fixation, laparotomy and open fracture fixation

**Denominator**

Total population

**Preferred data sources**

Routine facility information system or Facility registry/SARA surveys for facility data; Population survey/geospatial modeling for population denominator

**Other possible data sources**

WHO GPW13 Framework

**Disaggregation**

Density of specific services, facility ownership, location (district, province, national), type

**Expected frequency of data collection**

Annual

**Limitations**

The indicator collected by facility database and facility surveys such as SARA. Some evidence exists that geospatial modelling is not fully comparable with data collected through population surveys for population denominators.

**Data type**

Percentage

**Related links**

Core 100 Indicators / Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. Geneva: World Health Organization;
## GPW13 WHO Impact Framework: Target #1 Indicator Metadata

<table>
<thead>
<tr>
<th>Target #1</th>
<th>Increase the number of countries which have integrated people-centered quality health care services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator-4</td>
<td>Access to safe blood supply</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>Blood and blood products are essential components in the proper management of women suffering from bleeding associated with pregnancy and childbirth; children suffering from severe anaemia due to malaria and malnutrition; patients with blood and bone marrow disorders, inherited disorders of haemoglobin and immune deficiency conditions; victims of trauma, emergencies, disasters and accidents; and patients undergoing advanced medical and surgical procedures. Although the need for blood and blood products is universal, there is a marked difference in the level of access to safe blood and blood products across and within countries and in many countries, blood services face the challenge of making sufficient blood and blood products available while also ensuring its quality and safety.</td>
</tr>
<tr>
<td>Definition</td>
<td>Proportion of health facilities providing blood transfusion that meets requirements for sufficient and safe blood transfusion.</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>$% = \frac{\text{Health facilities that meet the requirement of safe blood supply (n)}}{\text{Health facilities where blood is transfused (n)}}$</td>
</tr>
<tr>
<td>Numerator</td>
<td># of health facilities that meet the requirement of safety blood supply as defined.</td>
</tr>
<tr>
<td>Denominator</td>
<td># of health facilities where blood is transfused (total or surveyed)</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>Service Availability and Readiness Assessment (SARA): <a href="https://www.who.int/healthinfo/systems/sara_indicators_questionnaire/en/">https://www.who.int/healthinfo/systems/sara_indicators_questionnaire/en/</a></td>
</tr>
<tr>
<td>Disaggregation</td>
<td>The proposed indicator will allow for the following disaggregation:</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Annual</td>
</tr>
<tr>
<td>Limitations:</td>
<td>Currently there are insufficient number of countries that conducted SARA (health facility) surveys regularly; WHO Global Database on Blood Safety (GDBS) annual survey has collected national supply and safety data which need be supplemented by the collection of access data in the data collection tool.</td>
</tr>
<tr>
<td>Data type</td>
<td>Percentage</td>
</tr>
</tbody>
</table>
Related links

Service Availability and Readiness Assessment (SARA):
https://www.who.int/healthinfo/systems/sara_indicators_questionnaire/en/
### GPW13 WHO Impact Framework: Target #2 Indicator Metadata

<table>
<thead>
<tr>
<th>Target #2.a</th>
<th>Decrease share of health expenditure funded through out-of-pocket payment by 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Out-of-Pocket Health Expenditure (OOPS) as % of Current Health Expenditure (OOPS%CHE)</td>
</tr>
<tr>
<td>SDG/Core 100</td>
<td>Definition</td>
</tr>
<tr>
<td></td>
<td>Out-of-Pocket Health Expenditure (OOPS) as a share of Current Health Expenditure (CHE) decreases by 10% of the baseline year.</td>
</tr>
<tr>
<td></td>
<td>Method of estimation/calculation</td>
</tr>
<tr>
<td></td>
<td>The share of out-of-Pocket Health Expenditure indicates the level of health system financing reliance on direct payments for health services. Health systems that rely largely on out-of-pocket expenditure can result in more households facing financial difficulties to pay for health services. The indicator is calculated as ((OOPS%CHE_{t+5} - OOPS%CHE_t) / OOPS%CHE_t)</td>
</tr>
<tr>
<td>Numerator</td>
<td>Out-of-Pocket Health Expenditure (OOPS)</td>
</tr>
<tr>
<td>Denominator</td>
<td>Current Health Expenditure</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>Global Health Expenditure Database (GHED) (to merge with the Global Health Observatory in 2020)</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td>Global Health Observatory (GHO)</td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td>No</td>
</tr>
<tr>
<td>Disaggregation</td>
<td></td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Annual</td>
</tr>
<tr>
<td>Limitations</td>
<td>As per metadata for each country on GHED</td>
</tr>
<tr>
<td>Data type</td>
<td>Percentage</td>
</tr>
</tbody>
</table>
| Related links | http://www.who.int/health-accounts/  
http://apps.who.int/nha/database |
### GPW13 WHO Impact Framework: Target #2 Indicator Metadata

<table>
<thead>
<tr>
<th>Target #2.b</th>
<th>Increase public financing for Primary Health Care (PHC) by 1% of GDP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>General Government Expenditure on PHC (GPHC) as % of Gross Domestic Product (GDP)</td>
</tr>
<tr>
<td>SDG/Core 100</td>
<td>-</td>
</tr>
<tr>
<td>Definition</td>
<td>General government spending on PHC increases by one percentage point of GDP, over a 10-year interval</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>The share of Gross Domestic Product spent by government on primary health care indicates the prioritization of the government to invest in primary health care from public resources. It expresses this priority by comparing the size of government expenditure on primary health care relative to the total size of the economy. The indicator is calculated as GPHC%GDP_t+10 - GPHC%GDP_t</td>
</tr>
<tr>
<td>Numerator</td>
<td>General Government Expenditure on PHC</td>
</tr>
<tr>
<td>Denominator</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>Global Health Expenditure Database (GHED) (to merge with the Global Health Observatory in 2020)</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td>Global Health Observatory (GHO)</td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td>-</td>
</tr>
<tr>
<td>Disaggregation</td>
<td>No</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Annual</td>
</tr>
<tr>
<td>Limitations</td>
<td>As per metadata for each country on GHED</td>
</tr>
<tr>
<td>Data type</td>
<td>Percentage</td>
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</table>
| Related links | [http://www.who.int/health-accounts/](http://www.who.int/health-accounts/)  
[http://apps.who.int/nha/database](http://apps.who.int/nha/database)  
[https://gh.bmj.com/content/4/1/e001497](https://gh.bmj.com/content/4/1/e001497) (Vande maele, Xu, Soucat, et al. 2019) |
### GPW13 WHO Impact Framework: Target #2 Indicator Metadata

<table>
<thead>
<tr>
<th>Target #2.c</th>
<th>Decrease inequality gaps in utilization of outpatient services by 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Ratio of the number of outpatient services per capita (OPD per capita) across different disaggregation dimensions (e.g. poor/rich; education level; rural/urban; sub-regional)</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>CORE 100</td>
</tr>
<tr>
<td>Definition</td>
<td>Number of outpatient visit per person per year</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>Requires complete and reliable recording and reporting of the number of outpatient visits by public and private facilities in addition to information on patient characteristics and location. When complete enumeration with additional information on patient characteristics is lacking, population surveys can also be used. In such case, the use of outpatient services ought to be captured using appropriate recall periods which may vary depending on the type of outpatient service (e.g. last 6 months or 3 months for preventive services; last month or last 2 weeks for other outpatient services depending upon the sample size of the survey).</td>
</tr>
<tr>
<td>Numerator</td>
<td>Total Number of Outpatient Visit per year</td>
</tr>
<tr>
<td>Denominator</td>
<td>Total population</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>Routine facility information systems (HMIS) with information on patient characteristics and geographic location; nationally representative population-based surveys. The most common data sources are socio-economic or living standards surveys, health focused surveys with a module on health seeking behavior. These surveys are typically implemented by or in close collaboration with national statistical bureaus.</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td></td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td></td>
</tr>
<tr>
<td>Disaggregation</td>
<td>Socio-economic group, education level, geographical</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Population based survey every 2 to 5 years; HMIS Annual</td>
</tr>
<tr>
<td>Limitations</td>
<td>For population-based surveys need for standardization of recall period; timeliness of the information is an issue, comparability of outpatient visits may be an issue. For HMIS, disaggregation by patient characteristics is an issue, coverage of private sector facilities might be an issue.</td>
</tr>
<tr>
<td>Data type</td>
<td>Ratio</td>
</tr>
</tbody>
</table>
### Target #2 Indicator Metadata

<table>
<thead>
<tr>
<th><strong>Target #2.d</strong></th>
<th>Decrease inequality gap in utilization of inpatient services by 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator</strong></td>
<td>Ratio of the number of inpatient treatment (IP per capita) across different disaggregation dimensions (e.g. poor/rich; education level; rural/urban; sub-regional)</td>
</tr>
<tr>
<td><strong>SDG/ Core 100</strong></td>
<td>CORE 100</td>
</tr>
<tr>
<td><strong>Definition</strong></td>
<td>Number of inpatient treatments per person per year across different disaggregation dimensions (e.g. poor/rich; education level; rural/urban; sub-regional)</td>
</tr>
<tr>
<td><strong>Method of estimation/calculation</strong></td>
<td>Requires complete and reliable recording and reporting of the number of inpatient treatment by public and private facilities in addition to information on patient characteristics and location. When complete enumeration with additional information on patient characteristics is lacking, population surveys can also be used. In such case, information on inpatient treatment ought to be captured using appropriate recall periods (e.g. last 6 months or last 12 months depending upon the sample size of the survey).</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>Total Number of Inpatient treatment per year</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Total population</td>
</tr>
<tr>
<td><strong>Preferred data sources</strong></td>
<td>Routine facility information systems (HMIS) with information on patient characteristics and geographic location; nationally representative population-based surveys. The most common data sources are socio-economic or living standards surveys, health focused surveys with a module on health seeking behavior. These surveys are typically implemented by or in close collaboration with national statistical bureaus.</td>
</tr>
<tr>
<td><strong>Other possible data sources</strong></td>
<td></td>
</tr>
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<td><strong>WHO GPW13 Framework</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Disaggregation</strong></td>
<td>Socio-economic group, education level, geographical</td>
</tr>
<tr>
<td><strong>Expected frequency of data collection</strong></td>
<td>Population based survey every 2 to 5 years; HMIS annual</td>
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<tr>
<td><strong>Limitations</strong></td>
<td>For population-based surveys, need for standardization of recall period; timeliness of the information is an issue, comparability of inpatient visits may be an issue. For HMIS, disaggregation by patient characteristics is an issue, coverage of private sector facilities might be an issue.</td>
</tr>
<tr>
<td><strong>Data type</strong></td>
<td>Ratio</td>
</tr>
<tr>
<td><strong>Related links</strong></td>
<td></td>
</tr>
</tbody>
</table>
### GPW13 WHO Impact Framework: Target #3 Indicator Metadata

<table>
<thead>
<tr>
<th>Target #3</th>
<th>Increase the share of public spending on health by 10%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Domestic General Government Health Expenditure (GGHED) as % of General Government Expenditure (GGHED%GGE).</td>
</tr>
<tr>
<td>SDG/Core 100</td>
<td>Share of government health expenditures from domestic sources in general government expenditures increase by 10% of the baseline year.</td>
</tr>
<tr>
<td>Definition</td>
<td>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 ( \frac{\text{GGHED%GGE}_{t+5} - \text{GGHED%GGE}_t}{\text{GGHED%GGE}_t} ).</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
<td>Domestic General Government Health Expenditure</td>
</tr>
<tr>
<td>Denominator</td>
<td>General Government Expenditure</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>Global Health Expenditure Database (GHED)</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td>Global Health Observatory (GHO)</td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td>No</td>
</tr>
<tr>
<td>Disaggregation</td>
<td>Annual</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Annual</td>
</tr>
<tr>
<td>Limitations</td>
<td>As per metadata for each country in GHED</td>
</tr>
<tr>
<td>Data type</td>
<td>Percentage</td>
</tr>
<tr>
<td>Related links</td>
<td><a href="http://www.who.int/health-accounts/">http://www.who.int/health-accounts/</a></td>
</tr>
</tbody>
</table>
### GPW13 WHO Impact Framework: Target #4 Indicator Metadata

