Indicators and Equity Stratifiers of the EWEC-LAC Regional Monitoring Framework

The Metrics and Monitoring Working Group (MMWG, as it referred below) for Every Woman, Every Child Latin America and the Caribbean (EWEC-LAC) has established a Regional Monitoring Framework to support countries in their efforts to reduce health inequities at the national level. The list of priority indicators is based on the Operational Framework of the Global Strategy for Women’s, Children’s and Adolescents’ Health, but has been adapted to reflect the priorities and realities of the region. The adaptation process was led by the members of the EWEC LAC’s MMWG group and consisted of a consultation process with regional experts and national representatives from countries of each subregion of Latin America and the Caribbean.

The final result is a priority list of 31 indicators and 6 stratifiers that constitute the Regional Monitoring Framework for Every Woman, Every Child Latin America and the Caribbean (EWEC LAC).

"The EWEC LAC Regional Monitoring and Evaluation Framework consists of 31 indicators and 6 stratifiers. These include 18 Sustainable Development Goals indicators and 10 indicators from the Global Strategy for Women’s, Children’s and Adolescents’ Health."
### Key indicators and stratifiers

**EWEC-LAC Regional Monitoring Framework**

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<th>Unit</th>
<th>SDG</th>
<th>Global EWEC</th>
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<tr>
<td><strong>Survive</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternal mortality ratio</td>
<td>Ratio by 100,000 live births</td>
<td>3.1.1</td>
<td>✓</td>
</tr>
<tr>
<td>Under-5 mortality rate</td>
<td>Rate by 1,000 live births</td>
<td>3.2.1</td>
<td>✓</td>
</tr>
<tr>
<td>Infant mortality rate (under 1)</td>
<td>Rate by 1,000 live births</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal mortality rate</td>
<td>Rate by 1,000 live births</td>
<td>3.2.2</td>
<td>✓</td>
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<tr>
<td>Low birth weight (prevalence)</td>
<td>Percentage</td>
<td></td>
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<tr>
<td>Antenatal care (ANC) - 4 visits or more (women aged 15-49)</td>
<td>Percentage</td>
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<tr>
<td>Antenatal care (ANC) with quality (i.e., blood test, urine test, check blood pressure) (women aged 15-49)</td>
<td>Percentage</td>
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<tr>
<td>Screen for syphilis during pregnancy (women aged 15-19 and 15-49)</td>
<td>Percentage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Births attended by skilled health personnel (women aged 15-19 and 15-49)</td>
<td>Percentage</td>
<td>3.1.2</td>
<td></td>
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<tr>
<td>Early breastfeeding (within the first hour of birth)</td>
<td>Percentage</td>
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<tr>
<td>Postpartum contact with a health provider within 2 days of delivery (women aged 15-19 and 15-49)</td>
<td>Percentage</td>
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</tr>
<tr>
<td>Postpartum contact with a health provider within 2 days of delivery (newborns)</td>
<td>Percentage</td>
<td></td>
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<tr>
<td>Maternal-infant transmission of HIV and syphilis</td>
<td>Percentage</td>
<td></td>
<td></td>
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<tr>
<td>Number of new HIV infections</td>
<td>Rate per 1,000 uninfected population</td>
<td>3.3.1</td>
<td></td>
</tr>
<tr>
<td>Screen for cervical cancer (women aged 30-49)</td>
<td>Percentage</td>
<td></td>
<td></td>
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<tr>
<td><strong>Thrive</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adolescent birth rate (ages 10-14 and 15-19)</td>
<td>Rate per 1,000 girls aged 10-14 or 15-19</td>
<td>3.7.2</td>
<td>✓</td>
</tr>
<tr>
<td>Demand for family planning satisfied with modern methods (women aged 15-19 and 15-49)</td>
<td>Percentage</td>
<td>3.7.1</td>
<td></td>
</tr>
<tr>
<td>Stunting (height for age &lt;-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age (prevalence)</td>
<td>Percentage</td>
<td>2.2.1</td>
<td>✓</td>
</tr>
<tr>
<td>Malnutrition (wasting and obesity) among children under 5 years of age (prevalence)</td>
<td>Percentage</td>
<td>2.2.2</td>
<td></td>
</tr>
<tr>
<td>Anemia in children under-5 (prevalence)</td>
<td>Percentage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early childhood development on track in health, learning and psychological wellbeing (children from 24 to 59 months old)</td>
<td>Percentage</td>
<td>4.2.1</td>
<td></td>
</tr>
<tr>
<td>Participation in organized learning (one year before the official primary entry age)</td>
<td>Percentage</td>
<td>4.2.2</td>
<td></td>
</tr>
<tr>
<td>Out-of-pocket health expenses as percentage of total health expenditure</td>
<td>Percentage</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td><strong>Transform</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Population living below the national poverty line, by sex and age</td>
<td>Percentage</td>
<td>1.2.1</td>
<td></td>
</tr>
<tr>
<td>Population using safely managed drinking water services</td>
<td>Percentage</td>
<td>6.1.1</td>
<td></td>
</tr>
<tr>
<td>Population with a handwashing facility with water and soap available on premises</td>
<td>Percentage</td>
<td>6.2.1</td>
<td>✓</td>
</tr>
<tr>
<td>Population using (a) safely managed sanitation services</td>
<td>Percentage</td>
<td>6.2.1</td>
<td>✓</td>
</tr>
<tr>
<td>Physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age (women aged 15-19 and 15-49)</td>
<td>Percentage</td>
<td>5.2.1</td>
<td>✓</td>
</tr>
<tr>
<td>Birth registration with a civil authority (children under 5 years of age)</td>
<td>Percentage</td>
<td>16.9.1</td>
<td>✓</td>
</tr>
<tr>
<td>Children and young people: (a) in grades second and third; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics</td>
<td>Percentage</td>
<td>4.1.1</td>
<td>✓</td>
</tr>
</tbody>
</table>

