



**Indicators for the Global Monitoring Framework on
Maternal, Infant and Young Child Nutrition
(24 November 2014)**

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I. Background and Purpose

In May 2012, the Sixty-fifth World Health Assembly (WHA) endorsed the Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition (MIYCN). The WHA resolution urges Member States to put the MIYCN Plan into practice by including proven nutrition interventions relevant to the country in maternal, child and adolescent health services and care. Interventions carried out should ensure universal access, and establish and engage policies in agriculture, trade, education, social support, environment and other relevant sectors to improve nutrition.

The MIYCN Plan includes six global nutrition targets to be achieved by 2025:

1. A 40% reduction of the global number of children under five who are stunted
2. A 50% reduction of anaemia in women of reproductive age
3. A 30% reduction of low birth weight
4. No increase in childhood overweight
5. Increase the rate of exclusive breastfeeding in the first six months up to at least 50%
6. Reduce and maintain childhood wasting to less than 5%

The MIYCN Plan also proposes five actions to support the achievement of the global targets.

1. Create a supportive environment for the implementation of comprehensive food and nutrition policies.
2. Include all required effective health interventions with an impact on nutrition in national nutrition plans.
3. Stimulate development policies and programmes outside the health sector that recognize and include nutrition.
4. Provide sufficient human and financial resources for the implementation of nutrition interventions.
5. Monitor and evaluate the implementation of policies and programmes.

Action 5 also calls for a well-defined framework, that would allow a harmonized and internationally accepted approach to monitoring of progress towards nutrition targets at both the national and global levels as well as on the actions taken to put the Comprehensive Implementation Plan into practice,.

Currently, many national nutrition surveillance and monitoring systems are fragmented and only a handful of indicators are tracked systematically across countries. By providing a globally agreed upon framework, targets and indicators can serve as a benchmark for countries and the international community to measure achievements, identify gaps and trigger corrective actions, and estimate global resource requirements.

Improvements in nutrition require collaboration among multiple sectors. The monitoring framework aims to capture the multi-sectoral nature of nutrition and consider indicators relating to underlying causes of malnutrition and broader policies and actions, including access to health services and policies outside the health sector. The monitoring framework also requires the inclusion of indicators that cut across health, agriculture, environment, as well as different disciplines within these sectors that examine biological outcomes, programme coverage, and the political environment.

The monitoring framework has a **core set of indicators**, to be reported by all countries and an **extended set of indicators**, from which countries can draw to design national nutrition surveillance systems fitting the specific epidemiological patterns and program decisions.

The monitoring framework needs to include four types of indicators that allow to monitor the results' pathway towards the global nutrition targets : (1) *primary outcome indicators* that measure the progress towards the six global nutrition targets; (2) *intermediate outcome indicators* that monitor how specific diseases and conditions on the causal pathways affect countries' trends towards the six targets; (3) *process indicators* that monitor programme and situation specific progress and (4) *policy environment and capacity indicators* that measure the political economy and capacity within a country.

In 2013, a set of indicators for a *Global Monitoring Framework* was issued for consultation.¹ These indicators are listed in **Annex I in Tables (A-C)**

Subsequently an informal consultation was completed with Member States and UN Agencies² and an open on-line consultation was held 30 September to 1 October 2013 to further refine these indicators. The consultation agreed on primary outcome indicators but recommended further work on the other types of indicators.

In addition, the consultation requested the Secretariat to develop a new paper including:

- an in-depth description of how indicators relate to targets, the links between indicators and more information on sources of data for each indicator,
- evidence of these relations,
- priorities for further work on indicator development and/or data collection, and
- a summary of nutrition actions needed to reach targets.

Primary outcome indicators were approved by the Sixty-seventh World Health Assembly in May 2014. This paper presents a complete proposal of the core set of indicators that can be used at global and country levels, a proposal on the extended set of indicators and provides background for the proposed choices, as requested by the consultation with Member States and UN Agencies in October 2013.

¹ http://www.who.int/nutrition/events/2013_consultation_indicators_globalmonitoringframework_WHO_MIYCN.pdf

² http://www.who.int/nutrition/events/draft_report_consultationglobal_targets2025.pdf?ua=1

II. Proposed Indicators

This section presents the proposed **core set of 20 indicators** to be collected by all countries (**Table 1**) and an **extended set of 16 indicators** (**Table 2**), which countries could report on where relevant.

The revised proposal for the **core set of indicators** includes the 6 global target indicators, 5 intermediate outcomes, 6 process and 3 policy environment and capacity indicators to be collected globally. The **extended set of indicators**, from which countries can choose or not choose to collect the data, has 6 intermediate outcome, 8 process, and 2 policy indicators.

Table 3 outlines how the proposed core set of indicators is related with the achievement of the global targets. It shows that target 3 has no process indicators and target 2 has only few intermediate and process indicators in the core list. However, there are indicators in the extended set that could be selected by countries that want to more closely track progress towards targets 2 and 3. Target 5 is also somewhat thin on process indicators and for this target there are no indicators in the extended set to fill the gap.

Table 1: Core set of indicators

#	Indicator	Data sources	Collection frequency	Analysis	Indicator type
	Primary outcome indicators, monitoring progress towards the six global nutrition targets				
1	Prevalence of low height-for-age in children under five years of age	DHS, MICS, NSS, NNS	3-5 years	Age, sex, u/r, region	WHA Target
2a	Prevalence of haemoglobin <11 g/dL in pregnant women	DHS, MICS, NSS, NNS	3-5 years	u/r, region	WHA Target
2b	Prevalence of haemoglobin <12 g/dL in non-pregnant women	DHS, MICS, NSS, NNS	3-5 years	u/r, region	WHA Target
3	Prevalence of infants born <2500 g	DHS, MICS, NSS, NNS	3-5 years	Sex	WHA Target
4	Prevalence of weight-for-height >2 SD in children under five years of age	DHS, NNS	3-5 years	Age, sex, u/r, region	WHA Target
5	Prevalence of exclusive breastfeeding in infants aged six months or less	DHS, MICS, NSS, NNS	3-5 years		WHA Target
6	Prevalence of low weight-for-height in children under five years of age	DHS, MICS, NSS, NNS	3-5 years	Age, sex, u/r, region	WHA Target
	Intermediate outcome indicators, monitoring conditions on the causal pathways to the targets				
7	Prevalence of diarrhoea in children under 5 years of age	DHS, MICS	3-5 years	u/r, region	intermediate outcome indicator
8	Proportion of women aged 15-49 years with low body mass index (<18.5 kg/m ²) ³	DHS, MICS	3-5 years	u/r, region	intermediate outcome indicator
9	Number of births during a given reference period to women aged 15-19 years /1000 females aged 15-19 years	DHS, MICS	3-5 years	u/r, region	intermediate outcome indicator
10	Proportion of overweight and obese women 18+-49 years of age (body mass index ≥25 kg/m ²)	DHS, MICS	3-5 years	u/r, region	intermediate outcome indicator
11	Proportion of overweight in school-age children and adolescents 5-18 years (BMI-for-age >+1 SD)	School-surveys, NNS	at least every 5 years	Age, sex, u/r, region	intermediate outcome indicator
	Process indicators, monitoring programmes and situation-specific progress				

³ Less than 2 SD below the mean body mass index for age in women aged 15-18 years.