<table>
<thead>
<tr>
<th>Target #4a</th>
<th>Increase availability of essential medicines for primary health care, including the ones free of charge to 80%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator-1</td>
<td>Proportion of health facilities that have a core set of relevant essential medicines available and affordable on a sustainable basis</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 3.b.3</td>
</tr>
<tr>
<td>Definition</td>
<td>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.</td>
</tr>
</tbody>
</table>
| Method of estimation/calculation | \[
\text{% availability} = \frac{\text{Number of facilities that have all essential medicines from the minimum list available}}{\text{Number of surveyed facilities}} \times 100\%
\] |
| 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 |
**GPW13 WHO Impact Framework: Target #4 Indicator Metadata**

<table>
<thead>
<tr>
<th>Target #4a</th>
<th>Increase availability of essential medicines for primary health care, including the ones free of charge to 80%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator-2</td>
<td>Availability of essential medicines for primary health care, including the ones free of charge</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>Yes</td>
</tr>
<tr>
<td>Definition</td>
<td>Proportion of health facilities that have available a core set of relevant essential medicines</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>Ratio of the health facilities with available medicines for primary health care over the total number of the surveyed health facilities</td>
</tr>
<tr>
<td>Numerator</td>
<td># of facilities with available medicines (as per core set of relevant essential medicines for primary health care)</td>
</tr>
<tr>
<td>Denominator</td>
<td># of surveyed facilities</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>The indicator relies on three data sources that have been used by countries to collect information on medicine prices and availability:</td>
</tr>
<tr>
<td></td>
<td>1) Health Action International Project supported by the WHO [HAI/WHO]</td>
</tr>
<tr>
<td></td>
<td>2) The Service Availability and Readiness Assessment survey [SARA]</td>
</tr>
<tr>
<td></td>
<td>3) The WHO Medicines Price and Availability Monitoring mobile application [EMP MedMon]</td>
</tr>
<tr>
<td></td>
<td>Health Action International Project supported by WHO [HAI/WHO] provides data from national and sub-national surveys that have used the WHO/HAI methodology, Measuring Medicine Prices, Availability and Affordability and Price Components. The database is available at the following link: <a href="http://haiweb.org/what-we-do/price-availability-affordability/price-availability-data/">http://haiweb.org/what-we-do/price-availability-affordability/price-availability-data/</a></td>
</tr>
<tr>
<td></td>
<td>The Service Availability and Readiness Assessment [SARA] is a health facility assessment tool designed to assess and monitor availability and readiness of the services provided in the health sector and to generate evidence to support the planning and managing of a health system.</td>
</tr>
<tr>
<td></td>
<td>The WHO Medicines Price and Availability Monitoring mobile application [EMP MedMon] can be considered as an updated version of the HAI/WHO tool for collecting data on medicine prices and availability. This data collection tool was created based on the two previously mentioned existing and well-established methodologies. This application is used at facility level to collect information on availability and price of the agreed-upon core basket of medicines.</td>
</tr>
<tr>
<td></td>
<td>The EMP MedMon is easier to use, faster to conduct and consumes much fewer resources for collecting data. It also allows for a modular approach to defining the basket, which is highly useful and convenient for the purposes of this indicator.</td>
</tr>
<tr>
<td></td>
<td>In order to compute historical data points prior to 2018, data from HAI/WHO is used. To compute current and future data points, SARA and EMP MedMon are recommended.</td>
</tr>
</tbody>
</table>

Other possible data sources: NA
<table>
<thead>
<tr>
<th>Disaggregation</th>
<th>Expected frequency of data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>The proposed indicator will allow for the following disaggregation:</td>
<td>Annual</td>
</tr>
<tr>
<td>1) public/private/mission sectors facilities (managing authority)</td>
<td></td>
</tr>
<tr>
<td>2) geography – rural/urban areas</td>
<td></td>
</tr>
<tr>
<td>3) therapeutic group</td>
<td></td>
</tr>
<tr>
<td>4) facility type (pharmacy/hospital)</td>
<td></td>
</tr>
<tr>
<td>5) medicine.</td>
<td></td>
</tr>
</tbody>
</table>
### Limitations

1) On basket of tracer essential medicines:

1.1) Although it is possible to regularly monitor all 400+ medicines on the current WHO Model List of Essential Medicines, indicator 3.b.3 requires a specific subset of this list. Over the years, several baskets of medicines have been defined for different purposes and used to conduct data collection and monitor price and availability. This core set of medicines does not replace the other existing baskets, and WHO teams and partners are encouraged and committed to continue ad hoc monitoring through other existing channels. Throughout the process of identifying the core set of medicines, one area of focus has been to balance the selection of the tracer medicines for primary health care with the size of the basket itself. The proposed basket represents a balanced approach to allow that relevant tracer medicines for primary health care are monitored yet ensuring a practical and feasible data collection and analysis. The 32 medicines listed in the basket are meant to be indicative of the access to medicines for primary health care but do not serve as a complete or exhaustive list.

1.2) As mentioned above, each medicine in the basket is weighted according to the regional Disability Adjusted Life Years (DALYs) for relevant disease from the WHO Global health estimates. Regional estimates are less sensitive to country-by-country variability of data quality, they sufficiently illustrate the disease distribution across countries in the region and work well due simplicity and comparability. Hence, regional weights for medicines are used to establish the associated country weights. However, this diminishes the specificity of the basket to the national context.

2) On the measurement of medicines’ availability:

The proposed approach for measuring the availability of medicines is based on the presence of the medicine on the day that the interviewer visits the facility and does not account for temporary and/or planned stock outs. The 32 medicines identified for the analysis should always be available in the facilities considering that in some (mainly rural) areas, the facility may be very difficult to reach and individuals may not have resources to travel on a daily basis. Moreover, in this proposed methodology the price of the medicine does not take into consideration the so-called indirect costs, which normally include transportation and other costs to reach the facility. Thus, the proposed measure for availability presents some limitations.

Furthermore, given the data collection occurs at the facility level and does not monitor quantities of any given medicine, an overall analysis of the available medicines compared to the national needs is not possible.

3) Other dimensions on access to medicines (quality)

The quality of the product is another equally important dimension of access to medicines. Currently, there is no systematic and publicly available data collection on quality of a single medicine or in a single country. WHO has, however, contributed to enhanced access to quality health products through different programmes such as regulatory systems strengthening and prequalification. A national regulatory authority (NRA) plays a key role in assuring the quality, safety, and efficacy of medical products until they reach the patient/consumer, as well as ensuring the relevance and accuracy of product information. Hence, stable, well-functioning and integrated regulatory systems are an essential component of a health system and contribute to better public health outcomes. NRA maturity and WHO prequalification of medicines can be considered as a proxy for ensuring that medicines in a country are of assured quality. The NRA maturity level is assessed using the WHO National Regulatory Authority Global Benchmarking Tool (WHO NRA GBT). After the evaluations, countries are assigned one of five levels of maturity, with a score of maturity level three representing the minimum acceptable regulatory capacity and maturity level five representing the highest level of functioning.

The importance of transparency and the disclosure of the results of assessments amongst regulators (from ML 3 up) are taken into consideration. However, the information on country-specific NRA maturity level is not currently publicly available and WHO is working to address this limitation through recent discussions on WHO Listed Authorities (WLA).


### Target #4b

#### Indicator

**ACCESS group antibiotics at ≥60% of overall antibiotic consumption**

Patterns of antibiotic consumption at national level

#### SDG/ Core 100

**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.

**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.

---

**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.
| **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** |
| **Preferred data sources** | 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. |
| **Other possible data sources** | National (or sampling of) antibiotic consumption data available at national level through different sources (sales / prescribing / dispensing / ...) |
| **Consumption data** | 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. |
| **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 |
| **Data type** | Percentage |
## GPW13 WHO Impact Framework: Target #5 Indicator Metadata

<table>
<thead>
<tr>
<th>Target #5</th>
<th>Increase coverage of essential health services among women and girls in the poorest wealth quintile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Coverage of essential health services (defined as the average coverage) for women and girls disaggregated by wealth quintile</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 3.8.1</td>
</tr>
<tr>
<td>Definition</td>
<td>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). It is currently measured based on the RMNCH service coverage index, but should be extended to all relevant services when data are available). The composite coverage index is a weighted score reflecting coverage of eight RMNCH interventions along the continuum of care: demand for family planning satisfied (modern methods); antenatal care coverage (at least four visits); births attended by skilled health personnel; BCG immunization coverage among one-year-olds; measles immunization coverage among one-year-olds; DTP3 immunization coverage among one-year-olds; children aged less than five years with diarrhoea receiving oral rehydration therapy and continued feeding; and children aged less than five years with pneumonia symptoms taken to a health facility. This indicator is based on aggregate estimates.</td>
</tr>
</tbody>
</table>
| Method of estimation/calculation | It is currently measured based on the RMNCH service coverage index, but should be extended to all relevant services, when data are available). The CCI is a weighted average of essential maternal and child health interventions along the continuum of care. It includes the following indicators: 1) demand for family planning satisfied with modern methods (DFPSmo), 2) at least four antenatal care visits (ANC4), 3) skilled birth attendant (SBA), 4) bacille Calmette-Guérin (BCG) vaccine; 5) three doses of diphtheria-tetanus-pertussis (DPT3) vaccine; 6) measles (MSL) vaccine; 7) oral rehydration salts for diarrhoea (ORS), and 8) care-seeking for suspected childhood pneumonia (CAREP).

\[
\text{DFPSmo} + \frac{(\text{ANC4} + \text{SBA})}{2} + \frac{(\text{MSL} + \text{BCG} + 2 \times \text{DPT3})}{4} + \frac{(\text{ORS} + \text{CAREP})}{2}
\]

documentation.https://www.who.int/gho/health_equity/services/rmnch_interventions_combined/en/ |
<p>| Numerator | This indicator is based on aggregate estimates. |</p>
<table>
<thead>
<tr>
<th>Denominator</th>
<th>This indicator is based on aggregate estimates.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred data sources</td>
<td>WHO Health Equity Monitor database: Data are derived from re-analysis of Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS) and Reproductive Health Surveys (RHS) micro-data which are publicly available using the standard indicator definitions as published in DHS, MICS or RHS.</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td></td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td></td>
</tr>
<tr>
<td>Disaggregation</td>
<td></td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Data collection based on household health surveys varies from every 3 to 5 years across tracer indicators, depending on the country.</td>
</tr>
<tr>
<td>Limitations</td>
<td>TBD</td>
</tr>
<tr>
<td>Data type</td>
<td>Index</td>
</tr>
<tr>
<td></td>
<td>Individual tracer indicators are available here:</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.who.int/healthinfo/universal_health_coverage/UHC_Tracer_Indicators_Metadata.pdf">http://www.who.int/healthinfo/universal_health_coverage/UHC_Tracer_Indicators_Metadata.pdf</a></td>
</tr>
<tr>
<td></td>
<td><a href="https://www.who.int/gho/health_equity/services/health_equity_rmnch_composite_coverage_index_2018.pdf?ua=1">https://www.who.int/gho/health_equity/services/health_equity_rmnch_composite_coverage_index_2018.pdf?ua=1</a></td>
</tr>
<tr>
<td></td>
<td><a href="https://www.who.int/gho/health_equity/services/rmnch_interventions_combined/en/">https://www.who.int/gho/health_equity/services/rmnch_interventions_combined/en/</a></td>
</tr>
</tbody>
</table>
### GPW13 WHO Impact Framework: Target #6 Indicator Metadata

