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 32 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 32 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

Indicator name	Unit	SDG	Global EWEC
Survive			
Maternal mortality ratio	Ratio by 100,000 live births	3.1.1	√
Under-5 mortality rate	Rate by 1,000 live births	3.2.1	√
Infant mortality rate (under 1)	Rate by 1,000 live births		
Neonatal mortality rate	Rate by 1,000 live births	3.2.2	√
Low birth weight (prevalence)	Percentage		
Antenatal care (ANC) - 4 visits or more (women aged 15-49)	Percentage		
Antenatal care (ANC) with quality (i.e., blood test, urine test, check blood pressure) (women aged 15-49)	Percentage		
Screen for syphilis during pregnancy (women aged 15-19 and 15-49)	Percentage		
Births attended by skilled health personnel (women aged 15-19 and 15-49)	Percentage	3.1.2	
Early breastfeeding (within the first hour of birth)	Percentage		
Exclusive breastfeeding	Percentage		
Postpartum contact with a health provider within 2 days of delivery (women aged 15-19 and 15-49)	Percentage		
Postpartum contact with a health provider within 2 days of delivery (newborns)	Percentage		
Maternal-infant transmission of HIV and syphilis	Percentage		
Number of new HIV infections	Rate per 1.000 uninfected population	3.3.1	
Screen for cervical cancer (women aged 30-49)	Percentage		
Thrive			
Adolescent birth rate (ages 10-14 and 15-19)	Rate per 1,000 girls aged 10-14 or 15-19	3.7.2	√
Demand for family planning satisfied with modern methods (women aged 15-19 and 15-49)	Percentage	3.7.1	
Stunting (height for age <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age (prevalence)	Percentage	2.2.1	√
Malnutrition (wasting and obesity) among children under 5 years of age (prevalence)	Percentage	2.2.2	
Anemia in children under-5 (prevalence)	Percentage		
Early childhood development on track in health, learning and psychological wellbeing (children from 24 to 59 months old)	Percentage	4.2.1	
Participation in organized learning (one year before the official primary entry age)	Percentage	4.2.2	
Out of-pocket health expenses as percentage of total health expenditure	Percentage		√
Transform			
Population living below the national poverty line, by sex and age	Percentage	1.2.1	
Population using safely managed drinking water services	Percentage	6.1.1	
Population with a handwashing facility with water and soap available on premises	Percentage	6.2.1	√
Population using (a) safely managed sanitation services	Percentage	6.2.1	
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)	Percentage	5.2.1	√
Birth registration with a civil authority (children under 5 years of age)	Percentage	16.9.1	√
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	Percentage	4.1.1	√
Global Strategy indicators at the national level with full disaggregation when relevant to the target.	Number of indicators and percentage	17.18.1	

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	These are key indicators as well, however, the measurement methodology for these indicators has not been agreed upon yet, and hence they are classified as Tier II. EWEC LAC will work to determine a common set of measures in the future.
Obstetric and neonatal complications managed with quality in-facility	
Youth/Adolescent substance abuse (drugs or alcohol)	

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.

Maternal Mortality Ratio
(women 15-19 and 15-49 years of age)

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Definitions	Annual number of women deaths related to or aggravated by pregnancy, childbirth or postpartum period, excluding accidental or incidental causes. Includes the period from conception to day 42 postpartum, regardless of pregnancy location, or its duration. It is expressed for every 100,000 live births.
Numerator	Number of maternal deaths in a place and period.
Denominator	Number of live births in the same place and period.
Measuring unit	X per 100,000 live births.
Considerations for indicator quality	It is important to correct for proportion of maternal deaths poorly classified, and to consider percentage of underreporting. For each death, information is required on pregnancy status, period in which death occurred (during gestation, delivery or on what day within 42 days after delivery), and cause of death.

Interpretation implications

MMR measures obstetric risk once a woman becomes pregnant. It is the most appropriate indicator if maternal health services are to be evaluated.

The Maternal Mortality Rate (its denominator is the number of women of reproductive age) measures the risk of dying and includes both the possibility of becoming pregnant (fertility) and of dying during pregnancy or postpartum period. If the intention is to measure the baseline or progress of reproductive health services, maternal mortality rate is a better measure because it incorporates progress in family planning (fertility, spacing, age at the time of pregnancy) as well as progress in maternity services (access and quality of care).

Context indicator	This indicator is relevant as a tracer because it captures failures in both primary care (prevention and early diagnosis) and hospital care (timely treatment and effective management of complications), and also in social conditions according to "delays model".

ODS framework

3 GOOD HEALTH AND WELL-BEING

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive	√	**Woman**	√	Imput		Sex	
Thrive		Childhood		Output		**Ethnicity**	√
Transform		Adolescence		Results		**Education**	√
				Impact	√	**Socioeconomic level (quintiles of national wealth)**	√
				Product		**Place of residence (urban / rural, or geographic location)**	√

Preferred data source

Vital records obtained routinely, in contexts where medical record coverage of causes of death is high, and with periodic evaluation of percentage of misclassification and underreporting.

Alternative data sources	• Household surveys, censuses, sentinel surveillance systems, ad hoc studies
Inter-agency group estimates	• WHO, UNICEF, UNFPA, the United Nations Population Division and the World Bank Group have developed a method to adjust existing data taking into account data quality issues and to ensure comparability of different data sources. This method involves evaluating data to determine whether it is complete and, where necessary, adjusting for misclassification of deaths, as well as preparing estimates using statistical models for countries not having reliable national level data.
Global monitoring frameworks	• Global Strategy for Women's, Children's and Adolescents' Health. Key indicator 1
For more information	• 100 WHO Basic Health Indicators, 2018. • Trends in maternal mortality: 2000 to 2017 • Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division: https://apps.who.int/iris/bitstream/handle/10665/327595/9789241516488-eng.pdf?ua=1
References	• Calvello EJ, Skog AP, Tenner AG, Lee &, Wallis A. Applying the lessons of maternal mortality reduction to global emergency health. Bull World Heal Organ [Internet]. 2015 [cited 2019 Feb 4];93:417–23. Available from: https://www.who.int/bulletin/volumes/93/6/14-146571.pdf

Mortality in children under 5 years of age (boys and girls under 5 years of age)

Definitions	Probability of dying between birth and 5 years of age, expressed per 1,000 live births.
Numerator	Number deaths in children under 5 years of age multiplied by 1,000.
Denominator	Number of live births in the same year and place.
Measuring unit	X per 1,000 live births.
Considerations for indicator quality	As with other mortality indicators, it is challenging to obtain accurate mortality rates in children under 5 years of age, given the difficulties in adequately classifying deaths, as well as the promptness and coverage of newborn registries, which many times vary according to the place (urban, rural), or ethnic group.

Interpretation implications

This indicator is not strictly a rate, but an estimated probability of death before the 5th birthday. The number of live births is used as a proxy for the number of children 5 years of age, so the estimate is subject to greater errors in contexts of low birth and death registration coverage. Statistical estimation methods have been applied to overcome some of these limitations. See, for example, the United Nations inter-agency group estimate.

Some methods for estimating this indicator are:

- Civil registry: the number of deaths at the age of 0 to 5 years for a place and year multiplied by 1,000 is used as a numerator; and as a denominator, the population of live births for the same place and year is used.
- Censuses and surveys: indirect method, after investigating how many births women of reproductive age have had and how many have survived; the Brass method is applied with this information.
- Surveys: direct method based on birth history that includes a series of specific questions for each son/daughter that have been had. To reduce sampling errors, estimates by this means are usually presented grouping 5 or 10 years prior to the survey.

Context indicator	The probability of dying before the 5th birthday is a sensitive indicator to the social determinants of health, because it covers a longer period of exposure to them than infant mortality. In a statistical model it was found that the reductions in the mortality rate in children under 5 years of age were explained by 55% because of: increase in the mother's schooling, increase in household income, internal migration, decrease in fertility rates, decrease in low birth weight, increase in early-onset infant lactation, increase in the prevalence of contraceptive use, decrease in childbirths (number of children per woman), and access to improved sanitation facilities.

ODS framework

3 GOOD HEALTH AND WELL-BEING

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive	√	Woman		Imput		**Sex**	√
Thrive		**Childhood**	√	Output		**Ethnicity**	√
Transform		Adolescence		Results		**Mother's education**	√
				Impact	√	**Socioeconomic level (quintiles of national wealth)**	√
				Product		**Place of residence (urban / rural, or geographic location)**	√

Preferred data source

Administrative records (civil registration of births and deaths) in cases where the registration coverage is high.

Alternative data sources	• Population surveys, censuses.
Inter-agency group estimates	• United Nations Inter-agency Group for the Estimation of Infant Mortality. Explanatory note in Spanish.
Global monitoring frameworks	• Global Strategy for Women's, Children's and Adolescents' Health. Key indicator Survive 2 • Countdown 2030: Demographic Indicators, Infant Mortality.
For more information	• https://data.unicef.org/topic/child-survival/under-five-mortality/
References	• https://childmortality.org/

Infant mortality (under 1 year of age)

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Definitions	Risk of dying for a boy or girl before reaching the first year of life in a given place and period, if exposed to the experience of age-specific mortality.
Numerator	Number deaths in children under 1 year of age multiplied by 1,000.
Denominator	Number of live births in the same year and place.
Measuring unit	X per 1,000 live births.
Considerations for indicator quality	As with other mortality indicators, it is challenging to obtain accurate infant mortality rates given the difficulties in properly classifying deaths, as well as the promptness and coverage of newborn registrations, which often vary according to place (urban, rural) or specific population group, such as ethnic population. Some methods for estimating this indicator are: • Civil registry: the number of deaths at the age of 0 for a place and year multiplied by 1,000 is used as a numerator; and as a denominator, the population of live births for the same place and year is used. • Censuses and surveys: indirect method, after investigating how many births women of reproductive age have had and how many have survived; the Brass method is applied with this information. • Surveys: direct method based on birth history that includes a series of specific questions for each son/daughter that have been had. To reduce sampling errors, estimates by this means are usually presented grouping 5 or 10 years prior to the survey.

Interpretation implications

It is interpreted as "X" deaths in children under 1 year of age per 1,000 live births. The estimates of interagency groups go through a statistical treatment that allows a better comparison between countries. To make comparisons between sub-national units within a country, variations in sources or birth registration coverage, for example, should be considered.

Context indicator	In addition to measuring child survival, the infant mortality rate is considered an important approximation of the measure of health in the population, and reflects the association between the causes of infant mortality and other social health determinants, such as economic development, general living conditions, social well-being, environmental quality, which are the object of action programs such as vaccination, oral hydration, wastewater and excreta management, firm ground that seek to reduce infant mortality levels. Also, of the opportunity and access to adequate medical care, especially medical care related to prenatal care. A historical review of interventions for the reduction of infant mortality concludes that structural interventions such as improvements in civil registration, and sanitation such as water purification and milk pasteurization are central to reduce this phenomenon.