12	Proportion of children aged 6-23 months who receive a minimum acceptable diet	DHS, MICS, NNS	3-5 years	Age, sex, u/r, region	process indicator
13	Proportion of population using a safely managed drinking service	DHS, MICS, WHS	3-5 years	u/r, region	process indicator
14	Proportion of population using a safely managed sanitation service	DHS, MICS, WHS	3-5 years	u/r, region	process indicator
15	Proportion of pregnant women receiving iron and folic acid supplements	DHS, MICS	3-5 years	u/r, region	process indicator
16	Percentage of births in baby friendly facilities	NutriDash, GINA	annual	u/r, region	process indicator
17	Proportion of mothers of children 0-23 months who have received counselling, support or messages on optimal breastfeeding at least once in the last year	NutriDash	annual	u/r, region	process indicator
<i>Policy environment and capacity indicators, measuring political commitment</i>					
18	Number of trained nutrition professionals /100,000 population	WHS	annual	region	policy and capacity indicator
19	Number of countries with legislation /regulations fully implementing the International Code of Marketing of Breast-milk Substitutes (resolution WHA34.22) and subsequent relevant resolutions adopted by the Health Assembly	NutriDash, GINA	annual		policy and capacity indicator
20	Number of countries with maternity protection laws or regulations in place	NutriDash, GINA	annual		policy and capacity indicator

DHS: Demographic Health Surveys

MICS: Multiple Indicator Cluster Surveys

NSS: National surveillance systems

NNS: National nutrition surveys

WHS: World Health Statistics (http://www.who.int/gho/publications/world_health_statistics/en/)

NutriDash: UNICEF internal data collection platform. Global report to be published early 2015.

GINA: Global database on the Implementation of Nutrition Action (<http://www.who.int/nutrition/gina/en/>)u/r: urban/rural

Table 2: Extended set of indicators

#	Indicator	Data sources	Collection frequency	Analysis	Type of indicator
1	Incidence of malaria	Surveys	Continuous	age, sex, u/r, region	intermediate outcome indicator
2	Median urinary iodine concentration in children aged 6-12 years	Surveys	3-5 years	region	intermediate outcome indicator
3	Proportion of stunted women of reproductive age (15-49 years)	Surveys	3-5 years	u/r, region	intermediate outcome indicator
4	Percentage of pregnant women, aged 15-49 years who used any tobacco product (smoked or smokeless)	Surveys	3-5 years	u/r, region	intermediate outcome indicator
5	Proportion of children born in the last 24 months who were put to the breast within one hour of birth	Surveys	3-5 years	u/r, region	intermediate outcome indicator
6	New cases of measles		annual		intermediate outcome indicator
7	Use of insecticide treated nets in children aged 0-5 years	Surveys	3-5 years	0-5 years, PW, SES, residence	process indicator
8	Proportion of children under 5 years old with diarrhea (in last two weeks) receiving oral rehydration salts (ORS packets or pre-packaged ORS fluids)	Surveys	3-5 years		process indicator
9	Percentage of households that have iodized salt (>15 ppm)	Surveys	3-5 years	Any iodine (>0ppm) vs adequate iodine (>15ppm), SES, residence	process indicator
10	Percentage of 1-year-olds who have received the appropriate doses of the recommended vaccines in the national schedule by recommended age	Surveys, WHS	annual	u/r, region	process indicator
11	Percentage of households consuming iron-fortified wheat flour products	Flour Fortification Initiative		u/r, region	process indicator
12	Appropriate use of micronutrient powders for children aged 6-23 months	NutriDash	annual	u/r, region	process indicator

13	Proportion of children with severe acute malnutrition having access to appropriate treatment including therapeutic foods and nutrition counselling	NutriDash	annual	u/r, region	process indicator
14	Proportion of children aged 12-59 months receiving at least one dose of deworming medication	NutriDash	annual	u/r, region	process indicator
15	Strength of nutrition governance	WHO/HANCI	annual		policy and capacity indicator
16	Number of countries with legislation /regulations to protect children from the marketing of unhealthy foods and beverages				policy and capacity indicator

Surveys: DHS; MICS and other random Household surveys

Flour Fortification Initiative (<http://www.ffinetwork.org/>)

WHS: World Health Statistics (http://www.who.int/gho/publications/world_health_statistics/en/)

NutriDash: UNICEF internal data collection platform. Global report to be published early 2015.

HANCI: Hunger and Nutrition Commitment Index (<http://www.hancindex.org/>)

u/r: urban/rural

PW: Pregnant women

SES: Socio-economic status

Table 3: Association between indicators and targets

Global targets	Intermediate outcome Indicators	Process indicators	Policy indicators
1 - Stunting	<p>Prevalence of diarrhoea in children under 5 years of age</p> <p>Number of births during a given reference period to women aged 15-19 years /1000 females aged 15-19 years</p> <p>Proportion of women aged 15-49 years with low body mass index (<18.5 kg/m²)</p>	<p>Proportion of children aged 6-23 months who receive a minimum acceptable diet</p> <p>Proportion of population using a safely managed drinking service</p> <p>Proportion of population using a safely managed sanitation service</p> <p>Percentage of births in baby friendly facilities</p> <p>Proportion of mothers of children 0-23 months who have received counselling, support or messages on optimal breastfeeding at least once in the last year</p>	<p>Number of trained nutrition professionals per 100,000 population</p> <p>Number of countries with legislation /regulations fully implementing the International Code of Marketing of Breast-milk Substitutes (resolution WHA34.22) and subsequent relevant resolutions adopted by the Health Assembly</p> <p>Number of countries with maternity protection laws or regulations in place</p>
2 - Anaemia	<p>Proportion of women aged 15-49 years with low body mass index (<18.5 kg/m²)</p> <p>Number of births during a given reference period to women aged 15-19 years /1000 females aged 15-19 years</p>	<p>Proportion of pregnant women receiving iron and folic acid supplements</p>	<p>Number of trained nutrition professionals per 100,000 population</p> <p>Number of countries with maternity protection laws or regulations in place</p>
3 - Low birth weight	<p>Proportion of women aged 15-49 years with low body mass index (<18.5 kg/m²)</p>	<p>Proportion of pregnant women receiving iron and folic acid supplements</p> <p>Percentage of births in baby friendly facilities</p>	<p>Number of trained nutrition professionals per 100,000 population</p>
4 - Overweight	<p>Proportion of overweight and obese women 18+-49 years of age (body mass index ≥25 kg/m²)</p> <p>Proportion of overweight in school-</p>	<p>Proportion of children 6-23 months of age who receive a minimum acceptable diet</p> <p>Percentage of births in baby friendly facilities</p>	<p>Number of trained nutrition professionals per 100,000 population</p> <p>Number of countries with legislation /regulations fully implementing the International Code of</p>