<table>
<thead>
<tr>
<th>Target #6</th>
<th><strong>Reduce the number of older adults 65+ years who are care dependent by 15 million</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator-1</td>
<td>Number of older adults 65+ years who are care dependent</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td></td>
</tr>
<tr>
<td>Definition</td>
<td>Number of people having moderate or extreme difficulty on one item (dressing, walking across a room, bathing or showering, eating, getting in or out of bed, using the toilet) of the ADL scale (Activities of Daily Living)</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>By definition</td>
</tr>
<tr>
<td>Numerator</td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td></td>
</tr>
<tr>
<td>Other possible data sources</td>
<td>Administrative data sources on older adults in long-term care facilities; censuses.</td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td></td>
</tr>
<tr>
<td>Disaggregation</td>
<td>Sex and household income or wealth quintiles</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Every two or three years</td>
</tr>
<tr>
<td>Limitations</td>
<td>Measurement error in surveys, Quality of surveys and administrative data sources</td>
</tr>
<tr>
<td>Data type</td>
<td>Absolute number.</td>
</tr>
<tr>
<td>Related links</td>
<td></td>
</tr>
<tr>
<td>Target #6</td>
<td><strong>Reduce the number of older adults 65+ years who are care dependent by 15 million</strong></td>
</tr>
<tr>
<td>-----------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Indicator-2</td>
<td>The proportion of people, 65+ years, who live in age-friendly cities and communities</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>Links to SDG indicators 11.1.1, 11.2.1, 11.3.1, 11.3.2, 11.5.1 (disasters); 11.7.1; 11.7.2 (elder abuse); 11.a.1</td>
</tr>
<tr>
<td>Definition</td>
<td>A city or community, whose Mayor or senior leadership, has undertaken a process of continuous improvement to foster healthy and active ageing.</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
<td>Population aged 65+ years, living in an age-friendly city or community</td>
</tr>
<tr>
<td>Denominator</td>
<td>Total population of people 65+ years.</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>WHO database of age-friendly cities and communities, geospatial modeling</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td>Population survey: Percentage of older people who reported they have problems in doing what they value due to barriers in the environment. Numerator: Number of older adults who report problems in doing what they value due to barriers in the environment. Denominator: Total number of older adults interviewed</td>
</tr>
<tr>
<td>Disaggregation</td>
<td>Health status, socioeconomic status, housing, transportation, green spaces, public spaces, access to health and long-term care.</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Annual</td>
</tr>
<tr>
<td>Limitations</td>
<td>The indicator collected by WHO database and geospatial modelling are not fully comparable with the indicators currently collected through population surveys.</td>
</tr>
<tr>
<td>Data type</td>
<td>Percentage</td>
</tr>
</tbody>
</table>
## GPW13 WHO Impact Framework: Target #7 Indicator Metadata

<table>
<thead>
<tr>
<th>Target #7</th>
<th>Increase the availability of oral morphine in facilities caring for patients in need of this treatment for palliative care at all levels from 25% to 50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Availability of oral morphine in facilities at all levels</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td></td>
</tr>
<tr>
<td>Definition</td>
<td>Proportion of health facilities that have oral morphine available. Oral morphine is available in a facility when it is found in this facility by the interviewer on the day of data collection. Availability is measured as a binary variable with 1 = medicine is available and 0 = otherwise</td>
</tr>
</tbody>
</table>
| Method of estimation/calculation | Ratio of the health facilities with available morphine over the total number of the surveyed health facilities  

\[
\text{Facilities with available oral morphine (n)} \quad \frac{}{\text{Surveyed Facilities (n)}}
\]

| Numerator | # of facilities with available oral morphine |
| Denominator | # of surveyed facilities |
| Preferred data sources | The indicator relies on three data sources that have been used by countries to collect information on medicine prices and availability:  
1) Health Action International Project supported by the WHO [HAI/WHO]  
2) The Service Availability and Readiness Assessment survey [SARA]  
3) The WHO Medicines Price and Availability Monitoring mobile application [EMP MedMon]  
Health Action International Project supported by WHO [HAI/WHO] provides data from national and sub-national surveys that have used the WHO/HAI methodology, Measuring Medicine Prices, Availability and Affordability and Price Components. The database is available at the following link: [http://haiweb.org/what-we-do/price-availability-affordability/price-availability-data/](http://haiweb.org/what-we-do/price-availability-affordability/price-availability-data/)  
The Service Availability and Readiness Assessment [SARA] is a health facility assessment tool designed to assess and monitor availability and readiness of the services provided in the health sector and to generate evidence to support the planning and managing of a health system.  
The WHO Medicines Price and Availability Monitoring mobile application [EMP MedMon] can be considered as an updated version of the HAI/WHO tool for collecting data on medicine prices and availability. This data collection tool was created based on the two previously mentioned existing and well-established methodologies. This application is used at facility level to collect information on availability and price of the agreed-upon core basket of medicines.  
The EMP MedMon is easier to use, faster to conduct and consumes much fewer resources for collecting data. It also allows for a modular approach to defining a basket of medicines, which is highly useful and convenient for the purposes of this indicator.  
In order to compute historical data points prior to 2018, data from HAI/WHO is used. To compute current and future data points, SARA and EMP MedMon are recommended. |
| Other possible data sources | NA |
| WHO GPW13 Framework | |
### Disaggregation

1. public/private/mission sectors facilities (managing authority)
2. geography – rural/urban areas
3. therapeutic group
4. facility type (pharmacy/hospital)

### Expected frequency of data collection

Annual

### Limitations

1) On the measurement of medicines’ availability:
The proposed approach for measuring the availability of oral morphine is based on the presence of the medicine on the day that the interviewer visits the facility and does not account for temporary and/or planned stock outs. The morphine should always be available in the facilities considering that in some (mainly rural) areas, the facility may be very difficult to reach and individuals may not have resources to travel on a daily basis. Furthermore, given the data collection occurs at the facility level and does not monitor quantities of morphine, an overall analysis of the available morphine compared to the national needs is not possible.

2) Other dimensions on access to medicines (quality)
The quality of the product is another equally important dimension of access to medicines. Currently, there is no systematic and publicly available data collection on quality of a single medicine or in a single country. WHO has, however, contributed to enhanced access to quality health products through different programmes such as regulatory systems strengthening and prequalification. A national regulatory authority (NRA) plays a key role in assuring the quality, safety, and efficacy of medical products until they reach the patient/consumer, as well as ensuring the relevance and accuracy of product information. Hence, stable, well-functioning and integrated regulatory systems are an essential component of a health system and contribute to better public health outcomes. NRA maturity and WHO prequalification of medicines can be considered as a proxy for ensuring that medicines in a country are of assured quality. The NRA maturity level is assessed using the WHO National Regulatory Authority Global Benchmarking Tool (WHO NRA GBT). After the evaluations, countries are assigned one of five levels of maturity, with a score of maturity level three representing the minimum acceptable regulatory capacity and maturity level five representing the highest level of functioning.

The importance of transparency and the disclosure of the results of assessments amongst regulators (from ML 3 up) are taken into consideration. However, the information on country-specific NRA maturity level is not currently publicly available and WHO is working to address this limitation through recent discussions on WHO Listed Authorities (WLA).

### Data type

Percentage

### Related links


## GPW13 WHO Impact Framework: Target #8 Indicator Metadata

<table>
<thead>
<tr>
<th>Target #8</th>
<th>Increase health workforce density with improved distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Health worker density and distribution</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 3.c.1</td>
</tr>
<tr>
<td>Definition</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td><strong>Density of nursing and midwifery personnel:</strong> 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.</td>
</tr>
<tr>
<td></td>
<td><strong>Density of dentists:</strong> 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.</td>
</tr>
<tr>
<td></td>
<td><strong>Density of pharmacists:</strong> 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.</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>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.</td>
</tr>
<tr>
<td>Numerator</td>
<td>Numerator is defined as the number of health workers, defined in headcounts.</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Denominator</td>
<td>Denominator data for workforce density (i.e. national population estimates) are obtained from the United Nations Population Division's World Population Prospects database.</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>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.</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td></td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td></td>
</tr>
<tr>
<td>Disaggregation</td>
<td>National level data, subnational level data</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Annual</td>
</tr>
<tr>
<td>Limitations</td>
<td>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.</td>
</tr>
<tr>
<td>Data type</td>
<td>Rate</td>
</tr>
<tr>
<td>Related links</td>
<td><a href="https://www.who.int/hrh/statistics/en/">https://www.who.int/hrh/statistics/en/</a></td>
</tr>
</tbody>
</table>
## GPW13 WHO Impact Framework: Target #9 Indicator Metadata

<table>
<thead>
<tr>
<th>Target #9</th>
<th>Increase in member states International Health Regulations capacities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Increase in countries International Health Regulations capacities as measured by the composite index of the States Parties Annual Reporting (SPAR).</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 3.d: Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks</td>
</tr>
<tr>
<td>Definition</td>
<td>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.</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>[ \text{IHR (2005) Capacity Level (Annual)} = \frac{\text{Sum of Self–Reported IHR Capacity Averages}}{13} ]</td>
</tr>
<tr>
<td>Numerator</td>
<td>State Party self-reported average of 13 IHR (2005) capacities, as measured by the SPAR.</td>
</tr>
<tr>
<td>Denominator</td>
<td>Total number of reported capacities (i.e., 13).</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>SPAR reports (available on the Global Health Observatory); Strategic Partnership for International Health Regulations (2005) and Health Security (<a href="https://extranet.who.int/sph/">https://extranet.who.int/sph/</a>)</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td>Joint external evaluation (JEE; available at <a href="https://extranet.who.int/sph/">https://extranet.who.int/sph/</a>); Current Health Expenditure (CHE; available on Global Health Observatory); previous years’ IHR (2005) self-assessment annual reporting data (available on Global Health Observatory).</td>
</tr>
<tr>
<td>WHO GPW13 Framework Disaggregation</td>
<td>Country; capacity.</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Annual</td>
</tr>
<tr>
<td>Limitations</td>
<td>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.</td>
</tr>
<tr>
<td>Data type</td>
<td>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.</td>
</tr>
<tr>
<td>Related links</td>
<td>Global Health Observatory: <a href="http://www.who.int/gho/ihr/en/">http://www.who.int/gho/ihr/en/</a>; SPH: <a href="https://extranet.who.int/sph/">https://extranet.who.int/sph/</a></td>
</tr>
</tbody>
</table>
### Target #10a

**Indicator**

Increase the availability of health facilities providing a minimum services package to people in fragile, conflict, or vulnerable settings to at least 80%

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**

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 midpoint.

**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/
## Target #10b: 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:**

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Preferred data sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaccination coverage (routine and/or campaign)</td>
<td>Target population</td>
<td>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)</td>
</tr>
</tbody>
</table>

**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:**
### GPW13 WHO Impact Framework: **Target #11** Indicator Metadata

<table>
<thead>
<tr>
<th>Target #11</th>
<th><strong>Reduce number of deaths, missing persons and persons affected by disaster per 100,000 population</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Number of deaths, missing persons and persons affected by disaster per 100,000 people</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 1.5.1</td>
</tr>
<tr>
<td>Definition</td>
<td>This indicator measures the number of people who died or went missing from disasters per 100,000 population.</td>
</tr>
</tbody>
</table>

#### Method of estimation/calculation

\[
\text{Number of deaths attributed to disasters} \times 100 \, 000
\]

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.

