

Indicator Reference Sheets: Global Financing Facility Measurement Framework (2021–2025)

This document is organized into three sections:

Section 1 includes reference sheets for the GFF core impact indicators, Section 2 includes reference sheets for the GFF core health outcome indicators, Section 3 includes details on the GFF core financing indicators.



Section 1.

GFF Core impact indicators

1. Adolescent birth rate
2. Percentage of births less than 24 months after preceding birth
3. Maternal mortality ratio
4. Stillbirth rate
5. Neonatal mortality rate
6. Under-five mortality rate
7. Stunting prevalence among children under five years of age (moderate and severe)
8. Wasting prevalence among children under five years of age (moderate and severe)

Indicator:

Adolescent birth rate

Concept and definition

- **Concept:**

Adolescent girls are at higher risk of morbidity and mortality due to complications of pregnancy, when compared to women of older ages. The adolescent birth rate represents the level of childbearing among adolescent girls (aged 10–19 years, disaggregated by ages 10–14 and 15–19). Reducing adolescent fertility and addressing its underlying complex multiple factors is important for increasing the life prospects of adolescent girls, improving maternal health, and reducing neonatal mortality. The adolescent birth rate is included in the United Nations Sustainable Development Goal (SDG) global indicator framework under SDG 3.0, *Ensure healthy lives and promote well-being for all at all ages*. The SDG 3.7 target is: By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes. SDG 3.7.2 is the adolescent birth rate indicator linked to the SDG 3.7 target. Adolescent birth rate is also linked to SDG Target 5.6 (ensure universal access to sexual and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and Development and the Beijing Platform for Action and the outcome documents of their review conferences). The United Nations Population Division, Department of Economic and Social Affairs (UN DESA), and the United Nations Population Fund are the SDG custodial agencies for this indicator.

- **Definition:**

The adolescent birth rate is defined as the annual number of births among women aged 10–14 or 15–19 years per 1,000 women in the respective age group. It is also referred to as the age-specific fertility rate for women aged 10–14 or 15–19.

- **Measurement type:** Rate

- **Numerator:** Number of women aged 15–19 with a live birth in a specific time-period

- **Denominator:** Number of live births in women aged 15–19 in a specific time-period

*Wherever data is available, adolescent fertility at ages 10–14 years can also be computed

- **Monitoring and evaluation framework component:** Impact type metric

Measurement guidance

- **Method of measurement:**

The adolescent birth rate is computed as a ratio. The specific approach to its measurement varies depending upon the data source. Detailed descriptions of how the birth rate is computed using civil registration and vital statistics data, household survey, census, or routinely collected administrative data are available in the SDG metadata document (<https://unstats.un.org/sdgs/metadata/files/Metadata-03-07-02.pdf>), the WHO-convened Mother and Newborn Information for Tracking Outcomes and Results Technical Advisory Group on-line indicator toolkit ([https://www.who.int/groups/mother-and-new-born-information-for-tracking-outcomes-and-results-\(monitor\)](https://www.who.int/groups/mother-and-new-born-information-for-tracking-outcomes-and-results-(monitor))), and in the UN Handbook on the Collection of Fertility and Mortality Data https://unstats.un.org/unsd/publication/seriesf/seriesf_92e.pdf. The limitations of each data source are also described.

- **Data sources:**

Primary data sources for this indicator include:

- a. Civil registration and vital statistics data
- b. Population-based household surveys (Demographic and Health Surveys, Multiple Indicator Cluster Surveys, Reproductive Health Surveys)
- c. Census data
- d. Routinely collected administrative data

The global database is produced by UN DESA in collaboration with UNFPA.

- **Level of disaggregation:**

By region (UNICEF/WHO/World Bank/SDG), World Bank country income group, sub-national (e.g., first and second administrative level; urban/rural). At the individual level, disaggregation is possible by woman's age, education, marital status, socioeconomic status, marital status, and number of living children.

- **Frequency of reporting:**

Updated data on the adolescent birth rate are released annually by UN DESA (data portal: <https://population.un.org/dataportal/home>) and World Population Prospects: <https://population.un.org/wpp/>).

Rationale for use/relevance for monitoring performance of the GFF strategy

The adolescent birth rate is one of the GFF core impact indicators used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. The Countdown to 2030 initiative works closely with the GFF on generating annual progress reports of the GFF supported countries focusing on the core impact indicators including the adolescent birth rate. The GFF also tracks country household survey-based adolescent fertility rates approved by countries and includes this data on the country profile pages.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives that track the adolescent birth rate in addition to the Global Financing Facility for Women, Children and Adolescents:

1. **UN Sustainability Goals.** Goal 3, “Ensure healthy lives and promote well-being for all at all ages” includes this age group. Transforming our World: The 2030 Agenda for Sustainable Development.
2. The Global Strategy for Women’s Children’s and Adolescent’s Health (2016–2030). <https://www.who.int/publications/i/item/A71-19>. The indicator and monitoring framework is available here: <https://platform.who.int/docs/default-source/mca-documents/rmncah/global-strategy/ga-indicator-and-monitoring-framework.pdf>.
3. UNICEF adolescent data portal (<https://data.unicef.org/adp/>)
4. The Global Action for Measurement of Adolescent Health (<https://www.who.int/data/maternal-newborn-child-adolescent-ageing/advisory-groups/gama/about-gama>).
5. Countdown to 2030, <https://www.countdown2030.org/>

Key publications:

1. Global Accelerated Action for the Health of Adolescents (AA-HA!) – Second edition (<https://www.who.int/publications/i/item/9789240081765>).
2. United Nations, Department of Economic and Social Affairs, Population Division. World Population Prospects. Geneva, 2022.

Note: The WHO-convened Mother and Newborn Information for Tracking Outcomes and Results Technical Advisory Group has developed an online indicator toolkit and reference sheets for all its recommended indicators. Adolescent birth rate is included in the toolkit.

Indicator:

Percentage of births less than 24 months after preceding birth

Concept and definition

- **Concept:**

The percentage of births less than 24 months after preceding birth indicator enables monitoring of how well countries are doing in helping families space their births to improve maternal, newborn, and child health. Short and long birth spacing intervals are independently associated with pregnancy complications and adverse birth outcomes for both mothers (e.g., higher rates of maternal morbidity) and babies (e.g., increased risk of preterm birth, intra-uterine growth retardation, stillbirth, miscarriage). Short birth intervals are also associated with a higher risk of mortality and malnutrition among other children in the household under the age of five years.

In 2005, WHO recommended intervals of 24 months before attempting the next pregnancy and 33 months before the next birth to promote positive maternal and child health outcomes. The WHO also recommended that women who experience pregnancy loss (from miscarriage or induced abortion) should wait at least 6 months before attempting their next pregnancy.

Although this indicator is not currently included in global frameworks, it is related to the Sustainable Development Goal targets 3.7 and 5.6 (By 2030, ensure universal access to sexual and reproductive health care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs) and to the goals of Family Planning 2030, and the aligned Ending Preventing Maternal Mortality (EPMM) and Every Newborn Action Plan (ENAP) initiatives.

- **Definition:**

Percentage of non-first births in the X* years preceding the survey by number of months since the preceding birth.

*For DHS this is 5 years. This is the broader definition around birth intervals. The indicator can be disaggregated by number of months (e.g., less than 24 months).

- **Measurement type:** Percentage

- **Numerator:** Number of births whose interval with the preceding birth is within the specified grouped number of months (7-17, 18-23, 24-35, 36-47, 48-59, 60+) (during a given timeframe)

- **Denominator:** Total number of births (during a given timeframe)

- **Monitoring and evaluation framework component:** Impact type metric

Measurement guidance

- **Method of measurement:**

The calculation of the indicator involves dividing the numerator by the denominator and multiplying by 100. Births covered include children both surviving and dead, excluding first-born children and their twins. The preceding birth interval is the difference between the birth date of the child and the birth date of the preceding child organized into the groups of 7–17 months, 18–23 months, 24–35 months, 36–47 months, 48–59 months, and 60+ months. For children of multiple births, the birth date of the preceding child is the number of months since the end of the preceding pregnancy that ended in a live birth.

More details on the methods are available in the DHS-8 tabulation plan, Table 5.5, and in the Guide to DHS statistics for DHS 8 (https://dhsprogram.com/data/Guide-to-DHS-Statistics/index.htm#t=Guide_to_DHS_Statistics_DHS-8.htm).

Note: Different studies on birth spacing have used various cutoff points and intervals, such as pregnancy to pregnancy interval, birth to pregnancy interval, and birth to birth interval.

The recommended indicator in the Measure evaluation, family planning and reproductive health indicator database (topic 7 in the summary indicator list) is:

Percentage of children aged 0–23 months who were born (to mothers who received healthy timing and spacing counseling/education) at least 33 months after the previous surviving child (<https://www.data4impactproject.org/prh/summary-list-of-indicators/>). This indicator is based on the WHO recommended birth-to-birth interval of 33 months.

- **Data sources:**

The main data source is household surveys. Other data sources (particularly for the indicator recommended in the Measure Evaluation indicator database) include program records, special surveys, and exit interviews.

- **Level of disaggregation:**

By number of months since the preceding birth, by characteristics of the mother (e.g., education level, parity, age).

- **Frequency of reporting:**

Household surveys are conducted every 3–5 years.

Rationale for use/relevance for monitoring performance of the GFF strategy:

The percentage of births less than 24 months after preceding birth indicators is one of the GFF core impact indicators used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. The GFF includes country-specific data for this indicator from household surveys on the country profile pages on the GFF data portal.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives that monitor birth spacing intervals in addition to the Global Financing Facility for Women, Children and Adolescents:

There are no other major initiatives that are tracking this indicator. However, the indicator is consistent with the aims of the SDG framework, the Global Strategy for Women's, Children's, and Adolescents' Health (2016–2030), Family Planning 2030, and ENAP–EPMM.

Key publications:

1. USAID. The effect of fertility behavior on child survival: Evidence from the Demographic and Health Surveys (AS88) (2012–2022). An analysis brief from the DHS program.
<https://dhsprogram.com/publications/publication-AS88-Analytical-Studies.cfm>.
2. WHO. 2007. Report of a WHO Technical Consultation on Birth Spacing, Geneva, Switzerland. 13–15 June 2005.
<https://www.who.int/publications/i/item/WHO-RHR-07.1>.
3. “Healthy timing and spacing of pregnancies: A Trainer’s Reference Guide”, 2008. USAID and ESD Project.

Measure evaluation, family planning and reproductive health indicators database. (Topic 7 on summary indicator list of “health timing and spacing of pregnancy”).
<https://www.data4impactproject.org/prh/summary-list-of-indicators/>.

Indicator: Maternal mortality ratio

Concept and definition

- **Concept:**

Nearly all maternal deaths are preventable with high quality, respectful care during the pregnancy, intrapartum and postpartum periods. Maternal deaths include the death of a woman during pregnancy, childbirth, or within 42 days of termination of pregnancy from any cause related to the pregnancy or its management, excluding deaths due to accidental or incidental causes. The maternal mortality ratio is included in the United Nations Sustainable Development Goal (SDG) global indicator framework under SDG 3.0, *Ensure healthy lives and promote well-being for all at all ages*. The SDG 3.1 target is: By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births. SDG 3.1.1 is the maternal mortality ratio indicator linked to the SDG 3.1 target. The United Nations Inter-agency group on maternal mortality estimation (UN MMEIG) produces the official SDG 3.1.1 global estimates as well as estimates for all countries and regional groupings. UN MMEIG updates these estimates approximately every 2–3 years (<https://mmr2020.srhr.org/about>).

- **Definition:**

The maternal mortality ratio is defined as the number of maternal deaths during a given time period per 100,000 live births during the same time period. It depicts the risk of maternal death relative to the number of live births, capturing the risk of death in a single pregnancy (proxied by a single live birth).

WHO has provided a more detailed definition in the International Classification of Diseases and Related Health Problems:

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 pregnancy or its management (from direct or indirect obstetric death), but not from accidental or incidental causes.

- **Measurement type:** Ratio (expressed as deaths per 100,000 live births)
- **Numerator:** Number of maternal deaths in a specified time-period
- **Denominator:** Total number of live births in a specified time-period
- **Monitoring and evaluation framework component:** Impact type metric

Measurement guidance

- **Method of measurement:**

The maternal mortality ratio quantifies the risk of maternal death relative to the number of live births. It can be calculated by dividing recorded (or estimated) maternal deaths by total recorded (or estimated) live births in the same period and multiplying by 100,000. Details on the measurement approach are available in the SDG metadata sheets: <https://unstats.un.org/sdgs/metadata/files/Metadata-03-01-01.pdf>, the UN MMEIG webpage on methodology <https://mmr2020.srhr.org/methodology>, and the WHO-convened Mother and Newborn Information for Tracking Outcomes and Results Technical Advisory Group (MONITOR) on-line indicator toolkit ([https://www.who.int/groups/mother-and-newborn-information-for-tracking-outcomes-and-results-\(monitor\)](https://www.who.int/groups/mother-and-newborn-information-for-tracking-outcomes-and-results-(monitor))).

- **Data sources:**

The main source for global, country and regional level estimates of this indicator is UN MMEIG. UN MMEIG compiles data from:

- a. Civil registration and vital statistics (CRVS) systems
- b. Specialized studies on maternal mortality (e.g., Reproductive Age Mortality Studies, Confidential enquiries into maternal deaths)
- c. Population-based household surveys (DHS and MICS)
- d. Census data
- e. Other sources for the estimation process (e.g., UNDESA's World Population Prospects, estimates of death due to HIV from the Joint United Nations Program on HIV/AIDS, data from the WHO-UNICEF joint skilled birth attendant database, gross domestic product per capita)

Data from routine health information systems may also collect information on the number of women who died from a cause related to or aggravated by pregnancy or its management. The MONITOR reference sheet includes details on how to calculate a health facility-based measure of maternal mortality.

- **Level of disaggregation:**

The UN MMEIG maternal mortality estimates are available at global, regional (SDG, UNICEF, WHO, World Bank regions), and country levels. They are also available by World Bank income classification. Disaggregation by age, place of residence (e.g., urban/rural) and socioeconomic status (e.g., household wealth quintile) is available through household survey data.

- **Frequency of reporting:**

The frequency of reporting varies by primary data source. The UN MMEIG estimates are produced approximately every 2–3 years. Household survey-based data are updated every 3–5 years, census data is typically updated every 10 years, and routine administrative data is updated more frequently.

