EVERY WOMAN
EVERY CHILD

INDICATOR AND MONITORING FRAMEWORK FOR THE GLOBAL STRATEGY FOR WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH (2016-2030)

Contents

EXECUTIVE SUMMARY

This report presents the indicator and monitoring framework for the Global Strategy for Women's, Children's and Adolescents' Health, (2016-2030) focusing on its Survive, Thrive and Transform objectives and 17 targets. The report details the selection process for the indicators and implications for monitoring, measurement, investments and reporting.

Based on technical reviews and an open consultative process, 60 indicators were selected. They refer to priority areas in the Global Strategy and have a proven measurement track record. The framework aims to minimize the burden of country-to-global reporting by aligning with 34 indicators from the Sustainable Development Goals (SDGs). An additional 26 indicators are drawn from established global initiatives for reproductive, maternal, newborn, child and adolescent health (RMNCAH). Together these 60 indicators provide sufficient depth and breadth for tracking progress on the Global Strategy and for evidence-informed advocacy and accountability for resources, results and rights. This framework can support national SDG and health monitoring, and countries could use additional contextual indicators as relevant. From the 60, 16 key indicators (see panel) are selected as a minimum subset to provide a snapshot of progress on the Global Strategy. Other subsets of indicators could be used for communication with different audiences and on different topics.

Separate priority topics are identified for developmental work and research investment. These include quality of care, early childhood development, causes of death, human rights and health, governance and accountability.

Monitoring the Global Strategy requires substantial investments in data collection, compilation, analysis, communication and use in countries. The Health Data Collaborative and others must play a critical role to:

- Advocate for and invest in strengthening and vital statistics (CRVS) systems through the CRVS window of the Global Financing Facility;
- Ensure every country has a regular programme of health surveys, supplemented by international survey programmes (e.g. DHS and MICS);

Key indicators

Survive

1. Maternal mortality ratio (SDG 3.1.1)
2. Under-5 mortality rate (SDG 3.2.1)
3. Neonatal mortality rate (SDG 3.2.2)
4. Stillbirth rate
5. Adolescent mortality rate

Thrive

6. Prevalence of stunting among children under 5 years of age (SDG 2.2.1)
7. Adolescent birth rate (10-14, 15-19) per 1000 women in that age group (SDG 3.7.2)
8. Coverage index of essential health services, including for infectious diseases, noncommunicable diseases and RMNCAH: family planning, antenatal care, skilled birth attendance, breastfeeding, immunization, childhood illnesses treatment (SDG 3.1.2, 3.7.1, 3.8.1)
9. Out-of-pocket health expenditure as a percentage of total health expenditure
10. Current country health expenditure per capita (including specifically on RMNCAH) financed from domestic sources
11. Number of countries with laws and regulations that guarantee women aged 15-49 access to sexual and reproductive health care, information and education (SDG 5.6.2)
12. Proportion of population with primary reliance on clean fuels and technology (SDG 7.1.2)

Transform

13. Proportion of children under 5 years of age whose births have been registered with a civil authority (SDG 16.9.1)
14. Proportion of children and young people in schools with proficiency in reading and mathematics (SDG 4.1.1)
15. Proportion of women, children and adolescents subjected to violence (SDG 5.2.1, 16.2.3)
16. Percentage of population using safely managed sanitation services including a hand-washing facility with soap and water (SDG 6.2.1)

Note: Equity is a cross-cutting consideration aligned with SDG 17.18.1, with disaggregation of indicators when relevant, including by age, sex, education, wealth and settings–rural, urban, humanitarian.

- Improve facility-based information systems, including web-based systems of routine reporting and feedback and regular facility surveys;
- Focus on disaggregated data to address equity and human rights considerations so that no one is left behind, including in humanitarian and fragile settings;
- Strengthen country capacities for analysis, communication and use of monitoring data;
- Improve monitoring of health system resources such as financing, health workforce and access to medicines, with a focus on RMNCAH;
- Promote investment in research for better measurement and monitoring; and
- Enhance health-related SDGs monitoring and accountability in countries.

The World Health Organization (WHO), together with the multilateral health agencies (H6) and other partners, will annually review and update data on the Global Strategy monitoring framework. In September 2016, a report will present initial data and discuss requirements to support robust monitoring of progress towards the Global Strategy objectives. From 2017, the data will be updated by April every year, in advance of the World Health Assembly, and be accompanied by an annual report. This will also serve as an input to country-led decision-making for implementation, multistakeholder support and mutual accountability. The monitoring framework also contributes to other dimensions of the Global Strategy's Unified Accountability Framework, including to strengthen partners' mutual accountability and contribute as appropriate to the Independent Accountability Panel's reports on progress towards women's, children's and adolescents' health in the SDG era.

1. BACKGROUND

The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) was launched in September 2015. It sets ambitious objectives to improve women's, children's and adolescents' health in alignment with the Sustainable Development Goals (SDGs) along three axes: 1) Survive (end preventable deaths); 2) Thrive (ensure health and well-being); and 3) Transform (expand enabling environments). Specific objectives include: reducing mortality rates (reducing global maternal mortality to less than 70 per 100 000 live births, and neonatal and under-5 mortality to at least as low as 12 and 25 per 1000 live births, respectively); ending major global epidemics (HIV, tuberculosis and malaria); meeting needs such as essential RMNCAH services coverage, adequate nutrition, clean water and environments; and achieving far-reaching targets such as ending extreme poverty, providing universal primary and secondary education and ending harmful practices and violence against women and girls.

To monitor implementation and track progress towards implementation of the Global Strategy and its Unified Accountability Framework, well-founded and robust indicators of progress towards its targets and objectives are needed. Since the targets are aligned with the SDG targets, the indicator and monitoring framework needs to align as much as possible with the SDG indicator framework, but at the same time provide sufficient depth for progress and performance tracking and evidence-informed advocacy in the context of the Global Strategy. This indicator and monitoring framework presents the results of a broad technical process of development, described in the next section. The framework presents the selected indicators and discusses the implications for monitoring, measurement investments and reporting.

2. PROCESS OF DEVELOPMENT

In recognition of the need to minimize the country reporting burden, a main goal of the initial indicator selection process was to harmonize with on-going monitoring efforts at the global level. It was also necessary to ensure adequate coverage of women, children and adolescents across the Survive, Thrive and Transform axes and in line with the 17 targets of the Global Strategy.

As a first step, a database was compiled of existing indicators from the following sources: the proposed SDG indicators; Every Newborn Action Plan (ENAP); indicators for Ending Preventable Maternal Mortality (EPMM); Universal Health Coverage (UHC) indicators; and the Global Reference List for 100 Core Health Indicators 2015. Then an initial review was undertaken to remove indicators that were duplicated or had been replaced by improved indicators. Using this compiled indicator list, a transparent, multistakeholder prioritization exercise was conducted between 15 December 2015 and 8 February 2016 using the following criteria for assessment of each indicator: 1) relevance for monitoring achievement of the Global Strategy goals; 2) validity of the indicator (measures what it is supposed to measure); 3) feasibility of measurement and data availability; 4) harmonization with existing indicators monitored via other strategies; and 5) resonance with policy-makers.

Over 100 responses were received, representing individual input as well as coordinated group responses. Respondents ranked the proposed indicators and made additional suggestions through over 700 open-ended comments. The comments were synthesized and the indicators mapped to the 17 Global Strategy targets. The indicators were initially classified into four categories, based on a mix of technical criteria derived from the UN Statistical Commission,[1] the Countdown to 2015[2] and the outcome and follow-up of the "Kirkland meeting",[3] keeping in mind the results of the prioritization exercise. This includes developmental indicators or subject areas that reflect important contributions to target monitoring but may currently have insufficient monitoring processes, or could be revised to reflect progress towards the targets, or lack thereof, more accurately.

The results of this open consultation process were considered by a group of technical, measurement and policy experts at a meeting in Montreux, Switzerland, on 18 and 19 February 2016. This led to a draft framework, which was circulated to the meeting participants and then revised based on their review.

The draft report from the Montreux meeting was circulated to participants during a meeting led by the Partnership for Maternal, Newborn & Child Health on 3 and 4 March 2016 in Johannesburg, South Africa. The draft report and list of indicators was also circulated to key stakeholders in areas identified at the previous meetings as needing further inputs, for example on financing, human rights and humanitarian action. Taken together, the feedback was used to help streamline the list of indicators and to fill indicator gaps identified by these additional reviews.