### Stratifiers

For inequality analysis, EWEC LAC recommends analyzing the 30 priority indicators using the following stratifiers - according to data availability:

- Ethnicity
- Gender (sex)
- Income
- Education
- Place of residence (urban/rural)
- State/municipality or lowest administrative disaggregation available

### Additional key indicators Tier II*

- Normal deliveries with quality in-facility care
- Obstetric and neonatal complications managed with quality in-facility
- Youth/Adolescent substance abuse (drugs or alcohol)

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Global EWEC refers to Key Indicators on the Global Strategy Monitoring Framework for EWEC.
SDG refers to indicators that are part of the Sustainable Development Goals.
Adolescent fertility (between 10 and 14 years of age and between 15 and 19 years of age)

**Definitions**
Annual number of births to women in the age group of interest per 1,000 women of that age group of interest. Also known as the age-specific fertility rate.

**Numerator**
- **Civil registry:** Number of registered live births to women of the age group of interest × 1,000
- **Surveys:** using retrospective data, number of births to women who were 10-14 or 15-19 years of age at birth, during a stipulated period prior to the survey.
- **Census:** Based on the date of last birth to obtain the number of births to women 10-14 years of age or 15-19 years in the 12 months prior to the survey × 1,000.

**Denominator**
- **Civil registry:** Estimated number of women in the age group of interest at mid-year
- **Surveys:** number of person-years of women between 10-14 or 15-19 years during the same period stipulated prior to the survey. Note: whenever possible, the stipulated period will be 5 years prior to the survey.
- **Census:** Number of women who were 10-14 years of age or 15-19 years of age in the 12 months prior to the survey is directly obtained.

**Measuring unit**
X for every 1,000 women in the age group of interest

**Considerations for indicator quality**
- Using civil registry data: quality is affected in contexts of low birth registration coverage, or monitoring children dying before being registered, or before the first 24 hours postpartum. Also affected by accuracy of the mother’s age record.
- Using data from population-based surveys: quality can be affected by wrong women’s age registration, and by omission of reporting births or errors in reporting or calculating dates of birth. Whenever possible, the stipulated period will be 5 years prior to the survey. In case of surveys that do not have data from birth histories, the date of last birth is reported, or the number of births in the 12 months prior to the survey.
- Using census data: Estimates are adjusted by sub-reporting level, using indirect methods as a reference.

**Interpretation implications**
Adolescent birth rate measures an edge of the reproductive health of the group of women in this age group, which is of interest after the observation that adolescent women in a gestation period, and give birth at an early age are exposed to increased risks of complications during delivery, including death; and their children are also more vulnerable. Therefore, preventing teenage pregnancies is a measure to improve maternal health and reduce infant mortality.

In relation to this, this indicator provides indirect evidence of the access level to reproductive health services. It has been documented that adolescent population and particularly women who are not married frequently experience difficulties in accessing this type of services. Expression of fertility in the interval from 10 to 14 years is not a rate, but a reason, under the assumption that most girls of 10 and 11 years still do not have their first menstruation, so they cannot be considered as exposed to the risk of pregnancy. However, it is so named for international comparison purposes.