ODS framework

3 GOOD HEALTH AND WELL-BEING

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive	√	Woman		Imput		Sex	√
Thrive		Childhood	√	Output		Ethnicity	√
Transform		Adolescence		Results		Mother's education	√
				Impact	√	Socioeconomic level (quintiles of national wealth)	√
				Product		Place of residence (urban / rural, or geographic location)	√

Preferred data source

Administrative records (vital statistics / civil registration of births and deaths) in cases where registration coverage is high

Alternative data sources	• Household surveys, systematized clinical records
Inter-agency group estimates	• United Nations Inter-agency Group for the Estimation of Infant Mortality. Explanatory note in Spanish.
Global monitoring frameworks	
For more information	• United Nations Inter-agency Group for the Estimation of Infant Mortality. https://childmortality.org/
References	• https://childmortality.org/

Neonatal mortality (first 28 days of life)

Definitions	Probability (expressed per 1000 live births) of a child dying during the first 28 days of life, for a given period and place, being subject to age-specific mortality rates in that period.
Numerator	Number of children deaths between 0 and 27 days 23 hours of life, excluding those with 28 days already completed (civil registry and survey).
Denominator	Number of live births during the period (civil registries). Number of surviving children at the beginning of the specified age range, during the 10 years prior to the survey (survey).
Measuring unit	X per 1,000 live births.
Considerations for indicator quality	In countries with low coverage of birth and mortality registration systems, it is recommended to resort to the estimates of interagency group IGME. If the data is available with sufficient coverage, for a higher level of analysis, neonatal deaths can be subdivided into "early": from 0 to 7 days, and "late" from the 8th to the 28th day.

Interpretation implications

Most neonatal deaths are expected to occur in the first week, with a predominance of the first day of life.

Context indicator	Globally, reductions in neonatal mortality rate have been less rapid than for infant mortality, which is expressed in a relative increase in their weight over all infant mortality. This indicator is sensitive to improvements in social health determinants (even outside the health sector); both to interventions based on people in the community (health education in women's groups, home visits the first 2 days of life), as well as those that improve the quality of care in pregnancy and childbirth, tetanus vaccination in women in fertile age, exclusive breastfeeding, proper application of neonatal resuscitation, umbilical cord care, management of neonatal infections; the presence of doctors and nurses trained in primary care, and improvements in medical infrastructure and equipment at the 2nd and 3rd levels of healthcare, and also referral and counter-referral systems.

ODS framework

3 GOOD HEALTH AND WELL-BEING

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive	√	Woman		Imput		**Sex**	√
Thrive		**Childhood**	√	Output		**Ethnicity**	√
Transform		Adolescence		Results		**Mother's education**	√
				Impact	√	**Socioeconomic level (quintiles of national wealth)**	√
				Product		**Place of residence (urban / rural, or geographic location)**	√

Preferred data source

Civil records / vital and health statistics with high coverage.

Alternative data sources	• Household surveys, censuses, systematized clinical records.
Inter-agency group estimates	• United Nations Inter-agency Group for the Estimation of Infant Mortality. (IGME) https://childmortality.org/
Global monitoring frameworks	• Global Strategy for Women's, Children's and Adolescents' Health. Key indicator 3.
For more information	• https://data.unicef.org/topic/child-survival/neonatal-mortality/
References	• https://childmortality.org/

Low birth weight (prevalence)

Definitions	Percentage of live births weighing less than 2,500 grams.
Numerator	Number of live births weighing less than 2,500 grams in a time period (e.g. 1 year).
Denominator	Number of live births in the same time period (e.g. 1 year).
Measuring unit	X percent (%).
Considerations for indicator quality	Birth weight is the first weight recorded after birth, ideally measured within the first few hours after birth, before significant postnatal weight loss occurs. This indicator could be subject to greater bias in contexts where the measurement instrument does not exist or is poorly calibrated. Or in cases where the source is birth records, the quality of the indicator could vary according to the birth record coverage percentage. It is also necessary to adjust survey-based estimates to adjust for missing data, as well as reporting bias in which birth weights are accumulated in multiples of 100g and 500g.

Interpretation implications

Low birth weight is an indicator of the physiological reserve that the mother has transmitted to the newborn, especially in terms of nutritional status. It is a reference to the starting point that a newborn has for the development of its functional trajectory in course of life.

It has been documented that the children of mothers under 19 years of age and between the periods of 35 to 40 years are more likely to course with LBW, regardless of their socioeconomic status, so this indicator will be influenced by the percentage of mothers in these age groups. (Lancet Glob Health. 2015 Jul;3(7):e366-77).

Context indicator	Low birth weight is related to increased risk of death in the neonatal period and beyond including the adolescence period, adverse outcomes during adulthood, for example, fasting altered glucose levels.

ODS framework

N / A

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive	√	**Woman**	√	Imput		**Sex**	√
Thrive		Childhood		Output		**Ethnicity**	√
Transform		Adolescence		Results		**Mother's education**	√
				Impact	√	**Socioeconomic level (quintiles of national wealth)**	√
				Product		**Place of residence (urban / rural, or geographic location)**	√

Preferred data source

Household surveys with national representativeness Administrative information systems (birth certificate records), Perinatal Computer System.

Alternative data sources	• Hospital records and electronic birth record systems.
Inter-agency group estimates	• Global Database on Low Birth Weight, 2019 Edition. UNICEF and WHO.
Global monitoring frameworks	• Global Nutrition Monitoring Framework.
For more information	• Child and adolescent development and health. 2017. • UNICEF/WHO. https://data.unicef.org/resources/unicef-who-low-birthweight-estimates-levels-and-trends-2000-2015/
References	• (Lancet Glob Health. 2015 Jul;3(7):e366-77) 10.1016/S2214-109X(15)00038-8. Epub 2015 May 18. • Eur J Epidemiol. 2019 Mar;34(3):279-300. doi: 10.1007/s10654-019-00502-9. Epub 2019 Mar 18. • Cutland CL, Lackritz EM, Mallett-Moore T, et al. Low birth weight: Case definition & guidelines for data collection, analysis, and presentation of maternal immunization safety data. Vaccine. 2017;35(48 Pt A):6492–6500. doi:10.1016/j.vaccine.2017.01.049 • Blencowe H, et al. National, regional, and worldwide estimates of low birthweight in 2015, with trends from 2000: a systematic analysis. Lancet Glob Health. May 15, 2019 DOI: https://doi.org/10.1016/S2214-109X(18)30565-5. • Watkins WJ, Kotecha SJ, Kotecha S. All-Cause Mortality of Low Birthweight Infants in Infancy, Childhood, and Adolescence: Population Study of England and Wales. PLoS Med 13(5): e1002018. pmid:27163787

Antenatal care, 4 or more checkups (women 15-19 and 15-49 years old)

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Definitions	Percentage of women aged 15-49 who have had a live birth and who received antenatal care on four or more occasions. This indicator can be calculated in the same way for women 15-19 years of age.
Numerator	Percentage of women aged 15-49 who have had a live birth and who received antenatal care on four or more occasions.
Denominator	Total number of women ages 15-49 who had a live birth in the same period.
Measuring unit	X percent (%).
Considerations for indicator quality	In the case data that comes from surveys, the reminder error should be considered, especially since it investigates pregnancies that occurred in the 2 to 5 years prior to the survey. Data from administrative systems should be used with caution and ensure that it includes public and private establishments and coverage of births is greater than 90 percent.

Interpretation implications

Reports based on household surveys of this indicator do not discriminate by the type of care received or the place where the care is received. Antenatal care coverage indicator for 1 or more occasions is specific to antenatal care provided by trained personnel.

Context indicator	Antenatal care is an access indicator and uses health services during pregnancy. Antenatal period is key to reaching pregnant women with interventions that could be vital and improve their well-being and of their children. Receiving at least 8 antenatal care sessions, the first during the first trimester of pregnancy, increases the possibility that they receive effective health interventions during the neonatal period. The World Health Organization (WHO) has recently published Recommendations on antenatal care for a positive pregnancy experience, including comprehensive considerations, for example, nutritional and alternative interventions for some common physiological pregnancy symptoms, among others.

ODS framework

3 GOOD HEALTH AND WELL-BEING

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive	√	**Woman**	√	Imput		Sex	
Thrive		**Childhood**	√	Output		**Ethnicity**	√
Transform		Adolescence		**Results**	√	**Education**	√
				Impact		**Socioeconomic level (quintiles of national wealth)**	√
				Product		**Place of residence (urban / rural, or geographic location)**	√

Preferred data source

Household surveys, for example: DHS (Demographic and Health Survey), MICS (Multiple Indicator Cluster Survey), FFS (Fertility and Family Survey), RHS (Reproductive Health Surveys)

Alternative data sources	• Administrative (routine) health systems sources.
Inter-agency group estimates	• N/A
Global monitoring frameworks	• Global Strategy for Women's, Children's and Adolescents' Health.
For more information	• UNICEF Data: Monitoring the Situation of Children and Women (UNICEF)
References	• https://data.unicef.org/topic/maternal-health/antenatal-care/

Definitions	Percentage of women aged 15-19 and 15-49 years having a live birth, receiving antenatal care on at least one occasion and undergoing a set of at least 6 basic interventions during their antenatal medical visits.
Numerator	Number of women aged 15-19 and 15-49 years having a live birth, receiving antenatal care on at least one occasion and undergoing a set of at least 6 basic interventions during their antenatal medical visits.
Denominator	Total number of women ages 15-49 having a live birth and receiving antenatal care on at least one occasion receiving care on at least one occasion.
Measuring unit	X percent (%).
Considerations for indicator quality	The way of asking about interventions carried out during antenatal care has not been standardized, therefore should be reported specifically what question was asked to women and in what context: if it was in a survey at the exit of a health care center, or household survey.

Interpretation implications

In the proposed operationalization for this indicator, obtaining 100% coverage means that all women receiving antenatal care underwent a series of basic interventions during their last pregnancy. This indicator does not reflect the magnitude of antenatal care coverage, that is, it does not report how many women were left without care, but rather gives an idea of how complete it was. That is why it is recommended to report and interpret this indicator together with the coverage of 4+ queries, because it is a complementary indicator.

It is also relevant to consider that effectiveness of some interventions depends on results of the tests being delivered and explained to women, for example, a woman may report that a urine sample was taken, but that does not guarantee she received the results in that same medical visit.

It has been reported that an earlier start of antenatal consultations is related to a better content of antenatal care (greater number of interventions).