As a final step, 16 indicators were selected to summarize the Global Strategy monitoring framework. These indicators are methodologically sound and regularly measured in countries. They provide a concise and focused "at a glance" understanding of the state of women's, children's and adolescents' health.

The Every Woman Every Child Strategy Coordination Group reviewed the draft report at their final meeting on April 2016, and made key recommendations to finalize the indicators and monitoring framework.

[1] UN Economic and Social Council. Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators. UN Statistical Commission 8-11 March 2016. 19 February 2016. E/CN.3/2016/2.Rev.1. http://unstats.un.org/unsd/statcom/47th-session/documents/2016-2-IAEG-SDGs-E-Revised.pdf

[2] Requejo JH, Newby H, Bryce J (2013) Measuring Coverage in MNCH: Challenges and Opportunities in the Selection of Coverage Indicators for Global Monitoring. PLoS Med 10(5): e1001416. doi:10.1371/journal.pmed.1001416

[3] Grove J, Claeson M, Bryce J, Amouzou A, Boerma T, Waiswa P, et al. Maternal, newborn, and child health and the Sustainable Development Goals–a call for sustained and improved measurement. Lancet. 2015;386(10003):1511-4. Updates presented by Tanya Marchant, LSHTM.

3. INDICATORS

Based on the process described above, Table 1 presents 16 key indicators on the status of women's, children's and adolescents' health. Almost all indicators align with proposed SDG indicators and all are included in the full table of 60 indicators in Table 2. Information presented in parentheses in Table 1 maps the indicator to the indicator from the SDG monitoring process.

Table 2 presents the full set of 60 indicators as a technical resource for monitoring the Global Strategy. Each target, organized by the Global Strategy axes, Survive, Thrive and Transform, has at least one indicator. The set of indicators is divided into two groups: 1) the proposed indicators for the 17 targets identified as central to the Global Strategy (34 indicators); and 2) indicators that are a priority for the Global Strategy but are not proposed for the SDG process (26 indicators). All indicators have fair to good data availability and are considered a priority for monitoring progress towards each of the 17 targets and central themes of the Global Strategy. The indicators have been mapped to the 17 targets in this table. In addition, a number of indicators that are cross-cutting (and do not fall within just one of the 17 targets) appear at the end of the table.

The full set of selected indicators is large, so not all indicators are likely to be used at all times. However, the alignment within major strategies and monitoring efforts for reproductive, maternal, newborn and child health – such as EPMM, ENAP, Nutrition, GFF, Countdown 2030, etc. – is good and the close correspondence with the SDG indicators is critical. Finally, almost all health indicators are part of the Global Reference List for 100 Core Health Indicators 2015. This alignment is intended to minimize the monitoring and reporting burden, but some additional effort and investments will be required to bolster the measurability and validity of some indicators.

In addition to the 60 indicators, a number of other indicators or topics for indicators have been identified. These would provide critical information and could potentially become good indicators of key aspects of the Global Strategy, but still have issues related to indicator definition, measurement and data availability. These indicators, listed in Table A1, require further investments and development as part of the measurement agenda for the Global Strategy and should be priorities for research investments.

Additional contextual indicators that indirectly influence women's, children's and adolescents' health should be considered during Global Strategy implementation. Table A2 includes established indicators currently being monitored as a part of other initiatives. They can provide additional information, especially in relation to the contextual factors for progress in implementation of the Global Strategy. This includes indicators for health system inputs and outputs, such as health workforce, access to medicines and specific services.

Table A3 maps each indicator, by target, to the population or populations covered (women, children or adolescents) in order to illuminate the depth and breadth of coverage across each one. This table notes where age disaggregation is recommended.

The Global Strategy indicator and monitoring framework provides sufficient depth and breadth for tracking progress on the Global Strategy and for evidence-informed advocacy and accountability for resources, results and rights. This framework can support national SDG and health monitoring, and countries could use additional contextual indicators as relevant. 16 key indicators (Table 1) are selected as a minimum subset to provide a snapshot of progress on the Global Strategy. Other subsets of indicators could be used for communication with different audiences and on different topics.

Table 1. Status of Women's, Children's, and Adolescents' Health: 16 Key Indicators

SURVIVE (END PREVENTABLE MORTALITY)

1. Maternal mortality ratio (SDG 3.1.1)
2. Under-5 mortality rate (SDG 3.2.1)
3. Neonatal mortality rate (SDG 3.2.2)
4. Stillbirth rate
5. Adolescent mortality rate

THRIVE (PROMOTE HEALTH AND WELLBEING)

6. Prevalence of stunting among children under 5 years of age (SDG 2.2.1)
7. Adolescent birth rate (10-14, 15-19) per 1000 women in that age group (SDG 3.7.2)
8. Coverage index of essential health services (index based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access) (SDG 3.8.1) (including RMNCAH: family planning [met need], antenatal care, skilled birth attendance, breastfeeding, immunization, childhood illnesses treatment) (SDG 3.1.2, 3.7.1, 3.8.1)
9. Out-of-pocket health expenditure as a percentage of total health expenditure
10. Current country health expenditure per capita (including specifically on RMNCAH) financed from domestic sources
11. Number of countries with laws and regulations that guarantee women aged 15-49 access to sexual and reproductive health care, information and education (SDG 5.6.2)
12. Proportion of population with primary reliance on clean fuels and technology (SDG 7.1.2)

TRANSFORM (EXPAND ENABLING ENVIRONMENTS)

13. Proportion of children under 5 years of age whose births have been registered with a civil authority (SDG 16.9.1)
14. Proportion of children and young people (in schools): (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex (SDG 4.1.1)
15. Proportion of ever-partnered women and girls aged 15 and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months (SDG 5.2.1) and proportion of young women and men aged 18-29 who experienced sexual violence by age 18 (SDG 16.2.3)
16. Percentage of population using safely managed sanitation services including a hand-washing facility with soap and water (SDG 6.2.1)

Note: Equity is a cross-cutting consideration aligned with SDG 17.18.1, with disaggregation of indicators when relevant, including by age, sex, education, wealth and settings–rural, urban, humanitarian.

Table 2. Indicators for the Global Strategy, by target

Target	Included in SDGs (text in parentheses denotes an SDG indicator)	Additional to SDGs
SURVIVE (END PREVENTABLE MORTALITY)		
Reduce global maternal mortality to less than 70 per 100 000 live births (SDG 3.1)	Maternal mortality ratio (3.1.1)	Proportion of women aged 15-49 who received 4 or more antenatal care visits
	Proportion of births attended by skilled health personnel (3.1.2)	Proportion of women who have postpartum contact with a health provider within 2 days of delivery
Reduce newborn mortality to at least as low as 12 per 1000 live births in every country (SDG 3.2)	Neonatal mortality rate (3.2.2)	Stillbirth rate
		Proportion of infants who were breastfed within the first hour of birth
		Proportion of newborns who have postnatal contact with a health provider within 2 days of delivery
		Proportion of women in antenatal care (ANC) who were screened for syphilis during pregnancy
Reduce under-5 mortality to at least as low as 25 per 1000 live births in every country (SDG 3.2)	Under-5 mortality rate (3.2.1)	Percentage of children with diarrhoea receiving oral rehydration salts (ORS)
		Proportion of children with suspected pneumonia taken to an appropriate health provider
		Percentage of infants <6 months who are fed exclusively with breast milk
		Percentage of children fully immunized
		Use of insecticide-treated nets (ITNs) in children under 5 (% of children)
End epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases (SDG 3.3)	Number of new HIV infections per 1000 uninfected population, by age and sex (3.3.1)	Percentage of people living with HIV who are currently receiving antiretroviral therapy (ART), by age and sex
	Malaria incident cases per 1000 persons per year (3.3.3)	Proportion of households with at least 1 ITN for every 2 people and/or sprayed by indoor residual spray (IRS) within the last 12 months
Reduce by 1/3 premature mortality from noncommunicable diseases and promote mental health and well-being (SDG 3.4)	Age-standardized prevalence of current tobacco use among persons 15 years and older, by age and sex (3.a.1)	Adolescent mortality rate, by sex
	Mortality between ages 30 and 70 years from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases, by sex (3.4.1)	Proportion of women aged 30-49 who report they were screened for cervical cancer
	Suicide mortality rate, by age and sex (3.4.2)	