**Context indicator**
Women becoming pregnant and giving birth at an early age reduce their opportunities for socioeconomic development, associated with high probability of not completing their studies. In cases of social isolation, difficulties of combining a working day with necessary activities for home maintenance are added. A related but different indicator is the proportion of adolescent fertility that is computed as the percentage of total fertility that is attributable to the 15-19 group.

**ODS framework**

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<td>Imput</td>
<td>Sex</td>
<td></td>
</tr>
<tr>
<td><strong>Thrive</strong> ✓ Child</td>
<td>Output</td>
<td>Ethnicity</td>
<td>✓</td>
</tr>
<tr>
<td>Transform Adolescence ✓ Results</td>
<td>Education</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Impact ✓ Socioeconomic level (quintiles of national wealth)</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Product Place of residence (urban / rural, or geographic location)</td>
<td>✓</td>
<td></td>
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</tr>
</tbody>
</table>

**Preferred data source**
Civil registry in contexts of coverage close to 100%

**Alternative data sources**
- Censuses, household surveys.

**Inter-agency group estimates**

**Global monitoring frameworks**
- Global Strategy for Women’s, Children’s and Adolescents’ Health.

**For more information**

**References**
- WHO Global Health Observatory.
## Definitions

Women of reproductive age (15-49 years) wishing to have no (additional) children or to postpone the next child and are currently using a modern contraceptive method.

### Numerator

Percentage of women on reproductive age (15-49 years) currently using, or whose sexual partner is currently using, at least one modern contraceptive method.

### Denominator

Family planning total demand (sum of contraceptive prevalence (any method) and unmet need for family planning).

- **Contraceptive prevalence** is the percentage of women currently using, or whose sexual partner is currently using, at least one contraceptive method, regardless of the method used.

- **Unmet need for family planning** is defined as percentage of women of reproductive age, either married or in a union, wanting to stop or delay pregnancy, but are not using any contraceptive method. Standard definition of unmet need for family planning includes women of childbearing age and sexually active in the numerator, reporting that they do not want (more) children, or reporting that they want to delay birth of their next child for at least two years, or undecided about the time of the next birth, but who are NOT using any contraceptive method. In addition, the numerator of unmet need includes pregnant women at the time of the survey whose gestation was unwanted or took place outside of the scheduled time, as well as postpartum amenorrheic women whose last gestation was unwanted or outside of scheduled time and not using any family planning method.

\[ \text{Must add } a + b \]

### Measuring unit

X percent (%).

### Considerations for indicator quality

Differences in survey design and implementation, as well as differences in how survey questionnaires are formulated and administered, can affect comparability of data. The most common differences are related to the range of contraceptive methods included. Time frame used to assess contraceptive prevalence may also vary. In most surveys there is no definition of what is meant by “currently using” a contraceptive method.

In some surveys, lack of probing questions, which are asked to make sure that the respondent understands the meaning of different contraceptive methods, can lead to an underestimation of contraceptive prevalence, particularly for traditional methods. Sampling variability can also be a problem, especially when measuring contraceptive prevalence for a specific subgroup (based on method, age group, level of educational attainment, place of residence) or by analyzing trends over time.

When complete data are not available for women ages 15-49, the following populations have been used: married or in union women ages 15-44, sexually active women (regardless of marital status), or women who have ever been married.

Estimates of this indicator are made for married women or in a union.

**Modern methods:** For analytical purposes, contraceptive methods are often classified as modern or traditional. Modern contraceptive methods include female and male sterilization, intrauterine device (IUD), implant, injectables, oral contraceptive pills, male and female condoms, vaginal barrier methods (including diaphragm, spermicidal foam, jelly, cream, and sponge), lactational amenorrhea (LAM) method, emergency contraception and other modern methods not reported separately (for example, contraceptive patch or vaginal ring). Traditional contraceptive methods include rhythm (i.e. fertility awareness-based methods, periodic abstinence), abstinence, and other traditional methods not reported separately.

### Interpretation implications

Levels of family planning demand met by modern methods of 75 percent or more are generally considered high, and values of 50 percent or less are generally considered extremely low.