Rationale for use/relevance for monitoring performance of the GFF strategy

The maternal mortality ratio is one of the GFF core impact indicators used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. The Countdown to 2030 initiative works closely with the GFF on generating annual progress reports of the GFF supported countries focusing on the core impact indicators including the maternal mortality ratio. The GFF also tracks country civil registration and vital statistic data where available or household survey-based maternal mortality data and includes these data on the country profile pages.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives that use the maternal mortality ratio rates to monitor maternal health in addition to the Global Financing Facility for Women, Children and Adolescents:

1. [UN Sustainability Goals](#). Goal 3, “Ensure healthy lives and promote well-being for all at all ages” includes this age group. Transforming our World: The 2030 Agenda for Sustainable Development.
2. The Global Strategy for Women’s Children’s and Adolescent’s Health (2016–2030). <https://www.who.int/publications/i/item/A71-19>. The indicator and monitoring framework is available here: <https://platform.who.int/docs/default-source/mca-documents/rmncah/global-strategy/gf-indicator-and-monitoring-framework.pdf>.
3. Ending preventable maternal mortality (<https://www.who.int/initiatives/ending-preventable-maternal-mortality>).
4. Countdown to 2030, <https://www.countdown2030.org/>

Key publications:

1. Trends in maternal mortality 2000 to 2020: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Geneva: World Health Organization; 2023. License: CD BY-NC-DA 3.0 IGO. <https://iris.who.int/bitstream/handle/10665/366225/9789240068759-eng.pdf?sequence=1>.
2. Data estimates, model codes and country profiles can be accessed through this webpage: <https://www.who.int/publications/i/item/9789240068759>; data visualizations are available at this webpage: <https://mmr2020.srhr.org/>.

Note: The WHO-convened Mother and Newborn Information for Tracking Outcomes and Results Technical Advisory Group has developed an online indicator toolkit and reference sheets for all its recommended indicators. The maternal mortality ratio is included in the toolkit.

Indicator: Stillbirth rate

Concept and definition

- **Concept:**

A stillbirth or fetal death is defined by the International Classification of Diseases 11th Revision as a baby born with no signs of life at 22 or more completed weeks of gestation. There are two categories of stillbirths by age: early gestation stillbirth (at 22 to 27 completed weeks of gestation) and late gestation stillbirth (at 28 or more completed weeks of gestation). Many stillbirths can be prevented with high quality and timely care during pregnancy and the intrapartum period.

Although the United Nations Sustainable Development Goal Framework does not include a target for stillbirth, the Ending Preventable Maternal Mortality and Every Newborn Action Plan initiatives include a joint global target for stillbirths: By 2030, reach 12 or fewer stillbirths per 1,000 total births in all countries and continue to close equity gaps (ENAP Goal 2). This same target is also included in the Every Woman Every Child Global Strategy for Women's, Children's, and Adolescents' Health (2016–2030) (<https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/global-strategy-data>). The United Nations Inter-agency group on child mortality estimation (UN IGME) produces global, regional, and country stillbirth estimates, and updates these regularly (<https://data.unicef.org/topic/child-survival/stillbirths/>).

- **Definition:**

The number of fetuses born per year with no sign of life and born with no signs of life at 28 weeks or more of gestation, per 1,000 total births*

Note: For the UN stillbirth estimates, the 28 weeks or more of gestation definition (late gestation stillbirth) is used.

- **Measurement type:** Rate (expressed as a rate per 1,000 total births)
- **Numerator:** Number of deaths in fetuses at 28 weeks or more of gestation in a specified time-period
- **Denominator:** Number of total births in a specified time-period
- **Monitoring and evaluation framework component:** Impact type metric

Measurement guidance

- **Method of measurement:**

The stillbirth rate is computed by dividing the numerator by the denominator and multiplying by 1,000. The specific method of measurement for the stillbirth rate varies by data source. Details on how the UN estimates are developed is available in the UN IGME stillbirth report (United Nations Inter-agency Group for Child Mortality Estimation (UN IGME). Never Forgotten: The situation of stillbirth around the globe, United Nations Children's Fund, New York, 2023).

Details on how to calculate the stillbirth rate using CRVS, HMIS, or Household survey data is available on the Every Woman Every Child Global Strategy for Women's, Children's and Adolescents' Health data portal (<https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/global-strategy-data>) and in the WHO-convened Mother and Newborn Information for Tracking Outcomes and Results Technical Advisory Group (MONITOR) on-line indicator toolkit ([https://www.who.int/groups/mother-and-newborn-information-for-tracking-outcomes-and-results-\(monitor\)](https://www.who.int/groups/mother-and-newborn-information-for-tracking-outcomes-and-results-(monitor))). A guidance document on measuring stillbirths through HMIS is also available (<file:///C:/Users/wb605020/Downloads/Stillbirth-definition-and-data-quality-assessment.pdf>).

- **Data sources:**

The main source for global, regional, and country level estimates of this indicator is United Nations Inter-Agency Group for Child Mortality Estimation (UN IGME). UN IGME compiles data from:

- a. Civil registration and vital statistics (CRVS) systems
- b. Routinely collected administrative data
- c. Population-based household surveys (DHS and MICS)
- d. Other (e.g., special studies)

- **Level of disaggregation:**

The level of disaggregation depends upon data source. For the modelled estimates, disaggregation is available by region (UNICEF/WHO/World Bank/SDG), country, World Bank Income classification, antepartum stillbirth and intrapartum stillbirth estimates.

Facility based estimates can also be generated using routine administrative system data. Disaggregations by sex, maternal age, and other stratifiers (e.g., subnational level, birthweight group) can potentially be computed.

- **Frequency of reporting:**

The frequency of reporting depends upon the data source. Two rounds of estimates have been published. In the last round of estimates, 22 countries had no stillbirth data and an additional 38 countries lacked quality stillbirth data. Most of these countries are low or lower-middle-income countries.

Where available, data from CRVS and HMIS are produced annually. Data from household surveys is generally available every 3–5 years.

Rationale for use/relevance for monitoring performance of the GFF strategy

The stillbirth rate is one of the GFF core impact indicators used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. The Countdown to 2030 initiative works closely with the GFF on generating annual progress reports of the GFF supported countries focusing on the core impact indicators including the stillbirth rate. The GFF also tracks country household survey-based data for this indicator and includes this data on the country profile pages.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives that use stillbirth rates to monitor maternal and child health in addition to the Global Financing Facility for Women, Children and Adolescents:

1. The Global Strategy for Women's Children's and Adolescent's Health (2016–2030). <https://www.who.int/publications/i/item/A71-19>. The indicator and monitoring framework is available here: <https://platform.who.int/docs/default-source/mca-documents/rmncah/global-strategy/gf-indicator-and-monitoring-framework.pdf>.
2. Every Newborn Action Plan: <https://www.who.int/initiatives/every-newborn-action-plan>.
3. Ending preventable maternal mortality (<https://www.who.int/initiatives/ending-preventable-maternal-mortality>).
4. Countdown to 2030, <https://www.countdown2030.org/>

Key publications:

1. United Nations Inter-agency Group for Child Mortality Estimation (UN IGME). Never Forgotten: The situation of stillbirth around the globe, United Nations Children's Fund, New York, 2023.
2. United Nations Inter-agency Group for Child Mortality Estimation (UN IGME), London School of Hygiene and Tropical Medicine. Stillbirth definition and data quality assessment for health management information systems (HMIS), 2022. <file:///C:/Users/wb605020/Downloads/Stillbirth-definition-and-data-quality-assessment.pdf> and <https://data.unicef.org/resources/stillbirth-definition-and-data-quality-assessment-for-health-management-information-systems/>.

Note: The WHO-convened Mother and Newborn Information for Tracking Outcomes and Results Technical Advisory Group has developed an online indicator toolkit and reference sheets for all its recommended indicators. The stillbirth rate is included in the toolkit.

Indicator: Neonatal mortality rate

Concept and definition

- **Concept:**

The first 28 days of life is a vulnerable time for survival. The rate of progress in reducing neonatal mortality compared to in children aged 1 month to 59 months has been slower in the past few decades. Consequently, the proportion of child mortality occurring in the neonatal period has increased. The neonatal mortality rate is included in the United Nations Sustainable Development Goal (SDG) global indicator framework under SDG 3.0, *Ensure healthy lives and promote well-being for all at all ages*. The SDG 3.2 target is: By 2030, end preventable deaths of newborns and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-five mortality to at least as low as 25 per 1,000 live births. SDG 3.2.2 is the neonatal mortality rate indicator linked to the SDG 3.2 target. The United Nations Inter-agency group on child mortality estimation (UN IGME) produces the official SDG 3.2.2 global, regional, and country estimates and updates these annually after reviewing all available data and assessing their quality (<https://childmortality.org/>).

- **Definition:**

The neonatal mortality rate is the probability of a child born in a specific year or period will die during the first 28 completed days of life, if subject to age-specific mortality rates of the specified year or period, expressed per 1,000 live births.

Neonatal deaths (deaths among live births during the first 28 completed days of life) may be subdivided into early neonatal deaths (occurring during the first 7 days of life) and late neonatal deaths (occurring after the 7th day but before the 28th completed day of life).

- **Measurement type:** Probability (expressed as a rate per 1,000 live births)
- **Numerator:** Number of deaths in children under the age of five in a specified time-period
- **Denominator:** Number of live births in a specified time-period
- **Monitoring and evaluation framework component:** Impact type metric

Measurement guidance

- **Method of measurement:**

The under-five mortality rate is not a rate, but a probability of death derived from a life table and expressed as a rate per 1,000 live births. More details on the measurement approach and metadata are available at: <https://unstats.un.org/sdgs/metadata/files/Metadata-03-02-02.pdf>, and from the UN IGME child mortality estimates webpage: <https://childmortality.org>.

- **Data sources:**

The main source for country and regional level estimates of this indicator is United Nations Inter-Agency Group for Child Mortality Estimation (UN IGME). UN IGME compiles data from:

- a. Civil registration and vital statistics (CRVS) systems
- b. Population-based household surveys (DHS and MICS)

All country data included in the modelling (and excluded) can be found on the website of the UN-IGME at: www.childmortality.org.

- **Level of disaggregation:**

By country, region (UNICEF/WHO/SDG/World Bank), World Bank income classification, sex, and age groups (newborn (first 28 days of life), infant (0 to 11 months) and under-5 (0 to 59 months)). UN IGME also produces subnational estimates by geographic region (first administrative level) pending data availability and quality.

Disaggregations by maternal education, household wealth status, and other stratifiers are available from household survey data.

- **Frequency of reporting:**

UN IGME produces estimates annually. Data from CRVS systems is available more frequently, and data from household surveys is available every 3–5 years.

Rationale for use/relevance for monitoring performance of the GFF strategy

The neonatal mortality rate is one of the GFF core impact indicators used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. The Countdown to 2030 initiative works closely with the GFF on generating annual progress reports of the GFF supported countries focusing on the core impact indicators including neonatal mortality. The GFF also tracks country civil and vital registration data and household survey-based neonatal mortality data where available and includes this data on the country profile pages.

- **Responsible team for reporting at the GFF Secretariat: Results Team**

Resources and references

Key Initiatives that use under-5 mortality rates to monitor child health in addition to the Global Financing Facility for Women, Children and Adolescents:

1. **UN Sustainability Goals.** Goal 3, “Ensure healthy lives and promote well-being for all at all ages” includes this age group. Transforming our World: The 2030 Agenda for Sustainable Development.
2. The Global Strategy for Women’s Children’s and Adolescent’s Health (2016–2030): <https://www.who.int/publications/i/item/A71-19>. The indicator and monitoring framework is available here: <https://platform.who.int/docs/default-source/mca-documents/rmncah/global-strategy/gs-indicator-and-monitoring-framework.pdf>.
3. Countdown to 2030, <https://www.countdown2030.org/>
4. The Child Health and Well-being Dashboard: <https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/child-health-and-well-being-dashboard>

Key publications:

1. UN IGME: Levels & Trends in Estimates developed by the UN Inter-agency Group for Child Mortality Estimation of Child Mortality, 2021. <https://childmortality.org/wp-content/uploads/2021/12/UNICEF-2021-Child-Mortality-Report.pdf>

Note: The WHO-convened Mother and Newborn Information for Tracking Outcomes and Results Technical Advisory Group ([https://www.who.int/groups/mother-and-newborn-information-for-tracking-outcomes-and-results-\(monitor\)](https://www.who.int/groups/mother-and-newborn-information-for-tracking-outcomes-and-results-(monitor))) has developed an online indicator toolkit and reference sheets for all its recommended indicators. The neonatal mortality rate is included in the toolkit.

Indicator: Under-five mortality rate

Concept and definition

- **Concept:**

Mortality rates in children under the age of five are a key measure of child health and well-being as well as overall social and economic development. It reflects access of children and communities to basic health interventions and to adequate nutrition. The under-5 mortality rate is included in the United Nations Sustainable Development Goal (SDG) global indicator framework under SDG 3.0, *Ensure healthy lives and promote well-being for all at all ages*. The SDG 3.2 target is: By 2030, end preventable deaths of newborns and children under five years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-five mortality to at least as low as 25 per 1,000 live births. SDG 3.2.1 is the under-five mortality rate indicator linked to the SDG 3.2 target. The United Nations Inter-agency group on child mortality estimation (UN IGME) produces the official SDG 3.2.1 estimates for all countries and regional groupings and updates these annually after reviewing all available data and assessing their quality (<https://childmortality.org/>).

- **Definition:**

The under-five mortality rate is the probability of a child born in a specific year or period dying before the age of 5 years, if subject to age-specific mortality rates of the specified year or period, expressed as deaths per 1,000 live births.

- **Measurement type:** Probability (expressed as a rate per 1,000 live births)

- **Numerator:** Number of deaths in children under the age of five in a specified time-period

- **Denominator:** Number of live births in a specified time-period

- **Monitoring and evaluation framework component:** Impact type metric

Measurement guidance

- **Method of measurement:**

The under-five mortality rate is not a rate, but a probability of death derived from a life table and expressed as a rate per 1,000 live births. More details on the measurement approach and metadata are available at: <https://unstats.un.org/sdgs/metadata/files/Metadata-03-02-01.pdf>, and from the UN IGME child mortality estimates webpage: <https://childmortality.org>.