Context indicator	Antenatal care is a health services access and use during pregnancy indicator. Antenatal period is key to reach pregnant women with interventions that could be vital to improve themselves and their children well-being. In addition to recommending between 4 and 8 antenatal consultations and having the first one between 12-15 weeks of gestation, it is relevant to monitor the type of care received through a basic package of interventions. The following monitoring interventions are proposed for this indicator: • Blood pressure measurement, test strip/general urine test, blood tests, iron supplementation, tetanus vaccination, communication of pregnancy warning signs and possible complications. • Other interventions include: HIV testing and delivery of results. The World Health Organization (WHO) has recently published WHO Recommendations on antenatal care for a positive pregnancy experience, including comprehensive considerations, for example, nutritional and alternative interventions for some common physiological pregnancy symptoms, among others.

ODS framework

N / A

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive	√	**Woman**	√	Imput		Sex	
Thrive		**Childhood**	√	Output		**Ethnicity**	√
Transform		Adolescence		**Results**	√	**Mother's education**	√
				Impact		**Socioeconomic level (quintiles of national wealth)**	√
				Product		**Place of residence (urban / rural, or geographic location)**	√

Preferred data source

Household surveys, for example: DHS (demographic and health survey), MICS (multiple indicator cluster survey), FFS (fertility and family survey), RHS (reproductive health surveys), SIP-CLAP, among others.

Alternative data sources	• Administrative (routine) health system sources.
Inter-agency group estimates	• N/A
Global monitoring frameworks	• Countdown 2030: Coverage indicators, Maternal and newborn health.

For more information	• UNICEF Data: Monitoring the Situation of Children and Women (UNICEF) • Demographic and Health Surveys (DHS) • Reproductive Health Monitoring and Evaluation (WHO) • Sustainable Development Goals (SDG) indicators • Indicator and monitoring framework for the Global Strategy for Women's, Children\'s and Adolescents\' Health
References	• Jiwani SS, Amouzou-Aguirre A, Carvajal L, Chou D, Keita Y, Moran AC, et al. Timing and number of antenatal care contacts in low and middle-income countries: Analysis in the Countdown to 2030 priority countries. J Glob Health. 2020 Jun 1;10(1):010502. • Benova L, Tunçalp Ö, Moran AC, Campbell OMR. Not just a number: Examining coverage and content of antenatal care in low-income and middle-income countries. BMJ Glob Heal. 2018 Mar 1;3(2).

Definitions	Percentage of women who received a screening test for syphilis as part of their prenatal care.
Numerator	Number of women who had access to prenatal care and had a screening test for syphilis.
Denominator	Number of women who had access to prenatal care.
Measuring unit	X percent (%).
Considerations for indicator quality	All women should be screened for syphilis at their first prenatal visit. If countries report syphilis screening data on subsequent visits, they should make this clarification. The use of both non-treponemal reaginine antibody tests (VDRL, RPR) and treponemal tests (TPHA, TPPA, EIA or rapid treponemal tests) can be reported.

Interpretation implications
N/A

Context indicator	Early detection and treatment (sufficiently early in gestation) can effectively prevent adverse outcomes from maternal syphilis exposure and is the most important intervention for the control of congenital syphilis. Syphilis screening is one of the basic prenatal interventions, so this indicator potentially functions as a tracer for the quality of prenatal basic services.

ODS framework

N / A

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive	√	**Woman**	√	Imput		Sex	
Thrive		Childhood		Output		**Ethnicity**	√
Transform		Adolescence		Results		**Education**	√
				Impact		**Socioeconomic level (quintiles of national wealth)**	√
				Product	√	**Place of residence (urban / rural, or geographic location)**	√

Preferred data source
Administrative records (reports from centers where prenatal care is provided).

Alternative data sources	• Sampling or sentinel center reports.
Inter-agency group estimates	• N/A
Global monitoring frameworks	• N/A
For more information	• Methods for surveillance and monitoring of congenital syphilis elimination within existing systems
References	• Prevention of Mother-to-Child-Transmission of Syphilis (Congenital Syphilis): http://www.who.int/reproductivehealth/congenital-syphilis/en/ • Global Health Sector Strategy on Sexually Transmitted Infections 2016–2021. Geneva: WHO; 2016. • Global guidance on criteria and processes for validation: elimination of mother-to-child transmission of HIV and syphilis, 2nd edition. Geneva: World Health Organization; 2017. Available from: http://www.who.int/reproductivehealth/publications/emtct-hiv-syphilis/en/ • Global Aids Monitoring Indicator 2.4 https://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf

Births attended by specialized health personnel (women 15-19 and 15-49 years)

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Definitions	Births attended by trained personnel for every 100 registered births. An indicator of the health system capacity to provide adequate care during birth, which is a period of high risk of morbidity and mortality for both the mother and the newborn.
Numerator	Number of births attended by health personnel (doctors, nurses, midwives) trained to provide obstetric care.
Denominator	Total number of births registered in the same period.
Measuring unit	X percent (%).
Considerations for indicator quality	Trained personnel are considered to be accredited health personnel - midwife, doctor or nurse - who have received education and training to master the skills required to manage normal (uncomplicated) pregnancies, conduct deliveries, and manage the immediate postnatal period (including resuscitation); as well as identification, management and timely referral of complications in women and neonates, in addition to adequate supervision, care and advice to women during pregnancy, postpartum period and upbringing. Traditional midwives, whether they have education or training or none, are excluded from the category of trained health personnel.
	In the case of data collected through household surveys, the reminder error should be considered as a potential source of bias, especially in deliveries that occurred several years prior to the survey.
	In the case of information collected by routine registers, the indicator could be overestimated if the denominator comes from routine registers that do not capture all pregnant women. In this case, it is recommended to correct according to the sub-registration of birth.

Interpretation implications

This indicator does not capture access to quality care, particularly in the presence of complications. Reducing maternal mortality requires not only trained personnel, but also that personnel have access to adequate equipment and options to refer complicated patients. Efforts have been made to standardize the definition of trained health personnel, however, the actual ability to provide appropriate care depends largely on the environment in which their activity is carried out.

Context indicator	All women should have access to health care and attention by trained personnel to ensure prevention, detection and management of complications. Delivery assistance by trained personnel in an environment that favors adequate care is essential to reduce maternal and neonatal deaths. Given the technical difficulties in accurately measuring maternal mortality and considering that the estimates from statistical models are not suitable for monitoring trends in the short term, this indicator is used as a context indicator of maternal mortality.

ODS framework

3 GOOD HEALTH AND WELL-BEING

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive	√	**Woman**	√	Imput		Sex	
Thrive		**Childhood**	√	Output		**Ethnicity**	√
Transform		Adolescence		**Results**	√	**Education**	√
				Impact		**Socioeconomic level (quintiles of national wealth)**	√
				Product		**Place of residence (urban / rural, or geographic location)**	√

Preferred data source

Household surveys.

Alternative data sources	• Hospital or community care center records.
Inter-agency group estimates	• UNICEF and WHO are responsible before SDG framework for monitoring and reporting this indicator. For this, they have an active information compilation process through their country offices. This process includes data verification and validation. The databases for this indicator are regularly updated. The main sources are both household surveys such as DHS and MICS and data from information systems.
Global monitoring frameworks	• Sustainable Development Goals: https://unstats.un.org/sdgs/
	• Global Strategy for Women's, Children's and Adolescents' Health.
For more information	• Definition of skilled health personnel providing care during childbirth 2018 joint statement by WHO, UNFPA, UNICEF, ICM, ICN, FIGO and IPA
References	• UNICEF/WHO joint database on SDG 3.1.2 Skilled Attendance at Birth, based on population based national household survey data and routine health systems. Available at: https://data.unicef.org/topic/maternal-health/delivery-care/

Early start breastfeeding (first hour of birth)

Definitions	Percentage of boys and girls born in the last 24 months who were placed in the mother's breast within one hour of their birth.
Numerator	Number of boys and girls born in the last 24 months who were placed in the mother's breast within one hour of their birth.
Denominator	Total number of children born in the last 24 months (or in the period defined in the survey).
Measuring unit	X percent (%).
Considerations for indicator quality	DHA and RHS data inquires over a period of 3 to 5 years before the survey. MICS inquires over the 2-year period.

Interpretation implications

This indicator could function as a tracer of breastfeeding patterns because it reports the first step that must be taken to trigger exclusive breastfeeding and then sustained breastfeeding during the first two years.

Early lactation onset contributes to decrease early neonatal mortality (responsible for 73% of postnatal deaths worldwide). Girls and boys who receive the benefits of breast milk are at least 6 times more likely to survive during the first months of life.

Context indicator	This indicator is part of a cluster of indicators that pursues monitoring early childhood feeding practices. Exposing the mother-child pair to adequate breastfeeding patterns and subsequent weaning has benefits for both. Another indicator related to breastfeeding that is also included in the Global Strategy is: exclusive breastfeeding of infants 0-5 months of age.

ODS framework

N / A

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive	√	**Woman**	√	Imput		**Sex**	√
Thrive		**Childhood**	√	Output		**Ethnicity**	√
Transform		Adolescence		**Results**	√	**Mother's education**	√
				Impact		**Socioeconomic level (quintiles of national wealth)**	√
				Product		**Place of residence (urban / rural, or geographic location)**	√

Preferred data source

Household surveys.

Alternative data sources	• Secondary analysis obtained by the WHO collaborating center: International Center for Equity in Health (Equidade) of the Federal University of Pelotas, Brazil.
Inter-agency group estimates	• UNICEF: Infant and young child feeding. https://data.unicef.org/topic/nutrition/infant-and-young-child-feeding/
Global monitoring frameworks	• Global Strategy for Women's, Children's and Adolescents' Health.
For more information	• UNICEF. https://data.unicef.org/resources/first-hour-life-new-report-breastfeeding-practices/ • UNICEF. https://data.unicef.org/resources/capture-the-moment/ • WHO, UNICEF. https://apps.who.int/iris/bitstream/handle/10665/44156/9789243596662_spa.pdf?sequence=1
References	• Natl Med J India. 2012 Jul-Aug;25(4):201-6. • Semin Fetal Neonatal Med. 2017 Jun;22(3):153-160. doi: 10.1016/j.siny.2017.02.006. Epub 2017 Feb 24.

Exclusive breastfeeding

Definitions	Percentage of infants 0–5 months of age who are fed exclusively with breast milk.
Numerator	Infants 0-5 months of age who received only breast milk during the previous day. (Note: Infants who are exclusively breastfed receive only breast milk, and not any other fluids or foods, except for oral rehydration solution, vitamins, mineral supplements and medicines).
Denominator	Infants 0-5 months
Measuring unit	X percent (%).
Considerations for indicator quality	The indicator should be assessed using 24-hour dietary recall data by asking the standard recommended list of liquids and foods.