Proportion of family planning demand met by modern methods is useful in evaluating overall levels of coverage on family planning programs and services. Access to and use of an effective means of preventing pregnancy helps women and their partners exercise their rights to freely and responsibly decide on the number and spacing of their children and to have the information, education and means to do so. Meeting the demand for family planning with modern methods also contributes to maternal and child health by preventing unwanted pregnancies and closely spaced pregnancies, which are at increased risk of poor obstetric outcomes.
## ODS framework

<table>
<thead>
<tr>
<th>Dimension</th>
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</tr>
</thead>
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<tr>
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</tr>
<tr>
<td>Product</td>
<td>Place of residence (urban / rural, or geographic location)</td>
<td></td>
</tr>
</tbody>
</table>

### Preferred data source

- Household surveys: Contraceptive Prevalence Surveys, Demographic and Health Surveys (DHS), Family and Fertility Surveys (FFS), Health Reproductive Surveys (HRS), Multipurpose Cluster Surveys (MICS), Monitoring and Accountability Surveys 2020 (PMA), World Fertility Surveys (WFS).

### Alternative data sources

- N/A

### Inter-agency group estimates


### Global monitoring frameworks

- Global Strategy for Women’s, Children’s and Adolescents’ Health

### For more information

- Global use of contraceptives 2019

### References

**Definitions**

Prevalence of Stunting (standard deviation of height/length for age <-2 of Stunting patterns for children under five years of the World Health Organization (WHO) median).

**Numerator**

Number of boys and girls under 5 years of age below minus two standard deviations (-2 SD) regarding height/length-for-age of WHO Stunting patterns median.

**Denominator**

Total boys and girls under 5 years of age.

**Measuring unit**

X percent (%).

**Considerations for indicator quality**

Not measured boys and girls, marked as out of range size for their age (aberrant values with SD <-6 or > 6), and not having recorded month and year of birth are excluded from the Stunting calculations (short height/length for age).

Depending on the child’s age and ability to stand, height or size is measured.

- If under 2 years of age, length is measured in lying flat position.
  - If the boy or girl does not sit still in this position, size is measured in the standing position and 0.7 cm are added to convert it to length during data analysis.
- If the child is 2 years of age or older, foot size is measured.
  - If not able to stand up, length is measured in the lying flat position and 0.7 cm subtracted to convert to size during data analysis.

Uncertainty of survey estimates is due to sampling errors and non-sampling errors (for example, technical errors in measurement, computation, among others). Neither source of error has been fully considered for derived estimates at the national, regional or global levels.

**Interpretation implications**

Stunting is an internationally recognized result as an indicator of children’s nutritional status. Stunting refers to a boy/girl being too short height/length for his/her age and is the cumulative result of chronic or recurrent malnutrition, including the effect of disease/infection from intrauterine life, with a life-cycle perspective. This measure is also interpreted as an indicator of poor environmental conditions that restrict potential growth of infants.

**Context indicator**

Stunting is a risk factor that contributes to infant mortality and is also a marker of human development inequalities. Children with Stunting may not reach their full physical and cognitive potential. Stunting is the devastating result of malnutrition in the womb and during childhood. Children with Stunting may not reach their full physical and cognitive potential. These children begin their lives at a marked disadvantage leading them to face consequences such as having learning difficulties in school, earning less as adults and facing barriers to participate in their communities.

**ODS framework**

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</tr>
<tr>
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</tr>
<tr>
<td>Transform</td>
<td>Adolescence</td>
<td>Results</td>
<td>Mother’s education</td>
</tr>
</tbody>
</table>

**Preferred data source**

National nutrition surveys, household surveys, and country nutrition surveillance systems.

**Alternative data sources**

N/A

**Inter-agency group estimates**

- Global database on growth and malnutrition in children: [WHO](https://www.who.int/nutgrowthdb/publications/methodology/en/)
- UNICEF: [https://data.unicef.org/topic/nutrition/malnutrition/](https://data.unicef.org/topic/nutrition/malnutrition/)
- World Bank Open Data

**Global monitoring frameworks**

- Global Strategy for Women’s, Children’s and Adolescents’ Health
<table>
<thead>
<tr>
<th>For more information</th>
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</thead>
<tbody>
<tr>
<td>Joint child malnutrition estimates - Levels and trends. UNICEF-WHO-WB. <a href="https://www.who.int/nutgrowthdb/estimates/en/">https://www.who.int/nutgrowthdb/estimates/en/</a></td>
<td></td>
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<tr>
<td>WHO Anthro Survey Analyzer</td>
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<tr>
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<tr>
<td>SDG metadata repository. <a href="https://unstats.un.org/sdgs/metadata/">https://unstats.un.org/sdgs/metadata/</a></td>
<td></td>
</tr>
<tr>
<td>WHO Anthropometric Measurement Specifications: <a href="https://www.who.int/childgrowth/publications/physical_status/es/">https://www.who.int/childgrowth/publications/physical_status/es/</a></td>
<td></td>
</tr>
</tbody>
</table>
### Overweight and obesity (boys and girls under 5 years of age), prevalence