- **Data sources:**

The main source for country and regional level estimates of this indicator is United Nations Inter-Agency Group for Child Mortality Estimation (UN IGME). UN IGME compiles data from:

- a. Civil registration and vital statistics (CRVS) systems
- b. Population-based household surveys (DHS and MICS)

All country data included in the modelling (and excluded) can be found on the website of the UN-IGME at: www.childmortality.org.

- **Level of disaggregation:**

by country, region (UNICEF/WHO/SDG/World Bank), World Bank income classification, sex, and age groups (newborn (first 28 days of life), infant (0 to 11 months) and under-5 (0 to 59 months)). UN IGME also produces subnational estimates by geographic region (first administrative level) pending data availability and quality.

- Disaggregations by maternal education, household wealth status, and other stratifiers are available from household survey data.

- **Frequency of reporting:**

UN IGME produces estimates annually. Data from CRVS systems is available more frequently, and data from household surveys is available every 3–5 years.

Rationale for use/relevance for monitoring performance of the GFF strategy

The under-five mortality rate is one of the GFF core impact indicators used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. The Countdown to 2030 initiative works closely with the GFF on generating annual progress reports of the GFF supported countries focusing on the core impact indicators including under-five mortality. The GFF also tracks civil and vital registration data and country household survey-based under-five mortality data where available and includes this data on the country profile pages.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives that use under-5 mortality rates to monitor child health in addition to the Global Financing Facility for Women, Children and Adolescents:

1. **UN Sustainability Goals.** Goal 3, “Ensure healthy lives and promote well-being for all at all ages” includes this age group. Transforming our World: The 2030 Agenda for Sustainable Development.
2. The U5MR is a core indicator recommended by the WHO-UNICEF co-convened Child Health Accountability Tracking Working Group. <https://www.who.int/groups/child-health-accountability-tracking-technical-advisory-group>.
3. The Global Strategy for Women’s Children’s and Adolescent’s Health (2016-2030): <https://www.who.int/publications/i/item/A71-19>. The indicator and monitoring framework is available here: <https://platform.who.int/docs/default-source/mca-documents/rmncah/global-strategy/gi-indicator-and-monitoring-framework.pdf>.
4. Countdown to 2030, <https://www.countdown2030.org/>
5. The Child Health and Well-being Dashboard: <https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/child-health-and-well-being-dashboard>

Key publications:

1. UN IGME: Levels & Trends in Estimates developed by the UN Inter-agency Group for Child Mortality Estimation of Child Mortality, 2021. <https://childmortality.org/wp-content/uploads/2021/12/UNICEF-2021-Child-Mortality-Report.pdf>

The WHO-UNICEF co-convened Child Health Accountability Tracking Technical Advisory Group has compiled an indicator toolkit of a core set of recommended indicators. U5MR is included in the toolkit: <https://chat.srhr.org/>.

Indicator:

Stunting prevalence among children under five years of age (moderate and severe)

Concept and definition

- **Concept:**

Stunting is a sign of past or chronic undernutrition and is associated with poverty, poor maternal health and nutrition, repeated infections, and inadequate psychosocial stimulation. Children who are stunted experience a higher risk of morbidity and mortality, developmental delays and lower learning capacity, and non-communicable diseases in later life. Stunting prevalence is included in the United Nations Sustainable Development Goal (SDG) global indicator framework under SDG 2.0, End hunger, achieve food security, and improved nutrition and promote sustainable agriculture. The SDG 2.2 target is: By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons. SDG 2.2.1 is the stunting prevalence indicator linked to the SDG 2.2 target. The UNICEF-WHO-World Bank Joint Child Malnutrition Estimates inter-agency group regularly updates the global and regional estimates for this indicator (<https://www.who.int/data/gho/data/themes/topics/joint-child-malnutrition-estimates-unicef-who-wb>).

- **Definition:**

Prevalence of stunting (moderate and severe) among children under five years of age (or percentage of stunted children aged 0–59 months). Moderate = height-for-age below –2 standard deviations from the WHO Child Growth Standards median; severe = height-for-age below –3 standard deviations from the WHO Child Growth Standards median.

- **Measurement type:** Percentage (%)

- **Numerator:** Number of children aged 0–59 months who were stunted (moderate and severe) (moderate = height-for-age below –2 standard deviations from the WHO Child Growth Standards median; severe = height-for-age below –3 standard deviations from the WHO Child Growth Standards median).

- **Denominator:** Total number of children aged 0–59 months who were measured

- **Monitoring and evaluation framework component:** Impact type metric

Measurement guidance

- **Method of measurement:**

Stunting prevalence is the percentage or proportion of children that are stunted (moderate and severe). More details on the measurement approach and metadata are available in the Global Nutrition Monitoring Framework: Operational Guidance for Tracking Progress in meeting targets for 2025 (<https://www.who.int/publications/i/item/9789241513609>) and in the SDG metadata files (<https://unstats.un.org/sdgs/metadata/files/Metadata-02-02-01.pdf>). Recommendations for collecting, analyzing and reporting on anthropometric measures for children under five years of age are available in a report developed by the WHO-UNICEF Technical Expert Advisory Group on Nutrition Monitoring (<https://data.unicef.org/resources/data-collection-analysis-reporting-on-anthropometric-indicators-in-children-under-5/>).

- **Data sources:**

The main source for global and regional level estimates of this indicator is the UNICEF-WHO-World Bank Joint Child Malnutrition Estimates (JME) inter-agency group. The global SDG indicator database includes only the modelled estimates.

Nationally representative household surveys (e.g., Demographic and Health Surveys, Multiple Indicator Cluster Surveys, national nutrition surveys) are the primary data source for most countries. Data from nutrition surveillance systems are also available for a limited number of countries. The JME group maintains a database of primary data sources, which is updated every six months, and used to generate the JME modelled estimates.

- **Level of disaggregation:**

For the JME modelled estimates, disaggregations are not available. National primary data sources (e.g., household surveys) include stratified data by sex, wealth, mother's education, residence, and age groups.

- **Frequency of reporting:**

Estimates are generated every other year and published jointly by WHO, UNICEF and the World Bank. Data collected through household surveys are available every 3–5 years.

Rationale for use/relevance for monitoring performance of the GFF strategy

Stunting prevalence is one of the GFF core impact indicators used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. It is a key indicator for GFF supported countries that have prioritized child and/or maternal nutrition in their investment cases. The Countdown to 2030 initiative works closely with the GFF on generating annual progress reports of the GFF supported countries focusing on the core impact indicators including stunting prevalence. The GFF also tracks country household survey-based stunting data and includes this data on the country profile pages.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives that use stunting prevalence to monitor child survival, health and development in addition to the Global Financing Facility for Women, Children and Adolescents:

1. **UN Sustainability Goals.** Goal 2, *End hunger, achieve food security, and improved nutrition and promote sustainable agriculture*. Transforming our World: The 2030 Agenda for Sustainable Development.
2. Global Targets 2025: To improve maternal, infant, and young child nutrition. <https://www.who.int/teams/nutrition-and-food-safety/global-targets-2025>. Policy briefs are available for each of the indicators including for stunting: https://iris.who.int/bitstream/handle/10665/149019/WHO_NMH_NHD_14.3_eng.pdf?sequence=1.
3. The Global Strategy for Women's Children's and Adolescent's Health (2016–2030). <https://www.who.int/publications/i/item/A71-19> and <https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/global-strategy-data>.
4. Countdown to 2030, <https://www.countdown2030.org/>

Key publications:

1. Global nutrition monitoring framework: operational guidance for tracking progress in meeting targets for 2025. World Health Organization, 20 December 2017. ISBN:9789241513609 <https://www.who.int/publications/i/item/9789241513609>.
2. Recommendations for data collection, analysis and reporting on anthropometric indicators in children under 5 years old. Geneva: World Health Organization and United Nations Children's Fund, 2019. License: CC BY-NC-SA 3.0 IG. <https://data.unicef.org/resources/data-collection-analysis-reporting-on-anthropometric-indicators-in-children-under-5/>.

The WHO-UNICEF co-convened Child Health Accountability Tracking Technical Advisory Group has developed an on-line indicator toolkit for a set of recommended child health and well-being indicators. Stunting prevalence is included in the toolkit: <https://chat.srhr.org/>.

Indicator:

Wasting prevalence among children under five years of age (moderate and severe)/ Children under five years who are wasted (moderate and severe)

Concept and definition

- **Concept:**

Wasting in children is associated with a high risk of death if not treated properly. It often indicates recent and severe weight loss, although it can persist for a long duration. Wasting prevalence is included in the United Nations Sustainable Development Goal (SDG) global indicator framework under SDG 2.0, End hunger, achieve food security, and improved nutrition and promote *sustainable agriculture*. The SDG 2.2 target is: By 2030, end all forms of malnutrition, including achieving, by 2025, the internationally agreed targets on stunting and wasting in children under 5 years of age, and address the nutritional needs of adolescent girls, pregnant and lactating women, and older persons. Wasting prevalence is one component of the composite SDG 2.2.2 indicator on prevalence of malnutrition among children under five years of age, by type (wasting and overweight). The UNICEF-WHO-World Bank Joint Child Malnutrition Estimates inter-agency group regularly updates the global and regional estimates for this indicator (<https://www.who.int/data/gho/data/themes/topics/joint-child-malnutrition-estimates-unicef-who-wb>).

- **Definition:**

Percentage of wasted (moderate and severe) children aged 0 to 59 months (moderate= weight for height less than 2 standard deviations from the median of the WHO Child Growth Standards; severe = weight for height less than 3 standard deviations from the median of the WHO Child Growth Standards).

- **Measurement type:** Percentage (%)

- **Numerator:** Number of children 0 to 59 months who were wasted

- **Denominator:** Total number of children 0 to 59 months who were measured

- **Monitoring and evaluation framework component:** Impact type metric

Measurement guidance

- **Method of measurement:**

Wasting prevalence is the percentage or proportion of children that are wasted (moderate and severe based on weight for height <-2 standard deviation from the WHO Child Growth Standards). More details on the measurement approach and metadata are available in the Global Nutrition Monitoring Framework: Operational Guidance for Tracking Progress in meeting targets for 2025 (<https://www.who.int/publications/i/item/9789241513609>) and in the SDG metadata files (<https://unstats.un.org/sdgs/metadata/files/Metadata-02-02-01.pdf>). Recommendations for collecting, analyzing and reporting on anthropometric measures for children under five years of age are available in a report developed by the WHO–UNICEF Technical Expert Advisory Group on Nutrition Monitoring (<https://data.unicef.org/resources/data-collection-analysis-reporting-on-anthropometric-indicators-in-children-under-5/>).

- **Data sources:**

The main source for global and regional level estimates of this indicator is the UNICEF–WHO–World Bank Joint Child Malnutrition Estimates (JME) inter-agency group. The global SDG indicator database includes only the modelled estimates.

Nationally representative household surveys (e.g., Demographic and Health Surveys, Multiple Indicator Cluster Surveys, national nutrition surveys) are the primary data source for most countries. Data from nutrition surveillance systems are also available for a limited number of countries. The JME group maintains a database of primary data sources, which is updated every six months, and used to generate the JME modelled estimates.

- **Level of disaggregation:**

For the JME modelled estimates, disaggregations are not available. National primary data sources (e.g., household surveys) include stratified data by sex, wealth, mother's education, residence, and age groups.

- **Frequency of reporting:**

Estimates are generated every other year and published jointly by WHO, UNICEF and the World Bank. Data collected through household surveys are available every 3–5 years.

Rationale for use/relevance for monitoring performance of the GFF strategy

Wasting prevalence is one of the GFF core impact indicators used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. It is a key indicator for GFF supported countries that have prioritized child nutrition in their investment cases. The Countdown to 2030 initiative works closely with the GFF on generating annual progress reports of the GFF supported countries focusing on the core impact indicators including wasting prevalence. The GFF also tracks country household survey-based wasting data and includes this data on the country profile pages.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives that use wasting prevalence to monitor child health, nutrition, and development in addition to the Global Financing Facility for Women, Children and Adolescents:

1. **UN Sustainability Goals.** Goal 2, End hunger, achieve food security, and improved nutrition and promote sustainable agriculture. Transforming our World: The 2030 Agenda for Sustainable Development.
2. **Global Targets 2025:** To improve maternal, infant, and young child nutrition. <https://www.who.int/teams/nutrition-and-food-safety/global-targets-2025>. Policy briefs are available for each of the indicators including for wasting: https://iris.who.int/bitstream/handle/10665/149023/WHO_NMH_NHD_14.8_eng.pdf?sequence=1.
3. **Global Action Plan for Child Wasting** (<https://www.childwasting.org/>).
4. **The Global Strategy for Women's Children's and Adolescent's Health (2016–2030).** <https://www.who.int/publications/i/item/A71-19> and <https://platform.who.int/data/maternal-newborn-child-adolescent-ageing/global-strategy-data>.
5. **Countdown to 2030,** <https://www.countdown2030.org/>

Key publications:

1. **Global nutrition monitoring framework: operational guidance for tracking progress in meeting targets for 2025.** World Health Organization, 20 December 2017. ISBN:9789241513609 <https://www.who.int/publications/i/item/9789241513609>.
2. **Recommendations for data collection, analysis and reporting on anthropometric indicators in children under 5 years old.** Geneva: World Health Organization and United Nations Children's Fund, 2019. License: CC BY-NC-SA 3.0 IG. <https://data.unicef.org/resources/data-collection-analysis-reporting-on-anthropometric-indicators-in-children-under-5/>.

The WHO-UNICEF co-convened Child Health Accountability Tracking Technical Advisory Group has developed an on-line indicator toolkit for a set of recommended child health and well-being indicators. Wasting prevalence is included in the toolkit: <https://chat.srhr.org/>.

Section 2.

GFF Core health outcome indicator reference sheets

These indicators are organized along the RMNCAH and nutrition continuum of care.

List of indicators

- 1. Family planning indicators**
 - Immediate postpartum family planning
 - Couple years of protection
 - Demand for family planning satisfied with modern methods
- 2. Antenatal care (4 or more visits)**
- 3. IFA supplementation during ANC**
- 4. IPTp (SP/Fansidar 3+ doses)**
- 5. Institutional deliveries**
- 6. Postnatal care for mothers**
- 7. Postnatal care for babies**
- 8. Early initiation of breastfeeding**
- 9. Kangaroo mother care**
- 10. Exclusive breastfeeding among children (<6 months)**
- 11. Penta 3 immunization**
- 12. Vitamin A supplementation**
- 13. Minimum acceptable diet**
- 14. Oral rehydration solution and zinc**
- 15. Careseeking for symptoms of acute respiratory infections**

Indicator:

Family planning indicators

For monitoring the implementation of family planning programs, GFF selected two core outcome indicators: Immediate postpartum family planning (IPFP) and couple years of protection. On the country-specific profile pages and the compare tab on the GFF data portal that enable cross-country comparisons, GFF tracks indicators related to demand for family planning satisfied by modern methods.