	age children and adolescents 5-18 years (BMI-for-age >+1 SD)	Proportion of mothers of children 0-23 months who have received counselling, support or messages on optimal breastfeeding at least once in the last year	Marketing of Breast-milk Substitutes (resolution WHA34.22) and subsequent relevant resolutions adopted by the Health Assembly
5 - Exclusive breastfeeding	Number of births during a given reference period to women aged 15-19 years /1000 females aged 15-19 years	Percentage of births in baby friendly facilities Proportion of mothers of children 0-23 months who have received counselling, support or messages on optimal breastfeeding at least once in the last year	Number of trained nutrition professionals per 100,000 population Number of countries with legislation /regulations fully implementing the International Code of Marketing of Breast-milk Substitutes (resolution WHA34.22) and subsequent relevant resolutions adopted by the Health Assembly Number of countries with maternity protection laws or regulations in place
6 - Wasting	Prevalence of diarrhoea in children under 5 years of age Proportion of women aged 15-49 years with low body mass index (<18.5 kg/m ²)	Proportion of children 6-23 months of age who receive a minimum acceptable diet Proportion of population using a safely managed drinking service Proportion of population using a safely managed sanitation service Percentage of births in baby friendly facilities Proportion of mothers of children 0-23 months who have received counselling, support or messages on optimal breastfeeding at least once in the last year	Number of trained nutrition professionals per 100,000 population Number of countries with legislation /regulations fully implementing the International Code of Marketing of Breast-milk Substitutes (resolution WHA34.22) and subsequent relevant resolutions adopted by the Health Assembly Number of countries with maternity protection laws or regulations in place

III. Evidence of indicators

In this section, we will highlight the evidence for the inclusion of the core set of indicators for the monitoring framework.

Intermediate outcome indicators

- **Prevalence of diarrhea in children under 5 years of age:** Diarrhea has a direct impact on mortality through stunting (1). Improved water sources and improved sanitation and hygiene also impact diarrhea (2). Improvements in breastfeeding behaviors and practices can also impact mortality due to wasting and diarrhea (3).
- **Proportion of women aged 15-49 years with low body mass index (<18.5 kg/m²):** Women who are thin tend to have increased risk of intrauterine growth restriction which increases the risk of neonatal mortality and future stunting in offspring (4). Improvements in balanced energy and protein supplementation can impact IUGR, and stunting (5). Maternal malnutrition is a key contributor to poor fetal growth, low birth weight (LBW) as well as short- and long-term infant morbidity and mortality (5). Bhutta et al (6) conducted a comprehensive review of interventions to address undernutrition and micronutrient deficiencies in women and children and assessed emerging new evidence for delivery platforms. They found that interventions targeted to women exist to address intra-uterine growth restriction and prevent small-for-gestational age (SGA) and pre-term births in low- and middle-income countries. These interventions include balanced energy protein, calcium, and multiple micronutrient supplementation and preventive strategies for malaria in pregnancy.
- **Number of births during a given reference period to women aged 15-19 years /1000 females aged 15-19 years:** Birth intervals shorter than 18 months are significantly associated with Small for Gestational Age (SGA), preterm birth and death in the first year of life. Lack of access to family planning interventions thus contributes to the burden of adverse birth outcomes and infant mortality in LMICs (7). SGA could be an indirect impact on stunting. The provision of access to voluntary family planning, especially effective contraceptive methods, is not only crucial for directly improve reproductive health outcomes, but is also positively associated with improvements in health, schooling, and economic outcomes (8), all of which are important determinants for improving nutritional outcomes.
- **Proportion of overweight and obese women 18+-49 years of age (body mass index ≥ 25 kg/m²):** Maternal overweight and obesity result in increased maternal morbidity and infant mortality (9). Maternal overweight is associated to overweight and metabolic syndrome in children (10, 11, 12).
- **Proportion of overweight school-age children and adolescents 5-18 years (BMI-for-age $>+1$ SD).** Obesity tracks into adulthood and childhood and adolescent obesity is sensitive to interventions. The obesity levels in this age group may indicate how the epidemic is developing into the next generation.

Process indicators

- **Proportion of children aged 6-23 months who receive a minimum acceptable diet:** It has been suggested that in addition to disease prevention strategies, complementary feeding interventions targeting this “critical window” are most efficient in reducing malnutrition and promoting adequate growth and development (13). According to the World Health Organization (WHO), the complementary feeding should be *timely*, meaning that all infants should start receiving foods in addition to breastmilk from 6 months onwards; *adequate*, meaning that the nutritional value of complementary foods should fulfil the needs of rapidly growing child; and *appropriate*, meaning that foods should be diverse, of appropriate texture and given in sufficient quantity (14, 15). Dewey et al. (15) conducted one of the most comprehensive systematic reviews on the efficacy and effectiveness of complementary feeding interventions in low- and middle-income countries. The key findings included educational interventions that stress feeding nutrient-rich animal foods may be more effective in terms of child growth compared with general educational messages. In areas with high levels of food insecurity, complementary feeding interventions that provide food in addition to education seem to be more effective for improving child growth outcomes.
- **Proportion of population using a safely managed drinking service:** Improved, safe drinking services which include a household connection as well as covered wells and bore holes can have an impact on preventing diarrhea incidence which can have an impact on stunting (2).
- **Proportion of population using a safely managed sanitation service:** Improved sanitation and hygienic practices have an impact on preventing diarrhea incidence which can have an impact on stunting (2). A systematic analysis also showed that improvements in WASH have also been seen to have mild impacts on stunting (16).
- **Proportion of pregnant women, receiving iron and folic acid supplements:** Iron and folic acid supplementation can decrease the risk of maternal anemia and neural tube defects in offspring. Iron-folic acid supplementation of pregnant women increases hemoglobin by 1.17 g/dL in developed countries and 1.13 g/dL in developing countries (17). The prevalence of maternal anemia can be reduced by one-third to one-half over a decade if action is taken to launch focused, large-scale programs (18).
- **Percentage of births in baby friendly facilities:** Babies born in baby friendly facilities have an increased breast-feeding initiation by 4% among mothers with lower education but not among mothers with higher education. BFHI accreditation also increased exclusive breast-feeding for ≥4 weeks by 4.5% among mothers with lower education who delivered in BFHI facilities (18).
- **Proportion of mothers of children 0-23 months who have received counselling, support or messages on optimal breastfeeding at least once in the last year:** Studies have shown that educating mothers on appropriate complementary feeding can improve child growth, in families who are food secure (19). Protein energy supplementation should be provided in support of education for those families who are food insecure. Imdad et al. (19) explored the impact of breastfeeding promotional strategies on EBF rates at 4 and 6 weeks and at 6 months (with the latter indicator being of most relevance to this study). On the whole they found that breastfeeding promotion interventions (which are disaggregated in the next section) led to an overall 137% increase, with a significant 6 times increase in EBF rates in low- and middle-income countries, compared to 1.3 fold increase in high-income countries (19).