Interpretation implications

Exclusive breastfeeding is based on a cross-section of children in a given age range, in this case children aged 0 to 5months. It represents the percentage of children 0-5 months of age who were exclusively breastfed **24 hours prior** to the **survey** and **should not be interpreted** as the percentage of infants who are exclusively breastfed from birth until just under 6 months of age.

It should be noted that using the previous day's feeding as a basis may cause the percentage of exclusively breastfed infants to be overestimated as some infants who may have been given other liquids or foods irregularly may not have received these in the day before the survey.

Context indicator	Exclusive breastfeeding is one of the World Health Assembly (WHA) Nutrition Targets that Member States have endorsed and are committed to report regularly on until at least 2030 for improving maternal, infant and young child nutrition.

ODS framework **N / A**	EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
	Survive	√	Woman	√	Imput		Sex	√
	Thrive		Childhood	√	Output		Ethnicity	√
	Transform		Adolescence		Results	√	Mother's education	√
					Impact		Socioeconomic level (quintiles of national wealth)	√
					Product		Place of residence (urban / rural, or geographic location)	√
							If sample size allows, by age-groups: 0–1 month, 2–3 months, 4–5 months and 0–3 months.	√

Preferred data source

Household surveys like DHS, MICS and national nutrition surveys.

Alternative data sources	• None
Inter-agency group estimates	• N/A
Global monitoring frameworks	• Global Nutrition Monitoring Framework
For more information	• A panel of data at the national level, obtained from household surveys, with socioeconomic breakdowns, is available on the UNICEF site: Infant and Young Child Feeding: https://data.unicef.org/topic/nutrition/infant-and-young-child-feeding/
References	• https://www.unicef.org/nutrition/files/IYCF_updated_indicators_2008_part_1_definitions.pdf • https://www.unicef.org/nutrition/files/IYCF_Indicators_part_II_measurement.pdf

Postnatal checkups for mothers with a health provider, up to 2 days after delivery (15-19 and 15-49-year-old women)

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Definitions	Women who had postpartum control with a healthcare provider 2 days after delivery.
Numerator	Number of women with a live newborn in a given period prior to the survey who received prenatal care within two days of delivery (without discriminating by the site of delivery).
Denominator	Number of women aged 15-49 who had a live newborn in the same period determined prior to the survey (without discriminating by the site of delivery).
Measuring unit	X percent (%).
Considerations for indicator quality	If survey data is used, consider the possible reminder error that is greater the longer it has been since birth.

Interpretation implications

Although contacts, consultations and interventions prior to postnatal release are not included in the measurement of this indicator, they are important as part of postpartum control. Means should be sought to reach women and newborns, even at home, in case of low access to primary health care.

Context indicator	Most maternal and neonatal deaths occur within the first 48 hours after delivery, so ensuring contact with health services in that time window helps improve survival, in addition to opening the possibility to offer alternatives for increase intergenetic interval (increase the time between one birth and the next). Interventions that can be applied during postnatal visits include guidance on exclusive breastfeeding, newborn care (hygiene, temperature maintenance), and recognition of disease warning signs. Extra visits could be granted for high-risk mother-child pairs, for example, those with HIV or for preterm and young children in gestational age. An effective referral system and good quality emergency services are essential to have a greater impact.

ODS framework

N / A

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive	√	**Woman**	√	Imput		Sex	
Thrive		Childhood		Output		**Ethnicity**	√
Transform		Adolescence		**Results**	√	**Education**	√
				Impact		**Socioeconomic level (quintiles of national wealth)**	√
				Product		**Place of residence (urban / rural, or geographic location)**	√

Preferred data source
Household surveys.

Alternative data sources	• Health care providers routine records.
Inter-agency group estimates	• N/A
Global monitoring frameworks	• PAHO Strategic Plan 2014-2019. RIT 3.1.3 POSTPARTUM CARE. This definition includes postpartum care in the 7 days following the event. https://www.paho.org/hq/dmdocuments/2016/ops-pe-14-19-compendium-indicadores-nov-2014.pdf
For more information	• WHO Global Health Observatory http://apps.who.int/gho/data/node.wrapper.imr?x-id=3248
References	• WHO recommendations on mother and newborn postnatal care. World Health Organization. 2013. ISBN: 978 92 4 150664 9

Postnatal checkups for newborns with a health provider, up to 2 days after delivery

Definitions	Percentage of newborns who had contact with a health care provider 2 days after birth
Numerator	Number of newborns (out-of-hospital birth) who had a postnatal care visit in the first 48 hours after delivery, plus the number of infants born in a hospital or health care facility in a given period before the survey. Only the last birth of each woman surveyed is counted.
Denominator	Number of live births in the same time period.
Measuring unit	X percent (%).
Considerations for indicator quality	If survey data is used, consider the possible reminder error that is greater the longer it has been since birth.

Interpretation implications
Although contacts, consultations and interventions prior to postnatal release are not included in the measurement of this indicator, they are important as part of postnatal control. Means should be sought to reach women and newborns, even at home, in case of low access to primary health care.

Context indicator	Most maternal and neonatal deaths occur within the first 48 hours after delivery, so ensuring contact with health services in that time window helps improve survival, in addition to opening the possibility to offer alternatives for increase intergenetic interval (increase the time between one birth and the next). Interventions that can be applied during postnatal visits include guidance on exclusive breastfeeding, newborn care (hygiene, temperature maintenance), and recognition of disease warning signs. Extra visits could be granted for high-risk mother-child pairs, for example, those with HIV or for preterm and young children in gestational age. An effective referral system and good quality emergency services are essential to have a greater impact.

ODS framework

N / A

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive	√	Woman		Imput		**Sex**	√
Thrive		**Childhood**	√	Output		**Ethnicity**	√
Transform		Adolescence		**Results**	√	**Mother's education**	√
				Impact		**Socioeconomic level (quintiles of national wealth)**	√
				Product		**Place of residence (urban / rural, or geographic location)**	√

Preferred data source
Household surveys

Alternative data sources	• Health care providers routine records
Inter-agency group estimates	• N/A
Global monitoring frameworks	• PAHO Strategic Plan 2014-2019. RIT 3.1.3 POSTPARTUM CARE. This definition includes postpartum care in the 7 days following the event. https://www.paho.org/hq/dmdocuments/2016/ops-pe-14-19-compendium-indicadores-nov-2014.pdf • Countdown 2030: Coverage indicators, Maternal and newborn health.
For more information	• WHO Global Health Observatory.
References	• WHO recommendations on mother and newborn postnatal care. World Health Organization. 2013. ISBN: 978 92 4 150664 9

Definitions	Vertical transmission of HIV and syphilis is preventable by primary prevention of HIV infection and syphilis in women of childbearing age, high coverage with quality prenatal care, including routine screening for infection by HIV and syphilis, in addition to the effective follow-up of HIV-positive women and exposed children under 1 year of age. The 3 sub-indicators are included according to PAHO compendium of indicators. A) Reported rate of mother-to-child HIV transmission — percentage of children under 1 year of age born to HIV-positive mothers whose HIV test results were positive. B) Annual rate of HIV reported cases on mother-to-child transmission per 1,000 live births. C) Annual rate of congenital syphilis reported cases per 1,000 live births.
Numerator	A) number of children under 1 year of age born to HIV-positive mothers in a calendar year given that they were diagnosed as HIV positive. B) number of children born to women with HIV infection with a positive diagnosis in a given calendar year × 1,000. C) number of congenital syphilis reported cases according to the national definition of cases in a given year. The national case definition should include the number of stillbirths due to syphilis × 1,000.
Denominator	A) reported number of children under 1 year of age born to HIV-positive mothers in a given calendar year, with a definitive diagnosis (HIV positive or HIV negative). B) calculated number of live births in the same defined calendar year. C) calculated number of live births in the same period.
Measuring unit	A) X percent (%). B) X per 1,000 live births. C) X per 1,000 live births.

Considerations for indicator quality	Delays between the occurrence of the event and date the data are made available must be considered, as well as the percentage of coverage and under-registration.
	
	Data for the three subindicators is obtained as follows:
	
	a) Reported rate of mother-to-child HIV transmission: percentage of children under 1 year of age born to HIV-positive mothers whose HIV test results were positive
	
	    Numerator and denominator: prenatal care records or other records from health facilities.
	
	b) Annual rate of HIV reported cases on mother-to-child transmission per 1,000 live births
	
	    Numerator: HIV and prenatal care case records or other records from health facilities.
	
	    Denominator: generated through a population estimate of the number of live births over the past 12 months. This can be obtained from national vital statistics, from calculations by the United Nations Population Division, or from PAHO's health information system.
	
	c) Annual rate of congenital syphilis reported cases per 1,000 live births
	
	    Numerator: In most Latin American and Caribbean countries, congenital syphilis is subject to mandatory notification; the data source is the national registration system for congenital syphilis cases.
	
	    Denominator: generated through a population estimate of the number of live births over the past 12 months. This can be obtained from national vital statistics, from calculations by the United Nations Population Division, or from PAHO's health information system.

Interpretation implications

This is a composite indicator that reflects the commitment of PAHO Member States to the dual elimination of congenital syphilis and mother-to-child transmission of HIV [resolution CD50.R12 (2010)]. Elimination refers to reducing vertical transmission of HIV and syphilis to a level below the importance for public health. A country or territory will have achieved elimination once the following sub-indicators have been reached:

- for HIV, a reduction in the rate of mother-to-child transmission of HIV to 2% or less, and a reduction in the incidence of mother-to-child transmission of HIV to 0.3 cases or less per 1,000 live births;

- for congenital syphilis: a reduction in the incidence of congenital syphilis (including stillbirths) to 0.5 cases or less per 1,000 live births.

Context indicator	It is also suggested to use a complementary indicator focused on monitoring the coverage of prevention of mother-to-child transmission of STDs. It is among the 100 WHO basic indicators: https://www.who.int/healthinfo/indicators/2015/chi_2015_84_pmtct.pdf?ua=1

ODS framework	EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
	Survive	√	**Woman**	√	Imput		Sex	
N / A	Thrive		**Childhood**	√	Output		**Ethnicity**	√
	Transform		Adolescence		Results		**Education**	√
					Impact	√	**Socioeconomic level (quintiles of national wealth)**	√
					Product		**Place of residence (urban / rural, or geographic location)**	√

Preferred data source
Routine sources of registration.

Alternative data sources	• N/A
Inter-agency group estimates	• N/A
Global monitoring frameworks	• N/A
For more information	• Elimination of mother-to-child HIV and syphilis transmission in the Americas: http://iris.paho.org/xmlui/bitstream/handle/123456789/34072/9789275119556-eng.pdf
References	• Compendium of indicators. PAHO Strategic Plan.