This reference sheet provides a brief overview of the IPFP and couple years of protection indicators, and detailed metadata for the demand for family planning satisfied by modern methods indicator.

Concept and definition

- **Concept:**

Immediate postpartum family planning

Immediate postpartum family planning is an integrated service, involving the provision of family planning counseling and contraceptives as part of care following childbirth within 48 hours. The postpartum period is a critical time to address family planning needs and to reduce the risk of unintended pregnancies and short pregnancy intervals, which are linked with higher rates of poor maternal, newborn, and child health outcomes.

Two indicators are typically used to monitor implementation of IPFP programs:

- Number/percent of women who delivered in a facility and received counseling on family planning prior to discharge.
- Number/percent of women who delivered in a facility and initiate or leave with a modern contraceptive method prior to discharge.

More information about these two indicators is available in the MEASURE Evaluation FP/RH indicators database: <https://www.data4impactproject.org/resources/prh-family-planning-and-reproductive-health-indicators-database/>.

Couple years of protection

This indicator provides an estimate of protection provided by family planning (FP) methods during a one-year period, based upon the volume of **all contraceptives sold or distributed free of charge** to clients during that period. This includes permanent methods, such as sterilization, and the lactational amenorrhea method (LAM). Because it is derived from routine data, it serves as a proxy indicator for the importance of investing in Health Management Information Systems and using routine data in countries.

More information about this indicator including how it is calculated are available in the Family Planning 2030 measurement framework (<https://wordpress.fp2030.org/wp-content/uploads/2023/10/Framework-06-03-2022-EXTERNAL.pdf>) and in the MEASURE Evaluation FP/RH indicators database: <https://www.data4impactproject.org/prh/family-planning/fp/couple-years-of-protection-cyp/>.

Demand for family planning satisfied with modern methods

This indicator is an aggregate or population-based measure of contraceptive coverage, estimating how much of total potential demand for modern contraception is covered by current use. The ‘demand’ does not reflect women’s stated desire to use modern contraception, but rather is derived by combining modern contraceptive use and unmet need. Also, the term “satisfied” in the common name for this indicator, “demand satisfied” does not reflect women’s satisfaction with their method. Rather, it could be interpreted as the total potential demand met by modern contraceptive use.

- **Definition:**
The percentage of women of reproductive age who want no more children or to postpone childbearing who are currently using (or their partners are using) a modern contraceptive method. The indicator assumes that all couples currently using modern contraception want to avoid a pregnancy and thus have their demand for modern contraception satisfied/met.
- **Measurement type:** Percentage (%)
- **Numerator:** Number of women of reproductive age (aged 15–49 years) who want no more children or to postpone childbearing who are currently using (or their partners are using) a modern contraceptive method
- **Denominator:** Total number of women of reproductive age (aged 15–49 years) who want no more children or to postpone childbearing
- **Monitoring and evaluation framework component:** Outcome type metric

Measurement guidance

- **Method of measurement:**
The indicator can be calculated based on household survey data or through the Family Planning Estimation Tool (FPET) estimation process.

Household surveys calculate the denominator of total demand (total number of women of reproductive age who want no more children or to postpone childbearing) as the sum of unmet need and met need/modern contraceptive rate. The percentage of demand for family planning satisfied by modern methods is computed by dividing met need (women of reproductive age who want no more children or to postpone childbearing who are currently using a modern contraceptive method) by total demand. Modern methods include female sterilization, male sterilization, IUD, injectables, implants, pill, male condom, female condom, emergency contraception, standard days method (SDM), lactational amenorrhea method (LAM), and other modern methods.

Details on the FPET estimation process are available here: https://www.track20.org/pages/data_analysis/publications/methodological/family_planning_estimation_tool.php. Access to the FPET web application is available here: <https://fpet.track20.org/>.

- **Data sources:**

Household surveys (Demographic and Health Surveys, Multiple Indicator Cluster Surveys, Performance Monitoring for Action Surveys, or National Reproductive Health Surveys). The FPET modelled statistics are based on household surveys and service statistics (routine health facility data).

More information on data sources and methodological approaches for calculating this indicator is available from the FP2030 measurement framework (<https://wordpress.fp2030.org/wp-content/uploads/2023/10/Framework-06-03-2022-EXTERNAL.pdf>) and from the SDG 3.7.1 metadata sheet (<https://unstats.un.org/sdgs/metadata/files/Metadata-03-07-01.pdf>).

- **Level of disaggregation:**

Data from household surveys: age of woman (15–19, 20–49, 15–49) socioeconomic status (e.g., education level, wealth quintile), residence (urban/rural, subnational region), married women, all women, sexually active unmarried women (defined as women who had sexual intercourse within 30 days preceding the survey)

- **Data from estimates:** married women and unmarried women

- **Frequency of reporting:**

Household surveys are typically conducted every 3–5 years. The FPET estimates are calculated annually.

Rationale for use/relevance for monitoring performance of the GFF strategy

Family planning indicators are core GFF indicators used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. The Countdown to 2030 initiative works closely with the GFF on generating annual progress reports of the GFF supported countries focusing on the core impact and outcome indicators including demand for family planning satisfied. The GFF tracks household survey-based data for this indicator on the country profile pages and on the compare tab on the GFF data portal.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives that use family planning indicators to monitor reproductive, maternal, newborn, child, and adolescent health in addition to the Global Financing Facility for Women, Children and Adolescents:

1. **UN Sustainability Goals.** Goal 3, “Ensure healthy lives and promote well-being for all at all ages” includes this age group. Transforming our World: The 2030 Agenda for Sustainable Development (indicator 3.7.1).
2. Countdown to 2030. <https://www.countdown2030.org/>
3. Family planning 2030. <https://www.fp2030.org/>
4. Ending Preventable Maternal Mortality (EPMM): http://who.int/reproductive-health/topics/maternal_perinatal/epmm/en/ (note: EPMM target 5 is related to SDG 5.6.1 on women’s empowerment regarding sexual relations, contraceptive use, and reproductive health care)

Key publications/additional resources

1. Global Health Observatory (GHO) Data – World Health Statistics: http://www.who.int/gho/publications/world_health_statistics/en/
2. World Health Organization. Guide women through their postpartum family planning options. <https://postpartumfp.srhr.org/>.
3. High Impact Practices in Family Planning. Immediate postpartum family planning: a key component of childbirth care. Washington, DC: HIP Partnership; 2022 May. Available from: <https://www.fphighimpactpractices.org/briefs/immediate-postpartum-family-planning/>.
4. Family Planning 2030 (FP2030) Measurement Framework. <https://wordpress.fp2030.org/wp-content/uploads/2023/10/Framework-06-03-2022-EXTERNAL.pdf>.
5. United Nations Population Division. World Family Planning 2022. https://www.un.org/development/desa/pd/sites/www.un.org.development.desa.pd/files/files/documents/2023/Feb/undesa_pd_2022_world-family-planning.pdf
6. United Nations Population Division. World Contraceptive Use database: <https://www.un.org/development/desa/pd/data/world-contraceptive-use>. And Family planning indicators: <https://www.un.org/development/desa/pd/data/family-planning-indicators>.

Indicator:

Antenatal care – at least four visits

Concept and definition

- **Concept:**

Antenatal care (ANC) is a critical intervention for improving maternal and newborn health. It provides a platform for the delivery of multiple health services ranging from health promotion, screening and diagnosis, injury and disease prevention, treatment services, birth preparedness counseling and preparation for the postnatal period. Respectful communication about physiological, biomedical, behavioural, sociocultural issues, as well as emotional and psychological support should also be provided to pregnant women during ANC visits.

- **Definition:**

The number of women of reproductive age with a live birth in a specified reference period who received ANC four or more times from any provider. Expressed as a percentage of women of reproductive age with a live birth in the same period.

- **Measurement type:** Percentage (%)

- **Numerator:** Number of women (aged 15–49 years) with a live birth who received ANC four or more times from any provider (in a specified time interval).

- **Denominator:** Total number of women (aged 15–49 years) with a live birth (in a specified time interval).

- **Monitoring and evaluation framework component:** Outcome type metric

Measurement guidance

- **Method of measurement:**

The indicator can be calculated based on household survey data or routine health information system data.

Individual women of reproductive age (15–49 years old) are asked during a household survey about ANC visits for their most recent live birth. Questions about ANC visits are asked irrespective of the child's current living status (dead or alive) and are for live births during a specified reference period, which is typically 2–5 years before the time of the survey completion. The definition is as follows: The percentage of interviewed women (aged 15 to 49 years) with a live birth in the 2–5 years prior to survey completion who received ANC four or more times from any provider.

Relevant information is recorded about the number and timing of ANC visits among all women who attended ANC during pregnancy at health facilities on paper forms completed by health personnel and/or through an electronic medical record. Data from paper or electronic sources are entered or abstracted into a database or registry and are compiled and analysed within the national and/or subnational HMIS. The Ministry of Health (MoH) and/or National Statistical Offices (NSO) are usually responsible for the calculation of this indicator using routine information sources.

- **Data sources:**

Household surveys (Demographic and Health Surveys, Multiple Indicator Cluster Surveys, or National Reproductive Health Surveys), or from routine health information systems (HMIS or District Health Information Management System).

More information on data sources and methodological approaches to indicator measurement is available in the MONITOR indicator sheet (<https://monitor.srhr.org/related-links>).

- **Level of disaggregation:**

Data from household surveys: Type of health personnel, place of residence (e.g., urban, rural), sex of live birth, birth order, socioeconomic status (e.g., education level, wealth quintile), age of woman at time of live birth

Data from routine information systems: Level of facility, location of facility (e.g., urban/rural)

- **Frequency of reporting:**

Household surveys are typically conducted every 3–5 years. Data from routine health information systems can be collected on a quarterly basis for facility level or subnational monitoring purposes. Aggregation of the data at national level on an annual basis is also recommended.

Rationale for use/relevance for monitoring performance of the GFF strategy

Antenatal care four or more visits is a core GFF outcome indicator used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. The Countdown to 2030 initiative works closely with the GFF on generating annual progress reports of the GFF supported countries focusing on the core impact and outcome indicators including antenatal care four or more visits. The GFF tracks household survey-based and routine health information system data for antenatal care indicators and includes this data on the country profile pages.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives that use antenatal care indicators to monitor maternal and newborn health in addition to the Global Financing Facility for Women, Children and Adolescents:

1. **UN Sustainability Goals.** Goal 3, “Ensure healthy lives and promote well-being for all at all ages” includes this age group. Transforming our World: The 2030 Agenda for Sustainable Development.
2. The Global Strategy for Women’s Children’s and Adolescent’s Health (2016–2030): <https://www.everywomaneverychild.org/global-strategy/#sect2>
3. Countdown to 2030, <https://www.countdown2030.org/>
4. Ending Preventable Maternal Mortality (EPMM): http://who.int/reproductivehealth/topics/maternal_perinatal/epmm/en/.
5. Every Newborn Action Plan (ENAP): http://apps.who.int/iris/bitstream/10665/127938/1/9789241507448_eng.pdf
6. ENAP/EPMM dashboards: <https://platform.who.int/data/maternal-new-born-child-adolescent-ageing/ENAP-EPMM-dashboard>.
7. Global Reference List of 100 Core Health Indicators, 2018: <https://www.who.int/healthinfo/indicators/2018/en/>

Key publications/additional resources

1. Global Health Observatory (GHO) Data – World Health Statistics: http://www.who.int/gho/publications/world_health_statistics/en/
2. UNICEF Data: Monitoring the situation of children and women: Antenatal care: <https://data.unicef.org/topic/maternal-health/antenatal-care/> UNICEF – Multiple Indicator Cluster Surveys: <http://mics.unicef.org/tools>
3. The DHS Program – Demographic and Health Surveys: <https://dhsprogram.com>
4. MEASURE Evaluation: Family Planning and Reproductive Health Indicators Database: Percent women attended at least four times for antenatal care during pregnancy https://www.measureevaluation.org/prh/rh_indicators/womens-health/sm/percent-women-attended-at-least-four-times-for
5. MONITOR indicator sheet (<https://monitor.srhr.org/related-links>).

Indicator: Antenatal iron-folic acid supplementation

Concept and definition

- **Concept:**

In 2012, the World Health Assembly (WHA) approved a Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition that identified six global targets related to priority nutrition outcomes to be achieved by 2025. In 2014, Member States approved the Global Nutrition Monitoring Framework (GNMF) on Maternal, Infant and Young Child Nutrition that included an operational guidance on how to track progress on these six targets plus additional nutrition indicators. Antenatal iron-folic acid supplementation is included in the operational framework as an indicator that should be monitored to assess progress towards the global target around reducing rates of anemia in women of reproductive age (target is the achievement of 50% reduction of anemia in women of reproductive age by 2025).

Anemia impairs women's health and increases the risk of maternal and neonatal adverse outcomes, including postpartum hemorrhage, miscarriages, stillbirths, prematurity, and low birth weight. Pregnant adolescents are particularly vulnerable to anemia because they have dual iron requirements, for their own growth and the growth of the fetus, and they are less likely to access antenatal care. It is estimated that around half of all cases of anemia are due to iron deficiency. Iron-folic acid (IFA) supplementation is an important strategy to reduce and control anemia during pregnancy.

- **Definition:**

The proportion of women who consumed any iron-containing supplements during the current or past pregnancy within the last 2 years.

Note: The data can be reported on any iron-containing supplement including iron and folic acid tablets (IFA), multiple micronutrient tablets or powders, or iron-only tablets which will vary by country policy.

- **Measurement type:** Percentage (%)

- **Numerator:** Number of women in the sample who consumed any iron-containing supplements during the current or past pregnancy within the last 2 years

- **Denominator:** Total number of women in the sample who are pregnant or have had a pregnancy in the last 2 years.

