Metadata of indicators for assessing the impact of the Nutrition Strategy (including compiled, core, optional - and those still under consideration).

| Indicator | Type | Definition | Population (not necessarily recommended - but considered by organisations) | Measurement & cut-off | Data Collection | eSMART | Used by | Setting | Rationale | Evidence | Limitations/comments | Notes |
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| Direct interventions to prevent and reduce general malnutrition - MDG1 | | | | | | | | | | | | |
| Underweight | Impact | COMPILED INDICATOR 1:<br>Percentage of underweight (weight-for-age less than -2 standard deviations of the WHO Child Growth Standards median) among children aged 0-5 years | Children 0-59 months, 6-59 months, 6-36 months; by age group, sex, SES, location | $Z\text{-score} = \frac{(\text{observed value}) - (\text{mean reference value})}{\text{standard deviation of reference population}}$<br>% of children with a low weight-for-age index; Moderate: <-2 z-scores; Severe: <-3 Z-scores.<br>*Reference population: WHO | Population-based surveys; local area-based surveys; facility-based data | Combination of stunting and wasting so not very specific | MDG1.8, **DFID, BRAC, CFPR,** UNICEF, MICS, DHS, WHO, FAO, CHAP, FIVIMS), CHAP, CFS, FANTA, FSAU, NGOs, INGO (not IRC), REACH, WFP | Stable situations | The under-five underweight prevalence is an internationally recognized public health indicator for monitoring nutritional status and health in populations. Child malnutrition is also monitored more closely than adult malnutrition. | Child growth is the most widely used indicator of nutritional status in a community and is internationally recognized as an important public-health indicator for monitoring health in populations. In addition, children who suffer from growth retardation as a result of poor diets and/or recurrent infections tend to have a greater risk of suffering illness and death. | The weight-for-age indicator reflects body mass relative to chronological age and is influenced by both the height of the child (height for age) and weight-for-height. Its composite nature makes interpretation complex. For example, weight for age fails to distinguish between short children of adequate body weight and tall, thin children. | Quality of data - especially age data | |
| Wasting | Impact | CORE INDICATOR 6:<br>Percentage of wasting (weight-for-height less than -2 standard deviations of the WHO Child Growth Standards median) among children aged 0-5 years | Children 0-59 months, 6-59 months, 6-36 months; by age group, sex, SES, location | $Z\text{-score} = \frac{(\text{observed value}) - (\text{mean reference value})}{\text{standard deviation of reference population}}$<br>% of children with a low weight-for-height index; Moderate: <-2 Z-scores; Severe: <-3 Z-scores.<br>*Reference population: WHO | Population-based surveys; local area-based surveys; facility-based data | Good; may not represent different populations well | MDG1, **DFID,** BRAC, CFPR,UNICEF, MICS, DHS, WHO, FAO, CHAP, CFS, **NOT FANTA***, FSAU ,NGO, INGO (not IRC), REACH, HNTS | Emergencies | "Global acute malnutrition (-2SD WHZ) is the most robust nutrition indicator available for children under five. It is not affected by lack of age data and indicates recent nutritional deprivation. GAM and severe acute malnutrition are strongly linked to mortality." CAP | Whereas there is a significant evidence base on the effectiveness of interventions in acute emergencies, especially in refugee settings, the evidence base is much weaker for situations of protracted conflict with longer term programmes in less controlled settings. | "Wasting not a good indicator for programme effects since it only reflects short term changes. Wasting should not be used for evaluation purposes as it is a relatively rare event and very susceptible to seasonal influences". (FANTA) | WtH has been consistently shown to be least effective predictor of mortality and that MUAC is superior to height-for-age and weight-for-age which are both superior to WtH. | There is no definition of impact in humanitarian assistance. The most commonly used definition of impact in international aid is the one provided by the OECD/DAC which defines impact very widely as: '[t]he positive and negative, primary and secondary, long-term effects produced by a development intervention, directly or indirectly, intended or unintended' |
| | | OPTIONAL INDICATOR:<br>Mid-Upper Arm Circumference (MUAC) | Children 6-59 months; by age group, sex, location, SES | Moderate malnutrition: <12.5-11.5cm;<br>Severe malnutrition: <11.5cm | Population-based surveys; local area-based surveys; facility-based data | Good; more sensitive in younger age groups; girls have lower MUAC than boys; country specific | HNTS, FSAU, WFP, NGOs | Emergencies | Recommended that when assessing the nutritional status of a population MUAC should be used in addition to, and not in place of, WFH (Jaspers Young 2006). | WtH has been consistently shown to be least effective predictor of mortality and that MUAC is superior to height-for-age and weight-for-age which are both superior to WtH. | MUAC and WFH identify different children as malnourished | | MUAC continues to be used as an independent criterion for admission. However, it is recommended that current cut-off for severe acute malnutrition be revised at MUAC < 115 mm instead of MUAC < 110 mm. This recommendation follows the release of WHO standards for MUAC-for-age, which showed that in a well-nourished population there are very few children aged 6-59 months with a MUAC < 115 mm. Children with a MUAC < 115 mm also have a highly elevated risk of death compared to those who are above. |
| Overweight | Impact | OPTIONAL INDICATOR:<br>Proportion of under-fives falling above plus 2 standard deviations from the median weight-for-height of the reference population. | Children 6-59 months; by age group, sex, location, SES | % of children with a high weight-for-height index;<br>>+2 Z-scores *Reference population: WHO | Population-based surveys; local area-based surveys; facility-based data | Good | WHO | Stable | Child growth is the most widely used indicator of nutritional status in a community and is internationally recognized as an important public-health indicator for monitoring health in populations. In addition, children who are overweight are more likely to be predisposed to future health problems. | | | | |