**Definitions**

| Percentage of children 0 to 59 months of age who present weight for height/length (W/H) greater than the cut-off point of 2 standard deviations (+2SD) of the WHO child growth standards median. |

**Numerator**

Number of children aged 0 to 59 months surveyed who present W/H greater than the cut-off point of 2 standard deviations (+2SD) from the median x 100.

**Denominator**

Total number of children from 0 to 59 months of age surveyed.

**Measuring unit**

X percent (%).

### Considerations for indicator quality

In the case of population nutrition surveys, interviewers are often trained to obtain measurements of weight and height as accurately as possible. This element must be considered in the case of other data sources. In order to calculate the overweight indicator in children under five years of age, it is necessary to measure weight, length for children under two years of age and height for those over two years of age. These measurements are transformed into anthropometric indexes, which allows classifying minors as overweight (including obesity) when the Z score is above +2 standard deviations.

For cleanliness of information, in accordance with WHO criteria, the value ranges between -6.0 and +5.0 Z points of weight for age should be considered as valid data; between -6.0 and +6.0 height-for-age Z points; between -5.0 and +5.0 Z points of weight for height and between -5.0 and +5.0 of BMI for age, with respect to the mean of the population of children under five years of age.

### Interpretation implications

Childhood overweight and obesity are associated with a higher probability of premature death and disability in adulthood and of suffering from noncommunicable diseases at younger ages. These conditions are not only related to the behavior of the boy or girl but also to social and economic development and policies in agriculture, transportation, urbanization, environment, education, food industrialization and promotion of physical activity. Therefore, a population-based, multisectoral, multidisciplinary approach adapted to cultural circumstances is required for the prevention and care of overweight.

Overweight (including obesity) in children under five years of age refers to a child who is very heavy for their height/length. It results from the energy imbalance between caloric intake and low physical activity. This form of malnutrition in children under 5 years of age has important consequences on physical and mental health. It conditions to present a greater probability of suffering from chronic diseases, orthopedics, self-esteem problems and discrimination in the future.

It is reported less frequently compared to those measures of deficiency malnutrition, despite the fact that many countries face a double burden with high numbers of children under five who are overweight.

### Context indicator

Overweight (including obesity) in children under five years of age refers to a child who is very heavy for their height/length. It results from the energy imbalance between caloric intake and low physical activity. This form of malnutrition in children under 5 years of age has important consequences on physical and mental health. It conditions to present a greater probability of suffering from chronic diseases, orthopedics, self-esteem problems and discrimination in the future.

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</tr>
</tbody>
</table>

### Preferred data source

National Household Health and Nutrition Surveys.

### Alternative data sources

- Censuses, ad hoc studies.

### Inter-agency group estimates

- The estimates of the indicator at the global and regional levels include boys and girls under 5 years of age. Information disaggregated by country is available in most household surveys. The interagency estimates have data disaggregation reports by sex, age group, education, residence, etc..

### Global monitoring frameworks

- Global Strategy for the Health of Women, Children and Adolescents.
- WHO. 100 basic Health indicators.
Weight and height-length measurements in children under 5 years of age should be performed in accordance with documented WHO measurement standard technical specifications. Convert raw weight and height-length data to z-scores and make estimates of the overweight and obesity indicator based on the WHO child growth charts.

### References

## Definitions

Boys and girls between 6 and 59 months with hemoglobin (Hb) concentration less than 110 g/L, adjusting for place of residence altitude.

### Numerator

Total boys and girls between 6 and 59 months with hemoglobin concentration of less than 110 g/L

### Denominator

Total population aged between 6 and 59 months.

### Measuring unit

X percent (%).

### Considerations for indicator quality

It is recommended not to include observations where Hb concentrations are implausible: less than 25 g/L or greater than 200 g/L.