- **Monitoring and evaluation framework component:** Outcome type metric

Measurement guidance

- **Method of measurement:**

Demographic and Health Surveys (DHS) collect data on antenatal iron consumption over any pregnancy in the last five years. It is possible to reanalyze the DHS data for pregnancies in the last 2 years, although samples will be smaller and therefore estimates less reliable. Multiple Indicator Cluster Surveys (MICS) may collect some data on iron and folic acid consumption in a pregnancy within the last two years. Many countries conduct regular national health and nutrition surveys (NHNS), but often collect consumption of iron-containing supplements as part of a general questionnaire on supplementation in the full population. Generally, the number of pregnant women sampled in these surveys is very small. Reliable estimates for pregnant women cannot be generated without oversampling this sub-population.

Some health management information systems (HMIS) collect data on provision of antenatal supplementation, but they generally do not verify consumption. Guidance on collection of IFA through routine administrative systems is available in the District Health Information Software 2 (DHIS 2) nutrition module:

<https://docs.dhis2.org/en/implement/health/chis-community-health-information-system/design/nutrition.html>.

More details on the measurement approach are available in the Global Nutrition Monitoring Framework (see resources and references).

- **Data sources:**

The main source for this indicator is population-based household surveys (Demographic and Health Surveys, Multiple Indicator Cluster Surveys, National Nutrition Surveys). Other sources include routine health management information systems or DHIS2.

- **Level of disaggregation:**

When sample sizes allow from household surveys, disaggregated data can be presented by maternal education, place of residence, and socioeconomic status (e.g., wealth quintile).

Data from routine information systems can be disaggregated by level of facility, location of facility (e.g., urban/rural).

- **Frequency of reporting:**

Household surveys are typically conducted every 3–5 years. Data from routine health information systems can be collected on a quarterly basis for facility level or subnational monitoring purposes. Aggregation of the data at national level on an annual basis is also recommended.

Rationale for use/relevance for monitoring performance of the GFF strategy

Antenatal iron-folic acid supplementation is one of the GFF core outcome indicators used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. The Countdown to 2030 initiative works closely with the GFF on generating annual progress reports of the GFF supported countries focusing on the core impact and outcome indicators including IFA supplementation. The GFF also includes this data on the country profile pages.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives that use IFA supplementation to monitor maternal and newborn health in addition to the Global Financing Facility for Women, Children and Adolescents:

1. Scaling up nutrition movement (SUN): <https://scalingupnutrition.org/>.
2. Countdown to 2030: <https://www.countdown2030.org/>.
3. Technical Expert Advisory Group on Nutrition Monitoring (TEAM): <https://www.who.int/groups/who-unicef-technical-expert-advisory-group-on-nutrition-monitoring/about>.

Key publications:

1. WHO. Developing and validating an iron and folic acid supplementation indicator for tracking progress towards global nutrition monitoring framework targets. Final report – June 2018. Geneva: World Health Organization; 2018 (<https://www.who.int/nutrition/publications/iron-folic-indicator-GNMF/en/>).
2. WHO. Weekly iron and folic acid supplementation as an anaemia-prevention strategy in women and adolescent girls. Lessons learnt from implementation of programmes among non-pregnant women of reproductive age. Geneva: World Health Organization; 2018 (<https://www.who.int/nutrition/publications/micronutrients/WIFS-anaemia-prevention-women-adolescent-girls/en/>).
3. WHO. Global nutrition targets 2025: anaemia policy brief (WHO/NMH/NHD/14.4). Geneva: World Health Organization; 2014.
4. MONITOR indicator reference sheets (<https://monitor.srhr.org/related-links>)
5. Global Nutrition Monitoring Framework: operational guidance for tracking progress in meeting targets for 2025. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.
6. Resolution WHA65.6. Comprehensive implementation plan on maternal, infant and young child nutrition. In: Sixty-fifth World Health Assembly Geneva, 21–26 May 2012. Resolutions and decisions, annexes. Geneva: World Health Organization; 2012:12–13 (http://www.who.int/nutrition/topics/WHA65.6_resolution_en.pdf?ua=1).

Indicator: Intermittent preventive treatment of malaria during pregnancy (IPTp)

Concept and definition

- **Concept:**

When given to pregnant women who are most vulnerable to malaria, preventive chemotherapy has been shown to be a safe, cost-effective strategy for reducing malaria disease burden and adverse outcomes including anemia, maternal mortality, preterm birth, low birth weight, stillbirth, early neonatal death, and congenital infection.

Since 2012, in countries with moderate to high rates of malaria transmission, the World Health Organization (WHO) has recommended intermittent preventive treatment (IPTp) during pregnancy, with sulfadoxine-pyrimethamine dispensed to all pregnant women at each scheduled antenatal visit starting in the second trimester.

In 2022, WHO updated its recommendations for three key malaria prevention strategies including IPTp (documented in the WHO consolidated guidelines for malaria published in October 2023). The updated guidelines recommend that IPTp should be delivered through antenatal care contacts or through community health workers and should be provided for all pregnant women regardless of parity (previous guidelines recommended IPTp only for the first and second pregnancies).

- **Definition:**

Percentage of women aged 15–49 who received intermittent preventive treatment for malaria during their last pregnancy (three doses of sulfadoxine-pyrimethamine during antenatal care).

- **Measurement type:** Percentage (%)

- **Numerator:** Number of women aged 15–49 years who received three or more doses of SP/Fansidar to prevent malaria during their last pregnancy that led to a live birth in the last 2 years.

- **Denominator:** Total number of women aged 15–49 years with a live birth in the last 2 years.

- **Monitoring and evaluation framework component:** Outcome type metric

The above metadata is based on data collected through household surveys. For routine health information systems, the numerator is number of pregnant women who have received zero/one/two/three or more doses of SP/Fansidar. The denominator needs to be calculated based on other sources of data.

Measurement guidance

- **Method of measurement:**

The method of measurement varies depending upon whether the data is collected through a household survey or through routine health information system/health facility data.

For household surveys, women aged 15–49 with a live birth in the 2 years preceding the survey are asked about receipt of one or more doses of SP/Fansidar, two or more doses of SP/Fansidar, and three or more doses of SP/Fansidar. For routine health information system data, health care providers first need to record information on their SP/Fansidar dispensing practices in health system registers or reporting forms. These data on the number of pregnant women who have received zero/one/two/three or more doses of SP/FA then need to be accurately transcribed into the country's routine health information system/DHIS2.

- **Data sources:**

Population-based household surveys such as Demographic and Health Surveys, Multiple Indicator Cluster Surveys and Malaria Indicator Surveys, and routine health information systems/District Health Information System 2 (DHIS2).

- **Level of disaggregation:**

Household survey data: Residence (e.g., urban/rural, subnational region), education, wealth quintile

Health facility data: level and type of facility, location of facility

- **Frequency of reporting:**

Household surveys are typically conducted every 3–5 years. Data from routine health information systems can be collected on a quarterly basis for facility level or subnational monitoring purposes. Aggregation of the data at national level on an annual basis is also recommended.

Rationale for use/relevance for monitoring performance of the GFF strategy

IPTp is one of the GFF core impact indicators used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. The Countdown to 2030 initiative works closely with the GFF on generating annual progress reports of the GFF supported countries focusing on the core impact and outcome indicators including IPTp. The GFF also includes these data on the country profile pages.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives that use IPTp to monitor maternal and newborn health in addition to the Global Financing Facility for Women, Children and Adolescents:

1. **UN Sustainability Goals.** Goal 3, “Ensure healthy lives and promote well-being for all at all ages” includes this age group. Transforming our World: The 2030 Agenda for Sustainable Development.
2. Roll Back Malaria Partnership – Malaria in Pregnancy Working Group.
3. Countdown to 2030: <https://www.countdown2030.org/>

Key publications:

1. WHO guidelines for malaria, 16 October 2023. Geneva: World Health Organization; 2023 (WHO/UCN/GMP/ 2023.01 Rev.1). License: CC BY-NC-SA 3.0 IGO.
2. WHO Global Health Observatory database.
<https://www.who.int/data/gho/indicator-metadata-registry/imr-details/proportion-of-women-aged-15-49-years-who-received-intermittent-preventive-treatment-for-malaria-during-last-pregnancy>.
3. District Health Information System 2 modules on malaria. (CH125 is the data element for IPTp).
<https://docs.dhis2.org/en/implement/health/chis-community-health-information-system/design/malaria.html>.

Indicator: Institutional delivery

Concept and definition

- **Concept:**

All women should have access to skilled care during pregnancy, childbirth, and the postpartum period to ensure prevention, detection, and management of complications as well as a positive birth experience. A key strategy for improving access to skilled delivery care is to increase the proportion of deliveries that take place in health facilities where obstetric complications can be managed when they arise.

- **Definition:**

The institutional delivery rate (or institutional birth rate) is the proportion of births occurring in health facilities in a specified area and time-period.

- **Measurement type:** Percentage (%)

- **Numerator:** Number of live births occurring in health facilities in a specified area and time-period.

- **Denominator:** Number of live births in a specified area and time-period.

- **Monitoring and evaluation framework component:** Outcome type metric

Note: Ideally the numerator and denominator would capture all births

Measurement guidance

- **Method of measurement:**

For population-based surveys: percentage of women who gave birth in a health facility (number of women who gave birth in a health facility/total number of live births in the same geographic/administrative area) x 100. For facility-based data: percentage of women who gave birth in a health facility (number of deliveries in facility/estimated total number of live births (or all births if available)) x 100. In household surveys, such as the Demographic and Health Surveys, the Multiple Indicator Cluster Surveys, and the Reproductive Health Surveys, the respondent is asked about each live birth and where the childbirth took place for a period up to five years (or three or two depending on survey type) before the interview. Service/facility records can be used where a high proportion of births occur in health facilities and are recorded.

- **Data sources:**

Data on institutional deliveries is available through population-based surveys, civil registration, and routine facility information systems.

- **Level of disaggregation:**

Household surveys: woman's socio-economic status, education level, age, parity

Facility data: Baby-friendly institutions, facility type, geographic location

- **Frequency of reporting:**

Household surveys are typically conducted every 3–5 years. Data from routine health information systems can be collected on a quarterly basis for facility level or subnational monitoring purposes. Aggregation of the data at national level on an annual basis is also recommended.

Rationale for use/relevance for monitoring performance of the GFF strategy

Institutional delivery is a core GFF outcome indicator used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. The Countdown to 2030 initiative works closely with the GFF on generating annual progress reports of the GFF supported countries focusing on the core impact and outcome indicators including institutional delivery. The GFF tracks household survey-based and routine health information system data for institutional delivery and includes this data on the country profile pages.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives that use institutional delivery to monitor maternal and newborn health in addition to the Global Financing Facility for Women, Children and Adolescents:

1. **UN Sustainability Goals.** Goal 3, “Ensure healthy lives and promote well-being for all at all ages” includes this age group. Transforming our World: The 2030 Agenda for Sustainable Development.
2. The Global Strategy for Women's Children's and Adolescent's Health (2016–2030): <https://www.everywomaneverychild.org/global-strategy/#sect2>
3. Countdown to 2030, <https://www.countdown2030.org/>

Key publications/other resources

1. UN IGME: Global Health Observatory (GHO) Data – World Health Statistics: http://www.who.int/gho/publications/world_health_statistics/en/ (<https://www.who.int/data/gho/indicator-metadata-registry/imr-details/institutional-birth>)
2. UNICEF Data: Multiple Indicator Cluster Surveys: <http://mics.unicef.org/tools>.
3. The DHS Program – Demographic and Health Surveys: <https://dhsprogram.com>

Indicator:

Postnatal care for mothers

Concept and definition

- **Concept:**

The postnatal period is defined as the time following delivery until six weeks after birth and is a critical phase in the lives of women and newborns. The first 48 hours after childbirth is a high-risk period for both mothers and babies. Contact with a health-care provider within two days of delivery is critical for improving the survival, health and well-being of mothers and newborns. WHO published updated consolidated postnatal care guidelines in 2022 that place the woman-newborn dyad at the center of care. The guidelines advise a minimum of four postnatal care contacts including one within the first 48 hours of childbirth for the provision of health promotion services, disease prevention, detection and management of problems, and psychosocial and emotional support.

- **Definition:**

The number of women of reproductive age with a live birth in a specified reference period who received a postnatal/postpartum care (PNC) check with a health provider within two days of delivery is expressed as a percentage of women in the same age range with a live birth in the same period.

- **Measurement type:** Percentage (%)

- **Numerator:** Number of women aged 15–49 years with a live birth who have postnatal contact with a health-care provider within two days of birth.

- **Denominator:** Total number of women aged 15–49 with a live birth.

- **Monitoring and evaluation framework component:** Outcome type metric

Note: This is the metadata for the survey-based indicator, if the data is collected through health facility sources (HMIS), then the numerator and denominator are modified to:

Numerator: Number of women who received PNC in a health facility within a specified time period. Denominator: Total number of deliveries in facility in a specified time period.

Measurement guidance

- **Method of measurement:**

There are differences in the measurement approach depending upon data source used (household survey or routine information system data). More information on data sources and methodological approaches to indicator measurement by data source is available in the MONITOR indicator sheet (<https://monitor.srhr.org/related-links>). The method used to collect data through household surveys is provided here:

Eligible women of reproductive age (15–49 years) are identified in a household survey for inclusion and interviewed using an individual women's questionnaire. Women are considered eligible for survey interview if they are either usual residents or visitors of the household who stayed there the night before the interview. All eligible and interviewed women between 15 and 49 years old who had a live birth during a specified reference period, typically 2–5 years prior to the time of the interview, are asked about “checks on your health after delivery.” The sequence of questions about the postnatal health checks are different depending on whether the delivery occurred in a health facility or outside a health facility. For deliveries that occurred in a health facility, women are asked “How long after delivery was your health first checked?” and “Who checked on your health at that time?” The survey also asks about any checks that occurred after discharge from the health facility. If a health check occurred after leaving the facility, women are asked similar questions about the timing of when it occurred, who performed the check, and where the check took place. For births that occurred outside a health facility, women are asked if there was any health check on her most recent birth right after delivery. The MoH and NSO typically conduct household surveys and compile, analyse and report the results for this indicator in collaboration with the survey programme (e.g., DHS, MICS, RHS) and funding agency.

- **Data sources:**

Population-based household surveys are the preferred data source in settings with a low utilization of health facility services or where private health sector data are excluded from routinely collected administrative data sources.

Other data sources include routine health information system data.