| Stunting | Impact | CORE INDICATOR 5:<br>Percentage of stunting (weight-for-age less than -2 standard deviations of the WHO Child Growth Standards median) among children aged 0-5 years | Children 0-59 months, 6-59 months, 6-36 months; by age group, sex, location, SES | $Z\text{-score} = \frac{(\text{observed value}) - (\text{mean reference value})}{\text{standard deviation of reference population}}$<br>% of children with a low height-for-age index; Moderate: <-2 Z-scores; Severe: <-3 Z-scores. *Reference population: WHO | Population-based surveys; local area-based surveys; facility-based data | Good | MDG1, **DFID,** UNICEF, MICS, DHS, WHO (not core), FAO, CHAP, CFS, FANTA, FSAU, INGO, (not IRC), NGO, REACH | Stable situations | Child growth is the most widely used indicator of nutritional status in a community and is internationally recognized as an important public-health indicator for monitoring health in populations. In addition, children who suffer from growth retardation as a result of poor diets and/or recurrent infections tend to have a greater risk of suffering illness and death. | There is good evidence that stunting in children less than five years old is a stronger indicator of hunger and of one of its determinants, poverty, than other anthropometric indicators or estimates of per capita income. This is because stunting indicates the chronic restriction of a child's growth potential, reflecting the cumulative effects of inadequate food intake and poor health conditions that result from endemic poverty. | Quality of data - especially age data needs to be checked | | In its 2006-2010 Action Plan, the Standing Committee on Nutrition (SCN) clearly stated that "one of the main tasks of the Task Force [Task Force on Assessment, Monitoring and Evaluation (TF-AME)] should be to establish stunting as the principal evaluative indicator for poverty reduction". |
| LBW (Low Birth Weight) | Impact (proxy for maternal malnutrition & IMR) | CORE INDICATOR 8:<br>Low birth weight infants | To assess the nutritional situation of newborns and of mothers during pregnancy; by sex, SES, location | percent under 2.5 kg at birth/ No. Live births x 100 | Population-based surveys; local area-based surveys; facility-based data; monitoring | Good | UNICEF, WHO, MICS, DHS, FAO (FIVIMS) | Stable situations | Low birth weight is a major determinant of mortality, morbidity and disability in infancy and childhood and also has a long-term impact on health outcomes in adult life. The consequences of poor nutritional status and inadequate nutritional intake for women during pregnancy not only directly affects women's health status, but may also have a negative impact on both weight and early development | At the population level, birth weight (proportion) is an important indicator of a number of public health problems including maternal health, nutritional status and care in pregnancy. On an individual basis this indicator is an important predictor of a newborn's chances for survival, growth, long-term health and psychosocial development. | Almost 60% of newborns in developing countries are not weighed; in South Asia this figure is about 70% and this region has the highest incidence of low-birth-weight babies. Generally, newborns who are weighed are better off (more likely to be born in health facilities, urban areas and of better-educated mothers), which can lead to an under-estimation of the incidence of low birth weight. | | Due to the lack of comparable estimates over time, both within and between countries, UNICEF and the World Health Organization (WHO) have adjusted the under-reporting and misreporting of birthweights with results from household surveys (Multiple Indicator Cluster Surveys and Demographic and Health Surveys). However, these results still need to be interpreted with caution as they may still underestimate the problem. |
| Micronutrient deficiency & supplementation | Outcome | OPTIONAL INDICATOR:<br>Vitamin A deficiency in children | Children 6-59 months; by age group, sex, location | Prevalence of xerophthalmia, including night blindness, and serum retinol values (mean and/or % of the survey population <0.35µmol/l, <0.70 µmol/l and 1.05 µmol/l) / Total children <5 x 100 | Population-based surveys; local area-based surveys; facility-based data, monitoring | Expensive if measuring serum retinol; look for clinical signs e.g. nightblindness | WHO, CDC, MICS, HKI, FAO, FSAU, WB | Emergencies & stable | Vitamin A is considered to be a critically important intervention for child survival owing to the strong evidence that exists for its impact on reducing child mortality | Daily multiple micronutrient supplementation combined with vitamin A was beneficial in improving growth (LAZ) among children with stunting, compared to vitamin A alone or to vitamin A plus zinc. | | | Food intake is important for more than dietary energy; inadequate diets have serious consequences beyond hunger, growth failure and thinness. Micronutrient deficiencies have been referred to as "hidden hunger" (WHO/UNICEF/World Bank/Canadian International Development Agency/US Agency for International Development/FAO/UNDP, 1991) |
| | Outcome | OPTIONAL INDICATOR:<br>Iron deficiency anaemia in children | Children 6-59 months; by age group, sex, location | % of pre-school children with iron deficiency anaemia; Hb <110 g/L / Total No. Children < 5 years x 100 | Population-based surveys; local area-based surveys; facility-based data, monitoring | Expensive if measuring all indicators; look for clinical signs e.g. Paleness | WHO, CDC, MICS, HKI, FAO, FSAU, WB | Stable situations | The consequence of iron deficiency is related to some metabolic processive alterations such as neurotransmitter synthesis and degradation, which affect brain function, physical activity, and motor and mental development. | Iron deficiency also impairs the transformation of the thyroid hormones, T4 triiodothyronine to T3 thyroxin, in peripheral tissues, the production and metabolism of epinephrine and norepinephrine, and leads to difficulty in maintaining body temperatures upon exposure to cold. | | | |