Definitions	Number of people who get HIV in the reporting period per 1,000 people not infected with the virus.
Numerator	Number of people who get HIV infection during the reporting period.
Denominator	Total number of uninfected inhabitants.
Measuring unit	X per 1,000 uninfected or people at risk.
Considerations for indicator quality	Methods for monitoring incidence (direct or indirect) can vary depending on the epidemic environment. Direct measurement at the population level is preferable but is often difficult to obtain. As a result, most countries rely on indirect measurements or triangulate direct and indirect methods.
	Strategies to directly quantify HIV incidence include longitudinal monitoring and repeated testing among people without HIV infection and estimates using laboratory tests on recent infections and clinical data on the population. Longitudinal monitoring is often expensive and difficult to perform at the population level. Laboratory tests on individuals to determine the antiquity level of infections also pose difficulties regarding their cost and complexity, since a nationally representative population-based survey is generally required to obtain estimates.
	Indirect methods most of the times are based on estimates built on mathematical modeling tools, such as the AIDS Epidemic Model in Spectrum software and. Those models can incorporate population and geographic HIV surveys, surveillance, case reporting, mortality, and program and clinical data. The models are based on assumptions regarding risk behaviors, HIV transmission, and survival with and without antiretroviral treatment. In some cases, countries may wish to triangulate such data with other estimation sources over the number of people who become infected, including serial population estimates of HIV prevalence or estimates of HIV prevalence among recently exposed young populations.

Interpretation implications

Case-based surveillance systems that capture new people who get HIV should not be used as a direct source for estimating the number of people who get HIV in the reporting period. Due to delays in information processes or under diagnosis situations, these new cases may not reflect the real rate of people contracting the infection. That information may be useful, however, for triangulation and validation purposes, especially when combined with tests aimed at determining how recent is the infection.

Incidence estimates and their change over time are the benchmark for monitoring the impact of programs. However, even in high-risk populations, it is a relatively rare event for new HIV infections to occur, so the precision (uncertainty) of these estimates should be included in the reports using confidence intervals when using indices on HIV incidence to monitor the impact of programs, especially when disaggregated by sex and age and for key population groups or in specific geographic areas. Precautions regarding the representativeness of surveys should also be taken when using population studies.

Context indicator	The overarching goal of the global AIDS response is to reduce the number of people who get HIV infection to less than 200,000 people by 2030. Monitoring the rate of people who get the infection over time serves to quantify progress. in prevention programs towards this goal.

ODS framework

3 GOOD HEALTH AND WELL-BEING

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive	√	**Woman**	√	Imput		**Sex**	√
Thrive		**Childhood**	√	Output		**Ethnicity**	√
Transform		**Adolescence**	√	Results		**Education**	√
				Impact	√	**Socioeconomic level (quintiles of national wealth)**	√
				Product		**Place of residence (urban / rural, or geographic location)**	√

Preferred data source

a) Household surveys in open population or of key populations that include HIV tests.

b) Statistical modeling with the UNAIDS SPECTRUM program.

Alternative data sources	• AIDSinfo. (http://aidsinfo.unaids.org/) • Country epidemiological surveillance systems (surveillance in key populations)
Inter-agency group estimates	• UNAIDS Reference Group on Estimates, Modelling and Projections
Global monitoring frameworks	• 100 Core Indicators. WHO. • Global Strategy for Women's, Children's and Adolescents' Health.

For more information	• Strategic Information Guides on HIV in the health sector.
	• Software Spectrum. Glastonbury (CT): Avenir Health; 2016.
References	• Indicator's Registry UNAIDS http://www.indicatorregistry.org/es/indicator/incidencia-del-vih

Cervical Cancer Screening
(Women 30-49 years of age)

Definitions	Women ages 30-49 reporting having been screened for cervical cancer using one of the following methods: visual inspection with acetic acid/vinegar (VIA), Pap test, human papilloma virus (HPV) test.
Numerator	Number of women ages 30-49 who ever reported having been screened for cervical cancer using any of the following methods: visual inspection with acetic acid/vinegar (VIA), Pap test, human papilloma virus (HPV) test.
Denominator	All 30-49 women who answered the survey.
Measuring unit	X percent (%).
Considerations for indicator quality	When this indicator is obtained from population surveys, sample design should be considered using established weights for analytical purposes, and thus preserve external validity. Screening types that have been included in the estimation of the indicator are useful. It is recommended to have a measurement at least every 5 years.

Interpretation implications

WHO cervical cancer screening guidelines apply to women age 30 and older, given the high risk of cervical cancer based on age, but the benefit of screening may extend to younger or older age groups, according to their baseline risk for CIN2+ injuries.

Information on epidemiological cancer profile and HPV infection by age groups will be important for interpretation of the indicator, because in contexts of higher CIN2+ risk in younger women, it will be necessary to interpret the indicator together with younger age women groups of figures.

In contexts where information about HIV infection is accessible, all sexually active women having been tested positive for HIV should be considered as a screening population target.

Context indicator	It is recommended that all women 30-49 years of age be screened at least once in a lifetime, on enhancing the number of times a woman is screened. More than 95% of cervical cancer burden is potentially avoidable by effective screening programs, and vaccination against HPV 16 and 18. Screening can reduce cervical cancer mortality by up to 80%. Early detection, including inexpensive technology, is essential in contexts of low access to complex cancer treatments.

ODS framework

N / A

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive	√	**Woman**	√	Imput		Sex	
Thrive		Childhood		Output		**Ethnicity**	√
Transform		Adolescence		**Results**	√	**Education**	√
				Impact		**Socioeconomic level (quintiles of national wealth)**	√
				Product		**Place of residence (urban / rural, or geographic location)**	√

Preferred data source
Administrative data from health service providers.

Alternative data sources	• N/A
Inter-agency group estimates	• N/A
Global monitoring frameworks	• Global Strategy for Women's, Children's and Adolescents' Health.
For more information	• Epidemiol Prev. 2017 Jan-Feb;41(1):1-32. doi: 10.19191/EP17.1S1.P001.001. PMID: 28322534. • Am J Public Health. 2015 Jul;105 Suppl 3:S438-42. doi: 10.2105/AJPH.2014.302417. Epub 2015 Apr 23. PMID: 25905832
References	• WHO Cervical Screening Guidelines.

Adolescent fertility (between 10 and 14 years of age and between 15 and 19 years of age)

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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

3 GOOD HEALTH AND WELL-BEING

EWEC-LAC framework	Dimension	Monitoring framework	Suggested stratifier for inequality analysis
Survive	Woman	Imput	Sex
Thrive √	Childhood	Output	**Ethnicity** √
Transform	**Adolescence** √	Results	**Education** √
		Impact √	**Socioeconomic level (quintiles of national wealth)** √
		Product	**Place of residence (urban / rural, or geographic location)** √

Preferred data source

Civil registry in contexts of coverage close to 100%

Alternative data sources	• Censuses, household surveys.
Inter-agency group estimates	• United Nations Population Division. UNPD. https://www.unfpa.org/data/world-population-dashboard
Global monitoring frameworks	• Global Strategy for Women's, Children's and Adolescents' Health.
For more information	• World population data dashboard. United Nations Population Division.
References	• WHO Global Health Observatory.

Satisfied need for family planning with modern methods (women 15-19 and 15-49 years of age)

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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). a. 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. b. 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. 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. <u>Modern methods:</u> 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.

Context indicator	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

3 GOOD HEALTH AND WELL-BEING

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive		**Woman**	√	Imput		Sex	
Thrive	√	**Childhood**	√	Output		**Ethnicity**	√
Transform		**Adolescence**	√	**Results**	√	**Education**	√
				Impact		**Socioeconomic level (quintiles of national wealth)**	√
				Product		**Place of residence (urban / rural, or geographic location)**	√

Preferred data source
<u>Household surveys</u>: 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	• Wheldon, M and others (2018). Methods to estimate and project key indicators of family planning among all women of reproductive age. United Nations, Department of Economic and Social Affairs, Population Division, Technical Document No. 2. New York: United Nations. Available at: https://www.un.org/en/development/desa/population/publications/technical/index.asp
Global monitoring frameworks	• Global Strategy for Women's, Children's and Adolescents' Health.
For more information	• Global use of contraceptives 2019.
References	• SDG metadata repository. https://unstats.un.org/sdgs/metadata/ • Alkema, LA and others (2013). National, regional and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015: A systematic and exhaustive analysis. The Lancet, Volume 381, Number 9878, pp.1642-1652. See also the web appendix with the technical details available at http://www.un.org/en/development/desa/population/theme/family-planning/index.shtml.

Stunting (height/length for age with standard deviation <-2 of the World Health Organization WHO growth patterns for children under 5 years of age median)

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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.
	  o 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.
	  o 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

2 ZERO HUNGER

EWEC-LAC framework		Dimension		Monitoring framework	Suggested stratifier for inequality analysis	
Survive		Woman		Imput	**Sex**	√
Thrive	√	Childhood		Output	**Ethnicity**	√
Transform		**Adolescence**	√	Results	**Mother's education**	√
				Impact √	**Socioeconomic level (quintiles of national wealth)**	√
				Product	**Place of residence (urban / rural, or geographic location)**	√

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/ • World Bank Open Data.
Global monitoring frameworks	• Global Nutrition Monitoring Framework. https://apps.who.int/nutrition/landscape/global-monitoring-framework • Global Strategy for Women's, Children's and Adolescents' Health.

For more information	• Joint child malnutrition estimates - Levels and trends. UNICEF-WHO-WB. https://www.who.int/nutgrowthdb/estimates/en/ • WHO Anthro Survey Analyzer. • The World Health Organization Global Database on Child Growth and Malnutrition: methodology and applications International. Journal of Epidemiology 2003;32:518-526.
References	• SDG metadata repository. https://unstats.un.org/sdgs/metadata/ • WHO Anthropometric Measurement Specifications: https://www.who.int/childgrowth/publications/physical_status/es/

Overweight and obesity (boys and girls under 5 years of age), prevalence

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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 × 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.

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.
	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.

ODS framework

2 ZERO HUNGER

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive		Woman		Imput		**Sex**	**√**
Thrive	**√**	**Childhood**	**√**	Output		**Ethnicity**	**√**
Transform		Adolescence		**Results**	**√**	**Mother's education**	**√**
				Impact		**Socioeconomic level (quintiles of national wealth)**	**√**
				Product		**Place of residence (urban / rural, or geographic location)**	**√**

Preferred data source

National Household Health and Nutrition Surveys.

Alternative data sources	• Censuses, ad hoc studies.
Inter-agency group estimates	• UNICEF/WHO/World Bank. Levels and trends in child malnutrition. Key Findings 2018. https://www.who.int/nutgrowthdb/2018-jme-brochure.pdf
	• 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.
	• Countdown 2030. Demographic indicators. Nutritional condition. Tier 2. Indicator B14.