Target	Included in SDGs (text in parentheses denotes an SDG indicator)	Additional to SDGs
THRIVE (PROMOTE HEALTH AND WELL-BEING)		
End all forms of malnutrition and address the nutritional needs of adolescent girls, pregnant and lactating women and children (SDG 2.2)	Prevalence of stunting (height for age <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age (2.2.1)	Prevalence of insufficient physical activity among adolescents
	Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight) (2.2.2)	Prevalence of anaemia in women aged 15-49, disaggregated by age and pregnancy status
		Proportion of children aged 6-23 months who receive a minimum acceptable diet
Ensure universal access to sexual and reproductive health-care services (including for family planning) and rights (SDG 3.7 and 5.6)	Percentage of women of reproductive age (15-49) who have their need for family planning satisfied with modern methods (3.7.1)	Proportion of men and women aged 15-24 with basic knowledge about sexual and reproductive health services and rights
	Adolescent birth rate (10-14, 15-19) per 1000 women in that age group (3.7.2)	
	Proportion of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (5.6.1)	
	Number of countries with laws and regulations that guarantee women aged 15-49 access to sexual and reproductive health care, information and education (5.6.2)	
Ensure that all girls and boys have access to good-quality early childhood development (SDG 4.2)	Percentage of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by sex (4.2.1)	
	Participation rate in organized learning (one year before the official primary entry age), by sex (4.2.2)	
Substantially reduce pollution-related deaths and illnesses (SDG 3.9)	Mortality rate attributed to household and ambient air pollution, by age and sex (3.9.1)	
	Proportion of population with primary reliance on clean fuels and technology (7.1.2)	

Target	Included in SDGs (text in parentheses denotes an SDG indicator)	Additional to SDGs
Achieve universal health coverage, including financial risk protection and access to quality essential services, medicines and vaccines (SDG 3.8)	Coverage of essential health services (index based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access) (3.8.1) (including RMNCAH: family planning; pregnancy and childbirth care; breastfeeding; immunization; childhood illnesses treatment)	Current country health expenditure per capita (including specifically on RMNCAH) financed from domestic sources
	SDG 3.8.2 to be decided*	Out of-pocket health expenses as percentage of total health expenditure
TRANSFORM (EXPAND ENABLING ENVIRONMENTS)		
Eradicate extreme poverty (SDG 1.1)	Proportion of population below the international poverty line, by sex, age, employment status and geographical location (1.1.1)	
Ensure that all girls and boys complete free, equitable and good-quality secondary education (SDG 4.1)	Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex (4.1.1)	
Eliminate all harmful practices and all discrimination and violence against women and girls (SDG 5.2 and 5.3)	Percentage of women aged 20-24 who were married or in a union before age 15 and before age 18 (5.3.1)	Proportion of young women and men aged 18-29 who experienced sexual violence by age 18 (16.2.3)
	Proportion of ever-partnered women and girls aged 15 and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age (5.2.1)*	Proportion of rape survivors who received HIV post-exposure prophylaxis (PEP) within 72 hours of an incident occurring
	Proportion of women and girls aged 15-49 who have undergone female genital mutilation/cutting (FGM/C), by age (5.3.2)	
	Whether or not legal frameworks are in place to promote, enforce and monitor equality and nondiscrimination on the basis of sex (5.1.1)	

* Indicator for SDG 3.8.2 proposed by the World Health Organization and the World Bank

Target	Included in SDGs (text in parentheses denotes an SDG indicator)	Additional to SDGs
Achieve universal and equitable access to safe and affordable drinking water and to adequate sanitation and hygiene (SDG 6.1 and 6.2)	Percentage of population using safely managed drinking water services (6.1.1)	
	Percentage of population using safely managed sanitation services including a hand-washing facility with soap and water (6.2.1)	
Enhance scientific research, upgrade technological capabilities and encourage innovation (SDG 8.2)	Research and development expenditure as a proportion of GDP (9.5.1) (disaggregated by health/RMNCAH)	
Provide legal identity for all, including birth registration (SDG 16.9)	Proportion of children under 5 years of age whose births have been registered with a civil authority, by age (16.9.1)	
	Proportion of countries that (a) have conducted at least one population and housing census in the last 10 years; and (b) have achieved 100% birth registration and 80% death registration (17.19.2)	
Enhance the global partnership for sustainable development (17.16)	Number of countries reporting progress in multistakeholder development effectiveness monitoring frameworks that support the achievement of the SDGs (17.16.1)	Governance index (voice, accountability, political stability and absence of violence, government effectiveness, regulatory quality, rule of law, control of corruption)
Additional equity, humanitarian and human rights cross-cutting indicators	Proportion of indicators at the national level with full disaggregation when relevant to the target (17.18.1) (for indicators from the Global Strategy for Women's, Children's and Adolescents' Health, this indicator would be relevant at regional and global levels too)	Proportion of countries that have ratified human rights treaties related to women's, children's and adolescents' health
		Humanitarian Response Index

4. MEASUREMENT, MONITORING AND INVESTMENT NEEDS

Monitoring the 17 SDGs and their 169 targets will be a major challenge for country statistical systems and for global and regional monitors. Monitoring the health-related SDG targets will also be challenging, including 26 proposed indicators under the health goal (SDG 3) and more than a dozen health-related indicators under other goals. The monitoring framework of the Global Strategy is closely linked to the overall SDG monitoring framework, building upon a selection of relevant SDG indicators and adding other indicators where needed.

Substantial investments in country systems will be required to support Global Strategy monitoring, including data collection, compilation, data quality assessment and analysis and dissemination and use. It is an essential component of the Unified Accountability Framework and should inform the functions of review and remedial action. Such investments will have to come from domestic sources and, in low- and lower-middle-income countries, from international support mechanisms. It is essential that global and regional support are aligned to maximize the efficiency and effectiveness of investments to support the creation, in each country, of a single health information system that is closely linked to the national statistical system. Therefore, implementation of the Global Strategy monitoring framework will occur in the context of the Health Data Collaborative, (www.healthdatacollaborative.org) a recent global effort of development partners, countries, civil society and academia to strengthen country health information systems in order to enhance SDG-related monitoring and accountability in countries.

MAPPING THE INDICATORS TO DATA SOURCES

The main sources for health data are civil registration and vital statistics (CRVS) systems, household and other population-based surveys, facility reports and facility surveys, and health system resources or administrative data systems. In addition, the population census is an important source of data for the health sector.

A mapping of the indicators against the data sources shows that multiple data sources are possible for several indicators. This is most commonly the case for service coverage indicators, for which data can be obtained from household surveys and facility reporting. For some indicators a well-functioning civil registration system (births, deaths, causes of death and marriages) would be the best source of data, but in the absence of such systems household surveys and sometimes facility reports are used to obtain data.

CRVS systems are the primary source of data on mortality, allowing much better measurement of child, adolescent and adult mortality than surveys. They also provide data for local disaggregation of mortality statistics. Furthermore, CRVS systems provide comprehensive data on the causes of death in children, women and adolescents, provided the majority of deaths are medically certified and coded using the International Classification of Diseases, tenth revision (ICD-10). In countries with poor coverage of medical certification, verbal autopsy can be used to obtain a probable cause of death through interviews with relatives of the deceased. CRVS systems can also provide data on births and marriages.

Household surveys can be used for almost all indicators (more than 80% of the 60), either as the main source or as an important additional or alternative source of data. In the absence of well-functioning CRVS systems, they provide data for mortality indicators and coverage of interventions, sometimes with facility data as a second source. They are often the only source for indicators of behaviours and risk factors. Furthermore, household surveys are critical because they provide disaggregated data for almost all indicators. The data can be stratified by sex, age, wealth and education. Geographic variables can also be stratified at the provincial or regional level.

Routine facility data are an important source for several coverage indicators, availability of services (readiness) and some quality-of-care proxies. The greatest advantages are that facility data are available on a continuous basis and can provide district or other local-level data for the indicators. Completeness, timeliness and other data-quality issues often hamper the utility of facility data, but with current efforts to establish web-based district health information systems (such as DHIS 2.0) in many countries there is considerable scope for improvement.