| | Outcome | OPTIONAL INDICATOR:<br>Iodine deficiency in school-aged children | School-aged children >6 years; by age group, sex, location | Mean urinary level of iodine; % Goitre (grade 0,I,II) / Total No. SAC x 100 | Population-based surveys; school-based surveys; facility-based data, monitoring | Possible problems in collecting urine samples from children; expensive. Look for goitre instead | WHO, CDC, MICS, HKI, FAO, FSAU, WB | Stable situations | Iodine deficiency is the number one cause of preventable brain damage, affecting millions of people worldwide. | The problem of iodine deficiency is especially serious for pregnant women and young children. During pregnancy, even a mild deficiency of iodine can reduce brain development of the fetus limiting the intellectual ability of an individual for life. | | | |
| | Output | OPTIONAL INDICATOR:<br>Vitamin A supplementation (children under age 5) | Percentage of children (6-34 months or 6-59 months) receiving Vitamin A Supplementation every six months; Children 6-12 months receiving 100,000 IU; children > 12 months receiving 200,000 IU | % of children receiving Vitamin A Supplementation every six months; Children 6-12 months receiving 100,000 IU; children > 12 months receiving 200,000 IU | Population-based surveys; local area-based surveys; facility-based data; monitoring | Good | UNICEF(IMICS), HKI, WB, FSAU, INGOs, | Emergencies & stable | Supplementation with vitamin A is considered to be a critically important intervention for child survival owing to the strong evidence that exists for its impact on reducing child mortality. Therefore, measuring the proportion of children who have received vitamin A within the last 6 months is crucial for monitoring coverage of interventions towards the child survival-related Millennium Development Goals and Strategies. | Yes. VFP (associated with WHZ, WAZ, HAZ) | | | |
| | Output | OPTIONAL INDICATOR:<br>Proportion of children under 5 receiving iron supplements | Children 6-59 months; by age group, sex, location | Number of children < 5 receiving iron supplements / total number of children < 5 x 100 | Population-based surveys; local area-based surveys; facility-based data; monitoring | Good | UNICEF(IMICS), HKI, WB, FSAU, INGOs | Emergencies & stable | | | | | |
| | Output | OPTIONAL INDICATOR:<br>% SAC consuming iodised oil | School-aged children >6 years; by age group, sex, location | Number of SAC receiving iodized oil/ Total No. SAC x 100 | Population-based surveys; local area-based surveys; monitoring | OK; assume utilisation good | UNICEF(IMICS), HKI, WB, FSAU, INGOs | Stable situations | | | | | |
| | Output | OPTIONAL INDICATOR:<br>% households consuming iodised salt | All households; by location, SES | Population consuming iodized salt/total population covered by distribution x 100 | Population-based surveys; local area-based surveys; monitoring | OK; assume households consume sufficient amounts | UNICEF(IMICS), HKI, WB, FSAU, INGOs | Stable situations | | | | | |
| Infant feeding | Outcome (exclusive breast feeding proxy for IMR) | OPTIONAL INDICATOR:<br>Early initiation of breastfeeding | Children < 24 months | Percentage of children breastfed in the first hour of birth = $\frac{\text{Children born in the last 24 months who put to the breast within 1 hour of birth}}{\text{Children born in the last 24 months}} \times 100$ | Population-based surveys; local area-based surveys; facility-based data; monitoring | OK; possible recall bias with older children | DFID, BRAC, CFPR, UNICEF, MICS, FAO (FIVIMS),WB, WHO, USAID, AED, IFPRI, FSAU | Emergencies & stable | Infant and young child feeding practices directly affect the nutritional status and survival of children. Exclusive breastfeeding is the single most effective intervention to improve the survival of children. Improving infant and young child feeding practices is therefore critical to improved nutrition, health and development of children. | Improved breastfeeding practices alone could save the lives of one million children under five and complementary feeding along with continual breastfeeding for up to two years or beyond could save the lives of another half million children each year. Also Dewey KG. Cross-cultural patterns of growth and nutritional status of breast-fed infants. Am J Clin Nutr. 1998 Jan;67(1):10-7. Review. | Various countries are still collecting information on under-four months old, hence affecting the results and comparability. Many developed countries do not collect this information regularly. | | |
| | | OPTIONAL INDICATOR:<br>Exclusive breastfeeding under 6 months | Children < 6 months; by 0–1 months, 2–3 months, 4–5 months and 6–3 months | % of infants 0–5 months of age who are fed exclusively with breast milk = $\frac{(\text{a})\text{last 0 – 5 months who received only breast milk during the previous day}}{(\text{b})\text{last 0 – 5 months}} \times 100$ | Population-based surveys; local area-based surveys; facility-based data; monitoring | Various countries are still collecting information on under-four months old, hence affecting the results and comparability. Many developed countries do not collect this information regularly. | DFID, BRAC, CFPR,UNICEF, MICS, FAO (FIVIMS),WB, WHO, USAID, AED, IFPRI, FSAU | Emergencies & stable | Infant and young child feeding practices directly affect the nutritional status and survival of children. Exclusive breastfeeding is the single most effective intervention to improve the survival of children. Improving infant and young child feeding practices is therefore critical to improved nutrition, health and development of children. | Improved breastfeeding practices alone could save the lives of one million children under five and complementary feeding along with continual breastfeeding for up to two years or beyond could save the lives of another half million children each year. Also Dewey KG. Cross-cultural patterns of growth and nutritional status of breast-fed infants. Am J Clin Nutr. 1998 Jan;67(1):10-7. Review. | Various countries are still collecting information on under-four months old, hence affecting the results and comparability. Many developed countries do not collect this information regularly. | | Associated: Exclusive breastfeeding under 6 months; Early initiation of breastfeeding; Children ever breastfed; Duration of breastfeeding; Continued breastfeeding at 1 year; Continued breastfeeding at 2 years |