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Global population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Global population</td>
</tr>
</tbody>
</table>

#### Preferred data sources

Data are available from the Sendai Framework monitoring platform, overseen by UNISDR ([https://sendaimonitor.unisdr.org/](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


#### 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

GPW13 WHO Impact Framework: **Target #12** Indicator Metadata

<table>
<thead>
<tr>
<th><strong>Target #12</strong></th>
<th><strong>Reduce the global maternal mortality ratio by 30%</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator-1</strong></td>
<td>Maternal mortality ratio</td>
</tr>
<tr>
<td><strong>SDG/ Core 100</strong></td>
<td>SDG 3.1.1</td>
</tr>
</tbody>
</table>

**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**

\[
\text{MMR} = \frac{\text{Total number of maternal deaths}}{\text{Total number of live births}} \times 100,000
\]

**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

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**


## GPW13 WHO Impact Framework: **Target #12** Indicator Metadata

<table>
<thead>
<tr>
<th>Target #12</th>
<th>Reduce the global maternal mortality ratio by 30%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator-2</td>
<td>Proportion of births attended by skilled health personnel</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 3.1.2</td>
</tr>
<tr>
<td>Definition</td>
<td>Percentage of live births for women aged 15-49 years attended by skilled health personnel (doctor, nurse or midwife).</td>
</tr>
<tr>
<td>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:</td>
<td></td>
</tr>
<tr>
<td>(i) provide and promote evidence-based, human-rights-based, quality, socioculturally sensitive and dignified care to women and newborns;</td>
<td></td>
</tr>
<tr>
<td>(ii) facilitate physiological processes during labour and delivery to ensure a clean and positive childbirth experience; and</td>
<td></td>
</tr>
<tr>
<td>(iii) identify and manage or refer women and/or newborns with complications.</td>
<td></td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>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).</td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
<td>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.</td>
</tr>
<tr>
<td>Denominator</td>
<td>The total number of live births of women aged 15-49 years in the same period.</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>National population-based surveys.</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td>Routine facility information systems.</td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td>Age, parity, place of residence, socioeconomic status.</td>
</tr>
<tr>
<td>Disaggregation</td>
<td>3-5 years for national population-based surveys, annual for routine facility information systems.</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Discrepancies possible if national figures are from health facilities rather than household level data. Institutional births may underestimate percentage of births with skilled attendant.</td>
</tr>
<tr>
<td>Limitations</td>
<td>Percentage</td>
</tr>
</tbody>
</table>
GPW 13WHO Impact Framework: **Target #13** Indicator Metadata

| Target #13 | 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. |

<p>| 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. |</p>
<table>
<thead>
<tr>
<th>Numerator</th>
<th>Total number of deaths among children aged 0-4 years (the total number is actually the probability of death derived from a life table)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator</td>
<td>Total number of live births</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>Civil registration and vital statistics, census; and household surveys.</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td></td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td>Outcome</td>
</tr>
<tr>
<td>Disaggregation</td>
<td>By sex, place of residence, wealth quintile and mother’s education</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Annual updates from the UN-IGME revisions</td>
</tr>
<tr>
<td>Limitations</td>
<td>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.</td>
</tr>
</tbody>
</table>

**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://apps.who.int/gho/data/node.wrapper.imr?x-id=1); [http://www.who.int/whosis/whostat2006InfantAndUnder5MortalityRate.pdf?ua=1](http://www.who.int/whosis/whostat2006InfantAndUnder5MortalityRate.pdf?ua=1); [http://apps.who.int/gho/data/node.wrapper.imr?x-id=4717](http://apps.who.int/gho/data/node.wrapper.imr?x-id=4717)

www.cme.org

UNICEF: [https://www.unicef.org/infobycountry/stats_popup1.html](https://www.unicef.org/infobycountry/stats_popup1.html)
### GPW13 WHO Impact Framework: Target #13 Indicator Metadata

<table>
<thead>
<tr>
<th>Target #13</th>
<th>Reduce the preventable deaths of newborns and children under 5 years of age by 17% and 30% respectively</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator-2</td>
<td>Neonatal mortality rate (NMR)</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 3.2.2</td>
</tr>
<tr>
<td><strong>Definition</strong></td>
<td>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)</td>
</tr>
<tr>
<td><strong>Method of estimation/calculation</strong></td>
<td>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 recombing 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.</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>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)</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Number of live births</td>
</tr>
<tr>
<td><strong>Preferred data sources</strong></td>
<td>Data from civil registration and vital statistics.</td>
</tr>
</tbody>
</table>
### 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://apps.who.int/gho/data/node.wrapper.imr?x-id=1); [http://www.who.int/whosis/whostat2006InfantAndUnder5MortalityRate.pdf?ua=1](http://www.who.int/whosis/whostat2006InfantAndUnder5MortalityRate.pdf?ua=1); [http://apps.who.int/gho/data/node.wrapper.imr?x-id=4717](http://apps.who.int/gho/data/node.wrapper.imr?x-id=4717)

**UNICEF:** [https://www.unicef.org/infobycountry/stats_popup1.html](https://www.unicef.org/infobycountry/stats_popup1.html)
<table>
<thead>
<tr>
<th>Target #14</th>
<th>Reduce the number of stunted children under 5 years of age by 30%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Prevalence of stunting (height for age &lt; -2 standard deviation from the median of the WHO Child Growth Standards) under 5 years of age</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 2.2.1</td>
</tr>
<tr>
<td>Definition</td>
<td>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.</td>
</tr>
</tbody>
</table>
| Method of estimation/calculation | Prevalence of stunted children aged <5 years = \[
\frac{\text{Number of children aged 0 – 4 years that fall below minus two standard deviations from the median length – or height – for – age of the WHO Child Growth Standards}}{\text{Total number of children aged 0 – 4 years that were measured}}\] \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 |
### GPW13 WHO Impact Framework: **Target #15** Indicator Metadata

<table>
<thead>
<tr>
<th>Target #15</th>
<th>Reduce the prevalence of wasting among children under 5 years of age to less than 5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Prevalence of wasting (weight-for-length or height &lt; -2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 2.2.2</td>
</tr>
<tr>
<td>Definition</td>
<td>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.</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>Prevalence of wasted children aged &lt;5 years = $\frac{\text{Number of children aged 0 – 4 years that fall below minus two standard deviations from the median weight – for – length or height of the WHO Child Growth Standards}}{\text{Total number of children aged 0 – 4 years that were measured}} \times 100%$</td>
</tr>
<tr>
<td>Numerator</td>
<td>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</td>
</tr>
<tr>
<td>Denominator</td>
<td>Total number of children aged 0-4 years that were measured</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>National nutrition surveys, any other nationally-representative population-based surveys with nutrition modules, and national surveillance systems.</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td></td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td>By age, sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g. mother’s education, wealth quintile).</td>
</tr>
<tr>
<td>Disaggregation</td>
<td></td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Annual or every 3-5 years based on survey availability in countries.</td>
</tr>
<tr>
<td>Limitations</td>
<td>Survey estimates come with levels of uncertainty due to both sampling and non-sampling error (e.g. measurement technical error, recording error etc.).</td>
</tr>
<tr>
<td>Data type</td>
<td>Prevalence</td>
</tr>
<tr>
<td>Target</td>
<td>Increase the proportion of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being to 80%</td>
</tr>
<tr>
<td>--------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Indicator</td>
<td>Proportion of children under 5 who are developmentally on track in health, learning and psychosocial well-being, by sex</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 4.2.1</td>
</tr>
<tr>
<td>Definition</td>
<td>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.</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>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.</td>
</tr>
<tr>
<td>Numerator</td>
<td>The number of children under the age of five who are developmentally on track in health, learning and psychosocial well-being multiplied by 100</td>
</tr>
<tr>
<td>Denominator</td>
<td>Total number of children under the age of five in the population</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>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.</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td></td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td></td>
</tr>
<tr>
<td>Disaggregation</td>
<td>Age, sex, place of residence, wealth, geographic location, caregiver education and other background characteristics.</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Annual</td>
</tr>
<tr>
<td>Limitations</td>
<td>Comparable data are available for 58 low- and middle-income countries since 2010</td>
</tr>
<tr>
<td>Data type</td>
<td>Percentage</td>
</tr>
<tr>
<td>Related links</td>
<td>WHO: <a href="https://data.unicef.org/topic/early-childhood-development/development-status/">https://data.unicef.org/topic/early-childhood-development/development-status/</a></td>
</tr>
</tbody>
</table>

* This indicator is being revised as part of the SDG work and this indicator and target might change in future to align with any new indicator and target from the SDGs.
## Target #17 Indicator Metadata

<table>
<thead>
<tr>
<th><strong>Target #17</strong></th>
<th><strong>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%</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator-1</strong></td>
<td>Proportion of children aged 1-17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month</td>
</tr>
<tr>
<td><strong>SDG/ Core 100</strong></td>
<td>SDG 16.2.1</td>
</tr>
<tr>
<td><strong>Definition</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Method of estimation/calculation</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>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</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>The total number of children aged 1-17 in the population</td>
</tr>
<tr>
<td><strong>Preferred data sources</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Other possible data sources</strong></td>
<td></td>
</tr>
<tr>
<td><strong>WHO GPW13 Framework</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Disaggregation</strong></td>
<td>Sex, age, income, place of residence, geographic location</td>
</tr>
<tr>
<td><strong>Expected frequency of data collection</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Limitations</strong></td>
<td>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”.</td>
</tr>
<tr>
<td><strong>Data type</strong></td>
<td>Percentage</td>
</tr>
</tbody>
</table>
### Target #17 Indicator Metadata

<table>
<thead>
<tr>
<th><strong>Target #17</strong></th>
<th>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%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator-2</strong></td>
<td>Prevalence of exposure to violence in the last 12 months to 1 or more of the following: physical violence, emotional violence, sexual violence, bullying, or witnessing violence of children aged 2-17 years, by sex.</td>
</tr>
<tr>
<td><strong>SDG/ Core 100</strong></td>
<td>The indicator relates to the following Core 100 indicators: Mortality rate due to homicide [SDG 16.1.1]; Intimate partner violence prevalence [SDG 5.2.1]; Non-partner sexual violence prevalence [SDG 5.2.2]; Sexual violence against children [SDG 16.2.3]. It also relates more broadly to SDG Targets 16.2 and 5.2.</td>
</tr>
<tr>
<td><strong>Definition</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Method of estimation/calculation</strong></td>
<td>Extraction of data on past-year prevalence of violent victimization by country, age group and type (physical, sexual, emotional, or multiple types) to generate minimum regional prevalence, derived from population-weighted averages of the country-specific prevalence (see Hillis et al. 2016).</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>Number of children aged 2-17 years exposed to physical violence, emotional violence, sexual violence, or bullying.</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Number of children aged 2-17 years.</td>
</tr>
<tr>
<td><strong>Preferred data sources</strong></td>
<td>Self-report by child and/or caregiver through nationally representative, population-based surveys, e.g. Violence against Children Surveys (VACS), Global School Health Surveys (GSHS), Health Behavior in School-Aged Children Surveys (HBSC), Multiple Indicator Surveys (MICS).</td>
</tr>
<tr>
<td><strong>Other possible data sources</strong></td>
<td></td>
</tr>
<tr>
<td><strong>WHO GPW13 Framework</strong></td>
<td>Healthier population billion.</td>
</tr>
<tr>
<td><strong>Disaggregation</strong></td>
<td>By sex, age group (2-14 years, 15-17 years) and region.</td>
</tr>
<tr>
<td><strong>Expected frequency of data collection</strong></td>
<td>Every 5 years.</td>
</tr>
<tr>
<td><strong>Limitations</strong></td>
<td>Inconsistencies between survey tools; underreporting of violence in earliest years; wide confidence intervals; regional breakdown not identical to WHO breakdown.</td>
</tr>
<tr>
<td><strong>Data type</strong></td>
<td>Percentage</td>
</tr>
<tr>
<td>Target #18</td>
<td>Increase the proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods to 66%</td>
</tr>
<tr>
<td>------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Indicator</td>
<td>Proportion of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 3.7.1</td>
</tr>
<tr>
<td>Definition</td>
<td>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.</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>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.</td>
</tr>
<tr>
<td>Numerator</td>
<td>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.</td>
</tr>
<tr>
<td>Denominator</td>
<td>Total demand for family planning (the sum of contraceptive prevalence (any method) and the unmet need for family planning).</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>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.</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td></td>
</tr>
<tr>
<td>Disaggregation</td>
<td>Age, geographic location, marital status, socioeconomic status and other categories, depending on the data source and number of observations.</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Annual</td>
</tr>
<tr>
<td>Limitations</td>
<td>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.</td>
</tr>
<tr>
<td>Data type</td>
<td>Percentage</td>
</tr>
</tbody>
</table>
## GPW13 WHO Impact Framework: **Target #19** Indicator Metadata