For more information	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	• World Health Organization. Physical Status: The use and interpretation of anthropometry. WHO technical report series 845. Geneva: WHO, 1995.
	• Galicia L, Grajeda R, López de Romaña D. Nutrition situation in Latin America and the Caribbean: current scenario, past trends, and data gaps. Rev PanamSaludPública. 2016;40(2):104-13.
	• UNICEF -WHO-World Bank Joint Child Malnutrition Estimates. (UNICEF, New York; WHO, Geneva; The World Bank, Washington, DC; 2012).
	• de Onis M, Blössner M, Borghi E, et al. (2004), Methodology for estimating regional and global trends of childhood malnutrition. Int J Epidemiol, 33(6):1260-70.
	• Yang H and de Onis M. Algorithms for converting estimates of child malnutrition based on the NCHS reference into estimates based on the WHO Child Growth Standards.
	• World Health Organization (2008). Training Course on Child Growth Assessment. Geneva, WHO, 2008.

Anemia (children under 5 years), prevalence

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: $Hb_{ajusted} = Hb_{not\ ajusted} + 0.32 \cdot (altitude \cdot 0.0033) - 0.22 \cdot (altitude \cdot 0.0033)^2$

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.

ODS framework

N / A

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive		Woman		Imput		**Sex**	√
Thrive	√	**Childhood**	√	Output		**Ethnicity**	√
Transform		Adolescence		**Results**	√	**Mother's education**	√
				Impact		**Socioeconomic level (quintiles of national wealth)**	√
				Product		**Place of residence (urban / rural, or geographic location)**	√

Preferred data source

National nutrition surveys or other household surveys

Alternative data sources	N/A
Inter-agency group estimates	• Nutrition Impact Model Study Group. 1995-2011 https://doi.org/10.1016/S2214-109X(13)70001-9 • WHO estimates 1990-2016 https://apps.who.int/gho/data/view.main.ANEMIACHILDRENv?lang=en
Global monitoring frameworks	• Global Nutrition Monitoring Framework. https://apps.who.int/nutrition/landscape/global-monitoring-framework
For more information	• Global Nutrition Report 2018. https://globalnutritionreport.org/blog/effect-population-estimates-country-level-nutrition-data-demographical-gymnastics-nutritional-conundrums/ • WHO. Worldwide anemia prevalence 1993-2005 https://www.who.int/nutrition/publications/micronutrients/anaemia_iron_deficiency/9789241596657/en/
References	• Lancet Glob Health. 2013 Jul;1(1):e16-25. doi: 10.1016/S2214-109X(13)70001-9. Epub 2013 Jun 25. • OMS. 100 basic health indicators https://www.who.int/healthinfo/indicators/2015/chi_2015_57_anaemia_children.pdf?ua=1

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

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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

4 QUALITY EDUCATION

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive		Woman		Imput		**Sex**	√
Thrive	√	**Childhood**	√	Output		**Ethnicity**	√
Transform		Adolescence		Results		**Mother's education**	√
				Impact	√	**Socioeconomic level (quintiles of national wealth)**	√
				Product		**Place of residence (urban / rural, or geographic location)**	√

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
References	• SDG metadata repository. 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 × 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

4 QUALITY EDUCATION

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive		Woman		Imput		**Sex**	√
Thrive	√	**Childhood**	√	Output		**Ethnicity**	√
Transform		Adolescence		**Results**	√	**Mother's education**	√
				Impact		**Socioeconomic level (quintiles of national wealth)**	√
				Product		**Place of residence (urban / rural, or geographic location)**	√

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.

Alternative data sources	N/A
Inter-agency group estimates	• To calculate this worldwide indicator, the Institute uses population estimates from the United Nations Population Division. • Estimates are available from UNESCO Institute for Statistics: http://data.uis.unesco.org/index.aspx?queryid=3409

Global monitoring frameworks	• Global Strategy for Women's, Children's and Adolescents' Health • Sustainable Development Goals: https://unstats.un.org/sdgs/
For more information	• UNESCO. SDG 4. http://uis.unesco.org/en/topic/sustainable-development-goal-4
References	• SDG metadata repository. https://unstats.un.org/sdgs/metadata/

Out-of-pocket health expenditure as a percentage of total health expenditure

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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. NHA's 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/

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 **N / A**	EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
	Survive		**Woman**	√	Imput		Sex	
	Thrive	√	**Childhood**	√	Output		**Ethnicity**	√
	Transform		**Adolescence**	√	**Results**		**Education**	√
					Impact	√	**Socioeconomic level (quintiles of national wealth)**	√
					Product		**Place of residence (urban / rural, or geographic location)**	√

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.

Population living below the national poverty line, disaggregated by sex and age

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Definitions	The underlined national poverty rate is the percentage of the total population living below the national poverty line.
	The rural poverty rate is the percentage of the rural population living below the national poverty line (or in cases where a separate, rural poverty line is used, the rural poverty line).
	Urban poverty rate is the percentage of the urban population living below the national poverty line (or in cases where a separate, urban poverty line is used, the urban poverty line).
Numerator	Number of people represented in the survey whose daily consumption/income is below the national poverty line.
Denominator	Total number of population represented in the survey.
Measuring unit	X percent (%).
Considerations for indicator quality	National poverty estimates are derived from household survey data.
	To be useful for poverty estimates, surveys must be nationally representative. They must also include enough information to compute a comprehensive estimate of total household consumption or income (including consumption or income from own production) and to construct a correctly weighted distribution of consumption or income per person.
	Monitoring national poverty is important for country-specific development agendas. National poverty lines are used to make more accurate estimates of poverty consistent with the country's specific economic and social circumstances and are not intended for international comparisons of poverty rates.
	In assessing poverty in a given country, and how best to reduce poverty according to national definitions, one naturally focuses on a poverty line that is considered appropriate for that country. Poverty lines across countries vary in terms of their purchasing power, and they have a strong economic gradient, such that richer countries tend to adopt higher standards of living in defining poverty. Within a country, the cost of living is typically higher in urban areas than in rural areas. Some countries may have separate urban and rural poverty lines to represent different purchasing powers.

Interpretation implications

Consumption is the preferred welfare indicator for several reasons . Income is generally more difficult to measure accurately. For example, the poor who work in the informal sector may not receive or report monetary wages; self-employed workers often experience irregular income flows; and many people in rural areas depend on idiosyncratic, agricultural incomes. Moreover, consumption accords better with the idea of the standard of living than income, which can vary over time even if the actual standard of living does not. Thus, whenever possible, consumption-based welfare indicators are used to estimate the poverty measures reported here. But consumption data are not always available. For instance, in Latin America and the Caribbean, most countries collect primarily income data. In those cases, there is little choice but to use income data.

In any case, these income/consumption-based poverty indicators do not fully reflect the other dimensions of poverty such as inequality, vulnerability, and lack of voice and power of the poor.

| **Context indicator** | National poverty rates use a country specific poverty line, reflecting the country's economic and social circumstances. In some case, the national poverty line is adjusted for different areas (such as urban and rural) within the country, to account for differences in prices or the availability of goods and services. Typically, the urban poverty line is set higher than the rural poverty line; reflecting the relatively higher costs of living in urban areas. |

ODS framework

1 NO POVERTY

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive		**Woman**	√	Imput		**Sex**	√
Thrive		**Childhood**	√	Output		**Ethnicity**	√
Transform	√	**Adolescence**	√	**Results**	√	**Education**	√
				Impact		Socioeconomic level (quintiles of national wealth)	
				Product		**Place of residence (urban / rural, or geographic location)**	√

Preferred data source

National poverty estimates are typically produced and owned by country governments (e.g., National Statistic Office), and sometimes with technical assistance from the World Bank and UNDP. Upon release of the national poverty estimates by the government, the Global Poverty Working Group of the World Bank assesses the methodology used by the government, validates the estimates with raw data whenever possible, and consults the country economists for publishing. Accepted estimates, along with metadata, will be published in the WDI database as well as the Poverty and Equity Database of the World Bank.

Alternative data sources	• Another source is World Bank's Poverty Assessments. The World Bank periodically prepares poverty assessments of countries in which it has an active program, in close collaboration with national institutions, other development agencies, and civil society groups, including poor people's organizations. Poverty assessments report the extent and causes of poverty and propose strategies to reduce it. The poverty assessments are the best available source of information on poverty estimates using national poverty lines. They often include separate assessments of urban and rural poverty.
Inter-agency group estimates	• The World Bank transparently shares and publicizes methodologies for all kinds of adjustments to the original data (for example, through its PovcalNet website and its various analytical documents).
Global monitoring frameworks	• Sustainable Development Goals (SDG) Global monitoring framework.
For more information	• SDG metadata repository portal: https://unstats.un.org/sdgs/metadata/files/Metadata-01-02-01.pdf
References	• SDG metadata repository. https://unstats.un.org/sdgs/metadata/

Population using safely managed water services for consumption

Definitions	The population using safely managed drinking water services is measured by the population using an improved on-site water source (accessibility), available when needed (availability), and free from contamination (quality). • Among the "_improved_" water sources are the following: piped water in homes, patios or plots; public taps or faucets; pipe wells; protected dug wells; protected springs; bottled water; supplied water and rainwater. • If the collection point is inside a home, yard, or plot is considered to be "_a water source located on site_". • "_Available when needed_": households can access enough water when needed. • "_Contamination-free_": Water complies with relevant national or local regulations. In the absence of such standards, reference is made to _WHO Guidelines for Drinking Water Quality_. • Thermotolerant coliforms is the preferred indicator of microbiological quality, and arsenic and fluorine are the priority chemicals for global reporting.
Numerator	Population using improved water sources that meet the following criteria: 1) Accessibility 2) Availability 3) Quality
Denominator	Total population
Measuring unit	Percentage % (X percent) * Note: calculation of the indicator comes from regression models implemented for urban and rural populations by the inter-agency group WHO and UNICEF's JMP (Joint Monitoring Program).
Considerations for indicator quality	The composition of this indicator implies multiple data source integration, consequently it is important to have a common level of aggregation to render feasible estimates. It is recommended to consult global estimates, using only data validated by national statistical offices. See "inter-agency group estimates". A linear regression model is currently used to deal with lack of information for some years, but it is expected that in the coming years models will be adjusted to the so-called "SDG ladder" working as a scale between "surface waters" and "safely managed service" categories.

Interpretation implications

This indicator adds dimensions of accessibility, availability and quality to "improved water sources" used for the MDGs. Given a greater "demand" for this indicator, estimates for this indicator are expected to be lower than for "improved water sources", not meaning that coverage has worsened.