| | | OPTIONAL INDICATOR:<br>Continued breastfeeding at 1 years | Children 12-15 months | Children 12–15 months of age who received breast milk during the previous day / Children 12–15 months of age x 100 | Population-based surveys; local area-based surveys; facility-based data; monitoring | OK; assume appropriate complementary feeding also | UNICEF,MICS, WFP, FAO (FIVIMS), WB, FSAU | Emergencies & stable | | | Sex: Indicators for assessing infant and young child feeding practices : conclusions of a consensus meeting held 6–8 November 2007 in Washington D.C., USA. | | |
| | | OPTIONAL INDICATOR:<br>Continued breastfeeding at 2 years | Children 6-23 months | Number of children age 6-23 months who are currently breastfeeding/ Total number of children age 6-23 months x 100 | Population-based surveys; local area-based surveys; facility-based data; monitoring | OK; assume appropriate complementary feeding also | UNICEF,MICS, WFP, FAO (FIVIMS), WB, FSAU | Emergencies & stable | | Yes. WFP (associated with WHZ, WAZ, HAZ) | Sex: Indicators for assessing infant and young child feeding practices : conclusions of a consensus meeting held 6–8 November 2007 in Washington D.C., USA. | | |
| | | OPTIONAL INDICATOR:<br>Minimum Dietary Diversity | Children 6-23 months | Number of children age 6-23 months who received foods for >= 4 food groups during the previous day/ Total number of children age 6-23 months x 100 | Population-based surveys; local area-based surveys; facility-based data; monitoring | Good | FANTA, TF-AME, FAO, WFP, DHS | Emergencies & stable | It has been shown to be associated with the mean micronutrient adequacy of the diet of both breastfed and non-breastfed children, of adolescents and of adults as well. Also been shown to be associated with the nutritional status of individuals (children under 5, women) after controlling for confounding socio-economic factors. | Dietary diversity is a proxy for adequate micronutrient-density of foods. Dietary data from children 6–23 months of age in 10 developing country sites have shown that consumption of foods from at least 4 food groups on the previous day would mean that in most populations, the child had a high likelihood of consuming at least one animal-source food and at least one fruit or vegetable, in addition to a staple food | Sex: Indicators for assessing infant and young child feeding practices : conclusions of a consensus meeting held 6–8 November 2007 in Washington D.C., USA. | | Dietary diversity (DD) relates to nutrient adequacy (coverage of basic needs in terms of macro and micro nutrients) and to diet variety/balance, which are two of the main components of diet quality. DD is thought to reflect the adequate intake of essential nutrients either at the household level (HDD), in which case it can be measured by a HDD score (HDDS) or by a Food Consumption Score (FCS), or at the individual level (IDD), in which case it can be measured by an IDD score (IDDS). |
| | | OPTIONAL INDICATOR:<br>Minimum acceptable diet (Proportion of children 6–23 months of age who receive a minimum acceptable diet (apart from breast milk).) | Children 6-23 months | Breastfed children 6–23 months of age who had at least the minimum dietary diversity and the minimum meal frequency during the previous day / Breastfed children 6–23 months of age and<br>Non-breastfed children 6–23 months of age who received at least 2 milk feedings and had at least the minimum dietary diversity / not including milk feeds and the minimum meal frequency during the previous day / Non-breastfed children 6–23 months of age | Population-based surveys; local area-based surveys; facility-based data; monitoring. NOT DHS doesn't collect info o freq of feeds for non-breastfed | Good | FANTA, WHO, UNICEF (MICS), DHS, WFP, WB, IFPRI, USAID | Emergencies & stable | Because appropriate feeding of children 6–23 months is multidimensional, it is important to have a composite indicator that tracks the extent to which multiple dimensions of adequate child feeding are being met. The minimum acceptable diet indicator combines standards of dietary diversity and feeding frequency by breastfeeding status. The numerator includes only those children who have received both the minimum dietary diversity and the minimum meal frequency for the child's breastfeeding status. The indicator thus provides a useful way to track progress at simultaneously improving the key quality and quantity dimensions of children's diets. | | Sex: Indicators for assessing infant and young child feeding practices : conclusions of a consensus meeting held 6–8 November 2007 in Washington D.C., USA. | | |
| | | OPTIONAL INDICATOR:<br>Age of introduction of complementary feeding | Infants aged 6 to 8 months | Introduction of solid, semi-solid or soft foods.<br>Proportion of infants aged 6-8 months who received solid, semi-solid or soft foods the previous day / Infants 6-8 months of age | Population-based surveys; local area-based surveys; facility-based data; monitoring. NOT DHS doesn't collect info o freq of feeds for non-breastfed | Good | FANTA, WHO, UNICEF (MICS), DHS, WFP, WB, IFPRI, USAID | Emergencies & stable | The untimely and inappropriate introduction of complementary foods have been shown to be risk factors for malnutrition (especially overweight, stunting) and micronutrient deficiencies. | | Because the indicator has a very narrow age range of 3 months, estimates from surveys with small sample sizes are likely to have wide confidence intervals. | | |
| Behavioural change communications | Output | OPTIONAL INDICATOR:<br>Percentage of women adopting breast feeding practices | Women with children in age bracket, by age, SES | Number of sessions conducted on behaviour change regarding breastfeeding | Programme information | Good; as long as utilised | UNICEF | Stable | | | | | |
| | | OPTIONAL INDICATOR:<br>Percentage of women adopting complementary feeding practices from 6 months to 2 years | Women with children in age bracket, by age, SES | Number of sessions conducted on behaviour change regarding Infant and young child feeding practices | Programme information | Good; as long as utilised | UNICEF | Stable | | | | | |
| Deworming | Output | OPTIONAL INDICATOR:<br>Percentage of children (12-34 months or 12-59 months) receiving de-worming | Children 12-34 months or 12-59 months | (Albendazole 1 to < 2 years 200 mg and > 2 years 400 mg or Mebendazole 1 to < 2 years 250 mg and > 2 years 500 mg) every six months / Total No. Target group x 100 | Population-based surveys; local area-based surveys; facility-based data; monitoring | Good; assume tablets consumed | WHO | Stable & emergencies | | Predictors of poor anthropometric status among children under 2 years of age in rural Uganda: Henry Wamani1,2,*,Public Health Nutrition 9(3), 320–326 | | | |