| Target #19 | **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%**
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Proportion of women aged 15-49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 5.6.1</td>
</tr>
<tr>
<td>Definition</td>
<td>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”</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>Proportion = Numerator X 100/Denominator [see numerator and denominator]</td>
</tr>
</tbody>
</table>
| 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 | Based on available DHS data, disaggregation is possible by age, geographic location, place of residence, education, and wealth quintile. |
| WHO GPW13 Framework Disaggregation | Currently data comes from the DHS which have three to five-year cycles. |
| Expected frequency of data collection | 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 |  |
| **Target #20** | **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%**  
Proportion of ever-partnered women and girls aged 15-49 years subjected to physical or sexual violence by a current and/or former intimate partner in the previous 12 months, by form of violence and by age. |
| **SDG/ Core 100** | SDG 5.2.1 (GPW 13 is adapted SDG to reflect currently available data) |
| **Definition** | This indicator measures the percentage of ever-partnered women and girls aged 15-49 years who have experienced physical, sexual or psychological violence by a current or former intimate partner, in the previous 12 months.  
Intimate partner violence is the most common form of violence against women and girls globally. Given prevailing social norms that sanction male dominance over women, violence between intimate partners is often perceived as ordinary, particularly in the context of marriage, cohabitation or any formal or informal union. Violence against women and girls is an extreme form of gender inequality.  
This indicator calls for breakdown by form of violence and by age group. Countries are encouraged to compute prevalence data for each form of violence, disaggregated by age as detailed below to assist comparability at regional and global levels:  
1. Physical violence:  
   Number of ever-partnered women and girls (aged 15-49 years who experience physical violence by a current or former intimate partner in the previous 12 months divided by the number of ever-partnered women and girls (aged 15 years and above) in the population multiplied by 100.  
2. Sexual violence:  
   Number of ever-partnered women and girls (aged 15-49 years) who experience sexual violence by a current or former intimate partner in the previous 12 months divided by the number of ever-partnered women and girls (aged 15 years and above) 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.  
See method of estimation / calculation  
See method of estimation / calculation |
| **Numerator** | 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. |
| **Denominator** | See method of estimation / calculation |
| **Preferred data sources** | |
| **Other possible data sources** | |
| **WHO GPW13 Framework** | 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. |
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
### GPW13 WHO Impact Framework: **Target #21** Indicator Metadata

<table>
<thead>
<tr>
<th>Target #21</th>
<th><strong>20% relative reduction in the premature mortality (age 30-70 years) from NCDs (cardiovascular, cancer, diabetes, or chronic respiratory diseases) through prevention and treatment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Mortality rate attributed to cardiovascular diseases, cancer, diabetes, or chronic respiratory diseases, measured by probability of dying between the exact ages of 30 and 70 years.</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 3.4.1</td>
</tr>
<tr>
<td>Definition</td>
<td>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.</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>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: $M_x = \frac{\text{Total deaths from four major NCD causes between exact age } x \text{ and exact age } x + 5}{\text{Total population between exact age } x \text{ and exact age } x + 5}$ Then translate the 5-year death rate to the probability of death in each 5-year age range: $q_x = \frac{M_x \times 5}{1 + M_x \times 2.5}$ The probability of death from age 30 to 70 years, independent of other causes of death can be calculated as: $\prod_{x=30}^{70} q_x$</td>
</tr>
<tr>
<td>Numerator</td>
<td>See above</td>
</tr>
<tr>
<td>Denominator</td>
<td>See above</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>Vital registration systems which record deaths with sufficient completeness to allow estimation of all-cause death rates.</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td>Sample registration systems; verbal autopsy.</td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td>Outcome</td>
</tr>
<tr>
<td>Disaggregation</td>
<td>By sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education, wealth quintile).</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Annual</td>
</tr>
<tr>
<td>Limitations</td>
<td>- incomplete or unusable death registration data</td>
</tr>
<tr>
<td>Data type</td>
<td>Probability</td>
</tr>
<tr>
<td>Target #22</td>
<td><strong>25% relative reduction in prevalence of current tobacco use in persons 15+ years</strong></td>
</tr>
<tr>
<td>-----------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Indicator</td>
<td>Age-standardized prevalence of current tobacco use among persons aged 15 years and older</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 3.a.1</td>
</tr>
<tr>
<td>Definition</td>
<td>“Smoked tobacco products” includes the consumption of cigarettes, bidis, cigars, cheroots, pipes, shisha (water pipes), fine-cut smoking articles (roll-your-own), krettas, and any other form of smoked tobacco. &quot;Smokeless tobacco” includes moist snuff, plug, creamy snuff, dissolvables, dry snuff, gum, loose leaf, red tooth powder, snus, chimo, gutka, khaini, gudakhu, zarda, quiwam, dohrah, 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.</td>
</tr>
</tbody>
</table>
| Method of estimation/calculation | Prevalence of current tobacco use = 
\[
\frac{\text{Number of respondents aged 15 + years currently using any tobacco product (smoked or smokeless)}}{\text{Number of survey respondents aged 15 + years}} \times 100\%
\] |
| 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 Disaggregation | Risk factor exposure
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 |
**Target #23**

**Indicator Metadata**

<table>
<thead>
<tr>
<th>Target #23</th>
<th>7% relative reduction in the harmful use of alcohol as appropriate, within the national context</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>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</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 3.5.2</td>
</tr>
<tr>
<td>Definition</td>
<td>Consumption of pure alcohol (ethanol) in litres per person aged 15+ years during one calendar year.</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>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.</td>
</tr>
<tr>
<td>Numerator</td>
<td>Sum of recorded and unrecorded alcohol consumed in a population during a calendar year, in litres.</td>
</tr>
<tr>
<td>Denominator</td>
<td>Midyear resident population aged 15+ for the same calendar year.</td>
</tr>
</tbody>
</table>
### 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
<table>
<thead>
<tr>
<th>Target #24</th>
<th>25% relative reduction in mean population intake of salt/sodium</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Age- standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 18+ years</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>Core 100</td>
</tr>
<tr>
<td>Definition</td>
<td>Mean population intake of salt/sodium in grams</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>Mean population intake of salt/sodium = [ \frac{\text{Sum of sodium excretion in urine samples from all respondents aged 18+ years}}{\text{Number of survey respondents aged 18 + years}} ]</td>
</tr>
<tr>
<td>Numerator</td>
<td>Sum of sodium excretion in urine samples from all respondents aged 18+ years. The gold standard for estimating salt intake is through 24-hour urine collection, however other methods such as spot urines and food frequency surveys may be more feasible to administer at the population level.</td>
</tr>
<tr>
<td>Denominator</td>
<td>All respondents of the survey aged 18+ years.</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>Population-based (preferably nationally representative) survey</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td>Data sets of FAO and UN Statistical office</td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td>Risk factor exposure</td>
</tr>
<tr>
<td>Disaggregation</td>
<td>By age, sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education, wealth quintile).</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Annual or every 5 years</td>
</tr>
<tr>
<td>Limitations</td>
<td>- measurement error</td>
</tr>
<tr>
<td>Data type</td>
<td>Mean</td>
</tr>
<tr>
<td><strong>Target #25</strong></td>
<td><strong>Halt and begin to reverse the rise in childhood overweight (0-4 years) and obesity (5-19 years)</strong></td>
</tr>
<tr>
<td>----------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Indicator-1</strong></td>
<td>Prevalence of childhood overweight (0-4 years)</td>
</tr>
<tr>
<td><strong>SDG/ Core 100</strong></td>
<td>SDG 2.2.2</td>
</tr>
<tr>
<td><strong>Definition</strong></td>
<td>For 0-4 years, overweight is defined as weight-for-length or height above two standard deviations of the WHO Child Growth Standards median.</td>
</tr>
<tr>
<td><strong>Method of estimation/calculation</strong></td>
<td>Prevalence of overweight = ( \frac{\text{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}}{\text{Number of children aged 0-4 years in the survey that were measured}} \times 100% )</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Total number of children aged 0-4 years in the survey that were measured.</td>
</tr>
<tr>
<td><strong>Preferred data sources</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Other possible data sources</strong></td>
<td>Data sets of FAO and UN Statistical office, Risk factor exposure.</td>
</tr>
<tr>
<td><strong>WHO GPW13 Framework</strong></td>
<td>Disaggregation By age, sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., mother’s education, wealth quintile).</td>
</tr>
<tr>
<td><strong>Expected frequency of data collection</strong></td>
<td>Annual or at least every 3-5 years based on survey availability in countries.</td>
</tr>
<tr>
<td><strong>Limitations</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Data type</strong></td>
<td>Prevalence</td>
</tr>
</tbody>
</table>
**GPW13 WHO Impact Framework: Target #25 Indicator Metadata**

<table>
<thead>
<tr>
<th>Target #25</th>
<th><strong>Halt and begin to reverse the rise in childhood overweight (0-4 years) and obesity (5-19 years)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator-2</td>
<td>Prevalence of childhood obesity (5-19 years)</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>Core 100</td>
</tr>
<tr>
<td>Definition</td>
<td>For 5-19 years, obesity is defined as body mass index-for-age above two standard deviations of the WHO Growth Reference for School-aged Children and Adolescents median. BMI is calculated by dividing the subject’s weight in kilograms by their own height in meters squared.</td>
</tr>
</tbody>
</table>
| Method of estimation/calculation | Prevalence of obesity = \[
\frac{\text{Number of children and adolescents aged 5–19 years whose body mass index–for–age are above two standard deviations from the WHO Growth Reference for School–aged Children and Adolescents median}}{\text{Number of children and adolescents aged 5–19 years in the survey that were measured}} \times 100\%
\] |
| Numerator   | Number of school–age children and adolescents in the sample with body mass index-for-age above two standard deviations of the WHO Growth Reference median for School-aged Children and Adolescents. |
| Denominator | Total number of children and adolescents aged 5-19 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 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                                                                                          |
## GPW13 WHO Impact Framework: Target #26 Indicator Metadata

<table>
<thead>
<tr>
<th>Target #26</th>
<th>Eliminate industrially produced trans fats (increase the percentage of people protected by effective regulation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Percentage of people protected by effective regulation</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td></td>
</tr>
<tr>
<td><strong>Definition</strong></td>
<td>Adoption of a policy to virtually eliminate partially hydrogenated oils (PHOs) in the food supply.</td>
</tr>
<tr>
<td><strong>Method of estimation/calculation</strong></td>
<td>Country can respond &quot;yes&quot; 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?”</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td></td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>WHO NCD Country Capacity Survey</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td>National nutrition and health survey</td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td></td>
</tr>
<tr>
<td><strong>Disaggregation</strong></td>
<td></td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Every 2 or 5 years</td>
</tr>
</tbody>
</table>
| **Limitations** | - bias through self-report  
- misunderstanding/ -interpretation of questions  
- limited validity of survey instruments                                 |
| **Data type** | Qualitative; percentage                                                                                   |
### GPW13 WHO Impact Framework: Target #27 Indicator Metadata

<table>
<thead>
<tr>
<th>Target #27</th>
<th>7% relative reduction in the prevalence of insufficient physical activity in persons aged 18+ years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Age-standardized prevalence of insufficiently physically active persons aged 18+ years (defined as less than 150 minutes of moderate-intensity activity per week, or equivalent)</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>Core 100</td>
</tr>
</tbody>
</table>
| Definition | Percentage of adults aged 18+ years not meeting any of the following criteria:  
– 150 minutes of moderate-intensity physical activity per week  
– 75 minutes of vigorous-intensity physical activity per week  
– an equivalent combination of moderate- and vigorous-intensity physical activity accumulating at least 600 MET-minutes* per week  

Minutes of physical activity can be accumulated over the course of a week but must be of a duration of at least 10 minutes.  