Several indicators derive data from *facility surveys*, which can provide information on service provision and the basics of the quality of care, such as service readiness and health-worker knowledge. More extensive information on the quality of care can be obtained through more intensive methods of data collection as part of facility surveys, such as exit surveys and patient-provider observation. A regular system of integrated facility surveys, in combination with a well-functioning routine facility data system, provides a wealth of local and national data on programme performance and can contribute data for several indicators of the Global Strategy.

Other sources of data include regular key informant surveys on policies, legislation and regulation, which should be maintained in a global policy database. National Health Accounts (with RMNCAH subaccounts using the OECD System of Health Accounts 2011 methodology) and health workforce accounts are needed to provide critical information on the financing and workforce indicators.

DISAGGREGATION

The SDGs have strong emphasis on equity, expressed most frequently as "no one being left behind". Much of the world's attention to the MDGs has been based on aggregate global, regional and national achievements, but much more attention is needed for populations within countries that are marginalized or under-served. Therefore, disaggregated statistics, including sex, age, income/wealth, race, ethnicity, migratory status, disability and geographic location, or other characteristics, are required to track all populations. SDG target 17.18 calls for countries to increase the availability of disaggregated data by a range of stratifiers. Age is a key stratifier for many indicators in the Global Strategy monitoring framework.

The required disaggregation presents a major challenge to many countries – and to global and regional monitoring. Often, disaggregated information is limited to indicators that were collected in household surveys that provide data on demographic and socioeconomic characteristics and can be used to identify disadvantaged populations. Most surveys do not have sample sizes that allow computation of reliable subnational statistics beyond the provincial or regional level. Data from health facilities and administrative sources can fill the local information gap, but data availability and quality still need considerable improvement in many countries. Finally, countries often lack reliable information on health indicators among migrant populations, minorities and other marginalized populations.

HUMANITARIAN SETTINGS

Humanitarian settings are also an important cross-cutting consideration. As such, the full set of indicators includes a subset of indicators that relate specifically to humanitarian settings, or have been identified by experts as additionally relevant to humanitarian settings when measured, such as the maternal mortality ratio. In some cases, disaggregation by setting, including humanitarian, can provide relevant information. In others, specialized and focused data collection is required.

DATA ANALYSIS, COMMUNICATION AND USE

The national capacity to strengthen analysis of data must go hand in hand with improvements in data collection. This includes development of tools and investment in health analysts in ministries of health, public health institutions and universities and national statistical offices. The focus should be on ascertaining the quality of data and combining data from different sources, especially from surveys and facility data. Greater transparency and data access through "open data" initiatives can be an important stimulus for improvement of data quality.

Communication and the use of indicators for decision-making need strengthening. Score cards and dashboards are helpful instruments for the presentation of data to programme workers and government policy-makers, as well as to media, civil society and parliamentarians. However, the use of data to inform decision-making cannot be taken for granted even if communication is carried out effectively. It needs to be supported at national and subnational levels through capacity strengthening and other mechanisms.

An institutionalized link between monitoring, review and remedial action is important. Regular, transparent and inclusive monitoring informed by independent reviews of progress and performance at all levels are instrumental to improving programme efficiency and effectiveness.

FURTHER RESEARCH

There are several critical target areas in the Global Strategy for which no indicators are available that meet the criteria for inclusion in the list of indicators. This is often due to issues with the numerator (e.g. difficult to define the intervention) or denominator (e.g. hard to define the population in need of the intervention); lack of evidence that the indicator can generate comparable data for countries over time; and current gaps in quality data.

The list of indicators or indicator areas in need of development highlights gaps that urgently need greater investment in the development of measurement methods and instruments. These include:

- Quality of care, including for:
  - pregnancy, childbirth, abortion, postpartum and postnatal care
  - newborn care
- Intrapartum stillbirth rate
- Essential adolescent services
- Child illness treatment coverage
- Causes of death
  - maternal causes
  - children and newborns
  - adolescent mortality rate and causes
- Governance, accountability and participation
- Shared indicators with other sectors e.g. for early childhood development or air pollution.

In several instances there is already an active research agenda (e.g. in the context of ENAP or EPMM) to further develop and field test indicators.

In some areas it may not be possible to develop indicators that can be used in many countries and provide reliable and valid information at country and global levels. Not everything can be expressed in a meaningful indicator. Operational and implementation research can also provide hugely significant and useful information on, for instance, quality of care. In this case the Global Strategy should rely on such data to provide a picture of progress and challenges.

5. MONITORING AND REPORTING MECHANISMS

The situation and trends for the indicators should be reported on a regular basis. They are well-established indicators with proven track records and good data availability, and are considered highly indicative of progress towards the target.

There is a need to set more explicit target values for the indicators. In some cases there is a numeric value in the Global Strategy/SDG target (e.g. for several mortality indicators). A good example of a detailed target is provided by the full immunization coverage rate indicator: achieve and sustain 90% national coverage and 80% coverage in every district with all vaccines in national programmes.

Monitoring progress towards targets – globally and for individual countries – requires a baseline value from a year close to 2016. A target should refer to 2030 but intermediate targets should also be set (e.g. 2020 and 2025), at country and global levels. Such interim targets would be especially important to ensure that the equity gap is reducing in support of the "no one left behind" agenda. For some of the indicators, setting a global baseline is still a challenge. At this point, the framework proposed here does not include any new targets beyond those already expressed in the SDG targets.

ALIGNMENT WITH THE SDGS: COUNTRY LEVEL

It is essential to align monitoring of the Global Strategy with the overall SDG monitoring and reporting process. The 2030 agenda puts strong emphasis on country follow-up and review processes as the basis for accountability. The SDG monitoring and review processes will be large and complex with 17 goals, 169 targets and 230 indicators.

Discussion of how this will be done is still ongoing in many countries. The SDGs encourage greater country ownership and country-specificity in such processes. At the same time, according to the proposals of the UN Statistical Commission, the global indicators are intended to be the core of all other sets of indicators, based on internationally agreed standards of collection, analysis and reporting.[4]

National statistical offices will lead the national SDG monitoring processes. Enhanced collaboration between the health sector and other sectors with statistical offices is essential. Many countries face major data gaps such as the lack of reliable mortality and cause of death data from civil registration and vital statistics systems, which are required for more than a dozen indicators. A collaborative effort is needed involving multiple sectors, and should include the health sector as an important partner in collection and use of data.

The health sector can play a role by supporting the strengthening of country statistical capacity. Statistical offices need to be able to support the health sector to achieve high-quality data collection and analysis. This also requires the presence and participation of country public health and academic institutions that work closely with the ministry of health.

Global health actors have joined forces in a Health Data Collaborative, which aims for more effective and efficient support of countries to strengthen country health statistical capacity to monitor the SDGs. This requires close collaboration between health and statistical constituencies in countries (and globally).

In several countries there is greater emphasis on *open data* (e.g. data on health facilities, or health facility reporting systems), but at present most countries do not have such systems. They require major investment because the data need to be of good quality, have excellent metadata, be archived in a standardized way etc., so it may take several years in most countries before there is adequate capacity to put such systems in place. Countries should receive support to move towards meaningful open data systems, while protecting privacy and confidentiality.

[4] UN Economic and Social Council. Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators. UN Statistical Commission 8-11 March 2016. 19 February 2016. E/CN.3/2016/2.Rev.1

In addition to regular country reviews, regional review processes can help support and take forward the work. Health governing bodies such as the WHO regional commissions and other regional organizations should conduct voluntary peer review of country progress. Such processes can galvanize peer learning and country action and can be used to provide synthesis reports for global review processes.

COUNTRY-TO-GLOBAL REPORTING

Like the targets, the indicators of the Global Strategy have been aligned with the SDG indicators. Where necessary, minor modifications were made to the SDG indicators, such as expansion to include adolescents. The SDG indicators by themselves, however, are not sufficient to monitor the priority areas of the Global Strategy. The Global Strategy monitoring needs to provide some further insights into how well countries are performing.

Global data for the indicators can be derived from country reports – defined as a specific request to countries – from international data sources and other kinds of publicly available data, and from estimation processes. Globally available data sources include mostly international survey programmes and published scientific literature. The findings of demographic and health surveys (DHS) and multiple indicator cluster surveys (MICS) are public, and the statistics derived from them are maintained in multiple international databases. This is one of the most important sources of data for monitoring the Global Strategy, given that so many indicators are derived from surveys. UN agencies should continue to maintain and regularly update such databases on RMNCAH indicators.