| Childhood Disease | Impact (proxy for mortality) | OPTIONAL INDICATOR:<br>Incidence of diseases that have an impact on nutrition (Measles, Diarrhoea, ARI, Malaria, HIV/AIDS) | Children <5 years; by age, sex, location, SES | Total number of children under age 5 with suspected (disease) in the previous 2 weeks/Total number of children < 5 years x 100 | Population-based surveys; local area-based surveys; facility-based data; monitoring | Problems with measurement (classification) error | WFP, UNICEF, MICS (malaria), IMPACT, IMCI | Emergencies & stable | Yes. WFP (associated with WHZ, WAZ, HAZ) | | | | |
| Maternal malnutrition | Impact or Outcome? (BMI proxy for IMR and maternal anaemia) | CORE INDICATOR 7:<br>% of non-pregnant women with a BMI outside normal range | Non-pregnant women 15-49 years; by location, SES | Moderate malnutrition = Number of non-pregnant women BMI <18.5/Total non-pregnant women x 100 (severe malnutrition = 16.0 cm) | Population-based surveys; local area-based surveys; facility-based data | Good; although measurement difficult for disabled and older women if they have spine curvature | DFID, WFP, INGOs, BRAC, CFPR | Emergencies & stable | Yes. WFP (associated with WHZ, WAZ, HAZ) | Henry Wamani 1,2,*, BMI also shows a consistently high correlation with body weight based on several different studies in different population groups. In a comparative series of analyses the correlation of WHZ with height varied from 0.0 to 0.2. (Khosla & Lowe, 1967; Micozzi et al., 1986).2 Thus, this index is relatively independent of height and is less biased by height than W/H. It is, therefore, the index of choice for epidemiological purposes. | | | |
| | | OPTIONAL INDICATOR:<br>% of pregnant women with MUAC outside normal range | Pregnant women; by location, SES | Number of pregnant women with MUAC <22.5 or 22.0 cm/total number pregnant women x 100 | Population-based surveys; local area-based surveys; facility-based data | ?? May not be sensitive | WFP | Emergencies & stable | FSAU | The nutritional status of a woman before and during pregnancy is important for a healthy pregnancy outcome | Study carried out on behalf of WFP in Burkina Faso indicates MUAC not a good indicator of malnutrition in pregnant women | | |
| | | OPTIONAL INDICATOR:<br>Iron deficiency anaemia in pregnant women | Pregnant women; by location, SES | % of pregnant women with Iron deficiency anaemia; Hb <110 g/L / Total pregnant women x 100 | Population-based surveys; local area-based surveys; facility-based data | Expensive if measuring all indicators; look for clinical signs e.g. Paleness | DFID, EEP, MICS, FAO, FSAU??, WB | Emergencies & stable | | | | | |

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| | | OPTIONAL INDICATOR:<br>Iron-folate supplementation in pregnant women | Pregnant women; by location, SES | Number of pregnant women receiving iron-folate / total number pregnant women x 100 | Population-based surveys; local area-based surveys; facility-based data | Good; assume utilisation | UNICEF(MICS), WB, INGOs | Emergencies & stable | | | | | | |
| | | OPTIONAL INDICATOR:<br>Vitamin A deficiency in pregnant women | All pregnant & lactating women; by location, SES | Prevalence of xerophthalmia, including night blindness, and serum retinol values (mean and/or % of the survey population <0.35μmol/l, <0.70 μmol/l and 1.05 μmol/l) / Total pregnant women x 100 | Population-based surveys; local area-based surveys; facility-based data; monitoring | Expensive if measuring all indicators; look for clinical signs e.g. Night blindness | MICS, FAO, FSAU??, WB | Emergencies & stable | Concentration of Vitamin A in breastmilk is dependent on maternal nutritional status and intake. | Vitamin A in breast milk the main determinant of infant vitamin A status | | | | |
| | | OPTIONAL INDICATOR:<br>Vitamin A supplementation in pregnant women | All pregnant & lactating women; by location, SES | Number of pregnant women receiving vitamin A / total number pregnant women x 100 | Population-based surveys; local area-based surveys; facility-based data; monitoring | Good; assume utilisation | UNICEF(MICS), WB, INGOs | Emergencies & stable | | | | | | |
| Prevent and reduce child mortality - MDG4 | | | | | | | | | | | | | | |
| Infant mortality rate (IMR) | Impact | OPTIONAL INDICATOR:<br>Infant mortality rate (probability of dying between birth and age 1 per 1000 live births) | Infants from birth to 1 years; by sex, location and SES | Infant mortality rate is strictly speaking not a rate (i.e. the number of deaths / the number of population at risk during a certain period of time) but a probability of death derived from a life table and expressed as rate per 1000 live births. | - Civil registration with complete coverage<br>- Population census<br>- Household surveys | Good if good measurement; see limitations | UNICEF, WHO, DHS, MICS, HNTS | Emergencies | Infant mortality represents an important component of under-five mortality. Like under-five mortality, infant mortality rates measure child survival. They also reflect the social, economic and environmental conditions in which children (and others in society) live, including their health care. Since data on the incidence and prevalence of diseases (morbidity data) frequently are unavailable, mortality rates are often used to identify vulnerable populations. Infant mortality rate is an MDG indicator. | | Civil registration systems are the preferred source of data on infant mortality. However, many developing countries lack fully functioning registration systems that accurately record all births and deaths. Thus, household surveys, such as Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS), have become the primary source of data on child mortality in developing countries; but there are some limits to their quality. | Estimates obtained from household surveys have attached confidence intervals that need to be considered when comparing values along time or across countries. Similarly, these estimates are often affected by non-sampling errors. Like census data, survey data on child mortality may omit births and deaths, include stillbirths along with live births, and suffer from survivor selection bias and age truncation. Direct estimates of child mortality based on survey data may also suffer from mothers misreporting their children's birth dates, current age or age at death — perhaps more so if the child has died. The heaping of deaths at age 12 months is especially common. Age heaping may transfer deaths across the one-year boundary and lead to underestimates of infant mortality rates. However, it has little effect on under-five mortality rates; making the USMR a more robust estimate than the infant mortality rate if the information is drawn from household surveys | |