Hemoglobin concentration adjustments by place of residence altitude is done using the following formula developed by CDC:

\[ \text{Hb}_{\text{adjusted}} = \text{Hb}_{\text{not adjusted}} + 0.32 \times (\text{altitude} \times 0.0033) - 0.22 \times (\text{altitude} \times 0.0033)^2 \]

### Interpretation implications

Anemia is a condition evaluated by measuring hemoglobin in blood. Prevalence of anemia in population is used to classify public health importance. Anemia negatively affects infant motor, weight, and cognitive development. Iron deficiency is considered the most common cause of anemia, but there are other nutritional and non-nutritional causes. Hemoglobin concentrations in blood are affected by many factors, such as altitude (meters above sea level), age and sex, as well as infant and young child feeding, iron supplement, among others.

### Context indicator

Prevalence of anemia varies considerably between world regions, and also inside countries. A recent review of global trends in prevalence of anemia indicates that the increase in mean hemoglobin concentrations worldwide has been marginal in recent decades.

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<td>Product</td>
</tr>
</tbody>
</table>

### Preferred data source

National nutrition surveys or other household surveys

### Alternative data sources

N/A

### Inter-agency group estimates


### Global monitoring frameworks


### For more information

- OMS. 100 basic health indicators. [https://www.who.int/healthinfo/indicators/2015/chi_2015_57_anaemia_children.pdf?ua=1](https://www.who.int/healthinfo/indicators/2015/chi_2015_57_anaemia_children.pdf?ua=1)

### References
Early childhood development (ECD) in terms of health, learning and psychosocial well-being, disaggregated by sex (children aged 24 to 59 months)

Definitions

Children 24 to 59 months with adequate development in terms of health, learning and psychosocial well-being. This indicator is currently measured through percentage of children aged 36 to 59 months showing adequate development in at least three of four domains: literacy–numerical, physical, socio-emotional and learning aptitude.

Domains included in the indicator that are used to report SDG indicator 4.2.1 are operationally defined as follows. Children are considered to have adequate development in the domain if:

1. Literacy and numerical aptitude. At least two of the following can be done: identify and name at least 10 letters of the alphabet; read at least 4 simple and popular words; recognize symbols and name all the numbers from 1 to 10.
2. Physical. Can pick up a small object with two fingers, such as a stick or rock from the ground, and the primary caregiver does not indicate that the child has sometimes felt too sick to play.
3. Social-emotional. At least two of the following are true: the boy or girl gets along well with other children; does not kick, bite, or hit other children or adults; the child is not easily distracted.
4. Learning. Follow simple instructions on how to do something correctly or when given something to do are able to do it independently.

Numerator

Number of children between 36 and 59 months of age meeting at least 3 of the 4 domains * 100.

Denominator

Total number of children between 36 and 59 months of age.

Measuring unit

X percent (%).

Considerations for indicator quality

UNICEF maintains the global database on this indicator that is part of the SDGs (Indicator 4.2.1) and other official reports. Before any data point is included in the database, focal points at UNICEF headquarters examine it to verify data consistency and overall quality. This review is based on a set of objective criteria to ensure that only the most recent and reliable information is included in the databases: data sources must include appropriate documentation; data values must be representative at national population level; data is collected using appropriate methodology (i.e. sampling); data values are based on a large enough sample; data conforming to the indicator standard definition, including age group and concepts, as far as possible; the data is plausible based on trends and consistency with previously published/reported estimates for the indicator.

Interpretation implications

Early childhood development (ECD) is essential for a healthy life course. Investing in ECD is one of the most cost-effective investments a country can make to improve adult health, education, and productivity to build human capital and promote sustainable development. Applying population strategies that promote ECD fosters equity from the beginning of life. Efforts to improve ECD can achieve improvements in human, social, and economic development for both individuals and populations.

Context indicator

It is considered appropriate to use the proxy “percentage of children 36 to 59 months showing adequate development in at least three of four domains” as long as the indicator operationalization is published, was classified as a Tier indicator II in the March 2020 review.

ODS framework

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Preferred data source

Countries collect data on state of children's development through household surveys, such as MICS (UNICEF), or demographic and health surveys (DHS). Some of the individual elements included in IPR measurement can be collected through other mechanisms (such as other surveys or administrative records) in high-income countries.