Policy and capacity indicators

- **Number of trained nutrition professionals /100,000 population:** A systematic analysis showed that improving health worker nutrition training improved daily energy intake of children in the critical window of opportunity (6 months to 2 years of age) as well as feeding frequency, and dietary diversity (20). It was also found that trained community health workers had increased nutrition counseling and better management of child undernutrition practices (21).
- **Number of countries with legislation /regulations fully implementing the International Code of Marketing of Breast-milk Substitutes (resolution WHA34.22) and subsequent relevant resolutions adopted by the Health Assembly:** Little progress in increasing breastfeeding rates is seen in absence of provisions of the International Code of Marketing Breast-milk Substitutes (22). However, the establishment of legislation is not sufficient and should be complemented by adequate implementation and monitoring mechanisms (23).
- **Number of countries with maternity protection laws or regulations in place:** Returning to work after maternity leave has been identified as a significant cause for stopping or never starting breastfeeding (24, 25, 26, 27). In most low- and middle-income countries, maternity leave is limited to formal sector employment or is not always provided in practice (28, 29, 30). In Canada, a reform which extended maternity leave from 6 months to 1 year, showed that breastfeeding increased 10 days with every additional month not at work (elasticity⁴ of 0.458) (25). The proportion of women attaining 6 months of exclusive breastfeeding increased about 8-9 percentage points over a pre-reform mean (25).

⁴ Elasticity is defined as the degree to which a dependent variable (in this case breastfeeding) changes in response to an associated independent variable (in this case months of maternity leave).

IV. Priorities for further work

Some of the selected indicators have been used in other contexts, such as the Countdown 2015 initiative, the Global Nutrition Report and the Scaling Up Nutrition framework. Implementation of the GMF has the potential to garner global harmonization on a set of core indicators that are systematically collected, as well as to contribute to the development of a monitoring and accountability system for the follow up of the political declaration of the 2nd International Conference on Nutrition and the post 2015 Sustainable Development Goals (SDGs).

WHO recently coordinated the development of a *Global Reference List of Core Indicators* for results monitoring. This list contains a standard set of 100 indicators prioritized by the global community to provide concise information of the health situation and trends, including responses at national and global levels. The reference list reflects indicators of relevance for country, regional and global reporting across the full spectrum of global health priorities relating to the MDG agenda, as well as to new and emerging priorities such as NCDs, universal health coverage and other key issues in the post-2015 development agenda. This list will be a “living document”, updated periodically as technologies develop, new priorities emerge and interventions change. The nutrition indicators proposed in the Global Monitoring Framework described in this paper contributes to this reference list.

The proposed monitoring framework will be periodically revised. A Scientific and Technical Advisory Group (STAG) will be established with this purpose. The next steps for the STAG will be to:

1. Review the core and extended list of indicators.
2. Align indicators with other on-going global and regional initiatives that are calling for a core set of indicators to track accountability.
3. Provide guidance on steps for countries to take when setting up surveillance systems that track these core and extended indicators.

The proposed monitoring framework and indicators will also be discussed and reviewed by Member States. It will be essential to get country buy-in and understand the challenges to include the proposed indicators to the current country nutrition surveillance systems.

Most of the currently proposed indicators are collected within the health sector and address nutrition-specific actions. The revisions may involve the inclusion of indicators that track policy implementation in other sectors. For example, although the set of indicators includes some dietary and food indicators (e.g. minimum acceptable diet, food fortification and micronutrient powders) they do not consider other food-based indicators such as sustainable consumption and agriculture supply/consumption patterns, which are reported by FAOStat and collected through the FAO Food Balance sheets. Further work is required to evaluate indicators to better track processes leading to the achievement of global nutrition targets; and to develop research around existing and new indicators.

V. Implementation of the Framework

The proposed set of indicators should be carefully evaluated with the purpose to not overwhelm personnel, programmes and surveillance systems. Usefulness of indicators for multiple reporting requirements need to be considered and duplicative reporting requirements should be avoided. Furthermore, a monitoring system should also help countries better manage their programmes and make improvements and adjustments in a timely manner.

Inclusion in monitoring systems: It will be important to ensure that countries begin to include the prioritized global target indicators into their national information and monitoring systems. However in many countries there is a dearth in human and monetary resources as well as other problems that constrain the design and strength of a nutrition surveillance system. Often, compromises must be made in the selection of indicators included in the surveillance system, the geographic coverage of the system, the frequency of the data collected, the extent to which the data collected represents the intended population, and the precision of the results. Part of this Framework's intention is to ensure that the number of global indicators to be collected were not over-burdensome. Some of the proposed intermediate, process and policy indicators are already systematically being collected in some countries. For those who do not collect on the current set of core indicators, an iterative process must be conducted that links country priorities to nutrition surveillance. It will also be important that country sectors investing in surveillance obtain the results regularly and in a timely fashion.

While some national surveillance systems are considered an integrated part in the government's health infrastructure, some countries establish ad-hoc systems during emergencies and humanitarian crises. It will be important for countries to develop sustainable surveillance systems with the view to monitor development over time. Hence, nutrition surveillance systems need to include indicators that can be tracked. It will also be important to understand how much the establishment, maintenance and running of robust surveillance systems will cost countries. This investment will allow for countries to track progress and global comparisons to be made in a temporal scale.

Data sources and frequency of data collection: The mapping of data sources for each indicator as well as data collection frequency are critical to this exercise. Some of the originally proposed indicators, while representative of important areas to monitor, have not yet been validated, or do not have reliable data sources. Of the revised indicators, sources of data are available that can be used for surveillance. Data will need to be collected through various mechanisms including repeated sample surveys, facility based surveys and community based sentinel sites. Data flow, aggregation and archiving will also be an important process that countries will need to establish. Tables 1 and 2 also include possible data sources for each of the proposed indicators as well as the recommended frequency of data collection.

Gender, socioeconomic status, education and urban/rural geographical disaggregation: It is important for countries to better understand where to act and how. By tracking the core set of indicators recommended in this framework, a situation analysis can be performed. It will be important for countries to develop better data collection and nutrition assessment tools and skills for interpretation. Geographic coverage can vary along with priority subnational areas (due to heightened vulnerability of food insecurity or disease outbreaks).