*MET refers to metabolic equivalent. It is the ratio of a person’s working metabolic rate relative to the resting metabolic rate. One MET is defined as the energy cost of sitting quietly, and is equivalent to a caloric consumption of 1 kcal/kg/hour. Physical activities are frequently classified by their intensity, using the MET as a reference.  

Prevalence of physical inactivity = \[ \frac{\text{Number of respondents aged 18+ years not meeting the recommended criteria for physical activity}}{\text{Number of respondents aged 18+ years in the survey}} \times 100\% \]

Number of respondents where all 3 of the following criteria are true:  
(1) Weekly minutes* of vigorous activity < 75 mins.  
(2) Weekly minutes* of moderate activity < 150 mins.  
(3) Weekly MET-minutes** < 600.  

* Weekly minutes is calculated by multiplying the number of days on which vigorous/moderate is done by the number of minutes of vigorous/moderate activity per day.  

** Weekly MET-minutes is calculated by multiplying the weekly minutes of vigorous activity by 8 and the number of weekly minutes of moderate activity by 4 and then adding these two results together.  

| Numerator | All respondents aged 18+ years in the survey.  
| Denominator | Prevalence-based (preferably nationally representative) survey  
| Preferred data sources | Data sets of FAO and UN Statistical office  
| Other possible data sources | Risk factor exposure  
| WHO GPW13 Framework | By age, sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education, wealth quintile).  
| Disaggregation | Annual or every 5 years.  
| Expected frequency of data collection | - bias through self-report, including over-reporting of activity  
| Limitations | - misunderstanding/interpretation of questions and/ or intensity of physical activity  
| Data type | - limited validity of survey instruments  
|
## GPW13 WHO Impact Framework: Target #28 Indicator Metadata

<table>
<thead>
<tr>
<th><strong>Target #28</strong></th>
<th><strong>Reduce suicide mortality rate by 15%</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator</strong></td>
<td>Suicide mortality rate</td>
</tr>
<tr>
<td><strong>SDG/ Core 100</strong></td>
<td>SDG 3.4.2</td>
</tr>
<tr>
<td><strong>Definition</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Method of estimation/calculation</strong></td>
<td>Suicide mortality rate = ( \frac{\text{Number of deaths from suicide}}{\text{Total population}} \times 100,000 )</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>Number of suicide deaths in a given period of time</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Total population in a given period of time</td>
</tr>
<tr>
<td><strong>Preferred data sources</strong></td>
<td>Vital registration systems which record deaths with sufficient completeness to allow estimation of cause-specific death rates.</td>
</tr>
<tr>
<td><strong>Other possible data sources</strong></td>
<td>Sample registration systems; verbal autopsy.</td>
</tr>
<tr>
<td><strong>WHO GPW13 Framework</strong></td>
<td>Outcome</td>
</tr>
<tr>
<td><strong>Disaggregation</strong></td>
<td>By sex, age.</td>
</tr>
<tr>
<td><strong>Expected frequency of data collection</strong></td>
<td>Annual</td>
</tr>
<tr>
<td><strong>Limitations</strong></td>
<td>- incomplete or unusable death registration data</td>
</tr>
<tr>
<td><strong>Data type</strong></td>
<td>Rate</td>
</tr>
<tr>
<td><strong>Related links</strong></td>
<td>WHO: <a href="http://www.who.int/gho/mental_health/mental_health_indicatorbook.pdf?ua=1">http://www.who.int/gho/mental_health/mental_health_indicatorbook.pdf?ua=1</a></td>
</tr>
</tbody>
</table>
## GPW13 WHO Impact Framework: Target #29 Indicator Metadata

| Target #29 | 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 | 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). |
| Preferred data sources | |
| Other possible data sources | |
| WHO GPW13 Framework | Types of road users, age, sex, income groups and WHO regions |
| Disaggregation | Biennial |
| Expected frequency of data collection | |
| 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 | Count, absolute number |
### GPW13 WHO Impact Framework: **Target #30** Indicator Metadata

<table>
<thead>
<tr>
<th>Target #30</th>
<th><strong>Increase service coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for severe mental health conditions to 50%</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator-1</td>
<td>Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 3.5.1 (tier 3)</td>
</tr>
<tr>
<td>Definition</td>
<td>Substance use disorders include substance dependence and harmful pattern of substance use. Severe substance use disorders include substance dependence only.</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>There are two approaches currently under development and testing towards the indicator report:</td>
</tr>
<tr>
<td></td>
<td>1) Estimation based on actual service utilization:</td>
</tr>
<tr>
<td></td>
<td>Treatment coverage = ( \frac{\text{Treatment demands} (\text{Number of people in contact with treatment services})}{\text{Treatment needs} (\text{Number of people with substance use disorders})} \times 100% )</td>
</tr>
<tr>
<td></td>
<td>2) Estimation based on composite indicator of service development: proxy-data reflecting major components of treatment systems for substance use disorders.</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of people with substance use disorders/substance dependence in contact with treatment services in a given year</td>
</tr>
<tr>
<td>Denominator</td>
<td>Total number of people with substance use disorders/substance dependence in the population in a given year</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>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 disorders availability and utilization.</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td>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.</td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td>By type of substances, substance use disorders and treatment modalities</td>
</tr>
<tr>
<td>Disaggregation</td>
<td>The frequency of data collection will remain the same:</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>- annual data collection for illicit drugs component; - annual or at least biennial for alcohol and other substance use component;</td>
</tr>
<tr>
<td>Limitations</td>
<td>Effective coverage estimation may not feasible or limited to few predominantly high-income countries;</td>
</tr>
<tr>
<td></td>
<td>In case of poor or unavailable data, country estimations may be limited to the level of availability coverage.</td>
</tr>
<tr>
<td>Data type</td>
<td>Percentage</td>
</tr>
<tr>
<td><strong>Target #30</strong></td>
<td><strong>Increase service coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for severe mental health conditions to 50%</strong></td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Indicator-2</strong></td>
<td><strong>Proportion of persons with severe mental condition who are using services</strong></td>
</tr>
<tr>
<td><strong>SDG/ Core 100</strong></td>
<td><strong>Core 100</strong></td>
</tr>
<tr>
<td><strong>Definition</strong></td>
<td><strong>Severe mental disorder: psychosis; bipolar affective disorder; moderate-severe depression</strong></td>
</tr>
<tr>
<td><strong>Method of estimation/calculation</strong></td>
<td><strong>Service coverage = [\frac{\text{Number of people in receipt of services}}{\text{Number of people with severe mental disorders}}] \times 100%</strong></td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td><strong>Cases of severe mental disorders in receipt of services in a given year</strong></td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td><strong>Total cases of severe mental disorder in the sampled population in a given year</strong></td>
</tr>
<tr>
<td><strong>Preferred data sources</strong></td>
<td><strong>Mental Health Atlas; Facility surveys; Routine information systems; Population-based household surveys; Modelling of prevalence using GBD data</strong></td>
</tr>
<tr>
<td><strong>Other possible data sources</strong></td>
<td><strong>Administrative data</strong></td>
</tr>
<tr>
<td><strong>WHO GPW13 Framework</strong></td>
<td><strong>By disorder</strong></td>
</tr>
<tr>
<td><strong>Disaggregation</strong></td>
<td><strong>Every 3-5 years. For example, the Mental Health Atlas collects data every 3 years on the proportion of people with mental disorders served by mental health systems.</strong></td>
</tr>
<tr>
<td><strong>Expected frequency of data collection</strong></td>
<td><strong>Limitations</strong></td>
</tr>
<tr>
<td><strong>Limitations</strong></td>
<td><strong>Current metrics only relate to specialist mental health services.</strong></td>
</tr>
<tr>
<td><strong>Data type</strong></td>
<td><strong>Percentage</strong></td>
</tr>
</tbody>
</table>
## Target #31 Indicator Metadata

### Target #31

#### Indicator

20% relative reduction in the prevalence of raised blood pressure

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

### 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 =

\[
\frac{\text{Number of respondents aged 18 + years with systolic blood pressure } \geq 140 \text{ mmHg or diastolic blood pressure } \geq 90 \text{ mmHg}}{\text{Number of survey respondents aged 18 + years}} \times 100\%
\]

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

Risk factor exposure

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

GPW13 WHO Impact Framework: **Target #32** Indicator Metadata

<table>
<thead>
<tr>
<th>Target #32</th>
<th><strong>Increase access to human papilloma virus vaccine among adolescent girls (9-14 years) to 50%</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Percentage of global population of 9-14 years old girls living in countries that have included HPV vaccination in the national immunization schedule</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td><strong>Availability of HPV vaccines as part of a national immunization schedule</strong></td>
</tr>
<tr>
<td>Definition</td>
<td>Country can indicate that they have added HPV vaccine to their national immunization programme, as reflected in their responses to the WHO-UNICEF Joint Reporting Form.</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>Number of adolescent girls aged 9-14 years living in countries where HPV vaccine is officially included in national immunization schedule</td>
</tr>
<tr>
<td>Numerator</td>
<td>Total number of adolescent girls aged 9-14 years globally</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>WHO GPW13 Framework</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td>WHO GPW13 Framework</td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td>WHO GPW13 Framework</td>
</tr>
<tr>
<td>Disaggregation</td>
<td>Impact</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>By age</td>
</tr>
<tr>
<td>Limitations</td>
<td>Annual</td>
</tr>
<tr>
<td>- Overestimate of coverage and protection against the virus because the indicator does not reflect the actual coverage of HPV but instead the hypothetical coverage of HPV if all girls within countries that include HPV in the schedule were immunized.</td>
<td></td>
</tr>
<tr>
<td>- Dealing with partial, step-wise introductions within (large) countries- misunderstanding/interpretation of questions</td>
<td></td>
</tr>
<tr>
<td>Data type</td>
<td>Percentage</td>
</tr>
</tbody>
</table>
GPW13 WHO Impact Framework: Target #33 Indicator Metadata

<table>
<thead>
<tr>
<th>Target #33</th>
<th>Increase proportion of women between 30-49 years who have been screened for cervical cancer to 25%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Proportion of women between the ages of 30–49 years screened for cervical cancer at least once, or more often, and for lower or higher age groups according to national programmes or policies</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>Proportion of women aged 30 - 49 years who report they were screened for cervical cancer using any of the following methods: Visual Inspection with Acetic Acid/vinegar (VIA), pap smear and Human Papillomavirus (HPV) test.</td>
</tr>
<tr>
<td>Definition</td>
<td>Number of female respondents aged 30 – 49 years who report ever having had a screening test for cervical cancer using any of these methods: Visual Inspection with Acetic Acid/vinegar (VIA), pap smear and Human Papillomavirus (HPV) test.</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>Number of female respondents aged 30 – 49 years × 100%</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of women aged 30-49 years who report ever having had a screening test for cervical cancer using any of these methods: Visual Inspection with Acetic Acid/vinegar (VIA), pap smear and Human Papillomavirus (HPV) test.</td>
</tr>
<tr>
<td>Denominator</td>
<td>All female respondents aged 30-49 years.</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>Population-based (preferably nationally representative) survey</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td>Facility based data</td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td></td>
</tr>
<tr>
<td>Disaggregation</td>
<td>Age, Sex, other relevant socio-demographic stratifiers where available</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>At least every 5 years</td>
</tr>
<tr>
<td>Limitations</td>
<td>Potential limitations include: - bias through self-report, including mistakenly assuming any pelvic exam was a test for cervical cancer - limited validity of survey instruments</td>
</tr>
<tr>
<td>Data type</td>
<td>Prevalence</td>
</tr>
<tr>
<td>Related links</td>
<td><a href="http://www.who.int/chp/steps/en/">http://www.who.int/chp/steps/en/</a></td>
</tr>
<tr>
<td></td>
<td><a href="http://www.who.int/reproductivehealth/publications/cancers/">http://www.who.int/reproductivehealth/publications/cancers/</a></td>
</tr>
</tbody>
</table>
## Target #34