Context indicator	This indicator is part of a broad strategy to monitor water and hygiene access services by UNICEF and WHO, given its relevance to public health.

ODS framework

6 CLEAN WATER AND SANITATION

EWEC-LAC framework	Dimension		Monitoring framework	Suggested stratifier for inequality analysis	
Survive	**Woman**	√	Imput	Sex	
Thrive	**Childhood**	√	Output	Ethnicity	
Transform √	**Adolescence**	√	**Results** √	Education	
			Impact	**Socioeconomic level (quintiles of national wealth)**	√
			Product	**Place of residence (urban / rural, or geographic location)**	√

Preferred data source	
Data on availability and safety of drinking water is increasingly available through a combination of household surveys and administrative sources, including regulatory, but definitions have not yet been standardized.	
Alternative data sources	N/A
Inter-agency group estimates	• WHO and UNICEF's JMP. www.washdata.org
Global monitoring frameworks	• Global Strategy for Women´s, Children´s and Adolescents´ Health. • Sustainable Development Goals: https://unstats.un.org/sdgs/
For more information	• Safely managed drinking water. UNICEF, WHO. JMP-2017
References	• SDG metadata repository. United Nations. • Top questions regarding water, sanitation and hygiene for use in household surveys - 2018 uptate • https://washdata.org/report/jmp-2018-core-questions-household-surveys-es

Population with hand washing facilities with soap and water

EVERY WOMAN EVERY CHILD
FOR HEALTHY AND EMPOWERED WOMEN, CHILDREN AND ADOLESCENTS
LATIN AMERICA AND THE CARIBBEAN

Definitions	Percentage of the population having a hand washing facility with soap and water.
Numerator	Population having a basic hand washing facility.
Denominator	Total population.
Measuring unit	Percentage % (X percent) * Note: calculation of the indicator comes from regression models implemented for urban and rural populations by the inter-agency group WHO and UNICEF's JMP (Joint Monitoring Programme).
Considerations for indicator quality	Household surveys provide data on the presence of hand washing materials in the home.

Interpretation implications

Related concepts:
- **Basic hand washing facility:** an on-site device to contain, transport, or regulate the flow of water to facilitate hand washing with soap and water at home.
- **Soap:** Includes soap bars, liquid soap, detergent powder, and soapy water.

Context indicator	A graphical version of the scale used by the inter-agency group is available to monitor and make similar measurements of safety level in sanitation: https://washdata.org/monitoring/hygiene.

ODS framework

6 CLEAN WATER AND SANITATION

EWEC-LAC framework		Dimension		Monitoring framework	Suggested stratifier for inequality analysis	
Survive		**Woman**	√	Imput	Sex	
Thrive		**Childhood**	√	Output	Ethnicity	
Transform	√	**Adolescence**	√	**Results** √	Education	
				Impact	**Socioeconomic level (quintiles of national wealth)**	√
				Product	**Place of residence (urban / rural, or geographic location)**	√

Preferred data source

Household surveys

Alternative data sources	N/A
Inter-agency group estimates	• WHO and UNICEF's JMP https://washdata.org/how-we-work/sdg-monitoring
Global monitoring frameworks	N/A
For more information	• WHO and UNICEF's JMP https://washdata.org/how-we-work/sdg-monitoring
References	• SDG metadata repository. United Nations. • Top questions regarding water, sanitation and hygiene for use in household surveys - 2018 update • https://washdata.org/report/jmp-2018-core-questions-household-surveys-es

Population using safely managed sanitation services

Definitions	Percentage of the population using safely managed sanitation services is currently measured by population using an improved sanitation facility that is not shared with other households and where excreta is safely disposed of on-site or treated off-site.
Numerator	Population using excreta disposal methods that they consider to be safely managed.
Denominator	Total population.
Measuring unit	X percent (%). * Note: calculation of the indicator comes from regression models implemented for urban and rural populations by the inter-agency group WHO and UNICEF's JMP (Joint Monitoring Program).
Considerations for indicator quality	Household surveys and censuses provide data on types of basic sanitation facilities use listed above, as well as the presence of hand washing materials at home. Percentage of the population using safely managed sanitation services is calculated by combining data on proportion of the population using different types of basic sanitation facilities with estimates of the proportion of faecal waste that is disposed of on-site or treated off-site.

Interpretation implications

Related concepts:

- <u>Improved sanitation facilities:</u> An improved sanitation facility is one that hygienically prevents user contact with human excreta. These include water-based sanitation technologies — such as flush or siphon toilets connected to the sewer system, septic tanks, or pit latrines — and dry sanitation technologies — such as pit latrines with flagstones and compost toilets.

- <u>Safely disposed of on-site:</u> When latrines and septic tanks are not emptied, excreta can remain isolated from human contact and can be considered safely managed. For example, with the new SDG indicator, households using twin latrines or safely leaving latrines and digging new facilities, a common practice in rural areas, would be counted as safely managed sanitation services.

- <u>Off-site treatment:</u> Not all excreta from toilets is transported into sewers (such as sewage) or emptied from pit latrines and septic tanks (such as faecal sludge) reach a treatment site. For example, a portion may leak from the sewer itself or, due to broken pumping facilities, be discharged directly into the environment. Similarly, a part of the emptied fecal sludge from containers can be discharged into open drains, to open the soil or bodies of water, instead of being transported to a treatment plant. And finally, even once the excreta reach a treatment plant, a portion may remain untreated, due to dysfunctional treatment equipment or inadequate treatment capacity, and be discharged into the environment.

Context indicator	A graphical version of the scale used by the inter-agency group is available to monitor and make similar measurements of safety level in sanitation: https://washdata.org/monitoring/hygiene.

ODS framework

6 CLEAN WATER AND SANITATION

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive		**Woman**	√	Imput		Sex	
Thrive		**Childhood**	√	Output		Ethnicity	
Transform	√	**Adolescence**	√	**Results**	√	Education	
				Impact		**Socioeconomic level (quintiles of national wealth)**	√
				Product		**Place of residence (urban / rural, or geographic location)**	√

Preferred data source	
Household surveys and censuses to estimate use of different types of facilities, and administrative data on excreta and wastewater treatment	
Alternative data sources	N/A
Inter-agency group estimates	• WHO and UNICEF's JMP. https://washdata.org/how-we-work/sdg-monitoring
Global monitoring frameworks	• Sustainable Development Goals: https://unstats.un.org/sdgs/
For more information	• WHO and UNICEF's JMP https://washdata.org/how-we-work/sdg-monitoring
References	• Sanitation and wastewater, WHO. • SDG metadata repository. United Nations. • Top questions regarding water, sanitation and hygiene for use in household surveys: 2018 update.

EVERY WOMAN EVERY CHILD

FOR HEALTHY AND EMPOWERED WOMEN, CHILDREN AND ADOLESCENTS
LATIN AMERICA AND THE CARIBBEAN

Definitions	Women and girls from 15 to 19 years of age, and from 15 to 49 years of age who have ever had a partner and have suffered physical, sexual or psychological violence by a current or previous partner, in the previous 12 months.
Numerator	Number of women in the age group of interest (15 to 19, or 15-49 years of age) who suffered physical, sexual and psychological violence at the hands of their current or former partner in the last 12 months × 100.
Denominator	Number of women surveyed from the age group of interest and who have ever had a partner.
Measuring unit	X percent (%).
Considerations for indicator quality	To elaborate the indicator, the following criteria will be used for selection of data to be included in the database that will guarantee quality and comparability of the data: (1) Representative data at national level; (2) Data collected through household surveys; (3) Comparable definition of physical, sexual and psychological violence in couples between countries; (4) Comparable age range (15-19 and 15-49); (5) Reliable data source.

Interpretation implications

According to the United Nations Declaration on the Elimination of Violence against Women (1993), Violence against Women is "any act of gender-based violence resulting in physical, sexual or psychological harm or suffering for women, threats of such acts, coercion or arbitrary deprivation of liberty, whether they occur in public or private life. Violence against women shall be understood to encompass, but is not limited to, the following: Physical, sexual and psychological violence that takes place within the family [...]". See underline full definition here.

Intimate partner violence includes any abuse perpetrated by a current or former partner in the context of marriage, cohabitation, or any other formal or informal union.

Different forms of violence included in the indicator are defined as follows:

1. Physical violence consists of acts aimed at physically injuring the victim and include, but are not limited to, pushing, grasping, arm twisting, hair pulling, slapping, kicking, biting or hitting with the fist or object, trying to strangle or suffocate, generate burns on purpose, or threaten or attack with some type of weapon or knife.

2. Sexual violence is defined as any type of harmful or unwanted sexual behavior that is imposed on someone. It includes abusive sexual contact, forced participation in sexual acts, attempt or performance of sexual acts without consent, incest, sexual harassment, among other actions.

3. Psychological violence includes a series of behaviors that include emotional abuse and control behavior actions. For a more detailed definition of physical, sexual and psychological violence against women, see Guidelines on producing statistics on violence against women.

Context indicator	For more information on best practices in producing statistics on violence against women, see: *United Nations Guidelines on producing statistics on violence against women - Statistical surveys (UN, 2014).* In addition to the form of violence and age, income/wealth, education, ethnicity (including indigenous status), disability status, geographic location, and frequency of violence are suggested as desired variables for disaggregation of this indicator.

ODS framework

5 GENDER EQUALITY

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive		**Woman**	√	Imput		Sex	
Thrive		Childhood		Output		**Ethnicity**	√
Transform	√	**Adolescence**	√	**Results**	√	**Education**	√
				Impact		**Socioeconomic level (quintiles of national wealth)**	√
				Product		**Place of residence (urban / rural, or geographic location)**	√

Preferred data source

National Statistical Offices (in most cases) or line ministries/other government agencies that conduct national surveys on violence against women and girls.

Although administrative data from health, police, courts, justice and social services, among other services used by violence survivors, can provide information on violence against women and girls; they do not produce data on violence against women and girls. prevalence, but data or the number of cases received in/reported to these services. Many abused women are known not to report violence, and those who do, tend to be only the most severe cases. Therefore, administrative data should not be used as a data source for this indicator.

For more information on best practices in producing statistics on violence against women, see: Guidelines on producing statistics on violence against women - Statistical surveys (UN, 2014).

Alternative data sources	• Household/demographic surveys that include a module on women's violence experiences, such as DHS.
Inter-agency group estimates	• Although standardized estimates are not available for all countries, the global UN Women database to limit violence against women is available: http://evaw-global-database.unwomen.org/es.
Global monitoring frameworks	N/A
For more information	• Guidelines on producing statistics on violence against women. • ONU Women 2016. Global database on violence against women. • UNICEF data portal. • UNSD portal on minimum set of gender indicators.
References	• SDG metadata repository.