Tracking indicators and accountability: The 2014 Global Nutrition Report shows that 79 of the 194 WHO Member States cannot track more than two of the four WHA indicators and 5 countries cannot track any. Of the 94 countries that had missing data on at least one indicator, nearly half of them were in Europe and North America. These high-income countries typically have the data, but these are not reported in ways that make them internationally comparable. High-, middle- and low-income countries should be held accountable equally in tracking these key targets, same as everybody will be concerned by the upcoming Sustainable Development Goals.

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Annex I: Indicators proposed in 2013

In 2013, a set of 39 priority indicators were proposed as being relevant for the achievement of one or more global targets.⁵ There were 16 intermediate outcomes, 18 process outcomes, and five indicators of the policy environment and the country capacities indicators. These indicators are listed in **Tables A-C**.

Set One: Proposed intermediate outcome indicators

Initially sixteen intermediate outcome indicators were recommended (**Table A**), each being matched to one or more of the six global targets. These indicators measure proxy outcomes that support the six global targets as well as their causal pathways. It was understood that not all indicators will be relevant to all countries.

Table A: Proposed intermediate outcome indicators

Indicator	Global Target Matching
IO1: Incidence of malaria	Target 1, 2,3, 6
IO2: Incidence of diarrhoea in children under 5	Target 1, 6
IO3: Median urinary iodine concentration (micrograms/L) in children aged 6-12 years	Target 1,
IO4: Proportion of adolescent girls with Hb concentration of <11g/dL	Target 2, 3
IO5: Proportion of children below five years of age with Hb concentration of <11 g/dL	Target 2, 3
IO6: Proportion of thin women of reproductive age	Target 3
IO7: Proportion of stunted women of reproductive age	Target 3
IO8: Prevalence of cigarette smoking in pregnant and breastfeeding women	Target 3
IO9: Mean maternal age of first child's birth	Target 3
IO10: Proportion of overweight and obese adults	Target 4
IO11: Proportion of overweight school-age children and adolescents (5-19 years)	Target 4
IO12: Early Initiation of breastfeeding	Target 5
IO13: Prevalence of measles	Target 6, 1
IO14: Prevalence of rubella	Target 6, 1
IO15: Prevalence of pertussis	Target 6, 1
IO16: Prevalence of polio	Target 6, 1

⁵ These can be summarised as: already validated; systems or instruments are in place to set a baseline and monitor changes; currently collected in most countries or can be added at minimal cost; country capacity for monitoring. See the background paper for an explanation of some of the conceptual and methodological issues and questions.

Set Two: Proposed process indicators

Eighteen process indicators were proposed (**Table B**), with each being matched to at least one of the six global targets. Not all indicators will be relevant to all countries and currently some of these processes are not systematically tracked in countries. These indicators measure mainly coverage of core interventions that would ultimately impact both intermediate outcomes and the primary outcomes, i.e. the global targets.

Table B: Proposed process indicators

Indicator	Global Target Matching
PR1: Proportion of children receiving a minimum acceptable diet at 6-23 months of age	Target 1, 6
PR2: Proportion of population using an improved water source	Target 1, 6
PR3: Proportion of population using improved sanitation facilities	Target 1, 6
PR4: Children sleeping under insecticide-treated nets	Target 1, 6
PR5: Proportion of children under five years old with diarrhea receiving oral rehydration salts	Target 1, 6
PR6: Proportion of population below minimum level of dietary energy consumption	
PR7: Proportion of households having access to iodized salt	Target 1
PR8: Mean dietary diversity scores	Target 1, 2, 6
PR9: Immunization coverage levels	Target 1, 6
PR10: Proportion of average household expenditure on food of the bottom three deciles	Target 1, 2, 6
PR11: Proportion of pregnant women receiving iron and folic acid supplements	Target 2, 3
PR12: Percentage of households consuming iron-fortified wheat flour products	Target 2, 3
PR13: Appropriate use of micronutrient powders	Target 2, 3
PR14: Proportion of children under five of age receiving iron supplements	Target 2, 3
PR15: Proportion of women who have received protein and energy supplements	Target 3
PR16: Proportion of hospitals providing maternity care designated as baby-friendly	Target 5
PR17: Proportion of children with severe acute malnutrition having access to appropriate treatment including therapeutic foods	Target 6
PR18: Proportion of children born to HIV-positive women who are feeding in line with national guidelines on HIV and infant feeding	Target 6
PR19: Proportion of infants exclusively breastfed for the first six months of life	Target 1, 4, 5

Set Three: Policy environment indicators

Five indicators of the policy environment and the country capacities were proposed (**Table C**). These five indicators are not linked to a specific global target but serve as proxies for the overarching political and capacity context and environment for each country. Not all indicators will be relevant to all countries and currently some of these indicators are not systematically tracked in countries.

Table C: Proposed policy and capacity indicators

Indicator
HP1: Ratio of community health workers to total population
HP2: Adoption and enforcement of International Code of Marketing of Breast-milk Substitutes and subsequent relevant WHA resolutions
HP3: Ratification and enforcement of ILO maternity protection convention 183 and its Recommendations 191 as a minimum standard
HP4: Number of staff with nutrition skills at each level of service delivery
HP5: Strength of nutrition governance

Annex II: Comments on 2013 proposed indicators received in public consultations and Secretariat response

The following set of tables (D-F) present suggested modifications to the previously proposed 39 indicators based on the informal consultation. Table (G) lists additional proposed indicators. For each indicator, a decision was made to:

- **Keep Global** = indicator should be kept as part of the **core set of global indicators**
- **Keep Optional** = indicator that is useful, correctly defined and validated but only applicable in some circumstances and to be kept as part of the **extended set of indicators**. It does not necessarily have to be reported globally but countries need to consider it in their frameworks.
- **Remove** = indicator should be dropped from both the global and extended sets of indicators to track
- **Modified** = indicator should be modified to address consultation concerns
- **Remove and consider in future** = indicator to be dropped from both the global and longer optional list but should be reconsidered for inclusion as data sources and collection improves.

The relevance of each indicator to the WHA targets is mentioned in the column “Justification”. Note that several indicators relate to more than one target, highlighting the indicator relevance.

The rationale for an indicator becoming optional was because the data may not be relevant to all countries and their context, or the data are not systematically collected. The rationale for an indicator suggested to being removed was because the data is not at all collected systematically or it did not tie concretely into the six global WHA targets. That does not mean that these indicators are totally excluded. Through rigorous consultation, indicators can be modified, and considered for inclusion in future years.