**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 Metadata

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator</strong></td>
<td>Number of cases of poliomyelitis caused by wild poliovirus (WPV)</td>
</tr>
<tr>
<td><strong>SDG/Core 100</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Definition</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Method of estimation/calculation</strong></td>
<td>Sum of reported cases.</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Preferred data sources</strong></td>
<td>Surveillance systems</td>
</tr>
<tr>
<td><strong>Other possible data sources</strong></td>
<td></td>
</tr>
<tr>
<td><strong>WHO GPW13 Framework</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Disaggregation</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Expected frequency of data collection</strong></td>
<td>Weekly</td>
</tr>
<tr>
<td><strong>Limitations</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Data type</strong></td>
<td>Count, absolute number of cases</td>
</tr>
</tbody>
</table>
### Target #35

**Eliminate at least one neglected tropical disease in 30 additional endemic member states (cumulative total number of member states)**

Number of people requiring interventions against neglected tropical diseases

**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

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+).
<table>
<thead>
<tr>
<th><strong>WHO GPW13 Framework</strong></th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disaggregation</strong></td>
<td>Disaggregation by age is required for PC: pre-school-aged children (1-4 years), school-aged (5-14 years) and adults (= 15 years).</td>
</tr>
<tr>
<td><strong>Expected frequency of data collection</strong></td>
<td>Annual</td>
</tr>
<tr>
<td><strong>Limitations</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Data type</strong></td>
<td>Absolute number</td>
</tr>
</tbody>
</table>
| **Related links**        | [https://unstats.un.org/sdgs/metadata/?Text=&Goal=3&Target=3.3](https://unstats.un.org/sdgs/metadata/?Text=&Goal=3&Target=3.3)  
<p>| <strong>Target #35</strong> | <strong>Eliminate at least one neglected tropical disease in 30 additional endemic member states (cumulative total number of member states)</strong> |
| <strong>Indicator-2</strong> | Total number of member states with an eliminated NTD |
| <strong>SDG/ Core 100</strong> |  |
| <strong>Definition</strong> | The cumulative total number of member states that have eliminated at least one NTD since 1995. |
| <strong>Method of estimation/calculation</strong> | A previously endemic member state added to the cumulative total once it is has been validated, verified or certified for elimination as a public health problem, elimination of transmission, or eradication, as assessed by WHO through a formal process; countries that have eliminated/eradicated more than one NTD are counted |
| <strong>Numerator</strong> | Total number of member states with an eliminated NTD |
| <strong>Denominator</strong> | Not applicable |
| <strong>Preferred data sources</strong> | WHO Global Health Observatory |
| <strong>Other possible data sources</strong> | Not applicable |
| <strong>WHO GPW13 Framework</strong> | Impact |
| <strong>Disaggregation</strong> | Not applicable |
| <strong>Expected frequency of data collection</strong> | Continuous |
| <strong>Limitations</strong> | This is a conservative measure of progress towards to end of the epidemic of NTDs (SDG 3.3): member states that have eliminated more than one NTD are counted only once; progress at the subnational level is not reflected until national elimination is achieved. It should be used alongside SDG indicator 3.3.5, the number of people requiring interventions against NTDs. |
| <strong>Data type</strong> | Absolute number |</p>
<table>
<thead>
<tr>
<th>Target #36</th>
<th>Reduce tuberculosis deaths (including TB deaths among people with HIV) by 50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator-1</td>
<td>Tuberculosis incidence per 100 000 population per year</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 3.3.2</td>
</tr>
<tr>
<td>Definition</td>
<td>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.</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>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.</td>
</tr>
<tr>
<td>Numerator</td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td></td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>High-quality surveillance systems in which underreporting is negligible, and strong health systems so that under-diagnosis is also negligible</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td>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</td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td>Outcome</td>
</tr>
<tr>
<td>Disaggregation</td>
<td>By country, sex, age (children vs adults).</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Annual</td>
</tr>
<tr>
<td>Limitations</td>
<td>Uncertainty in indicator values</td>
</tr>
<tr>
<td>Data type</td>
<td>Rate</td>
</tr>
</tbody>
</table>
### Target #36

**Indicator-2**

**SDG / Core 100**

**Definition**

Reduce tuberculosis deaths (including TB deaths among people with HIV) by 50%

Number of deaths caused by TB (including TB deaths among people with HIV) per year

The absolute number of deaths caused by TB (all forms of TB, and including deaths among people with HIV) in a year

Deaths from TB excluding TB deaths among people with HIV are based on ICD-10 code: A16 – A19.

Total number of deaths from TB (including TB deaths among people with HIV) in a given year. TB deaths among people with HIV are estimated using a case fatality approach.

Vital registration systems which record deaths with sufficient completeness to allow estimation of all-cause and cause-specific death rates.

Sample registration systems; verbal autopsy.

Outcome

By sex, age, HIV status, location (states/provinces of large countries).

Annual

Reliance on modelling in countries with incomplete or unusable death registration data

Count, absolute number of deaths

**Related links**

## GPW13 WHO Impact Framework: **Target #37** Indicator Metadata

<table>
<thead>
<tr>
<th>Target #37</th>
<th>Reduce malaria deaths by 50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator-1</td>
<td>Malaria incidence per 1 000 population</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 3.3.3</td>
</tr>
<tr>
<td>Definition</td>
<td>The number of new cases of malaria per 1,000 people at risk each year.</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>Three main methods are used to estimate the number of malaria cases and incidence.</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred data sources</td>
<td>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)</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td>Representative household surveys</td>
</tr>
</tbody>
</table>

**WHO GPW13 Framework**
- **Outcome**
- **Country**
- **Annual**

**Expected frequency of data collection**
- 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](https://unstats.un.org/sdgs/metadata/files/Metadata-03-03-03.pdf)
## Target #37

**Reduce malaria deaths by 50%**

Number of malaria deaths

### Definition

The sum deaths from malaria from confirmed and probable cases.

### Method of estimation/calculation

WHO compiles data on reported deaths from malaria, submitted by the national malaria control programmes (NMCPs). Predominant type of statistics: unadjusted

### Numerator

### Denominator

Vital registration systems which record deaths with sufficient completeness to allow estimation of all-cause death rates.

### Preferred data sources

Sample registration systems; verbal autopsy.

### Other possible data sources

Sample registration systems; verbal autopsy.

### WHO GPW13 Framework

#### 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

Count, absolute number of deaths

### Related links

WHO: [http://apps.who.int/gho/data/node.wrapper.imr?x-id=2967](http://apps.who.int/gho/data/node.wrapper.imr?x-id=2967);
<table>
<thead>
<tr>
<th>Target #38</th>
<th><strong>Reduce the number of HBV or HCV related deaths by 40%</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator-1</td>
<td>Hepatitis B incidence per 100,000 population</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 3.3.4 (Cumulated incidence of chronic HBV infection in children 5 years of age)</td>
</tr>
<tr>
<td>Definition</td>
<td>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.</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>Number of survey participants with Total anti — HBc and HBsAg positive test / Number in survey with Total anti — Hc/HBsAg result</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of survey participants with Total anti-HBc and HBsAg positive test</td>
</tr>
<tr>
<td>Denominator</td>
<td>Number in survey with Total anti-Hc/HBsAg result</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>Serosurvey</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td>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 %)</td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td>Outcome</td>
</tr>
<tr>
<td>Disaggregation</td>
<td>By sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education, wealth quintile).</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Intermittent, dependent on population seroprevalence of HBsAg before hepatitis B immunization and infant hepatitis B vaccination coverage.</td>
</tr>
<tr>
<td>Limitations</td>
<td>Rate</td>
</tr>
</tbody>
</table>
### Target #38

**Target #38**
Reduce the number of HBV or HCV related deaths by 40%

**Indicator Metadata**

**Definition**
The sum deaths attributable to HBV and HCV infection. Deaths were based on ICD-10 code related to HBV (B16.0-B16.9, B17.0, B18.0, B18.1) or HCV (B17.1, B18.2) and on the deaths from cirrhosis (K74.0–K74.69) and hepatocellular carcinoma (C22.0) that can be attributed to HBV and HCV infections.

**Method of estimation/calculati**
Compilation of the ICD-10 codes directly attributed to HBV and HCV infection and the fraction of the deaths of from cirrhosis and hepatocellular carcinoma that are attributable to HBV and HCV infection.

**Numerator**
Number of HBV and HCV related deaths

**Denominator**
Combination of data from two sources:

1. Vital registration systems which record deaths with sufficient completeness to allow estimation of all-cause;
2. Fraction of cirrhosis and hepatocellular carcinoma attributable from HBV and HCV infections, from sentinel sites (As per WHO protocol: World Health Organization: Protocol for surveillance of the fraction of cirrhosis and hepatocellular carcinoma attributable to viral hepatitis in clinical centres of excellence. WHO/CDS/HIV/18.5. (See related link, below))

**Preferred data sources**
Other data sources on the proportion of cirrhosis and hepatocellular carcinoma attributable to HBV and HCV infection include:

1. Locally published cirrhosis and hepatocellular carcinoma case series;
2. Cancer registries that collect data on risk factors, including HBV and HCV infection.

**WHO GPW13 Framework**
Sample registration systems; verbal autopsy.

**Disaggregation**
By sex, age 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
- Lack of in-country data on the fraction of cirrhosis / hepatocellular carcinoma attributable to HBV and HCV infection

**Data type**
Count, absolute number of deaths

**Related links**
WHO: https://apps.who.int/iris/bitstream/handle/10665/280097/WHO-CDS-HIV-19.4-eng.pdf?ua=1
### GPW13 WHO Impact Framework: Target #39 Indicator Metadata

<table>
<thead>
<tr>
<th>Target #39</th>
<th>Reduce number of new HIV infections per 1000 uninfected population, by sex, age, and key populations by 73%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator-1</td>
<td>Number of new HIV infections per 1,000 uninfected population, by sex, age, and key populations.</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 3.3.1</td>
</tr>
<tr>
<td>Definition</td>
<td>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.</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>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.</td>
</tr>
<tr>
<td>Numerator</td>
<td>Number of new HIV infections by sex, age and key populations</td>
</tr>
<tr>
<td>Denominator</td>
<td>Total uninfected population by sex, age and key populations</td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>Spectrum modelling, household or key population surveys with HIV incidence-testing</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td>Other possible data sources: Regular surveillance system among key populations.</td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td>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 (&lt; 25, 25+ years), mode of transmission (including mother-to-child transmission), place of residence, sex</td>
</tr>
<tr>
<td>Disaggregation</td>
<td></td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td></td>
</tr>
<tr>
<td>Limitations</td>
<td></td>
</tr>
<tr>
<td>Data type</td>
<td>Rate</td>
</tr>
<tr>
<td><strong>GPW13 WHO Impact Framework: Target #39 Indicator Metadata</strong></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Target #39</strong></td>
<td>Reduce number of new HIV infections per 1000 uninfected population, by sex, age, and key populations by 73%</td>
</tr>
<tr>
<td>Indicator-2</td>
<td>Number of HIV-related deaths</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>Number of HIV-related deaths</td>
</tr>
<tr>
<td>Definition</td>
<td></td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td>TBD</td>
</tr>
<tr>
<td>Numerator</td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td></td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>Vital registration systems which record deaths with sufficient completeness to allow estimation of all-cause death rates.</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td>By sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education, wealth quintile).</td>
</tr>
<tr>
<td>WHO GPW13 Framework Disaggregation</td>
<td>By sex, location (urban/rural, major regions/provinces), and socio-economic characteristics (e.g., education, wealth quintile).</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Annual</td>
</tr>
<tr>
<td>Limitations</td>
<td>- incomplete or unusable death registration data</td>
</tr>
<tr>
<td>Datatype</td>
<td>Count, number of deaths</td>
</tr>
<tr>
<td></td>
<td>UNAIDS Global AIDS response progress reporting 2015: construction of core indicators for monitoring the 2011</td>
</tr>
</tbody>
</table>
### Target #40 Indicator Metadata