First and foremost, country reporting should be focused on informing national review processes. Country reporting to global reporting is secondary. This has often resulted in countries being overburdened with reporting requirements related to programme-specific monitoring and grant mechanisms. In health, the global reference list of 100 health indicators is an example of a multiagency effort to reduce the reporting burden on countries and improve the quality of what is reported.[5] It is necessary to accompany these efforts with harmonization and alignment of international reporting requirements and maximize the use of country mechanisms. This is a major goal of the newly established Health Data Collaborative.

A light-touch process is desirable for the collection of data from countries. Existing reporting mechanisms should be used as much as possible and rationalized. Global reporting by countries should be minimized and, given the selected indicators and data availability, could be implemented as an innovative process in which a regular (e.g. annual or biennial) sheet of indicators is pre-populated by global agencies and sent to countries for additional information and verification and further debate on the results. A country report on progress towards the targets of the Global Strategy would have great value within countries as part of review and accountability processes. Countries that produce such reports should share them with global agencies.

THE ROLE OF ESTIMATES

Global monitoring relies extensively on modelling and estimates to fill data gaps and obtain comparable statistics. This pertains especially to mortality indicators, but is increasingly used for coverage indicators and for subnational statistics. Using models, predictions are made to obtain data for the year of reporting. It is important that much attention is paid to the underlying data, especially for monitoring progress. No matter how advanced the models, predicting progress for monitoring purposes is far from ideal, especially if special efforts were made in the past to address a problem (e.g. to reduce child mortality), but predictions made now do not take these efforts into account. UN agencies should continue to produce global estimates for the key indicators, using transparent methods and processes, supported by global expert groups. There is, however, a critical need to invest more in country capacity to collect empirical data and use them to improve modelling and estimates, while also developing appropriate modelling tools and methods and strengthening local capacity to test and use them.

SDG REPORTING MECHANISMS

A complex and intensive process of reporting, follow-up and review will include an annual SDG Progress Report by the United Nations Secretary-General with support from the UN system. The report in mid-2016 will inform the High Level Political Forum (HLPF) for Sustainable Development, which operates under the auspices of the Economic and Social Council (ECOSOC). The HLPF will also receive a Global Sustainable Development Report. There will most likely be a small number of themes every year, aiming to cover all SDGs in a four-year period. Every four years, under the auspices of the United Nations General

[5] http://www.who.int/healthinfo/indicators/2015/en/

Assembly (UNGA), the HLPF will provide guidance on the SDG agenda and its implementation. Review mechanisms will also be established at regional and national level and are likely to be more active and relevant than has been the case for the MDGs.

GLOBAL STRATEGY MONITORING AND REPORTING

While the link to the overall SDG monitoring process is critical, it is also clear that this process cannot be the main mechanism to monitor the Global Strategy. The Global Strategy monitoring framework includes indicators that interact with other efforts. For instance, there are indicators from monitoring frameworks of related global initiatives such as Ending Preventable Maternal Mortality; the Every Newborn Action Plan; the Integrated Global Action Plan for the Prevention and Control of Pneumonia and Diarrhoea; Global Nutrition Targets 2025 and others.

The monitoring framework also links to other dimensions of the Global Strategy's Unified Accountability Framework. These include assessment of progress in the context of country-led implementation and multistakeholder participation, including through the Global Financing Facility (GFF), Innovation Marketplace and other EWEC partnership mechanisms to strengthen partners' mutual accountability.

WHO, together with the multilateral health agencies (H6) and other partners, will annually review and update data on the Global Strategy monitoring framework. Several technical mechanisms such as the Countdown 2030, Global Nutrition report, HIV global report etc. will help inform this review and updating process.

The results will be available publicly as a special section of the WHO Global Health Observatory database, harmonized with other H6 databases as needed.[6] In September 2016, an initial report will present the initial situation and trends and discuss requirements to support robust monitoring of progress towards the Global Strategy objectives. From 2017, the data will be updated by April every year, in advance of the World Health Assembly, and be accompanied by an annual report. This global process will serve as an input to country-led decision-making for implementation, multistakeholder support and mutual accountability.

Implementing the Global Strategy monitoring framework would also contribute, as appropriate, to the Independent Accountability Panel's reports on progress towards women's, children's and adolescents' health in the SDG era.

[6] Global Health Observatory data: http://www.who.int/gho/en/

6. RECOMMENDATIONS

Invest in strengthening birth and death registration systems

- The focus should be on birth registration and death registration, with establishment of a reliable cause of death.
- Implementation of the Global Strategy monitoring framework should support the strengthening of CRVS systems. The health sector plays a critical role in CRVS systems, as a provider and user of data. At the individual level, birth registration (at the time of birth or as soon as possible after birth) is a human right.
- The CRVS window of the Global Financing Facility is an excellent opportunity to strengthen birth and death registration, including cause of death for women, children and adolescents.
- Such global efforts to strengthen country CRVS systems should be fully aligned with regional and country strategies.

Ensure every country has a programme of regular health surveys

- Without regular surveys the Global Strategy cannot be monitored, as most indicators and disaggregation require population-based data.
- Standardized international survey programmes are the backbone for low- and lower-middle income countries, notably DHS and MICS. These programmes should continue to complement countries' efforts by implementing regular surveys that collect the data for key RMNCAH indicators.
- In parallel, there is a need to strengthen national survey capacity and enhance integration of health surveys in support of national SDG-related statistical strategies.

Improve the functioning of facility-based information systems

- The potential for improving facility-based data is considerable in many countries. Global partners should align with and support country strengthening of (web-based) facility-based systems, including rationalization of indicators, data-quality improvement and better analysis, dissemination and use.
- The need to identify key indicators is a prerequisite of core investments in facility-based information systems.
- This includes implementing a regular health-facility survey that collects information on the readiness and quality of services where possible, focusing on RMNCAH but integrating with other health subjects where possible.

Focus on disaggregated data

- For many indicators the disaggregation by age, sex, socioeconomic status and other dimensions is critical to ensure that no one is left behind, including in humanitarian and other fragile settings. This will require special attention to data collection, analysis and communication for most indicators.

Strengthen analysis, communication and use of health data

- The capacity of key country institutions to generate, compile, analyse and disseminate data on key indicators from multiple sources needs to be strengthened. This includes ministry of health, public health institutions, academia and national statistical offices.
- A concerted effort is also needed through aligned efforts to strengthen subnational capacity for analysis and use of data.
- Data use implies effective communication of data and their implications to the right audiences and decision-makers, including programmes, policy-makers, parliamentarians, civil society and media. The capacity to communicate data in this way should be strengthened.
- Support countries in development and improvement of score cards or dashboards where appropriate.

Improve monitoring of health system resources

- Financing: continue the work started as part of the follow-up of the recommendations of the Commission on Information and Accountability (CoIA), focusing on subaccounts using SHA 2011.
- Health workforce: focus on the development of national health workforce accounts and analytical capacity to produce reliable statistics from such accounts.
- Access to medicines, including supply chain and procurement issues, with a focus on RMNCAH.