Table D: Proposed revisions to intermediate outcome indicators

Indicator code	Indicator	Comments from Consultation	Status	Justification
IO1	<p>Previous: Prevalence of malaria</p> <p>Revised: Prevalence of malaria in women of reproductive age</p> <p>Revised from Core Health Indicator (CHI) list : malaria incidence rate</p>	None	Modified Keep Optional	<p>Regularly collected, relevant to nutrition and global health data systems</p> <p><i>Intermediate outcome for WHA target 2, 3, and via these, 1.</i></p>
IO2	<p>Incidence of diarrhoea in children under 5</p> <p>Revised from CHI: Prevalence of children with diarrhoea receiving ORS</p>	None	Keep Global	<p>Prevalence data is regularly collected, relevant to nutrition and global health data systems.</p> <p><i>Intermediate outcome for WHA target 1 and 6.</i></p>
IO3	Median urinary iodine concentration (micrograms/L) in children aged 6-12 years (Additional health indicator AHI)	None	Keep Optional	While the indicator is important, <i>not directly related to the targets.</i>
IO4	<p>Previous: Proportion of adolescent girls with Hb concentration of <11g/dL</p> <p>Revised: Proportion of adolescent girls (10-19 years) with Hb concentration of <11g/d L</p>	There were questions about access to quality data	Remove and consider in future	<p>Data is collected by DHS but quality of data is questionable. This is a "hard to reach" group but with recent evidence, and growing importance, it will be important.</p> <p><i>Intermediate outcomes for WHA target 2.</i></p>
IO5	Proportion of children 6-59 months with Hb concentration of <11 g/dL	<p>Recommendation to delete this indicator from current recommended list</p> <p>If this indicator were to remain, proposal to amend it to restrict to children under two because this would be more sensitive and covers most important period.</p>	Remove and consider in future	<p>Data is not regularly or systematically collected.</p> <p><i>Not directly related to the targets.</i></p>

Indicator code	Indicator	Comments from Consultation	Status	Justification
IO6	<p>Previous: Proportion of thin women of reproductive age</p> <p>Revised: Proportion of thin women of reproductive age (adult: body mass index) (BMI) of <18.5 kg/m² Adolescents 15-19 BMI <-2SD)</p>	Clarification that ' <i>thin</i> ' means a body mass index (BMI) of <18.5 kg/m ² in adult women and <-2SD of BMI-for-age in adolescent girls of reproductive age (15-19 years)	Modified Keep Global	<p>AHI indicator: Proportion of women of reproductive age who are underweight.</p> <p><i>Intermediate outcome for WHA target 1, 2 and 3</i></p>
IO7	<p>Previous : Proportion of stunted women of reproductive age</p> <p>Revised: Proportion of stunted women of reproductive age (adult : height <145 cm); adolescents (15-19 years) <-2SD of height-for-age)</p>	There were questions about the availability of data on prevalence of stunted women of reproductive age. The WHO Secretariat indicated the data is available, and this is valuable in highlighting intergenerational effect. In adult women, stunting is defined as having height <145 cm); in adolescent girls of reproductive age (15-19 years) it is < -2SD of height-for-age	Keep Optional	<p>Information on women's height is collected in DHS surveys and other national surveys in which BMI data are collected.</p> <p><i>Intermediate outcome for WHA target 1, 2, 3</i></p>
IO8	<p>Prevalence of cigarette smoking in pregnant women</p> <p>Revised from CHI: Current tobacco use (adults/adolescents) – with pregnant women as disaggregation level</p>	None	Keep Optional	<p>Risk factor for NCDs and low birth weight outcomes. Multiple definition used for this indicator. Not relevant for all countries</p> <p><i>Intermediate outcome for WHA target 3.</i></p>
IO9	<p>Previous: Mean maternal age of first child's birth</p> <p>Revised: Proportion of children born to women below the cut off age (18 or younger)</p>	Proposal to change this indicator to base it on a cut-off age for early pregnancy (proportion of women having first birth at 18 or earlier). This could be more informative than the mean maternal age.	Modified Keep Global	<p>Indicator has been changed to: 'Proportion of children born to women below the cut off age (18 or younger)'. These data are collected by UNICEF.</p> <p><i>Intermediate outcome for WHA target 1, 3, 4, 5.</i></p>

Indicator code	Indicator	Comments from Consultation	Status	Justification
	Birth spacing	Not just age at first birth, but also birth spacing relevant to nutrition outcomes		
IO10	Previous: Proportion of overweight and obese adults Revised: Proportion of overweight and obese women of reproductive age (BMI > 25 kg/m ²)	It was pointed out that maternal BMI is in fact the more important factor. Maternal BMI, therefore, could be included as an indicator.	Modified Keep Global	Indicator has been changed to: 'Proportion of overweight and obese women of reproductive age (BMI > 25).
IO11	Proportion of overweight school-age children and adolescents (5-19 years)		Keep Global	<i>Part of global monitoring framework for NCDs.</i>
IO12	Previous; Timely initiation of breastfeeding Revised: Proportion of children born in the last 24 months who were put to the breast within one hour of birth Revised from CHI: Early initiation of breastfeeding	The wording ' <i>early initiation</i> ' of breastfeeding is more widely understood than the wording ' <i>timely initiation</i> ' currently proposed. It was suggested, therefore, to change this to ' <i>early initiation of breastfeeding</i> '. The indicator would benefit from having the definition included in the wording of the indicator.	Keep Optional	Indicator has been changed to: Proportion of children born in the last 24 months who were put to the breast within one hour of birth <i>Intermediate outcome for WHA target 1, 5, 6</i>
IO13	Prevalence of measles Revised from CHI: New cases of vaccine preventable diseases (with disaggregation levels: measles, rubella, poliomyelitis, meningitis, etc.)	none	Keep Optional	Relevance will depend on countries' epidemiology. <i>Intermediate outcome for WHA target 1 and 6.</i>
IO14	Prevalence of rubella Revised from CHI: New cases of vaccine preventable diseases (with disaggregation levels: measles, rubella, poliomyelitis, meningitis, etc.)	none	Remove	Routinely collected but relevance will depend on countries' epidemiology. <i>Important intermediate outcome of WHA target 1 and 6.</i>

Indicator code	Indicator	Comments from Consultation	Status	Justification
IO15	Prevalence of pertussis Revised from CHI: New cases of vaccine preventable diseases (with disaggregation levels: measles, rubella, poliomyelitis, meningitis, etc.)	none	Remove	Routinely collected but relevance will depend on countries' epidemiology.
IO16	Prevalence of polio Revised from CHI: New cases of vaccine preventable diseases (with disaggregation levels: measles, rubella, poliomyelitis, meningitis, etc.)	In relation to wasting: Since this indicator does not have a strong evidence base for a link to wasting, it was proposed to delete it.	Remove	Routinely collected but relevance will depend on countries' epidemiology.