- **Level of disaggregation:**

Data from household surveys: Type of health personnel, place of residence (e.g., urban, rural), sex of live birth, birth order, socioeconomic status (e.g., education level, wealth quintile), age of woman at time of live birth

Data from routine information systems: Level of facility, location of facility (e.g., urban/rural)

- **Frequency of reporting:**

Household surveys are typically conducted every 3–5 years. Data from routine health information systems can be collected on a quarterly basis for facility level or subnational monitoring purposes. Aggregation of the data at national level on an annual basis is also recommended.

Rationale for use/relevance for monitoring performance of the GFF strategy

Postnatal care for mothers/women is a core GFF outcome indicator used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. The Countdown to 2030 initiative works closely with the GFF on generating annual progress reports of the GFF supported countries focusing on the core impact and outcome indicators including postnatal care. The GFF tracks household survey-based and routine health information system data for postnatal care and includes this data on the country profile pages.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives: that use postnatal care indicators to monitor maternal and newborn health in addition to the Global Financing Facility for Women, Children and Adolescents:

1. **UN Sustainability Goals.** Goal 3, “Ensure healthy lives and promote well-being for all at all ages” includes this age group. Transforming our World: The 2030 Agenda for Sustainable Development.
2. The Global Strategy for Women’s Children’s and Adolescent’s Health (2016–2030): <https://www.everywomaneverychild.org/global-strategy/#sect2>.
3. Countdown to 2030, <https://www.countdown2030.org/>
4. Ending Preventable Maternal Mortality (EPMM): http://who.int/reproductive-health/topics/maternal_perinatal/epmm/en/.
5. Every Newborn Action Plan (ENAP): http://apps.who.int/iris/bitstream/10665/127938/1/9789241507448_eng.pdf
6. ENAP/EPMM dashboards: <https://platform.who.int/data/maternal-new-born-child-adolescent-ageing/ENAP-EPMM-dashboard>.
7. Global Reference List of 100 Core Health Indicators, 2018: <https://www.who.int/healthinfo/indicators/2018/en/>

Key publications:

1. WHO recommendations on maternal and newborn care for a positive postnatal experience. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO.
2. MONITOR indicator reference sheets (<https://monitor.srhr.org/related-links>)

Indicator:

Postnatal care for babies

Concept and definition

- **Concept:**

The postnatal period is defined as the time following delivery until six weeks after birth and is a critical transition phase. The first 48 hours after childbirth is a high-risk period for both mothers and babies. Contact with a health-care provider within two days of delivery is critical for improving the survival, health and well-being of mothers and newborns. WHO published updated consolidated postnatal care guidelines in 2022 that place the woman-newborn dyad at the center of care. The guidelines advise a minimum of four postnatal care contacts including one within the first 48 hours of childbirth for the provision of health promotion services, disease prevention, detection and management of problems, and psychosocial and emotional support.

- **Definition:**

The number of women of reproductive age with a live birth in a specified reference period whose newborn received a postnatal care (PNC) check with a health provider within two days of birth. Expressed as a percentage of women in the same age range with a live birth in the same period.

- **Measurement type:** Percentage (%)

- **Numerator:** Number of newborns who have postnatal contact with a health-care provider check within two days of birth

- **Denominator:** Total number of live births

- **Monitoring and evaluation framework component:** Outcome type metric

Note: This is the metadata for the survey-based indicator, if the data is collected through health facility sources, then the numerator and denominator are modified to:

Numerator: Number of newborns who received PNC in the health facility within a specified time period. Denominator: Total number of live births in the health facility in a specified time period.

Measurement guidance

- **Method of measurement:**

There are differences in the measurement approach depending upon data source used (household survey or routine information system/health facility data). More information on data sources and methodological approaches to indicator measurement by data source is available in the MONITOR indicator sheet (<https://monitor.srhr.org/related-links>). The method used to collect data through household surveys is provided here:

Eligible women of reproductive age (15–49 years) are identified in a household survey for inclusion and interviewed using an individual women's questionnaire. Women are considered eligible for survey interview if they are either usual residents or visitors of the household who stayed there the night before the interview. All eligible and interviewed women between 15 and 49 years old who had a live birth during a specified reference period, typically 2–5 years prior to the time of the interview, are asked about “checks on (NAME)’s health after delivery.” (“name” refers to the name of the live birth the woman had during the same reference period). The sequence of questions about the postnatal health checks are different depending on whether the birth occurred in a health facility or outside a health facility. For births that occurred in a health facility, women are asked “How long after delivery was (NAME)’s health first checked?” and “Who checked on (NAME)’s health at that time?” The survey also asks about any checks that occurred after discharge from the health facility. If a health check occurred after leaving the facility, women are asked similar questions about the timing of when it occurred, who performed the check, and where the check took place. For births that occurred outside a health facility, women are asked if there was any health check on her most recent birth right after delivery. The MoH and NSO typically conduct household surveys and compile, analyse and report the results for this indicator in collaboration with the survey programme (e.g., DHS, MICS, RHS) and funding agency.

- **Data sources:**

Population-based household surveys are the preferred data source in settings with a low utilization of health facility services or where private health sector data are excluded from routinely collected administrative data sources.

Other data sources include routine health information system data.

- **Level of disaggregation:**

Data from household surveys: Type of health personnel, place of delivery, mode of delivery, place of residence (e.g., urban, rural), timing and location of PNC health check, births attended by skilled health personnel, sex of live birth, birth order, socioeconomic status (e.g., education level, wealth quintile of mother), age of woman at the time of delivery.

Data from routine information systems: Level of facility, location of facility (e.g., urban/rural), timing and location of health check.

- **Frequency of reporting:**

Household surveys are typically conducted every 3–5 years. Data from routine health information systems can be collected on a quarterly basis for facility level or subnational monitoring purposes. Aggregation of the data at national level on an annual basis is also recommended.

Rationale for use/relevance for monitoring performance of the GFF strategy

Postnatal care for newborns is a core GFF outcome indicator used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. The Countdown to 2030 initiative works closely with the GFF on generating annual progress reports of the GFF supported countries focusing on the core impact and outcome indicators including postnatal care. The GFF tracks household survey-based and routine health information system data for postnatal care and includes this data on the country profile pages.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives: that use postnatal care indicators to monitor maternal and newborn health in addition to the Global Financing Facility for Women, Children and Adolescents:

1. **UN Sustainability Goals.** Goal 3, “Ensure healthy lives and promote well-being for all at all ages” includes this age group. Transforming our World: The 2030 Agenda for Sustainable Development.
2. The Global Strategy for Women’s Children’s and Adolescent’s Health (2016–2030): <https://www.everywomaneverychild.org/global-strategy/#sect2>
3. Countdown to 2030, <https://www.countdown2030.org/>
4. Ending Preventable Maternal Mortality (EPMM): http://who.int/reproductivehealth/topics/maternal_perinatal/epmm/en/.
5. Every Newborn Action Plan (ENAP): http://apps.who.int/iris/bitstream/10665/127938/1/9789241507448_eng.pdf
6. ENAP/EPMM dashboards: <https://platform.who.int/data/maternal-new-born-child-adolescent-ageing/ENAP-EPMM-dashboard>.
7. Global Reference List of 100 Core Health Indicators, 2018: <https://www.who.int/healthinfo/indicators/2018/en/>

Key publications:

1. WHO recommendations on maternal and newborn care for a positive postnatal experience. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO.
2. MONITOR indicator reference sheets (<https://monitor.srhr.org/related-links>)

Indicator: Early initiation of breastfeeding

Concept and definition

- **Concept:**

Breastfeeding has many health and well-being benefits for both mother and child. Early initiation of breastfeeding within the first hour of life is associated with reduced newborn mortality and morbidity, including protection against infections. Initiation of breastfeeding shortly after birth also improves the likelihood that mothers will be able to successfully initiate and maintain optimal breastfeeding practices. According to WHO and UNICEF recommendations, breastfeeding should begin no later than one hour after birth simultaneously with skin-to-skin contact between mother and baby for bonding and maternal-infant stimulation, which facilitates suckling and an effective latch.

- **Definition:**

The number of newborns breastfed within one hour of birth during a specified reference period, expressed as a percentage of the total number of live births in the same period.

- **Measurement type:** Percentage (%)

- **Numerator:** Number of newborns breastfed within the first hour of birth

- **Denominator:** Total number of live births

- **Monitoring and evaluation framework component:** Outcome type metric

Note: This is the metadata for the survey-based indicator, if the data is collected through health facility data (HMIS), then the numerator and denominator are modified to:

Numerator: Number of newborns breastfed within one hour of birth in a health facility within a specified time period.

Denominator: Number of total live births in a health facility in a specified time period.

Measurement guidance

- **Method of measurement:**

There are differences in the measurement approach depending upon data source used (household survey or routine information system data). More information on data sources and methodological approaches to indicator measurement by data source is available in the MONITOR indicator reference sheet (<https://monitor.srhr.org/related-links>). The method used to collect data through household surveys is provided here:

Eligible women of reproductive age (15–49 years) are identified in the household survey for inclusion and interview using an individual women’s questionnaire. Women are considered eligible for a survey interview if they are either usual residents or visitors of the household who stayed there the night before the interview. All eligible and interviewed women (between 15 and 49 years old) who had a live birth during a specified reference period, typically 2–5 years prior to the time of interview, are asked “Did you ever breastfeed (NAME)?”, where “name” refers to the name of the live birth the woman had during the same reference period. The woman is asked to indicate whether she ever breastfed her last live birth, even if the child died very young. If the child was ever breastfed, she is then asked, “How long after birth did you first put (NAME) to the breast?” For the early breastfeeding indicator calculation, the woman must report that the baby was put to the breast either immediately after birth or within the first hour after delivery. The MoH and NSO typically conduct household surveys and compile, analyse and report the results for this indicator in collaboration with the survey programme (e.g., DHS, MICS, RHS) and funding agency.

- **Data sources:**

The two main data sources for this indicator are population-based household surveys (Demographic and Health Surveys, Multiple Indicator Cluster Surveys, and Reproductive Health Surveys) and routinely collected administrative data.

- **Level of disaggregation:**

For household survey data: Place of delivery (private or public health facility, community), mode of delivery, place of residence (e.g., urban, rural), sex of live birth, birth order, socioeconomic status (e.g., education level, wealth quintile), age of woman at the time of delivery, births attended by skilled health personnel, timing of first antenatal care, and timing (within two days) and location of postnatal health check.

For facility data: By level of facility, location of facility and place of maternal residence (e.g., urban, rural), subnational administrative units (e.g., districts, provinces, regions), type of health personnel, intention to breastfeed, birthweight, gestational age, and timing of breastfeeding.

- **Frequency of reporting:**

Household surveys are typically conducted every 3–5 years. Data from routine health information systems can be collected on a quarterly basis for facility level or subnational monitoring purposes. Aggregation of the data at national level on an annual basis is also recommended.

Rationale for use/relevance for monitoring performance of the GFF strategy

Early initiation of breastfeeding is one of the GFF core outcome indicators used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. The Countdown to 2030 initiative works closely with the GFF on generating annual progress reports of the GFF supported countries focusing on the core impact and outcome indicators including early initiation of breastfeeding. The GFF also includes this data on the country profile pages.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives that use early initiation of breastfeeding to monitor maternal and newborn health in addition to the Global Financing Facility for Women, Children and Adolescents:

1. Countdown to 2030, <https://www.countdown2030.org/>
2. Every Newborn Action Plan (ENAP):
http://apps.who.int/iris/bitstream/handle/10665/127938/1/9789241507448_eng.pdf
3. Technical Expert Advisory Group on Nutrition Monitoring:
<https://www.who.int/groups/who-unicef-technical-expert-advisory-group-on-nutrition-monitoring/about>.

Key publications:

1. Every Newborn Action Plan Metrics. WHO technical consultation on newborn health indicators. Ferny Voltaire, France 3–5 December 2014. ISBN 978 92 150938 1.
2. The 2016 and 2023 Lancet Breastfeeding Series papers.
<https://www.thelancet.com/series/breastfeeding> and <https://www.thelancet.com/infographics-do/2023-lancet-series-breastfeeding>.
3. MONITOR indicator reference sheets (<https://monitor.srhr.org/related-links>)

Indicator:

Kangaroo mother care

Concept and definition

- **Concept:**

Kangaroo mother care is a method of caring for preterm and low-birth-weight newborns by direct, continuous skin to-skin contact, in the kangaroo position, with their mother or guardian. The current evidence base indicates that KMC reduces mortality among newborns weighing < 2500 g. WHO guidelines published in 2022 recommend KMC as routine care for all preterm or low-birth weight infants initiated in the health care facility or at home and given for 8–24 hours per day. The guidelines also recommend that KMC be started as soon as possible after birth and state that KMC can be initiated before the infant is clinically stable unless the infant is unable to breathe spontaneously after resuscitation, is in shock or needs mechanical ventilation.

- **Definition:**

Kangaroo mother care (KMC) is care of preterm and/or low-birth weight infants carried skin-to-skin with the mother. Its key features include the early, continuous, and prolonged skin-to-skin contact between the mother and the baby, and exclusive breastfeeding (ideally) or feeding with breastmilk.

The following metadata is based on initiation of KMC in facilities:

The percentage of live-born preterm and/or low birth weight (<2500 g) newborns born in a health facility who are initiated on KMC or admitted to a KMC unit if a separate unit exists.

- **Measurement type:** Percentage (%)
- **Numerator:** Number of admitted preterm and/or low birth weight newborns (<2500 g) who are initiated on KMC anywhere in the facility
- **Denominator:** Number of admitted preterm and/or low birth weight newborns (<2500 g)
- **Monitoring and evaluation framework component:** Outcome type metric

Note: For data from routine health management information systems, the numerator can be number of newborns who received facility-based KMC care, and the denominator could be expected number of live births or expected number of preterm and/or low-birth weight babies.

Measurement guidance

- **Method of measurement:**

Demographic and Health Surveys include a proxy indicator on percentage of births that had skin-to-skin contact immediately following delivery (which is considered by the Every Newborn Action Plan/ENAP to be an element of routine essential care for all newborns), for women's most recent live birth in the 3 years preceding the survey.

Country health information systems can include monitoring of coverage and quality of KMC in health care facilities, aggregated to the district and national levels. An EMAP publication on this topic is forthcoming.

The DHIS2 module on newborn health allows for capturing data on preterm newborns discharged from the facility that received follow-up on KMC by a community health worker, and on preterm newborns receiving skin-to-skin contact immediately after birth.