<table>
<thead>
<tr>
<th><strong>Target #40</strong></th>
<th><strong>Increase coverage of 2nd dose of measles containing vaccine (MCV2) to 85%</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator</strong></td>
<td>Coverage of 2nd dose of measles containing vaccine (MCV2)</td>
</tr>
<tr>
<td><strong>SDG/ Core 100</strong></td>
<td>3.b.1</td>
</tr>
<tr>
<td><strong>Definition</strong></td>
<td>Percentage of children who received two doses of measles containing vaccine according to nationally recommended schedule through routine immunization services.</td>
</tr>
<tr>
<td><strong>Method of estimation/calculation</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>Number of children vaccinated in the target group. (12-23 months or other age group depending on recommended national immunization schedule).</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Number of 2 years old children globally</td>
</tr>
<tr>
<td><strong>Preferred data sources</strong></td>
<td>National Health Information Systems or National Immunization systems National immunization registries</td>
</tr>
<tr>
<td><strong>Other possible data sources</strong></td>
<td>High quality household surveys with immunization module (e.g. DHS, MICS, national in-country surveys)</td>
</tr>
<tr>
<td><strong>WHO GPW13 Framework</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Disaggregation</strong></td>
<td>Geographical location, i.e. regional and national and potentially subnational estimates</td>
</tr>
<tr>
<td><strong>Limitations</strong></td>
<td>Time series of coverage are subject to change when new data becomes available.</td>
</tr>
<tr>
<td><strong>Data type</strong></td>
<td>Percentage</td>
</tr>
</tbody>
</table>
## GPW13 WHO Impact Framework: **Target #41** Indicator Metadata

<table>
<thead>
<tr>
<th>Target #41 Indicator</th>
<th><strong>Increase treatment coverage of rifampicin-resistant (RR)-TB to 80%</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>SDG/ Core 100</td>
<td>Treatment coverage for RR-TB in a given year</td>
</tr>
<tr>
<td>Definition</td>
<td>The percentage of incident cases of bacteriologically-detectable RR-TB enrolled on treatment for RR-TB in a given year. RR-TB incidence is the sum of the incidence of primary RR-TB and RR-TB acquired in the course of treatment. RR-TB is detected using either phenotypic or genotypic tests, which require bacteriological confirmation of the underlying TB disease (some forms of TB cannot be bacteriologically confirmed using the best diagnostics currently available).</td>
</tr>
</tbody>
</table>
| Method of estimation/calculation | RR-TB treatment coverage (%) =  
\[
\frac{Number \ of \ cases \ enrolled \ on \ RR-TB \ treatment \ in \ a \ year}{Estimated \ incidence \ of \ bacteriologically-detectable \ RR-TB \ in \ the \ same \ year} \times 100\% 
\] |
| Numerator            | Number of cases enrolled on RR-TB treatment in a given year       |
| Denominator          | Estimated incidence of bacteriologically-detectable RR-TB during the same year |
| Preferred data sources | National surveillance systems with routine diagnostic testing for drug-resistant TB; facility registers and other programme monitoring tools; facility reporting systems. |
| Other possible data sources | National surveys of anti-TB drug resistance. |
| WHO GPW13 Framework Disaggregation | Outcome |
| Expected frequency of data collection | Annual |
| Limitations          | Estimates of the incidence of RR-TB are based on modelling in some settings. |
| Data type            | Percentage |
### Target #42

**Reduce the percentage of bloodstream infections due to selected AMR organisms by 10%**

**Indicator**
Percentage of bloodstream infections due to AMR organisms

**SDG/ Core 100**
SDG 3.d.1

**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 bloodstream 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**
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**
Prevalence

**Related links**
**GPW13 WHO Impact Framework: Target #43 Indicator Metadata**

**Target #43**

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.

\[
 PA F = \frac{\sum_{i=1}^{n} P_i \times RR_i - \sum_{i=1}^{n} P_i' \times RR_i}{\sum_{i=1}^{n} P_i \times RR_i}
\]

\[
P_i = \text{proportion of population at exposure level } i, \text{ current exposure}
\]

\[
P_i' = \text{proportion of population at exposure level } i, \text{ counterfactual or ideal level of exposure}
\]

\[
RR_i = \text{the relative risk at exposure level } i
\]

\[
n = \text{the level of exposure levels}
\]

Mortality rate attributed to household and ambient air pollution =

\[
\frac{\text{Total number of deaths attributed to household and ambient air pollution}}{\text{Total population}} \times 100,000
\]

**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

**GPW13 WHO Impact Framework: Target #43 Indicator Metadata**

| **Target #43** | **Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination**

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** |

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 |

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4255749/ |
## Target #43
Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

### Indicator Metadata

<table>
<thead>
<tr>
<th>Target #43</th>
<th>Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator-3</td>
<td>Mortality rate attributed to unintentional poisoning.</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 3.9.3</td>
</tr>
</tbody>
</table>

#### 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.

\[
\text{Mortality rate attributed to unintentional poisoning} = \frac{\text{Total number of deaths attributed to unintentional poisoning}}{\text{Total population}} \times 100,000
\]

#### 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
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
**GPW13 WHO Impact Framework: Target #43 Indicator Metadata**

<table>
<thead>
<tr>
<th><strong>Target #43</strong></th>
<th><strong>Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator-4</strong></td>
<td>Proportion of population with primary reliance on clean fuels and technology</td>
</tr>
<tr>
<td><strong>SDG/ Core 100</strong></td>
<td>SDG 7.1.2</td>
</tr>
<tr>
<td><strong>Definition</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Method of estimation/calculation</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>The number of people using clean fuels and technologies for cooking, heating and lighting</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Total population</td>
</tr>
<tr>
<td><strong>Preferred data sources</strong></td>
<td>National survey, population census, household surveys</td>
</tr>
<tr>
<td><strong>Other possible data sources</strong></td>
<td>National survey, population census, household surveys</td>
</tr>
<tr>
<td><strong>WHO GPW13 Framework</strong></td>
<td>Outcome</td>
</tr>
<tr>
<td><strong>Disaggregation</strong></td>
<td>Location (urban/rural)</td>
</tr>
<tr>
<td><strong>Expected frequency of data collection</strong></td>
<td>Annual</td>
</tr>
<tr>
<td><strong>Limitations</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Data type</strong></td>
<td>Percentage</td>
</tr>
</tbody>
</table>
| **Related links** | [https://www.who.int/airpollution/data/HAP_exposure_results_final.pdf?ua=1](https://www.who.int/airpollution/data/HAP_exposure_results_final.pdf?ua=1)  
[https://www.who.int/indoorair/publications/burning-opportunities/en/](https://www.who.int/indoorair/publications/burning-opportunities/en/) |
### GPW13 WHO Impact Framework: Target #43 Indicator Metadata

<table>
<thead>
<tr>
<th>Target #43</th>
<th>Reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator-5</td>
<td>Annual mean levels of fine particulate matter (e.g. PM2.5 and PM10) in cities (population weighted)</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 11.6.2</td>
</tr>
<tr>
<td><strong>Definition</strong></td>
<td>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 [$\mu$g/m$^3$].</td>
</tr>
<tr>
<td><strong>Method of estimation/calculation</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>Sum of levels of fine particulate matter in monitored locations</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>Number of monitored locations</td>
</tr>
<tr>
<td><strong>Preferred data sources</strong></td>
<td>Special studies</td>
</tr>
<tr>
<td><strong>Other possible data sources</strong></td>
<td></td>
</tr>
<tr>
<td><strong>WHO GPW13 Framework</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Disaggregation</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Expected frequency of data collection</strong></td>
<td>Every 2-3 years</td>
</tr>
<tr>
<td><strong>Limitations</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Data type</strong></td>
<td>Mean</td>
</tr>
<tr>
<td><strong>Related links</strong></td>
<td><a href="http://www.who.int/gho/phe">www.who.int/gho/phe</a></td>
</tr>
</tbody>
</table>
**Target #44**

**Indicator Metadata**

**Reduce mortality from climate-sensitive diseases by 10%**

Mortality from climate-sensitive diseases (based on total deaths for diarrheal diseases, malaria, African trypanosomiasis, leishmaniasis, schistosomiasis, intestinal nematode infections, and dengue fever)

**SDG/ Core 100**

Definition

Evidence from epidemiological studies has shown that climate change is linked with a range of conditions. Taking into account only a subset of the possible health impacts, evidence for the following climate-sensitive health outcomes have been assessed on sufficiently strong basis for inclusion in the burden of disease estimates: diarrheal diseases, malaria and other selected vector-borne diseases, unintentional Injuries and deaths related to flooding, extreme heat, extreme cold, or malnutrition.

Mortality rate attributed to climate-sensitive diseases =

\[
\frac{\text{Total number of deaths attributed to climate-sensitive diseases}}{\text{Total population}} \times 100,000
\]

**Numerator**

Total number of deaths attributed to climate-sensitive diseases in a given period of time

**Denominator**

Total population in a given period of time

**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

Data type

Rate

Related links

WHO: [http://apps.who.int/gho/data/node.wrapper.imr?x-id=2391](http://apps.who.int/gho/data/node.wrapper.imr?x-id=2391);
### GPW13 WHO Impact Framework: **Target #45** Indicator Metadata

<table>
<thead>
<tr>
<th><strong>Target #45</strong></th>
<th><strong>Provide access to safely managed drinking water services for 1 billion more people</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Indicator</strong></td>
<td>Proportion of population using safely managed drinking water services</td>
</tr>
<tr>
<td><strong>SDG/ Core 100</strong></td>
<td>SDG 6.1.1</td>
</tr>
<tr>
<td><strong>Definition</strong></td>
<td>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. 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.</td>
</tr>
<tr>
<td><strong>Method of estimation/calculation</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Numerator</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Preferred data sources</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Other possible data sources</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>WHO GPW13 Framework</strong></td>
<td>Disaggregation by place of residence (urban/rural) and socioeconomic status (wealth, affordability) is possible for all countries. Disaggregation by other stratifiers of inequality (subnational, gender, disadvantaged groups, etc.) will be made where data permit. Drinking water services will be disaggregated by service level (including no services, basic, and safely managed services) following the JMP drinking water ladder.</td>
</tr>
<tr>
<td><strong>Disaggregation</strong></td>
<td>Disaggregation by place of residence (urban/rural) and socioeconomic status (wealth, affordability) is possible for all countries. Disaggregation by other stratifiers of inequality (subnational, gender, disadvantaged groups, etc.) will be made where data permit. Drinking water services will be disaggregated by service level (including no services, basic, and safely managed services) following the JMP drinking water ladder.</td>
</tr>
<tr>
<td><strong>Expected frequency of data collection</strong></td>
<td>Biennial</td>
</tr>
<tr>
<td><strong>Limitations</strong></td>
<td>Percentage</td>
</tr>
<tr>
<td><strong>Data type</strong></td>
<td>Percentage</td>
</tr>
</tbody>
</table>
## GPW13 WHO Impact Framework: **Target #46** Indicator Metadata

<table>
<thead>
<tr>
<th>Target #46</th>
<th><strong>Provide access to safely managed sanitation services for 800 million more people</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator</td>
<td>Proportion of population using safely managed sanitation services, including a hand-washing facility with soap and water</td>
</tr>
<tr>
<td>SDG/ Core 100</td>
<td>SDG 6.2.1</td>
</tr>
<tr>
<td>Definition</td>
<td>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. Households 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.</td>
</tr>
<tr>
<td>Method of estimation/calculation</td>
<td></td>
</tr>
<tr>
<td>Numerator</td>
<td></td>
</tr>
<tr>
<td>Denominator</td>
<td></td>
</tr>
<tr>
<td>Preferred data sources</td>
<td>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.</td>
</tr>
<tr>
<td>Other possible data sources</td>
<td></td>
</tr>
<tr>
<td>WHO GPW13 Framework</td>
<td>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.</td>
</tr>
<tr>
<td>Expected frequency of data collection</td>
<td>Biennial</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data type</td>
</tr>
<tr>
<td>Related links</td>
</tr>
</tbody>
</table>

www.washdata.org
JMP website: www.washdata.org.
JMP 2017 update and SDG baselines