Table E: Proposed revisions to process indicators

Indicator code	Indicator	Comments from Consultation	Status	Justification
PR1	Proportion of children receiving a minimum acceptable diet at 6-23 months of age	In relation to overweight: It was questioned whether this indicator, as it stands, would be able to pick up a diet that is poor quality because it is high in sugar, fat, etc. This is not possible from this indicator as it stands.	Keep Global	Indicator is established and collected in all DHS. <i>Process indicator for WHA target 1, 4 and 6.</i>
PR2	Proportion of population using an improved water source	Water quality: It was pointed out that data on water testing is increasingly included in surveys.	Keep Global	<i>Process indicator for WHA target 1 and 6.</i>
PR3	Proportion of population using improved sanitation facilities	none	Keep Global	<i>Process indicator for WHA target 1 and 6.</i>
PR4	Children sleeping under insecticide-treated nets	There was a suggestion that intermittent preventive treatment (IPT) could be added as an optional process indicator.	Keep Optional	IPT not done in all countries so recommend indicator remains the same. <i>Indirectly linked to WHA targets.</i>
PR5	Proportion of children under five years old with diarrhea receiving oral rehydration salts (ORS packets or pre-packaged ORS fluids)	There was a suggestion that an indicator on hand washing might be more appropriate than the indicator for diarrhoea treatment.	Keep Optional	<i>Process indicator for WHA target 1 and 6.</i>
PR6	Proportion of population below minimum level of dietary energy consumption	Methodological issues with this and the other indicators relating to food security/insecurity drawing on work which is already ongoing. FAO does have a food security indicator based on analysis of Food Balance Sheets, but probably not ideal for this purpose. FAO and partners are well down the line in a process of developing new indicators of food security e.g. Food Insecurity Experience Scale.	Remove	Collected yearly by FAO as part of SOFI report. <i>Indirectly linked to WHA targets.</i>

Indicator code	Indicator	Comments from Consultation	Status	Justification
PR7	Proportion of households having access to adequately iodized salt	It was noted that it is valuable to ensure that iodine is included somewhere in the global monitoring framework, to underline its importance even if it does not figure in the global LBW targets.	Keep Optional	<i>Information is available for a large number of countries but It is not directly related to any of the targets</i> Indirectly linked to WHA targets.
PR8	Mean dietary diversity scores	Proposal to make this indicator more focused on children by replacing it with WHO's IYCF indicator of dietary diversity based on food groups. Suggestion to move it up to become an intermediate outcome rather than a process indicator. Work currently going on to define a threshold for minimum dietary diversity for women (should be on table by mid-2014). This indicator is also relevant as a process indicator for the anaemia target.	Remove and consider in Future	Suggest that once Women's Dietary Diversity Scoring methods become validated and available, indicator is considered. However the data is currently not collected in any survey tools. Indirectly linked to WHA targets.
PR9	Previous: Immunization coverage levels Revised: Immunization coverage for measles	none	Keep Optional	Indirectly linked to WHA targets.
PR10	Proportion of average household expenditure on food of the bottom three deciles	none	Remove and consider in future	While important, this data is not systematically collected. Indirectly linked to WHA targets.
PR11	Proportion of pregnant women receiving iron and folic acid supplements	Although data is available on this indicator, it relates to health system delivery and does not cover all women of reproductive age. A lot of methodological work is needed on this indicator to standardize definitions etc. Inclusion of an indicator specific to	Keep Global	Data and indicator is not systematically collected on but if available, an important indicator. Process indicator for WHA target 2 and 3.

Indicator code	Indicator	Comments from Consultation	Status	Justification
		marginalized groups would be more relevant for some regions (e.g. EURO).		
PR12	Percentage of households consuming iron-fortified wheat flour products	<p>It was acknowledged that this indicator is not global—since wheat flour is not a staple in all regions or countries. There was discussion as to whether it is appropriate for inclusion, when it is not relevant to all regions.</p> <p>One option would be to delete it. Another would be to amend it to refer to ‘<i>iron-fortified staple foods</i>’ to also capture fortified rice etc.</p>	Keep Optional	<i>Process indicator for WHA target 2.</i>
PR13	Appropriate use of micronutrient powders for children	This is of limited relevance, not a global indicator.	Keep Optional	<i>Process indicator for WHA target 2.</i>
PR14	Proportion of children under five of age receiving iron supplements	<p>More methodological work to be done here to refine definitions and standardizing indicators.</p> <p>WHO and CDC are currently working on operationalizing indicators for micronutrient programmes.</p> <p>This is not really a global indicator and relates to treatment as well as prevention.</p>	Remove	Not systematically done in programmes and data not available.

Indicator code	Indicator	Comments from Consultation	Status	Justification
PR15	Proportion of women who have received protein and energy supplements	This indicator, which is linked to programmes, is relevant to specific countries or contexts. Questions were raised about how coverage would be measured for this indicator.	Remove and consider in future	Recently recommended in Lancet 2013 series however data and indicator has not been methodologically validated for collection.
PR16	Previous: Proportion of hospitals providing maternity care designated as baby-friendly Revised 1: Countries with at least one hospital/maternal facility ever certified as "Baby Friendly" Revised 2: Average proportion of hospitals/maternal facilities ever certified as "Baby Friendly Facilities"	It was proposed to develop this indicator, in line with current WHO/UNICEF work on assessing baby-friendly maternity services, so that it better reflects the <i>current</i> situation rather than refer to a historic one-off certification. This should also include community-based baby friendly maternity care. It was suggested that possible links between this indicator and other health system indicators were worth exploring.	Modified Keep Global	Indicator has been changed to two indicators: Countries with at least one hospital/maternal facility ever certified as "Baby Friendly" and Average proportion of hospitals/maternal facilities ever certified as "Baby Friendly." These indicators are collected as part of UNICEF's IYCF assessment and NutriDash. Process indicator for WHA target 1, 4, 5, and 6.
PR17	Previous: Proportion of children with severe acute malnutrition having access to appropriate treatment including therapeutic foods Revised: Proportion of children ages 6-59 months with SAM admitted for treatment.	This indicator measure changes in mortality rather than in prevalence of wasting itself. It was acknowledged that SAM treatment will impact on incidence of wasting, and not specifically on prevalence. Data on annual incidence, however, are not available. This is why additional indicator on moderate malnutrition treatment coverage is presented as an optional indicator for discussion. Clarification on what is meant by coverage is required. It should be specified whether this is by geographical area, population, health facilities etc.	Keep Optional	Currently, data is not collected systematically thus it is impossible to collect. The landscape is changing. UNICEF's Nutridash is asking countries to collect on these data annually. Indicator has been changed to: Proportion of children ages 6 to 50 months with SAM admitted for treatment. Process indicator for WHA target 6.