Note: The EN-BIRTH multi-country validation study examined the potential to collect data on KMC through household surveys and through routine health information systems. Salim, N., Shabani, J., Peven, K. *et al.* Kangaroo mother care: EN-BIRTH multi-country validation study. *BMC Pregnancy Childbirth* **21** (Suppl 1), 231 (2021). <https://doi.org/10.1186/s12884-020-03423-8>

- **Data sources:**

Demographic and Health surveys (proxy indicator); health facility registers, KMC registers and health facility records (data reported to routine health information systems/DHIS2).

- **Level of disaggregation:** Disaggregate by <2000 when possible.

Data from routine information systems: Level of facility, location of facility (e.g., urban/rural).

- **Frequency of reporting:**

Data from routine health information systems can be collected on a quarterly basis for facility level or subnational monitoring purposes. Aggregation of the data at national level on an annual basis is also recommended.

Rationale for use/relevance for monitoring performance of the GFF strategy

KMC is one of the GFF core impact and outcome indicators used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. The GFF includes this data on the country profile pages.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives that use KMC to monitor newborn health in addition to the Global Financing Facility for Women, Children and Adolescents:

1. Every Newborn Action Plan (ENAP):
http://apps.who.int/iris/bitstream/10665/127938/1/9789241507448_eng.pdf

Key publications:

1. WHO recommendations on maternal and newborn care for a positive postnatal experience. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO.
2. Every Newborn Action Plan Metrics. WHO technical consultation on newborn health indicators, Ferney Voltaire, France 3-5 December 2014. ISBN 978 92 4 150938 1.
3. WHO recommendations for care of the preterm or low birth weight infant. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO
4. World Health Organization. Standards for improving quality of maternal and newborn care in health facilities. 2016. Available:
<https://www.who.int/publications-detail-redirect/9789241511216>.
(care for preterm birth babies is described in standard 1.6b).
5. Engmann C, Wall S, Darmstadt G, Valsangkar B, Claeson M. Consensus on kangaroo mother care acceleration. *Lancet*. 2013;382:e26-7.
doi: 10.1016/S0140-6736(13)62293-X

Indicator:

Exclusive breastfeeding (<6 months/0–5 months)

Concept and definition

- **Concept:**

In 2012, the World Health Assembly (WHA) approved a Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition that identified six global targets related to priority nutrition outcomes to be achieved by 2025. In 2014, Member States approved the Global Nutrition Monitoring Framework (GNMF) on Maternal, Infant and Young Child Nutrition that included an operational guidance on how to track progress on these six targets plus additional nutrition indicators. The exclusive breastfeeding target is to increase the global rate of exclusive breastfeeding in the first 6 months up to at least 50%.

WHO recommends exclusive breastfeeding for the first six months of life (and sustained for up to two years). Breastfeeding provides essential nutrients and immunologic protection for babies and ensures optimal growth and development. It also helps with attachment and bonding, birth spacing, and reduces the risk of ovarian and breast cancers for mothers.

- **Definition:**

The number of infants 0–5 months (< 6 months) of age who are fed exclusively with breast milk during a specified reference period. The indicator is expressed as a percentage of the total number of infants 0–5 months (< 6 months) of age in the same period.

- **Measurement type:** Percentage (%)

- **Numerator:** Number of infants 0–5 months of age who are exclusively breastfed

- **Denominator:** Total number of infants 0–5 months of age

- **Monitoring and evaluation framework component:** outcome type metric

Measurement guidance

- **Method of measurement:**

Information is collected in the questionnaire from eligible women or mothers/caregivers based on a 24-hour recall of all solids and/or liquids consumed by the infant in the day or night prior to the interview. For the child to be considered “exclusively breastfed” the mother/caregiver must respond by saying that the child (a) is currently breastfeeding; (b) has had breast milk in the past 23 hours; and (c) has not received any other solids, semi-solids, or solid foods in the last day and night prior to the interview. The infant is allowed to have had vitamins, mineral supplements, medicine and/or ORS in the last day. Only children who are less than 6 months old at the time of the interview are included in the indicator calculation.

- More details on the measurement approach and metadata are available in the MONITOR indicator reference sheet (<https://monitor.srhr.org/related-links>).

- **Data sources:**

Population based household surveys (Demographic and Health Surveys, Multiple Indicator Cluster Surveys, National Nutrition Surveys).

- **Level of disaggregation:**

By age (e.g., 0–1 month, 0–5 months), sex, place of residence (e.g., urban, rural), subnational administrative units (e.g., districts, provinces, regions), socioeconomic status of the mother (e.g., education level, household wealth quintile), age of woman at the time of delivery

- **Frequency of reporting:**

Household surveys are typically conducted every 3–5 years.

Rationale for use/relevance for monitoring performance of the GFF strategy

Exclusive breastfeeding is one of the GFF core outcome indicators used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. The Countdown to 2030 initiative works closely with the GFF on generating annual progress reports of the GFF supported countries focusing on the core impact and outcome indicators including exclusive breastfeeding. The GFF also includes these data on the country profile pages.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives that use exclusive breastfeeding to monitor child health in addition to the Global Financing Facility for Women, Children and Adolescents:

1. Countdown to 2030: <https://www.countdown2030.org/>
2. Child Survival Action:
<https://www.childhealthtaskforce.org/hubs/child-survival-action>.
3. Scaling up nutrition movement (SUN): <https://scalingupnutrition.org/>.
4. Technical Expert Advisory Group on Nutrition Monitoring:
<https://www.who.int/groups/who-unicef-technical-expert-advisory-group-on-nutrition-monitoring/about>.

Key publications:

1. The 2016 and 2023 Lancet Breastfeeding Series papers.
<https://www.thelancet.com/series/breastfeeding> and <https://www.thelancet.com/infographics-do/2023-lancet-series-breastfeeding>.
2. MONITOR indicator reference sheets (<https://monitor.srhr.org/related-links>)
3. Global Nutrition Monitoring Framework: operational guidance for tracking progress in meeting targets for 2025. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO.
4. WHO/UNICEF. Global nutrition targets 2025: breastfeeding policy brief (WHO/NMH/NHD/14.7). Geneva: World Health Organization; 2014.
5. World Health Assembly Resolution 65.6.
https://apps.who.int/gb/ebwha/pdf_files/wha65-rec1/a65_rec1-en.pdf.

Indicator: Penta 3 immunization

Concept and definition

- **Concept:**

The pentavalent vaccine protects against five diseases in one vaccine: Diphtheria, pertussis, tetanus (DTP), hepatitis B (HepB) and haemophilus influenza type b (HiB) vaccines. Gavi, the Vaccine Alliance, has been supporting the pentavalent vaccine since 2001. As of 2023, countries eligible for Gavi support have the option to apply to switch to the hexavalent vaccine that adds the inactivated polio vaccine.

Childhood vaccination is one of the most cost-effective public health interventions, saving millions of children's lives every year and preventing severe morbidity from vaccine-preventable diseases. Immunization services can also provide a platform for the delivery of other essential child health interventions. Coverage estimates of three doses of the pentavalent vaccine (Penta 3) are used to monitor access to immunization services and to guide disease eradication efforts. It is also a good measure of health system performance.

- **Definition:**

Percentage of surviving infants (1-year olds) who received three doses of the combined pentavalent vaccine (Penta 3) in a given year.

- **Measurement type:** Percentage (%)

- **Numerator:** Number of surviving infants who received three doses of Penta 3 (in a given year/specified time-period)

- **Denominator:** Estimated number of surviving infants (1-year olds) (in a given year/specified time period)

- Monitoring and evaluation framework component: Outcome type metric

Note: WHO and UNICEF global databases include DTP3, the acronym for penta 3 is DTPcv-3.

Measurement guidance

- **Method of measurement:**

WHO and UNICEF produce annual estimates of national immunization coverage based on all available country data (e.g., combination of survey, census, and administrative sources). A detailed methodological note on how these estimates are developed is available here: https://www.who.int/docs/default-source/immunization/immunization-coverage/wuenic_notes.pdf?sfvrsn=88ff590d_6

Administrative data includes reports of vaccinations performed by service providers (more details are available in the DHIS2 toolkit for immunization: <https://dhis2.org/immunization/>).

Household survey items correspond to caretaker responses to children's history questions. The indicator is estimated as the percentage of children ages 12–23 months who received three doses of the combined diphtheria, tetanus toxoid and pertussis vaccine at any time before the survey.

- **Data sources:**

WHO and UNICEF (WUENIC) estimates of national immunization coverage.

Routine health information systems/facility records.

Household surveys (Expanded Programme on Immunization 30-cluster survey, Multiple Indicator Cluster Survey, Demographic and Health Surveys).

- **Level of disaggregation:**

The WUENIC estimates are only available at national, regional, and global levels.

Household survey data: Vaccine dose (0, 1, 2, 3 and booster), Age (0–11 months, 12–23 months for infant immunization), by source of information (vaccine card, mothers report, etc.), by residence (urban/rural, subnational region), mother's education level, age, and wealth quintile.

Facility level data: facility type and facility location.

- **Frequency of reporting:**

The WHO–UNICEF (WUENIC) estimates are updated annually. Household surveys are typically conducted every 3–5 years. Data from routine health information systems can be collected on a quarterly basis for facility level or subnational monitoring purposes. Aggregation of the data at national level on an annual basis is also recommended.

Rationale for use/relevance for monitoring performance of the GFF strategy

Penta 3 is one of the GFF core impact and outcome indicators used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. The Countdown to 2030 initiative works closely with the GFF on generating annual progress reports of the GFF supported countries focusing on the core impact indicators including on immunization. The GFF includes household survey-based immunization data (DTP3) on the country profile pages.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives that use penta3 or DTP3 to monitor child health in addition to the Global Financing Facility for Women, Children and Adolescents:

1. **UN Sustainability Goals.** Goal 3, “Ensure healthy lives and promote well-being for all at all ages” includes this age group. Transforming our World: The 2030 Agenda for Sustainable Development. (3.b.1, access to affordable medicines and vaccines)
2. Countdown to 2030: <https://www.countdown2030.org/>
3. Immunization Agenda 2030: <https://www.immunizationagenda2030.org/>.
4. Gavi, the Vaccine Alliance: <https://www.gavi.org/>.

Key publications:

1. Leave no one behind with immunization. Gavi 5.0 Measurement framework (2021–2025). www.gavi.org.
2. IA2030 Monitoring and Evaluation Framework. (Annex of the IA2030 Strategy, and the document “Implementing the Immunization Agenda 2030: A Framework for Action”). https://www.immunizationagenda2030.org/images/documents/IA2030_Annex_FrameworkForActionv04.pdf.
3. United Nations SDG metadata for 3.b.1. (proportion of the target population covered by all vaccines included in their national programme). <https://unstats.un.org/sdgs/metadata/files/Metadata-03-0B-03.pdf>.
4. WHO UNICEF immunization coverage estimates 2022 revision (released 18 July 2023). Methodological notes: https://www.who.int/docs/default-source/immunization/immunization-coverage/wuenic_notes.pdf?sfvrsn=88ff590d_6.

Indicator: Vitamin A supplementation (2 doses)

Concept and definition

- **Concept:**
Vitamin A deficiency is the leading cause of preventable childhood blindness and increases the risk of death from common childhood illnesses such as diarrhoea. Periodic, high-dose vitamin A supplementation is a low-cost intervention proven effective at reducing child mortality. This indicator measures access to two age-appropriate doses of vitamin A in children aged 6 to 59 months.
- **Definition:**
Percentage of children aged 6–59 months who received two age-appropriate doses of vitamin A in the past 12 months.
- **Measurement type:** Percentage (%)
- **Numerator:** Number of children aged 6–59 months who received two age-appropriate doses of vitamin A supplements in the last 12 months.
- **Denominator:** Number of children aged 6–59 months
- **Monitoring and evaluation framework component:** Outcome type metric

Measurement guidance

- **Method of measurement:**
There are two main types of vitamin A supplementation coverage indicators: 1) those that can be reported annually for each semester using data from administrative sources and 2) those that require a sample survey and are only sporadically available (and not necessarily aligned with any semester). The UNICEF Global Vitamin A Supplementation Coverage Database relies on the first type of indicator, although the administrative data has challenges with double counting and denominator issues. While it could be possible to report on the semester-wise indicators using sample surveys, resource constraints have prevented countries from employing surveys to estimate national vitamin A supplementation coverage for individual semesters. Detailed information on measurement of vitamin A supplementation through administrative data sources and household surveys is available in the following publication: United Nations Children's Fund, Estimates of Vitamin A Supplementation Coverage in Preschool-age Children: Methods and processes for the UNICEF global database, UNICEF, New York, 2020.

- **Data sources:**

Population based household surveys (Demographic and Health Surveys, Multiple Indicator Cluster Surveys, National Nutrition Surveys) and administrative data (event-based tally sheets, health information system reports).

- **Level of disaggregation:**

Available from household survey data: sex, place of residence (e.g., urban, rural, subnational region), socioeconomic status of the mother (e.g., education level, household wealth quintile).

Available from administrative data: type of distribution mechanism (campaign-style event, facility level and type)

- **Frequency of reporting:**

Annual for administrative data. Household survey data is generally available every 3–5 years.

Rationale for use/relevance for monitoring performance of the GFF strategy

Vitamin A supplementation (2 doses) is one of the GFF core impact and outcome indicators used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. The GFF includes vitamin A supplementation data on the country profile pages and in the GFF annual reports.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives that use vitamin A supplementation to monitor child health in addition to the Global Financing Facility for Women, Children and Adolescents:

1. Countdown to 2030:
<https://www.countdown2030.org/>
2. Child Survival Action:
<https://www.childhealthtaskforce.org/hubs/child-survival-action>.
3. Scaling up nutrition movement (SUN):
<https://scalingupnutrition.org/>
4. Technical Expert Advisory Group on Nutrition Monitoring (TEAM):
<https://www.who.int/groups/who-unicef-technical-expert-advisory-group-on-nutrition-monitoring/about>.
5. Child Health Accountability Tracking Technical Advisory Group:
<https://www.who.int/groups/child-health-accountability-tracking-technical-advisory-group>.

Key publications:

1. Indicators for assessing infant and young child feeding practices: definitions and measurement methods. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2021. License: CC BYNC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>.
2. United Nations Children's Fund, Estimates of Vitamin A Supplementation Coverage in Preschool-age Children: Methods and processes for the UNICEF global database, UNICEF, New York, 2020.
3. UNICEF maintains the global database on vitamin A supplementation, and data are published annually on the UNICEF data website and included in the flagship UNICEF State of the World's Children report.
4. Child Health Accountability Tracking Technical Advisory Group indicator reference sheets: <https://chat.srhr.org/related-links>.