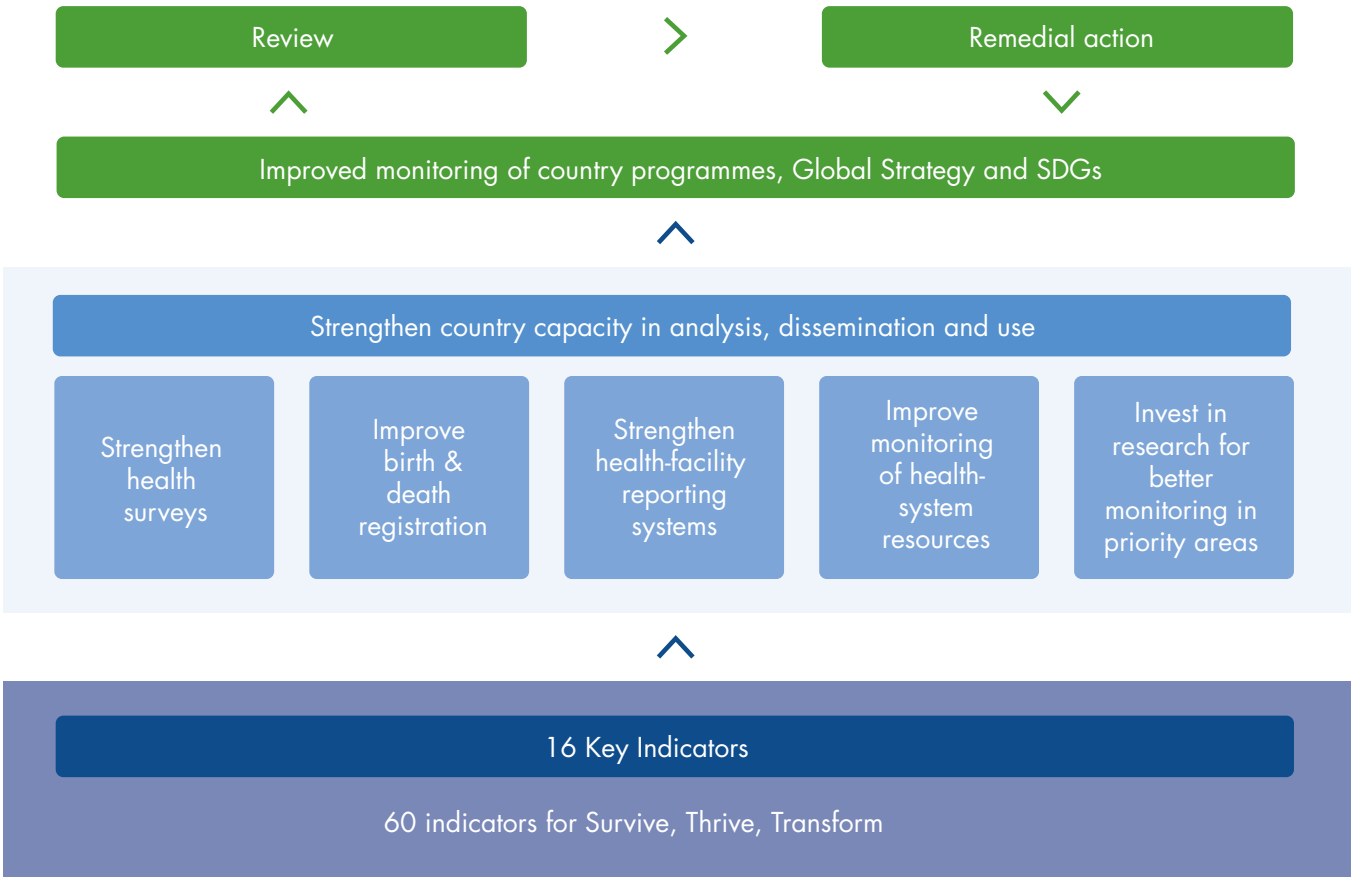
Promote investment in research for better measurement and monitoring in key areas

The key priority areas for investment are quality of care, treatment coverage, causes of death and governance and accountability.

- The investments should focus on the development of reliable and valid indicators that can be used in many countries and on the development of research methods that can be used locally as part of monitoring systems.

The Global Strategy monitoring framework aims to minimize the burden of country-to-global reporting by maximizing its linkages with the SDG monitoring mechanisms, UN agencies and other established global monitoring processes in health and other sectors. WHO, with H6, UN and Health Data Collaborative partners, will annually collate, review and update data on the Global Strategy. This will serve as an input to country-led decision-making for implementation and accountability, and to the Independent Accountability Panel's reports on progress towards women's, children's and adolescents' health in the SDG era.

Figure 1. Strengthening country monitoring and measurement in the context of the Global Strategy



Annex – Indicators for further development and additional context

Table A1. Global Strategy indicators requiring further development, by target

GLOBAL STRATEGY (2016-2030) TARGETS	INDICATORS FOR FURTHER DEVELOPMENT
SURVIVE (end preventable mortality)	
Reduce global maternal mortality to less than 70 per 100 000 live births (SDG 3.1)	Maternal cause of death (direct/indirect)
	Proportion of women with obstetric complications due to abortion
	Antenatal, intrapartum and postpartum quality of care, including satisfaction with services received
Reduce newborn mortality to at least as low as 12 per 1000 live births in every country (SDG 3.2)	Causes of newborn deaths
	Measurement of prevalence of low birth weight and small for gestational age
	Postnatal quality of care
	Newborn care coverage: treatment of severe neonatal bacterial infection; resuscitation initiated; thermal care; care for small and sick newborns
Reduce under-5 mortality to at least as low as 25 per 1000 live births in every country (SDG 3.2)	Treatment of sick children: diarrhoea, pneumonia and malaria
	Causes of child deaths
End epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases (SDG 3.3)	Human papilloma virus (HPV) vaccine coverage among adolescents
Reduce by 1/3 premature mortality from noncommunicable diseases and promote mental health and well-being (SDG 3.4)	Prevalence of depression, by age and sex
	Harmful use of alcohol among adolescents
	Adolescent cause of death
THRIVE (promote health and well-being)	
Ensure universal access to sexual and reproductive health-care services (including for family planning) and rights (SDG 3.7 and 5.6)	Proportion of secondary schools that provide comprehensive sexuality education (CSE)

GLOBAL STRATEGY (2016-2030) TARGETS	INDICATORS FOR FURTHER DEVELOPMENT
TRANSFORM (expand enabling environments)	
Eradicate extreme poverty (SDG 1.1)	
Ensure that all girls and boys complete free, equitable and good-quality secondary education (SDG 4.1)	Indicator of youth disenfranchisement
Eliminate all harmful practices and all discrimination and violence against women and girls (SDG 5.2 and 5.3)	Health-sector specific indicator on discrimination
	Percentage of the population reporting having personally felt discriminated against or harassed within the last 12 months on the basis of a ground of discrimination prohibited under international human rights law, disaggregated by age and sex (10.3.1)
Enhance scientific research, upgrade technological capabilities and encourage innovation	Proportion of countries that have systematic innovation registration mechanisms in place for women's, children's and adolescents' health and are reporting top 3 domestic innovations on an annual basis
	Proportion of countries that have mechanisms to review innovations using effective Health Technology Assessment approaches
Enhance the global partnership for sustainable development (17.16)	Proportion of countries that address young people's multisectoral needs within their national development plans and poverty reduction strategies (16.7.2)
	Implementation rate of commitments to the Global Strategy
	Participation measures – women's groups, youth, civil society etc.
Equity, humanitarian and human rights as cross-cutting considerations	Health-sector-specific indicators on anti-corruption and transparency
	Percentage of programmes in humanitarian settings based on health needs assessments of women, children and adolescents
	Funding gap in the transition from humanitarian aid to sustainable development

Table A2. Global Strategy additional contextual indicators, by target

GLOBAL STRATEGY (2016-2030) TARGETS	ADDITIONAL INDICATORS
SURVIVE (end preventable mortality)	
Reduce global maternal mortality to less than 70 per 100 000 live births (SDG 3.1)	Number of functional emergency obstetric and newborn care (EmONC) facilities per 500 000 population
THRIVE (promote health and well-being)	
Ensure universal access to sexual and reproductive health-care services (including for family planning) and rights (SDG 3.7 and 5.6)	Number of circumstances under which abortion is legal, by country
	Proportion of health facilities that provide essential sexual and reproductive health services
	Total fertility rate
Substantially reduce pollution-related deaths and illnesses (SDG 3.9)	
Achieve universal health coverage, including financial risk protection and access to quality essential services, medicines and vaccines (SDG 3.8)	Number of health workers per 10 000 population, by categories, geographic distribution, place of employment, etc. (3.c.1)
	Proportion of population with access to affordable essential medicines on a sustainable basis (3.b.1)
	Growth rate in government health expenditure compared to the GDP growth
	Current country health expenditure per capita financed by development assistance
	Percentage of development assistance for health that is on budget
	Government purchase price of a selected basket of essential RMNCAH medicines compared to the international reference price
TRANSFORM (expand enabling environments)	
Ensure that all girls and boys complete free, equitable and good-quality secondary education (SDG 4.1)	Proportion of 15-24 year olds not in education, employment or training (NEET) (8.6.1)