| Under 5 mortality rate (U5MR) | Impact | OPTIONAL INDICATOR:<br>Under-five mortality rate (probability of dying by age 5 per 1000 live births) | Children from birth to 5 years; by sex, location and SES | Under-5 mortality rate, is strictly speaking, not a rate (i.e. the number of deaths / the number of population at risk during a certain period of time) but a probability of death derived from a life table and expressed as rate per 1,000 live births. | - Civil registration with complete coverage<br>- Population census<br>- Household surveys | Good if good measurement; see limitations | MDG4, UNICEF, WHO, DHS, MICS, FSAU, NGOs (not World Vision) | Emergencies | The target of Millennium Development Goal 4 is to "Reduce by two thirds, from 1'990 to 2015, the under-five mortality rate". | | Civil registration systems are the preferred source of data on under-five mortality. However, many developing countries lack fully functioning registration systems that accurately record all births and deaths. Thus, household surveys, such as Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS), have become the primary source of data on child mortality in developing countries; but there are some limits to their quality. | Estimates obtained from household surveys have attached confidence intervals that need to be considered when comparing values along time or across countries. Similarly, these estimates are often affected by non-sampling errors. Like census data, survey data on child mortality may omit births and deaths, include stillbirths along with live births, and suffer from survivor selection bias and age truncation. Direct estimates of child mortality based on survey data may also suffer from mothers misreporting their children's birth dates, current age or age at death — perhaps more so if the child has died. The heaping of deaths at age 12 months is especially common. Age heaping may transfer deaths across the one-year boundary and lead to underestimates of infant mortality rates. However, it has little effect on under-five mortality rates; making the USMR a more robust estimate than the infant mortality rate if the information is drawn from household surveys. | Efforts to improve child survival can be effective only if they are based on reasonably accurate information about the causes of childhood deaths. Cause-of-death information is needed to prioritize interventions and plan for their delivery, to determine the effectiveness of disease-specific interventions, and to assess trends in disease burden in relation to national and international goals. |
| Measles immunization coverage (MCV) | Impact (proxy for mortality) and outcome (coverage) | OPTIONAL INDICATOR:<br>Number of children age 12-23 months who received measles vaccine before their first birthday | Total number of children age 12-23 months; by sex, location and SES | MCV coverage among 1-year-olds (%). The percentage of children under one year of age who have received at least one dose of measles-containing vaccine in a given year / Total No. children 12-23 months. | - Household surveys<br>- Facility reporting system | Good | MDG 4.3, GAVI, WHO, UNICEF (MICS), DHS | Emergencies & stable | Immunisation is one of the most powerful and cost-effective forms of primary prevention. A classical prevention strategy which should be maintained to continue effective protection.For example, there is strong evidance that immunising children against measles has a direct effect on reducing mortality from measles; therefore, immunisation coverage can be used as a proxy for impact on mortality | Immunization is an essential component for reducing under-five mortality. Immunization coverage estimates are used to monitor coverage of immunization services and to guide disease eradication and elimination efforts. It is a good indicator of health system performance. Measles vaccination coverage is often used as a proxy for estimating the vaccine coverage of the total EPI strategy since it's usually lower than DPT3 coverage | For countries recommending the first dose of measles vaccine in children over 12 months of age, the indicator is calculated as the proportion of children less than 12-23 months of age receiving one dose of measles-containing vaccine. | Percentage of children under one year of age immunized against measles is one of MDG indicators. | 1. Spiegel PB, Bunkle FM Jr, Dey CC, Salama P: Developing Public Health Indicators in Complex Emergency Response. Prehospital Disaster Med 2001, 16:281-285. 2. Toole M: The Public-Health Consequences of Inaction. A Framework for Survival. In Health, Human Rights and Humanitarian Assistance in Conflicts and Disasters. Edited by: Cahill K, Routledge, London; 1999. |
| Pneumonia disease treatment | Outcome | OPTIONAL INDICATOR:<br>Number of children under age 5 with suspected pneumonia in the previous 2 weeks who received antibiotics | Children under 5 years; by sex, location and SES | Number of children under age 5 with suspected pneumonia in the previous 2 weeks who received antibiotics / Total number of children under age 5 with suspected pneumonia in the previous 2 weeks x 100 | Household surveys; facility reporting system; IMCI projects; health & nutrition assessments; monitoring | Difficult to measure accurately | MICS, DHS, WHO, NGOs | Emergencies & stable | Most deaths in crisis are same and were also same causes before the crisis. Evidence that pneumonia and diarrhoea major killers in crisis | *Toole MJ, Waldman RJ, The public health aspects of complex emergencies and refugee situations. Ann. Rev. of Public Health. Vol. 18: 283-312 (Volume publication date May 1997)* | | | | |