Alternative data sources

N/A
| **Inter-agency group estimates** | UNICEF conducts a comprehensive consultative process to collect and evaluate data from national sources to update its global databases on situation of children. Starting in 2018, UNICEF launched a new country consultation process with national authorities. The consultation process requested comments directly from National Statistical Offices, as well as from other government agencies responsible for official statistics, on indicator compilation, including data sources used, and the application of internationally agreed definitions, classifications and methodologies for data from that source. |
| **Global monitoring frameworks** | • Global Strategy for Women's, Children's and Adolescents' Health. |
| **For more information** | • UNICEF, [http://data.unicef.org/ecd/development-status.html](http://data.unicef.org/ecd/development-status.html) |
| **References** | • SDG metadata repository, [https://unstats.un.org/sdgs/metadata/](https://unstats.un.org/sdgs/metadata/) |
Participation in organized learning (one year before the official age of enrollment in primary education)

Definitions

Boys and girls in the age range included one year before entering primary school participating in one or more organized learning programs, including programs that offer a combination of education and care. The age range will vary according to the country depending on the official age to enter primary education. The indicator measures children’s exposure to organized learning activities in the year prior to primary school start. It includes exposure of children that, being younger than the official primary school enrollment age, are already studying at this level of education. A high value of the indicator shows a high degree of participation in organized learning immediately before the official age to enter primary education. Number of children in the included age group participating in an organized learning program is expressed as a percentage of the total population in the same age range.

Numerator

Number of boys and girls enrolled in early childhood education or primary education (ISCED levels 0 and 1) who are one year below the official entry age to primary education x 100.

Denominator

Total children population one year under official entry age to primary education.

Measuring unit

X percent (%).

Considerations for indicator quality

Official entry age for primary education is the age at which children are required to start primary education in accordance with national legislation or policies. When more than one age is specified, for example, in different parts of a country, the most common official entry age is used (i.e. the age at which most children in the country are expected to start primary school) to calculate this indicator worldwide.

Interpretation implications

Learning programs in the early years is not a full-time participation for many children, meaning that exposure to learning environments outside the household will vary in intensity. Indicator measures the percentage of children exposed to organized learning, but not the intensity of the program, which limits the ability to draw conclusions about the extent to which this objective is being achieved. More work is needed to ensure that the definition of learning programs is consistent across multiple surveys and defined so that respondents can easily understand it, ideally with supplemental information collected regarding the amount of time children spend in learning programs.

Context indicator

An organized learning program consists of a coherent set or sequence of educational activities designed with the intention of achieving predetermined learning outcomes or performing a specific set of educational tasks. Primary and early childhood programs are examples of organized learning programs. Early childhood and primary education are defined in the 2011 revision of the International Standard Classification of Education (ISCED 2011). Early childhood education is typically designed with a holistic approach to support children's early cognitive, physical, social, and emotional development and introduce young children to organized instruction outside of the family context. Elementary education offers learning and educational activities designed to provide students with fundamental skills in reading, writing and mathematics and to establish a solid foundation for learning and understanding basic areas of knowledge and development. It focuses on learning at a basic level of complexity with little specialization, if any.

ODS framework

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Preferred data source

The indicator can be calculated from both administrative data and household surveys. Administrative: the number of enrollments in organized learning programs are reported by schools and the population in the age group under one year of official primary school enrollment age is derived from population estimates. Household surveys: both enrollments and population are collected at the same time.

Preferred data source

N/A

Alternative data sources

- To calculate this worldwide indicator, the Institute uses population estimates from the United Nations Population Division.
<table>
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Out-of-pocket health expenditure as a percentage of total health expenditure

### Definitions
- **Out-of-pocket expenses level expressed as a percentage of total health expenditure.**
- **Out of pocket costs:** Household health expenditures as direct payments to health care providers. Must be net of health insurance reimbursements.
- **Household:** individual or a group of people sharing the same accommodation, grouping part, or all, of their income and wealth and consuming certain types of goods and services collectively, mainly housing and food.
- **Total Health Expenditure (THE):** Sum of all expenses for maintenance, restoration or health improvement paid in cash or supplied in kind. Sum of Governments’ General Expenditure in Health and Private Expenditure in Health.

### Numerator
- Out-of-pocket health expenditure for the relevant fiscal year × 100.

### Denominator
- Total expenditure on health for the same fiscal year and in the same monetary unit as the numerator.

### Measuring unit
- X percent (%).

### Considerations for indicator quality
- National health accounts (NHA) track agents’ financing flows who decide on the use of funds. NHAs strategy is to track transaction records, without double counting and to achieve comprehensive coverage. Therefore, insurance reimbursements must be deducted. Monetary and non-monetary transactions are accounted for at the buyers’ value, so payments in kind must be valued at the buyers’ price. There are guidelines to generate national health accounts. (OECD, 2000; WHO-World Bank-USAID, 2003).
- It is recommended to follow the guidelines for production of national health accounts: [https://www.who.int/health-accounts/documentation/system_of_health_accounts_2011/en/](https://www.who.int/health-accounts/documentation/system_of_health_accounts_2011/en/)

### Interpretation implications
- This is a central indicator of health financing systems. It helps to understand the relative weight of direct household payments in total health expenditures.