GLOBAL STRATEGY (2016-2030) TARGETS	ADDITIONAL INDICATORS
Eliminate all harmful practices and all discrimination and violence against women and girls (SDG 5.2 and 5.3)	Proportion of women and girls aged 15 and older subjected to sexual violence by persons other than an intimate partner, in the last 12 months, by age group and place of occurrence (5.2.2)
	Percentage of countries with systems to track and make public allocations for gender equality and women's empowerment
	Proportion of women in Parliament
	Percentage of health facilities with clinical management of rape survivors (as per WHO guidelines)
Enhance scientific research, upgrade technological capabilities and encourage innovation	Number of innovations from the Every Woman Every Child (EWEC) Innovation Marketplace that have received investments to scale
Enhance the global partnership for sustainable development (17.16)	Districts/provinces have community accountability mechanisms (e.g. score cards, community consultations, community conversations, community charters, community health committees, civil society hearings etc.) in place to support women's, children's and adolescents' health.
Equity, humanitarian and human rights as cross-cutting considerations	Percentage of attributes of 13 core capacities that have been attained at a specific point in time

Table A3. Global Strategy Indicators, by focal population

GLOBAL STRATEGY (2016-2030) TARGETS	Women	Children	Adolescents
Reduce global maternal mortality to less than 70 per 100 000 live births (SDG 3.1)			
Maternal mortality ratio (3.1.1)	✓		✦
Proportion of births attended by skilled health personnel (3.1.2)	✓		✦
Proportion of women aged 15-49 who received 4 or more antenatal care visits	✓		✓
Proportion of women who had postpartum contact with a health provider within 2 days	✓		✦
Maternal cause of death (direct/indirect)	✓		✦
Proportion of women with obstetric complications due to abortion	✓		✦
Antenatal, intrapartum and postpartum quality of care, including satisfaction with services received	✓		
Reduce newborn mortality to at least as low as 12 per 1000 live births in every country (SDG 3.2)			
Neonatal mortality rate (3.2.2)		✓	
Stillbirth rate		✓	
Proportion of infants who were breastfed within the first hour of birth		✓	
Proportion of newborns who had postnatal contact with a health provider within 2 days		✓	
Causes of newborn deaths		✓	
Measurement of prevalence of low birth weight and small for gestational age		✓	
Postnatal quality of care		✓	
Newborn care coverage: treatment of severe neonatal bacterial infection; resuscitation initiated; thermal care; care for small and sick newborns		✓	
Reduce under-5 mortality to at least as low as 25 per 1000 live births in every country (SDG 3.2)			
Under-5 mortality rate (3.2.1)		✓	
Percentage of infants <6 months who are fed exclusively with breast milk		✓	
Full childhood immunization coverage		✓	
Percentage of children with diarrhoea receiving oral rehydration salts (ORS)		✓	
Proportion of children with suspected pneumonia taken to an appropriate health provider		✓	

GLOBAL STRATEGY (2016-2030) TARGETS	Women	Children	Adolescents
Use of insecticide-treated nets (ITNs) in children under-5 (% of children)		✓	
Treatment of sick children: diarrhoea, pneumonia and malaria		✓	
Causes of child deaths		✓	
End epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases (SDG 3.3)			
Number of new HIV infections per 1000 uninfected population, disaggregated by age and sex (3.3.1)	✓	✓	✓
Malaria incident cases per 1000 persons per year (3.3.3)	○	○	○
Percentage of people living with HIV who are currently receiving antiretroviral therapy (ART), by age and sex	✓	✓	✓
Proportion of households with at least 1 ITN for every 2 people and/or sprayed by indoor residual spray (IRS) within the last 12 months	○	○	○
Human papilloma virus (HPV) vaccine coverage among adolescents			✓
Reduce by 1/3 premature mortality from noncommunicable diseases and promote mental health and well-being (SDG 3.6)			
Age-standardized prevalence of current tobacco use among persons 15 years and older, disaggregated by age (3.a.1)	✓		✓
Suicide mortality rate, by age and sex (3.4.2)	✦	✦	✦
Adolescent mortality rate, by sex			✓
Proportion of women aged 30-49 who report they were screened for cervical cancer	✓		
Prevalence of depression, by age and sex	✦	✦	✦
Adolescent cause of death			✓
Harmful use of alcohol among adolescents			✓
End all forms of malnutrition, and address the nutritional needs of adolescent girls, pregnant and lactating women and children (SDG 2.2)			
Prevalence of stunting (height for age <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age (2.2.1)		✓	
Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting, overweight) (2.2.2)		✓	

GLOBAL STRATEGY (2016-2030) TARGETS	Women	Children	Adolescents
Prevalence of insufficient physical activity among adolescents			✓
Prevalence of anaemia in women aged 15-49, disaggregated by age and pregnancy status	✓		✓
Proportion of children aged 6-23 months who receive a minimum acceptable diet (apart from breast milk)		✓	
Ensure universal access to sexual and reproductive health-care services (including for family planning) and rights (SDG 3.7 and 5.6)			
Percentage of women of reproductive age (15-49) who have their need for family planning satisfied with modern methods (3.7.1)	✓		✓
Adolescent birth rate (10-14, 15-19) per 1000 women in that age group (3.7.2)			✓
Proportion of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (5.6.1)	✓		✓
Number of countries with laws and regulations that guarantee women aged 15-49 access to sexual and reproductive health care, information and education (5.6.2)	✓		✓
Proportion of men and women aged 15-24 with basic knowledge about sexual and reproductive health and rights (SRHR)	✓		✓
Proportion of secondary schools that provide comprehensive sexuality education (CSE)			✓
Ensure that all girls and boys have access to good-quality early childhood development (SDG 4.2)			
Percentage of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by sex (4.2.1)		✓	
Participation rate in organized learning (1 year before the official primary entry age), by sex (4.2.2)		✓	
Substantially reduce pollution-related deaths and illnesses (SDG 3.9)			
Mortality rate attributed to household and ambient air pollution, by age and sex (3.9.1)	○	○	○
Proportion of population with primary reliance on clean fuels and technology (7.1.2)	○	○	○

GLOBAL STRATEGY (2016-2030) TARGETS	Women	Children	Adolescents
Achieve universal health coverage, including financial risk protection and access to quality essential services, medicines and vaccines (SDG 3.8)			
Coverage of essential health services, including RMNCAH (3.8.1)	○	○	○
Proportion of the population with financial protection (3.8.2)	○	○	○
Current country health expenditure per capita (including specifically on RMNCAH) financed from domestic sources	○	○	○
Out-of-pocket expenditure as percentage of total health expenditure	○	○	○
Eradicate extreme poverty (SDG 1.1)			
Proportion of population below international poverty line, by sex, age and employment (1.1.1)	○	○	○
Ensure that all girls and boys complete free, equitable and good-quality secondary education (SDG 4.1)			
Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex (4.1.1)		✓	✓
Indicator of youth disenfranchisement			✓
Eliminate all harmful practices and all discrimination and violence against women and girls (SDG 5.2 and 5.3)			
Percentage of women aged 20-24 who were married or in a union before age 15 and before age 18 (5.3.1)		✓	✓
Proportion of ever-partnered women and girls aged 15 and older subjected to physical, sexual or psychological violence by a current or former intimate partner, in the last 12 months, by form of violence and by age group (5.2.1)	✓		✓
Proportion of women and girls aged 15-49 who have undergone female genital mutilation/cutting (FGM/C), by age (5.3.2)	✓		✓
Whether or not legal frameworks are in place to promote, enforce and monitor equality and nondiscrimination on the basis of sex (5.1.1)	✓	✓	✓
Proportion of young women and men aged 18-29 who experienced sexual violence by age 18 (16.2.3)		✓	✓