Indicator code	Indicator	Comments from Consultation	Status	Justification
PR18	Proportion of children born to HIV-positive women who are feeding in line with national guidelines on HIV and infant feeding	<p>There was discussion of whether HIV prevalence in women should be added as indicator. It was pointed out that this is already incorporated in the current proposed indicator (through the calculation of children born to HIV+ mothers).</p> <p>There was also a suggestion to add an indicator on prevention of mother-to-child-transmission (PMTCT) ARV coverage. It was also noted, however, that there are problems with data systems for this at this moment.</p>	Remove and consider in future	Data not systematically collected.

Table F: Proposed revisions to policy environment and capacity Indicators

Indicator code	Indicator	Comments from Consultation	Status	Justification
	Government expenditure on nutrition			
HP1	Ratio of community health workers to total population	<p>There was discussion about whether the indicator should state 'health workers' rather than 'community health workers'. The latter term is usually understood as a particular term which refers only to those at the community level. Measures of physician density and nurse/midwife density, however, also correlate closely with health outcomes and are relevant.</p> <p>There was also discussion of whether there could be an appropriate threshold or cut-off point for the ratio? The suggestion was to identify the cut-off point for ratio which has an impact. It may be worth exploring ways of linking with all the current work on monitoring Universal Health Coverage and strengthening health systems.</p>	Modified Keep Global	Indicator has been modified to:

Indicator code	Indicator	Comments from Consultation	Status	Justification
	Antenatal care is another critical platform for delivery of nutrition interventions			
HP2	Adoption and implementation of International Code of Marketing of Breast-milk Substitutes and subsequent relevant WHA resolutions	<p>It was recommended that this indicator should be moved up to the level of process indicator.</p> <p>There was considerable discussion of the importance of, as well as difficulties with, measuring implementation of the Code, as well as adoption.</p> <p>There was an initial proposal to remove 'and implementation' from the indicator because of these difficulties with measurement. Strong support emerged, however, for keeping the concept of implementation and strengthening it if possible. This could draw on ongoing work by UNICEF (on a process for measuring Code implementation) and by IBFAN's International Code Documentation Centre (assessments of Code adoption).</p> <p>It was suggested that more guidance be given to countries on monitoring Code implementation and that a consultation on this issue could be useful for further indicator development.</p>	Keep Global	<p>Indicator is kept as a policy indicator but changed to two indicators:</p> <ol style="list-style-type: none"> 1. Countries with existing International Code of Marketing of Breast-milk Substitutes law/regulation 2. Countries with Code monitoring and enforcement system in place <p>These indicators are collected as part of UNICEF's IYCF assessment and NutriDash.</p> <p><i>Important process outcome for WHA target 1, 4, 5, and 6.</i></p>

Indicator code	Indicator	Comments from Consultation	Status	Justification
	Policy environment permits promotion of nutritious complementary foods to children 6-24	The inverse of the BMS indicator: countries such as Bangladesh have made it impossible to promote even the best complementary foods, which should be viewed as a negative aspect of the environment, not a positive		
HP3	<p>Previous: Adoption and implementation of ILO maternity protection convention and its recommendations</p> <p>Revised: Countries with maternity protection laws or regulations in place covering all working women.</p>	<p>As with the Code, more clarity is needed on what precisely is meant by '<i>adoption and implementation</i>' of the Maternity Protection Convention.</p> <p>It would be useful to adapt this indicator to measure the universality of measures that are in place (e.g. what proportion of women is eligible for maternity benefits etc.) It would also be useful to explore how women working in the informal economy could be included.</p> <p>Some data do exist on this issue.</p>	Modify Keep Global	<p>Indicator changed to: Countries with maternity protection laws or regulations in place.</p> <p>These indicators are collected as part of UNICEF's IYCF assessment and NutriDash.</p>

Indicator code	Indicator	Comments from Consultation	Status	Justification
HP4	Number of staff with nutrition skills at each level of service delivery	<p>There was support for this issue as being important to monitor. More clarity, however, was required on how exactly to define the indicator. Further methodological work was recommended to develop better, more objective measures of nutrition skills. It would be useful if the indicator could capture data on nutrition competencies in other (non-health) sectors.</p> <p>It would also be valuable to include skills relevant to prevention of malnutrition in the definition of skills.</p> <p>It may also be useful to measure staff with nutrition skills that are working with the specific population of interest (women, infants, young children) for the implementation plan.</p>	<p>Remove</p> <p>Keep highlighted item as optional as this will be a beneficial support for mothers and families to receive counseling on breastfeeding and family based complementary feeding</p>	Data not systematically collected.
HP5	Strength of nutrition governance	<p>This indicator was recognized as being very important, but also challenging to operationalize. WHO has used a composite measure of nutrition governance and others have undertaken similar processes.</p> <p>These different processes have come to similar conclusions on the identification of key elements which are meaningful within the concept of nutrition governance.</p>	Keep Optional	<p>Data is labor intensive to collect and not collected on an annual basis. Consider only at country level.</p> <p>The HANCI may also serve as a key indicator of governance.</p>

The consultation also recommended a set of new indicators. These are shown in **Table G**, including some comments and justification.

Table G: Proposed additional indicators

New Indicators	Indicator	Comments from Consultation	Status	Justification
New 1	Proportion of children with moderate acute malnutrition having access to appropriate supplementary foods	WFP is doing some work to combine an indicator of MAM treatment with other food indicators. This will be tested in some countries next year.	Remove and consider in future	Data not systematically collected
New 2	Continued breastfeeding for 2 years and beyond	There appeared to be broad support for this proposal as an additional indicator.	Optional	Data collected and fits with WHA Target 1, 4 and 6. Collecting on EBF and initiation as well as the minimum acceptable diet may be sufficient.
New 3	Soft drink consumption in children	There was considerable support for development of this as an additional new process indicator. It was pointed out, however, that in general this may be of more relevance to school-age children than to infants and young children. The terminology 'sugar-sweetened beverages' should be used rather than 'soft drinks'.	Remove and consider in future	Data not systematically collected
New 4	Marketing regulations	There appeared to be broad support for development of this as possible new indicator.	Remove and consider in future	Data not systematically collected
New 5	Proportion of mothers of children 0-5 months who have received counselling, support on optimal breastfeeding	Recommended by UNICEF to include	Global	Facility based reporting

New Indicators	Indicator	Comments from Consultation	Status	Justification
New 6	Proportion of mothers with children 6-23 months who have received counseling, and support for continued breastfeeding 6-24 months and beyond and on optimal complementary feeding	Recommended by UNICEF to include	Global	Facility based reporting
New 7	Proportion of children 12-59 months receiving at least one dose of de-worming medication during the previous six months	Recommended by UNICEF to include	Global	Facility based reporting
New 8	Net enrollment ratio secondary school girls	Seems very odd to have no education indicator when such a major influence on nutrition outcomes		