Indicator:

Minimum acceptable diet

Concept and definition

- **Concept:**

As children grow, their nutrient needs change. At 6 months of age, it is recommended that children should begin eating their first solid foods while continuing to breastfeed until age 2 years or longer. The nutritional needs for growth and development in children 6–23 months of age are greater per kilogram of body weight than at any other time in life. Therefore, frequent feeding of a variety of foods is important to help ensure children's nutrient needs are met to fuel their developing brains and bodies.

- **Definition:**

Percentage of children 6–23 months of age who consumed a minimum acceptable diet during the previous day.

- **Measurement type:** Percentage (%)

- **Numerator:** Children 6–23 months of age who consumed a minimum acceptable diet during the previous day

- **Denominator:** Children 6–23 months of age

- **Monitoring and evaluation framework component:** Outcome type metric

Measurement guidance

- **Method of measurement:**

Women survey respondents are asked about the foods eaten on the previous day by their last-born child 6–23 months of age. Eight food groups are used for the calculation of the indicator: (1) breastmilk, (2) grains, roots, tubers, and plantains (3) pulses (beans, peas, lentils), nuts and seeds, (4) dairy products (infant formula, milk, yogurt, cheese), (5) flesh foods (meat, fish, poultry and liver/organ meats), (6) eggs, (7) vitamin-A rich fruits and vegetables, and (8) other fruits and vegetables.

Minimum is defined as two times solid, semi-solid or soft foods for breastfed infants 6–8 months of age; 3 times solid, semi-solid or soft foods for breastfed children 9–23 months of age; and 4 times solid, semi-solid or soft foods and/or mild feeds including at least 1 non-mild feeding for non-breastfed children 6–23 months of age.

Note: Three other associated indicators are also tracked around children's diet. These include egg and/or flesh food consumption, minimum dietary diversity, and minimum meal frequency. UNICEF hosts the global database for these indicators and metadata is available here: <https://data.unicef.org/topic/nutrition/diets/>.

- **Data sources:** The main source of data for this indicator is population-based household surveys (Demographic and Health Surveys, Multiple Indicator Cluster Surveys, National Nutrition Surveys)
- **Level of disaggregation:** Sex, Location (urban/rural), wealth quintile
- **Frequency of reporting:** Household surveys are typically conducted every 3–5 years.

Rationale for use/relevance for monitoring performance of the GFF strategy

The minimum acceptable diet is one of the GFF core and outcome impact indicators used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. The GFF includes these data on the country profile pages.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives that use minimum acceptable diet to monitor child health in addition to the Global Financing Facility for Women, Children and Adolescents:

1. Child Survival Action (tracks minimum dietary diversity): <https://www.child-healthtaskforce.org/hubs/child-survival-action>.
2. Technical Advisory Group on Nutrition Monitoring (TEAM). <https://www.who.int/groups/who-unicef-technical-expert-advisory-group-on-nutrition-monitoring/about>.
3. Child Health Accountability Tracking Technical Advisory Group (CHAT) (recommends minimum dietary diversity). <https://www.who.int/groups/child-health-accountability-tracking-technical-advisory-group/about-us>.
4. Scaling up nutrition movement (SUN): <https://scalingupnutrition.org/>.
5. Countdown to 2030 (tracks minimum dietary diversity), <https://www.countdown2030.org/>

Key publications:

1. United Nations Children's Fund, Division of Data, Analysis, Planning and Monitoring (2023). Global UNICEF Global Databases: Infant and Young Child Feeding: Egg and/or flesh food consumption, Minimum dietary diversity, Minimum meal frequency, Minimum acceptable diet, New York, December 2023.
2. Indicators for assessing infant and young child feeding practices: definitions and measurement methods. Geneva: World Health Organization and the United Nations Children's Fund (UNICEF), 2021. Licence: CC BYNC-SA 3.0 IGO; <https://creativecommons.org/licenses/by-nc-sa/3.0/igo>.

Indicator:

Diarrhoea treatment with ORS and zinc

Concept and definition

- **Concept:**

Diarrhoea is a leading cause of child under-5 mortality. Diarrhoea deaths are preventable through vaccination, access to safe water and sanitation, good hygiene practices, and treatment with oral rehydration solutions (ORS) plus a zinc supplement. Diarrhoea treatment for children with ORS and zinc is safe, affordable, and effective and should be accessible worldwide to those in need. This indicator measures coverage of ORS and zinc to treat diarrhoea in children under-5 years of age in low-and-middle-income countries.

- **Definition:**

Percentage of children under 5 years of age with diarrhoea in the last two weeks receiving ORS (fluids made from ORS packets or pre-packaged ORS fluids) and zinc supplement.

- **Measurement type:** Percentage (%)

- **Numerator:** Number of children under 5 years of age with diarrhoea in the last two weeks receiving ORS (fluids made from ORS packets or pre-packaged ORS fluids) and zinc supplement.

- **Denominator:** Total number of children under 5 with diarrhoea

- **Monitoring and evaluation framework component:** Outcome type metric

Note: The above metadata is for collection through household surveys. For routine health information system data, the metadata is proportion of childhood cases of diarrhoea given/prescribed treatment for diarrhoea in health facilities.

Numerator: Number of children who received treatment for diarrhoea in facilities;

Denominator: Number of children with diarrhoea seen in facilities. The numerator can be specific on type of treatment received (ORS alone, zinc alone, or ORS and zinc).

Measurement guidance

- **Method of measurement:**

Details on measurement approaches for health facility data are available in the following WHO–UNICEF publication: Analysis and use of health facility data: guidance for maternal, newborn, child and adolescent health programme managers. Geneva: World Health Organization; 2023. Licence: CC BY-NC-SA 3.0 IGO. The District Health Information System (DHIS2) programme also provides guidance on collecting information on treatment for childhood diarrhoea through health facility records.

Household survey programs collect data typically through the women's questionnaire on children with diarrhea (used to establish the denominator, not as a robust measure of disease prevalence), careseeking for diarrhea, feeding practices during diarrhea, source of advice or treatment for children with diarrhea, and treatments for diarrhea (ORS, zinc, continued feeding and other treatments).

- **Data sources:** Population based household surveys (Demographic and Health Surveys, Multiple Indicator Cluster Surveys), and routine health information systems/District Health Information System 2.
- **Level of disaggregation:** Household survey data: Treatment type (ORS and zinc, ORS alone, zinc alone), sex of child, place of residence (e.g., urban, rural, subnational region), age and socioeconomic status of the mother (e.g., education level, household wealth quintile), source of drinking water, and type of toilet facility.

Health facility data: Type and location of facility

- **Frequency of reporting:** Household surveys are typically conducted every 3–5 years.

Facility based data can be collected quarterly and reported annually.

Rationale for use/relevance for monitoring performance of the GFF strategy

ORS and zinc is one of the GFF core impact and outcome indicators used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. The Countdown to 2030 initiative works closely with the GFF on generating annual progress reports of the GFF supported countries focusing on the core impact and outcome indicators including ORS and zinc. The GFF includes data for this indicator on the country profile pages.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives that use ORS and zinc to monitor child health in addition to the Global Financing Facility for Women, Children and Adolescents:

1. **UN Sustainability Goals.** Goal 3, “Ensure healthy lives and promote well-being for all at all ages” includes this age group. Transforming our World: The 2030 Agenda for Sustainable Development.
2. ORS and zinc is a core indicator recommended by the WHO-UNICEF co-convened Child Health Accountability Tracking Working Group. <https://www.who.int/groups/child-health-accountability-tracking-technical-advisory-group>.
3. The Global Strategy for Women’s Children’s and Adolescent’s Health (2016–2030): <https://www.everywomaneverychild.org/global-strategy/#sect2>
4. Countdown to 2030, <https://www.countdown2030.org/>
5. Child Survival Action: <https://www.childhealthtaskforce.org/hubs/child-survival-action>

Key publications:

1. Ending preventable child deaths from pneumonia and diarrhoea by 2025. The integrated Global Action Plan for Pneumonia and Diarrhoea (GAPPD). Geneva: World Health Organization/United Nations Children’s Fund; 2013 (http://apps.who.int/iris/bitstream/10665/79200/1/9789241505239_eng.pdf).
2. Child Health Accountability Tracking Technical Advisory Group indicator reference sheets: <https://chat.srhr.org/related-links>.
3. Analysis and use of health facility data: guidance for maternal, newborn, child and adolescent health programme managers. Geneva: World Health Organization; 2023. Licence: CC BY-NC-SA 3.0 IGO.

Indicator: Careseeking for symptoms of acute respiratory infections (ARI)

Concept and definition

- **Concept:**

Acute respiratory infections (ARI) including pneumonia are a leading cause of under-5 mortality globally. Child deaths from ARI are preventable through vaccination, accurate diagnosis, treatment with first-line antibiotics, and oxygen therapy as needed. Care seeking for ARI is a proxy indicator for timely management of childhood pneumonia and can be used to monitor policy and programmatic actions aimed at improving under-5 survival in low-and-middle income countries.

- **Definition:**

Percentage of children under 5 years of age with symptoms of acute respiratory infection (cough and difficult breathing NOT due to a problem from a blocked nose) in the two weeks preceding the survey, taken to an appropriate health facility or provider.

- **Measurement type:** Percentage (%)

- **Numerator:** Number of children under 5 years of age with symptoms of acute respiratory infection (cough and difficult breathing NOT due to a problem from a blocked nose) in the two weeks taken to an appropriate health facility or provider.

- **Denominator:** Total number of children under 5 with symptoms of acute respiratory infection.

- **Monitoring and evaluation framework component:** Outcome type metric

The above metadata is for collection through household surveys. For routine health information system data, the metadata is:

Total number of children presenting to health facility with any sign of ARI (no denominator provided).

WHO and UNICEF also recommend collecting the following treatment indicator through health facility records: Proportion of childhood cases of pneumonia given/prescribed amoxicillin in health facilities. This is computed by dividing the number of children with pneumonia given/prescribed amoxicillin in facilities divided by number of children with pneumonia seen in facilities.

Measurement guidance

- **Method of measurement:**

Household surveys such as the Demographic and Health surveys include questions on care-seeking for symptoms of ARI typically in the women's questionnaire. The questions start with asking mothers about whether their child had specific symptoms (i.e., cough; fast, short, rapid breaths or difficulty breathing; fast or difficult breathing due to a problem in the chest or to a blocked or runny nose). The next set of questions ask about whether and where the mother/caretaker sought advice or treatment for the child.

Details on data collection through health facilities is available in the updated WHO-UNICEF facility guidance for maternal, newborn, child, and adolescent health program managers (Analysis and use of health facility data: guidance for maternal, newborn, child and adolescent health programme managers. Geneva: World Health Organization; 2023. Licence: CC BY-NC-SA 3.0 IGO). The District Health Information System (DHIS2) child health module also provides information on how to collect data on breathing and chest problems for children under five years of age (<https://docs.dhis2.org/en/implement/health/chis-community-health-information-system/design/child-health.html>).

- **Data sources:**

Population based household surveys (Demographic and Health Surveys, Multiple Indicator Cluster Surveys), and routine health information systems/ District Health Information System 2.

- **Level of disaggregation:**

Household surveys: Child age and sex, mother's characteristics (e.g., smoking status, age, wealth quintile, education level), residence (e.g., urban/rural, subnational region), cooking fuels and technology

Health facility data: Type and location of facility

- **Frequency of reporting:**

Household surveys are typically conducted every 3-5 years.

Facility based data can be collected quarterly and reported annually.

Rationale for use/relevance for monitoring performance of the GFF strategy

Careseeking for symptoms of acute respiratory infections is one of the GFF core impact and outcome indicators used to assess country progress in prioritizing and scaling up evidence driven investments to improve RMNCAH&N. The Countdown to 2030 initiative works closely with the GFF on generating annual progress reports of the GFF supported countries focusing on the core indicators including careseeking for symptoms of acute respiratory infections. The GFF also includes data on this indicator on the country profile pages.

- **Responsible team for reporting at the GFF Secretariat:** Results Team

Resources and references

Key Initiatives that use careseeking for symptoms of acute respiratory infections to monitor child health in addition to the Global Financing Facility for Women, Children and Adolescents:

1. **UN Sustainability Goals.** Goal 3, “Ensure healthy lives and promote well-being for all at all ages” includes this age group. Transforming our World: The 2030 Agenda for Sustainable Development.
2. Careseeking for symptoms of acute respiratory infections is a core indicator recommended by the WHO-UNICEF co-convened Child Health Accountability Tracking Working Group. <https://www.who.int/groups/child-health-accountability-tracking-technical-advisory-group>.
3. Countdown to 2030, <https://www.countdown2030.org/>

Key publications:

1. Ending preventable child deaths from pneumonia and diarrhoea by 2025. The integrated Global Action Plan for Pneumonia and Diarrhoea (GAPPD). Geneva: World Health Organization/United Nations Children’s Fund; 2013 (http://apps.who.int/iris/bitstream/10665/79200/1/9789241505239_eng.pdf).
2. Child Health Accountability Tracking Technical Advisory Group indicator reference sheets: <https://chat.srhr.org/related-links>.
3. Analysis and use of health facility data: guidance for maternal, newborn, child and adolescent health programme managers. Geneva: World Health Organization; 2023. Licence: CC BY-NC-SA 3.0 IGO.

Section 3.

GFF Core Financing Indicators

The four core health financing indicators provide information about the medium- and long-term outcomes of investments and financial reforms and are critical milestones towards the achievement of the GFF aim of strengthened country financial systems.

The following three indicators are consistent with standard indicators tracked by the World Health Organization and available in the Global Health Expenditure Database (<https://apps.who.int/nha/database>):

- 1. Share of government expenditure to health, which captures information on government commitment.**
- 2. Out of pocket expenditure, an important measure of catastrophic household spending and impoverishment and consistent with SDG indicator 3.8.2.**
- 3. Government health budget execution rate to monitor the degree to which approved financial, operational, and capital health plans are being implemented.**

The data collection process for the indicator on share of health expenditures going to frontline providers is tailored to each country's context and definition of frontline providers.

Data for all four of these financing indicators are available on the GFF country pages on the GFF data portal.