GLOBAL STRATEGY (2016-2030) TARGETS	Women	Children	Adolescents
Proportion of rape survivors who received HIV post-exposure prophylaxis (PEP) within 72 hours of an incident occurring	○	○	○
Health-sector specific indicator on discrimination	○	○	○
Percentage of the population reporting having personally felt discriminated against or harassed within the last 12 months on the basis of a ground of discrimination prohibited under international human rights law, disaggregated by age and sex (10.3.1)	✦		✦
Achieve universal and equitable access to safe and affordable drinking water and to adequate sanitation and hygiene (SDG 6.1 and 6.2)			
Percentage of population using safely managed sanitation services including a hand washing facility with soap and water (6.2.1)	○	○	○
Percentage of population using safely managed drinking water services (6.2.2)	○	○	○
Enhance scientific research, upgrade technological capabilities and encourage innovation (SDG 8.2)			
Research and development expenditure as a proportion of GDP, disaggregated by health/RMNCAH (9.5.1)	○	○	○
Proportion of countries that have systematic innovation registration mechanisms in place for women's, children's and adolescents' health (WCAH) and are reporting top 3 domestic innovations on an annual basis	○	○	○
Proportion of countries that have mechanisms to review innovations using effective Health Technology Assessment approaches	○	○	○
Provide legal identity for all, including birth registration (SDG 16.9)			
Percentage of under-5 births that have been registered with the civil authority, disaggregated by age (16.9.1)		✓	
Proportion of countries that (a) have conducted at least 1 population and housing census in the last 10 years; and (b) have achieved 100% birth registration and 80% death registration (17.19.2)	○	○	○
Enhance the global partnership for sustainable development (17.16)			
Number of countries reporting progress in multistakeholder development effectiveness monitoring frameworks that support the achievement of the SDGs (17.16.1)	○	○	○
Governance Index (voice, accountability, political stability and absence of violence, government effectiveness, regulatory quality, rule of law, control of corruption)	○	○	○

GLOBAL STRATEGY (2016-2030) TARGETS	Women	Children	Adolescents
Does the national RMNCAH strategy/plan of action specify that there should be community participation in decision-making, delivery of health services and monitoring and evaluation?	O	O	O
Proportion of countries that address young people's multisectoral needs within their national development plans and poverty reduction strategies (16.7.2)	O	O	O
Participation measures – women's groups, youth, civil society etc.	O	O	O
Implementation rate of commitments to the Global Strategy	O	O	O
Equity, humanitarian and human rights as cross-cutting considerations			
Proportion of indicators at the national (regional, global) level with full disaggregation when relevant, for GS indicators (17.18.1)	O	O	O
Ratification of human rights treaties related to women's, children's and adolescents' health	O	O	O
Humanitarian Response Index	O	O	O
Health-sector specific indicators on anti-corruption and transparency	O	O	O
Percentage of programmes in humanitarian settings based on health needs assessments of women, children and adolescents	O	O	O
Funding gap in the transition from humanitarian aid to sustainable development	O	O	O

Legend:
✓ Covers that population, including specified age ranges ✦ Covers that population if age disaggregated (no specified age range) O Applicable to all
Core indicator (SDG); Core indicator (additional to SDGs); *Indicator for development*

Annex – Data definitions and sources

Table A4. Indicator definitions for the key indicators

SURVIVE	Numerator	Denominator	Disaggregation
1. Maternal mortality ratio (SDG 3.1.1)	Number of maternal deaths	Number of live births	Age, place of residence
2. Under-5 mortality rate (SDG 3.2.1)	Number of deaths among children aged 0-4 years (0-59 months)	Number of live births	Place of residence, sex, socioeconomic status
3. Neonatal mortality rate (SDG 3.2.2)	Number of children who died during the first 28 days of life	Number of live births	Age in days/weeks, birth weight, place of residence, sex, socioeconomic status
4. Stillbirth rate	Number of fetuses and infants born per year with no sign of life and born after 28 weeks gestation, or weighing ≤1000 g	Total births	Age in days/weeks, birth weight, place of residence, sex, socioeconomic status
5. Adolescent mortality rate	Number of deaths among adolescents aged 10-19, by age and sex	Number of adolescents aged 10-19	Ages 10-14 and 15-19, sex, place of residence, socioeconomic status
THRIVE	**Numerator**	**Denominator**	**Disaggregation**
6. Prevalence of stunting among children under 5 years of age (SDG 2.2.1)	Number of children under 5 years whose height for age is more than 2 standard deviations below the median	Number of children aged 0-59 months	Place of residence, sex, socioeconomic status
7. Adolescent birth rate (10-14, 15-19) per 1000 women in that age group (SDG 3.7.2)	Number of live births to women aged 15-19	Exposure to childbearing by women aged 15-19	Marital status, place of residence, socioeconomic status
8. Coverage of essential health services, based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, noncommunicable diseases and service capacity and access (SDG 3.8.1, 3,1.2, 3,7,1) (including RMNCAH: family planning [met need]; pregnancy and childbirth care; breastfeeding; immunization; childhood illnesses treatment)	Number of people receiving the intervention	Number of people who need the intervention	Stratified by equity: sex, age, socioeconomic position, geographic

9. Out-of-pocket health expenditure as a percentage of total health expenditure			
10. Current country health expenditure per capita (including specifically on RMNCAH) financed from domestic sources			
11. Number of countries with laws and regulations that guarantee women aged 15-49 access to sexual and reproductive health care, information and education (SDG 5.6.2)			
12. Proportion of population with primary reliance on clean fuels and technology (SDG 7.1.2).	Number of people using clean fuels and technologies for cooking, heating and lighting ("Clean" is defined by WHO guidelines for indoor air quality: household fuel combustion)	Total population reporting use of any cooking, heating or lighting fuels and technologies	Age, sex, education, wealth quintile and setting
TRANSFORM	**Numerator**	**Denominator**	**Disaggregation**
13. Proportion of children under 5 years of age whose births have been registered with a civil authority (SDG 16.9.1)	Number of children whose births have been registered with a civil authority	Total number of children	Sex, age, place of residence, wealth quintiles
14. Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex (SDG 4.1.1)	Number of children and young people at the end of primary or lower secondary education achieving or exceeding the minimum proficiency level in the given subject	Number of children and young people at the end of primary or lower secondary education	Place of residence, sex, socioeconomic status
15. Proportion of young women and men aged 18-29 who experienced sexual violence by age 18 (SDG 16.2.3) and/or proportion of ever-partnered women and girls aged 15 and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months (SDG 5.2.1);	Number of young women and men aged 18-24 who report having experienced any sexual violence by age 18	Number of young women and men aged 18-24	Age, marital status, place of residence, wealth quintiles
16. Percentage of population using safely managed sanitation services including a hand-washing facility with soap and water (SDG 6.2.1)	Number of people using safely managed sanitation services	Total population	Place of residence, socioeconomic status

Table A5. Data source for the 60 indicators

INDICATOR	CRVS	Survey	Facility	Other
Maternal mortality ratio	x	x	(x)	
Skilled attendance at birth		x	x	
Antenatal care 4+ visits		x	x	
Postpartum contact		x	x	
Neonatal mortality	x	x		
Stillbirth rate		x	x	
Early breastfeeding initiation		x		
Postnatal care (contact)		x	x	
Antenatal care syphilis screening		x	x	
Under-5 mortality	x	x		
Oral rehydration salts treatment		x		
Pneumonia care seeking		x		
Exclusive breastfeeding		x		
Full immunization coverage		x	x	
HIV incidence		x		
Antiretroviral therapy coverage			x	
Insecticide-treated net coverage among children	x	x		x
Tobacco use (age-sex disaggregated)		x		
Noncommunicable disease mortality (ages 30-70)	x	x	(x)	
Suicide mortality rate	x	x		
Cervical cancer screening		x	(x)	
Adolescent mortality rate	x	(x)		

x denotes a source that is readily available; (x) denotes a potential source that requires further investment

INDICATOR	CRVS	Survey	Facility	Other
Child stunting		x		
Malnutrition		x		
Adolescent insufficient physical activity		x		
Anaemia prevalence disaggregated		x		
Children minimum acceptable diet		x		
Family planning need satisfied		x	(x)	
Adolescent birth rate		x		
Informed decisions by women		x		
Country laws – sexual and reproductive health (SRH) access				x
SRH knowledge (ages 15-24)		x		
Children developmentally on track		x		
Organized learning		X		x
Pollution-related mortality and illness	x	x		
Clean fuels and technology		x		x
Essential services, tracer health interventions		x	x	(x)
Financial protection		x		x
Current country health and RMNCAH expenditure per capita				x
Out-of-pocket health expenditure				x

INDICATOR	CRVS	Survey	Facility	Other
Poverty		x		x
Reading and math proficiency		x		x
Partner violence		x		
Early marriage	x	x		
Female genital mutilation/cutting		x		
Laws against discrimination				x
Sexual violence against women and men		x		
HIV post-exposure prophylaxis – rape survivors		x	(x)	
Safe drinking water		x		
Sanitation		x		
Research and development expenditure				x
Birth (death) registration	x	x		
Census				x
Effective monitoring frameworks				x
Data disaggregation				x
Treaties for women's, children's and adolescents' health and rights				x
Humanitarian Response Index				x

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