Birth registration with the civil authority (boys and girls under 5 years of age)

Definitions	Boys and girls under 5 years of age whose births have been registered with a civil authority.
Numerator	Number of children under the age of five whose births are reported as registered with the relevant national civil authorities × 100.
Denominator	Total boys and girls under five years of age.
Measuring unit	X percent (%).
Considerations for indicator quality	Number of children who have acquired their right to a legal identity is collected mainly through censuses, civil registry systems and household surveys. Civil registry systems that work effectively compile vital statistics used to compare the estimated total number of births in a country with the absolute number of births registered during a given period. However, systematic registration of births in many countries remains a serious challenge. In the absence of reliable administrative data, household surveys have become a key source of data to monitor levels and trends in birth registration. As information technologies advance, they should be incorporated to improve these records.

Interpretation implications

According with the strengthening vital statistics regional plan, each country establishes a goal based on its previous coverage. In general, countries are encouraged to reach 90% coverage to consider an adequate level. https://www.paho.org/hq/dmdocuments/2013/CD52-INF4-H-s.pdf

Context indicator	Registering children at birth is the first step to ensure their recognition before the law, safeguard their rights and ensure that any violation of these rights does not go unnoticed.
	The right of boys and girls to a name and nationality is enshrined in the Convention on the Rights of the Child (CRC) under Article 7.

ODS framework

16 PEACE, JUSTICE AND STRONG INSTITUTIONS

EWEC-LAC framework	Dimension	Monitoring framework	Suggested stratifier for inequality analysis	
Survive	Woman	Imput	**Sex**	√
Prosper	**Childhood** √	Output	**Ethnicity**	√
Transform √	Adolescence	**Results** √	**Mother's education**	√
		Impact	**Socioeconomic level (quintiles of national wealth)**	√
		Product	**Place of residence (urban / rural, or geographic location)**	√

Preferred data source

National vital registry systems

Alternative data sources	• Censuses, household surveys (MICS and DHS)
Inter-agency group estimates	• UNICEF-UNSD. http://data.unicef.org/child-protection/birth-registration.html
Global monitoring frameworks	• Global Strategy for Women's, Children's and Adolescents' Health.
For more information	• Birth registry. UNICEF.
References	• SDG indicators Metadata repository. United Nations Statistics Division.

Children and young people who, a) in the second and third grades, b) at the end of primary education and c) at the end of lower secondary education, have reached at least a minimum proficiency level in i) reading and ii) mathematics

Definitions	Percentage of children in 2nd or 3rd grade of primary education (1), at the end of primary education (2) and at the end of lower secondary education (3) who achieve at least a minimum level of proficiency in (a) reading and b) mathematics. The minimum proficiency level will be measured relative to the new common reading and mathematics scales currently in development.
Numerator	(1) Number of children in 2nd or 3rd grade of primary education who achieve at least a minimum level of proficiency in reading and mathematics, (2) Number of children at the end of primary education who achieve at least a minimum level of proficiency in reading and mathematics, (3) Number of adolescents at the end of secondary education who achieve at least a minimum level of proficiency in reading and mathematics.
Denominator	(1) Number of children enrolled in 2nd or 3rd grade of primary education; (2) Number of children enrolled at the end of primary education; (3) Number of adolescents enrolled at the end of secondary education.
Measuring unit	X percent (%).
Considerations for indicator quality	Each country sets its own standards, so performance levels may not be comparable. One option is to link regional assessments that share a common framework. The calculation of this indicator requires specific information on the ages of the boys and girls participating in the assessments to create globally comparable data. The ages of the boys and girls reported by the head of the household may not be consistent and reliable, making the calculation of the indicator even more difficult.

Interpretation implications

The indicator is a direct measure of the learning outcomes achieved in the two subject areas at the end of the relevant stages of education. The three measurement points will have their own established minimum standard. There is only one threshold that divides students above and below the minimum:

a) Below the minimum is the percentage of students who do not reach a minimum standard established by the countries in accordance with the minimum competencies defined worldwide.

b) Above the minimum is the percentage of students who have reached the minimum standards. Due to the heterogeneity of performance levels established by national and national assessments, these performance levels will have to be mapped to globally defined minimum performance levels.

Context indicator	Assessments are typically administered within school systems, current indicators cover only school-based indicators, and the proportion of target populations in school may vary from country to country due to the diverse out-of-school child population. Assessing the competencies of out-of-school children would require home-based surveys. Screening of children at home is being considered, but it can be awfully expensive and difficult to administer and is unlikely to be available on the scale needed in the next 3-5 years. Due to the complication in the assessment of out-of-school children and the focus on improving the education system, the UNESCO Institute for Statistics is taking a tiered approach. It will focus on assessing children in school in the medium term, where a lot of data is available, and then develop a more consistent implementation plan to assess children who are out of school in the long term.

ODS framework

4 QUALITY EDUCATION

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis	
Survive		**Woman**	√	Imput		**Sex**	√
Prosper		**Childhood**	√	Output		**Ethnicity**	√
Transform	√	**Adolescence**	√	Results		**Mother's education**	√
				Impact	√	**Socioeconomic level (quintiles of national wealth)**	√
				Product		**Place of residence (urban / rural, or geographic location)**	√

Preferred data source

Entities responsible for conducting learning assessments (including Ministries of Education, National Statistical Offices, and other data providers). UNESCO Institute for Statistics

For multinational assessments, data providers are the International Association for the Assessment of Educational Achievement (IEA), Latin American Laboratory for Assessment of the Quality of Education (LLECE), the Organization for Economic Cooperation and Development (OECD), Programa d'Analyse des Syst-mes Educatifs of CONFEMEN (PASEC) and Consortium for the Monitoring of Educational Quality (SACMEQ).

(a) Short-term strategy: Use national assessment data representative of large-scale national assessments, even though performance levels are not directly comparable. (b) Medium-term strategy: Use a global reporting scale based on a new test or statistical linking of national, regional and national assessments.

Alternative data sources	Multinational learning assessments, including: CONFEMEN's systémes éducatifs analysis program (PASEC), Progress in the International Reading Literacy Study (PIRLS), International Student Assessment Program (PISA), Consortium for Quality Monitoring Educational (SACMEQ), Third Regional Comparative and Explanatory Study (TERCE) and Trends in the International Study of Mathematics and Science.
Inter-agency group estimates	N/A
Global monitoring frameworks	- UNESCO Institute for Statistics. - Global Strategy for Women's, Children's and Adolescents' Health. - Countdown 2030. . Demographic Indicators. Population. Tier 1. Indicator A4. (percentage of girls graduating from high school)
For more information	- http://www.uis.unesco.org/Pages/default.aspx - Programa d'analyse des systems éducatifs de la CONFEMEN (PASEC). - Progress in the International Reading Literacy Study (PIRLS). - Program for International Student Assessment (PISA). - The Consortium for the Monitoring of Educational Quality (SACMEQ). - Third Regional Comparative and Explanatory Study (TERCE). - Third Regional Comparative and Explanatory Study (TIMSS).
References	SDG metadata repository. UNSTATS. https://unstats.un.org/sdgs/metadata/

National level Global Strategy Indicators with complete disaggregation relevant to the objective

EVERY WOMAN
EVERY CHILD
FOR HEALTHY AND EMPOWERED WOMEN,
CHILDREN AND ADOLESCENTS
LATIN AMERICA AND THE CARIBBEAN

Definitions	Monitoring framework indicators data for Every Women Every Children in Latin America and the Caribbean (EWEC-LAC) can be extracted from national sources with at least one disaggregation relevant to the indicator objective.
Numerator	Number of indicators data can be extracted disaggregated from national reporting sources.
Denominator	30 = Number of EWEC-LAC national level monitoring framework indicators with possible data disaggregation.
Measuring unit	X percent. Percent %
Considerations for indicator quality	Disaggregation by age group is not considered for this indicator because it does not make sense to make social stratifying in equality comparisons by age group in all cases, but rather it is more informative to disaggregate by any of the stratifiers included in EWEC-LAC monitoring framework.

Interpretation implications

This type of disaggregation is possible when administrative data having nominal records is used including sex, socioeconomic level, or other variables, or when data from population-based surveys or censuses is available.
To calculate social inequalities in health at the ecological level metrics, it is sufficient to have available stratifiers at the same level of disaggregation as health and population indicators. For example, when social inequality in health at the national level is analyzed, it is recommended to have the 3 types of indicators disaggregated at the same geographic level.

Context indicator	This type of indicator is also included in the SDGs framework as a tracer of the countries' monitoring capacity. In case of EWEC-LAC, it is additionally relevant because disaggregation allows calculating social inequalities in health.

ODS framework

17 PARTNERSHIPS FOR THE GOALS

EWEC-LAC framework		Dimension		Monitoring framework		Suggested stratifier for inequality analysis
Survive		**Woman**	√	Imput		Sex
Thrive		**Childhood**	√	Output		Ethnicity
Transform	√	**Adolescence**	√	**Results**	√	Education
				Impact		Socioeconomic level (quintiles of national wealth)
				Product		**Place of residence (urban / rural, or geographic location)** √

Preferred data source

National calculation based on EWEC-LAC monitoring framework

Alternative data sources	N/A
Inter-agency group estimates	N/A
Global monitoring frameworks	N/A. SDG 17.18.1 is listed as tier III, and no drafts for calculation methodology have been published.
For more information	N/A
References	• SDG metadata repository.

Stratifiers

These are social determinants used in health inequality analysis to define the groups to be compared.

| Sex | Ethnicity | Education | Socioeconomic level | Place of residence |

Sex

Definition	Conceptual considerations	Examples of categories (operationalization)
Biological construct based on characteristics that allow sexual reproduction.	For health inequality analysis, the gender variable is limited to self-identification information reported by participants in health surveys or in routine collection systems.	Male and female • percentage of male population. • percentage of female population.

Ethnicity

Definition	Conceptual considerations	Examples of categories (operationalization)
It refers to human groups that share a cultural and ancestral heritage	Ethnic groups often define themselves based on shared cultural and physical characteristics, such as the language they speak or the color of their skin	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.

Education

Definition	Conceptual considerations	Examples of categories (operationalization)
Indicates the highest level of education obtained by the population	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	Education level • Percentage of population that has completed secondary school. • Years of schooling.

Socioeconomic level

Definition	Conceptual considerations	Examples of categories (operationalization)
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

Definition	Conceptual considerations	Examples of categories (operationalization)
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.

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2. Oakes JM, Kaufman JS, editors. Methods in social epidemiology. San Francisco: John Wiley & Sons, Inc; 2006.
3. Canadian Institute for Health Information. In Pursuit of Health Equity: Defining Stratifiers for Measuring Health Inequality A Focus on Age, Sex, Gender, Income, Education and Geographic Location. Ottawa: CIHI; 2018.