| | Output | OPTIONAL INDICATOR:<br>Number of children under age 5 with suspected pneumonia in the previous 2 weeks who were taken to an appropriate health provider | Children under 5 years; by sex, location and SES | Number of children under age 5 with suspected pneumonia in the previous 2 weeks who were taken to care provider / Total number of children under age 5 with suspected pneumonia in the previous 2 weeks x 100 | Household surveys; facility reporting system; IMCI projects; health & nutrition assessments; monitoring | Difficult to measure accurately | MCS, DHS, WHO, NGOs | Emergencies & stable | Health seeking-behaviour | | | | | |
| Diarrhoeal disease treatment & prevention | Outcome | OPTIONAL INDICATOR:<br>Number of children under age 5 with diarrhoea in the previous 2 weeks who received ORT (ORS packet or recommended homemade fluid or increased fluids) and continued feeding during the episode of diarrhoea | Children under 5 years; by sex, location and SES | Number of children under age 5 with diarrhoea in the previous 2 weeks who received ORT / Total number of children under age 5 with diarrhoea in the previous 2 weeks x 100 | Household surveys; facility reporting system; IMCI projects; health & nutrition assessments; monitoring | Difficult to measure accurately | DFID, MICS, INGOs, NGOs | Emergencies & stable | Most deaths in crisis are same and were also same causes before the crisis. Evidence that pneumonia and diarrhoea major killers in crisis | Diarrhoeal diseases remain one of the major causes of mortality among under-fives, accounting for 1.8 million child deaths worldwide, despite all the progress in its management and the undeniable success of the oral rehydration therapy (ORT). Therefore monitoring of the coverage of this very cost-effective intervention is crucial for the monitoring of progress towards the child survival-related Millennium Development Goals and Strategies. | These indicators are usually collected in DHS and MICS surveys; however, the accuracy of reporting in household surveys varies and is likely to be prone to recall bias. Also, seasonal influences related to the prevalence of diarrhoeal disease may affect the results of data collection for this indicator. The comparability of results across countries and over time may therefore be affected. Frequent changes in the definition of this indicator have seriously compromised the ability to reliably assess trends over time. | There are two specific limitations with some of the associated terms of this indicator:1. Discussions have been held on whether treated should be considered when the electrolyte solution was 'given', 'received', 'ingested', or 'offered' to the child; and 2. Comparability of data on appropriate household solution. | |
| | | OPTIONAL INDICATOR:<br>Children aged <5 years with diarrhoea receiving zinc supplement | Children under 5 years; by sex, location and SES | Number of children under age 5 with diarrhoea in the previous 2 weeks who received zinc / Total number of children under age 5 with diarrhoea in the previous 2 weeks x 100 | Household surveys; facility reporting system; IMCI projects; health & nutrition assessments; monitoring | Good; assume tablets consumed | MICS, DHS, WHO, NGOs | Emergencies & stable | | For dietary indicators, the prevalence (or probability) of zinc intakes below the appropriate estimated average requirement (EAR) should be used, as determined from quantitative dietary intake assessments. Where the prevalence of inadequate intakes of zinc is greater than 25%, the risk of zinc deficiency is considered to be elevated. Previous studies indicate that stunted children respond to zinc supplementation with increased growth. When the prevalence of low height-for-age is 20% or more, the prevalence of zinc deficiency may also be elevated. | | | |
| Malaria treatment & prevention | Outcome | OPTIONAL INDICATOR:<br>Number of children under age 5 reported to have had fever in the previous 2 weeks who were treated with an appropriate antimalarial | Children under 5 years; by sex, location and SES | Number of children under age 5 reported to have had fever in the previous 2 weeks who were treated with an appropriate antimalarial / Total number of children under age 5 reported to have had fever in the previous 2 weeks x 100 | Household surveys; facility reporting system; IMCI projects; health & nutrition assessments; monitoring | Difficult to measure accurately | MDG 6.8, MICS, DHS, WHO | Emergencies & stable | | | | | | |
| | | OPTIONAL INDICATOR:<br>Number of children under age 5 who slept under an insecticide-treated mosquito net the previous night | Children under 5 years; by sex, location and SES | Number of children under age 5 who slept under an insecticide-treated mosquito net the previous night / Total number of children under age 5 x 100 | Household surveys; facility reporting system; IMCI projects; health & nutrition assessments; monitoring | Good | MDG 6.7, MICS, DHS, WHO | Emergencies & stable | | | | | | |
| Improve maternal health - MDG5 | | | | | | | | | | | | | | |
| Maternal mortality (Maternal mortality ratio - MMR) | Impact | OPTIONAL INDICATOR:<br>MMR is the annual number of female deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 live births, for a specified year. Late maternal deaths are excluded from this calculation. | Pre and post partum women.<br>By: Age group; Location; Education level; Wealth quintile; Administrative regions; Health regions | $MMR = \frac{\text{Number of Maternal Deaths}}{\text{Number of live births}} \times 100{,}000$<br>Deaths per 100 000 live births | - Civil registration with complete coverage and medical certification of cause of death<br>- Population census<br>- Household surveys<br>- Special studies<br>- Sample or sentinel registration systems | Difficult to measure accurately | WHO, UNFPA, UNICEF, MICS, WB, | Emergencies & stable | Used as a priority indicator by who? | | | Due to the very large confidence limits of maternal mortality estimates, the MDG statistics track trends only at the regional level. The country estimates are not suitable for assessing trends over time or for making comparisons between countries. As a result, it is recommended that process indicators, such as attendance by skilled health personnel at delivery and use of health facilities for delivery, be used to assess progress towards the reduction in maternal mortality. | |
| Direct programme evaluation | | | | | | | | | | | | | | |