### Context indicator
- High out-of-pocket payments are strongly associated with catastrophic and impoverishing spending. This indicator is key to support planning and equity processes.

### ODS framework

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SDG indicator 3.8.2 is related to this indicator but uses income/expenditure at the household level as the denominator, as an approximation to the objective of financial protection.

### Preferred data source
- National Health Accounts
- Administrative information systems
- Household income and expenditure surveys

### Alternative data sources
- Special studies.

### Inter-agency group estimates
- National and regional data available in the Global Health Expenditure Database, WHO.

### Global monitoring frameworks
- Global Strategy for Women’s, Children’s and Adolescents’ Health.
- WHO: 100 basic health indicators: expend out of pocket.

### For more information
- Tool for production of national Health accounts, WHO.

### References
- Global Health Observatory Metadata Registry, WHO.
These are social determinants used in health inequality analysis to define the groups to be compared.

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<tr>
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<th>Education</th>
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<td></td>
<td>Conceptual considerations</td>
<td></td>
<td>Examples of categories (operationalization)</td>
<td></td>
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<tr>
<td>Biological construct based on characteristics that allow sexual reproduction.</td>
<td></td>
<td>For health inequality analysis, the gender variable is limited to self-identification information reported by participants in health surveys or in routine collection systems.</td>
<td>Male and female • percentage of male population. • percentage of female population.</td>
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<td><strong>Ethnicity</strong></td>
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<tr>
<td>It refers to human groups that share a cultural and ancestral heritage</td>
<td></td>
<td>Ethnic groups often define themselves based on shared cultural and physical characteristics, such as the language they speak or the color of their skin</td>
<td>Indigenous population • Percentage of population with indigenous self-identification. • Percentage of the population that speaks an indigenous language. Afro-descendant population • Percentage of population that is Afro-descendant.</td>
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<td><strong>Education</strong></td>
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<tr>
<td>Indicates the highest level of education obtained by the population</td>
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<td>Access to education is recognized as having an impact on the health conditions of the population since it facilitates contact and interaction with health services. In the event of making comparisons over time or between countries, it should be considered that there are variations in the effects of education on health between cohorts from the same geographic location and also between countries</td>
<td>Education level • Percentage of population that has completed secondary school. • Years of schooling.</td>
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### Socioeconomic Level

<table>
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| It refers to social and economic factors that influence what position individuals will take in society | Income and wealth are the two indicators of socioeconomic status that most directly measure material circumstances. To interpret results in cross-sectional analysis, it should be considered that there is a double directionality in the relationship between income/wealth and health: both wealth can help achieve health, and healthy people have a greater opportunity to achieve wealth. Conversely, sick individuals can also suffer impoverishment due to the disease | Income  
- Household income is used frequently based on survey estimates of income and expenditure. It presents high levels of variability over time.  
- It is recognized that consumption estimates offer greater reliability in contexts where a high percentage of the population works in the informal sector.  
Wealth  
- Generally used in survey analysis. It is generally estimated at the household level. The analysis includes the assets owned in the home and the quality of the home in which they live. It is usually analyzed in wealth quintiles at the household level. |

### Place of Residence

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| Also called geographic location, it refers to location in rural or urban areas. | Evidence indicates that the inhabitants of dispersed or more remote populations tend to have different demographic characteristics from rural areas, with a higher proportion of children and older adults, as well as indigenous people, and lower socioeconomic levels on average, compared to urban areas. Among the barriers encountered by rural populations are: long distances to health facilities, adverse weather events, and health services that are not aligned with cultural preferences | Urban / rural  
- Conventional criteria are applied according to the type of study, or institutional objectives:  
  - Number of inhabitants.  
  - Population density.  
  - Public transport networks.  
  - Availability of sanitation services. |

**DATA SOURCES:**

Data for the stratifiers can be obtained from different sources, depending on whether you want to do analysis at the individual or ecological level (with grouped data). In the first case - individual level – it is strongly recommended to use representative survey data at least in urban and rural strata; In the case of analysis with data grouped by geographic unit, administrative data from routine collection systems are usually used, taking into account political, historical or economic events that explain significant changes in the social determination of health over time.