| SAM (Severe Acute Malnutrition) | Output | OPTIONAL INDICATOR:<br>Recovery rate, Death rate, Defaulter rate, weight gain, length of stay, coverage | Children 6-59 months; by age group, sex, location, SES | Recovery rate: > 75% (acceptable); < 50% (alarming).<br>Death rate: < 10% (<5% preferable)(acceptable) ; > 15% (alarming). Defaulter rate: < 15% (acceptable); > 25% (alarming). Weight gain: >= 8 g/kg/day (acceptable) ; < 8 g/kg/day (alarming). Length of stay: < 4 weeks (acceptable) ; > 6 weeks (alarming). Coverage: > 50% in rural areas; > 70% in urban areas; > 90% in a camp (acceptable); <40% any situation (alarming). | Monitoring | Good | DFID, HRF, UNICEF, CHAP, NGO, INGO, Sphere, **HNTS** | Emergencies | | | | | | Not necessary to distinguish type of emergency for core indicators as will be good deal of overlap. |
| MAM (Moderate Acute Malnutrition) | Output | OPTIONAL INDICATOR:<br>Recovery rate, Death rate, Defaulter rate, coverage | Children 6-59 months; by age group, sex, location, SES | Recovery rate: > 75% (acceptable); < 50% (alarming). Death rate: < 3% (acceptable) ; > 5% (alarming). Defaulter rate: < 15% (acceptable) ; > 25% (alarming). Coverage: > 50% in rural areas; > 70% in urban areas; > 90% in a camp (acceptable); <40% any situation (alarming). | Monitoring | Good | DFID, HRF, UNICEF, CHAP, NGO, INGO, Sphere, **HNTS** | Emergencies | | | | | | Not necessary to distinguish type of emergency for core indicators as will be good deal of overlap. |
| Number of people directly assisted by food security programmes | Output | OPTIONAL INDICATOR:<br>Number of household members in households that have access to food security programmes eg Food aid | Total population; by SES and location | Number of people directly assisted by food security programmes (funded by DFID)/Total population x 100 | Household surveys, programme monitoring, food security surveys | Good | DFID, FAO, WFP, WB | Emergency situations | Lack of food is a direct cause of malnutrition. | | Food quality is often overlooked when quantity more strived for. Hidden hunger emerges when food quality is poor. | | | |
| Number of people directly assisted by social protection programmes | Output | OPTIONAL INDICATOR:<br>Number of household members in households that have access to social protection programmes eg Cash or food transfers, child protection networks (OVC) | All population; by SES and location | Number of household members in households that have access to social protection programmes (funded by DFID) / Total population x 100 | Household surveys, programme monitoring, child protection networks | Good | DFID, UNICEF | Emergency & stable | Increasing evidence suggesting cash transfers (or 'safety nets) provide an effective way to prevent hunger, especially in ongoing famine situations where the resilience of vulnerable communities needed to be built up over time | | | | | |
| Food Security | | | | | | | | | | | | | | |
| Poverty | Impact | OPTIONAL INDICATOR:<br>% Population below $1 per day | Total population; by location | $P_0 = \frac{1}{N}\sum_{i=1}^{q} I(y_i \leq z) = \frac{N_p}{N}$<br>Where $I(.)$ is an indicator function that takes on a value of 1 if the bracketed expression is true, and 0 otherwise. If individual consumption or income ($y$) is less than the poverty line ($z$), then $I(.)$ is equal to 1 and the individual is counted as poor. $Np$ is the total number of the poor. N is the total population. | The indicator is produced by the World Bank Development Research Group based on microlevel data from nationally representative household surveys, which are conducted by national statistical offices or by private agencies under the supervision of government or international agencies and obtained from government statistical offices and World Bank Group country departments. | Good | MDG 1.1, WHO | Stable | *Only nationally representative surveys that are of good quality, contain sufficient information to produce a comprehensive consumption or income aggregate, and allow for the construction of a correctly-weighted distribution of per capita consumption or income are used. - Ref: http://unstats.un.org/unsd/mdg/Metadata.aspx?IndicatorId=1 | International comparisons of poverty estimates entail both conceptual and practical problems. A key building block in developing income and consumption measures of poverty is the poverty line—the critical threshold value below which an individual or household is determined to be poor. Countries set their poverty lines at different thresholds, making consistent international comparisons of poverty difficult. The $1.25 a day poverty line corresponds to the value of the poverty lines used in some of the poorest countries. Local poverty lines tend to have higher purchasing power in rich countries, where more generous standards are used, than in poor countries. | | For monitoring country poverty trends, indicators based on national poverty lines should be used, where available. | |
| Prevalence of undernourishment in total population | Impact | OPTIONAL INDICATOR:<br>Proportion of population below minimum level of dietary energy consumption | Total population; by gender, age, location and SES | FAO's estimates of the prevalence of undernourishment are essentially a measure of food deprivation based on the calculation of three key parameters for each country: the average amount of food available for human consumption per person, the level of inequality in access to that food and the minimum number of calories required for an average person. | FAO statistics division; Country statistics on local food production, trade, stocks and non-food uses; food consumption data from national household surveys; country anthropometric data by gender and age and UN country population estimates, total and by gender and age. | Relies on reliable and accurate data to calculate indicator | MDG 1.9, FAO, WHO | Stable | The indicator measures an important aspect of the food insecurity of a population. Sustainable development demands a concerted effort to reduce poverty, including finding solutions to hunger and malnutrition. Alleviating hunger is a prerequisite for sustainable poverty reduction since under-nourishment seriously affects labour productivity and earning capacity. Malnutrition can be the outcome of a range of circumstances. In order to work, poverty reduction strategies must address food access, availability (physical and economical) and safety. | http://www.fao.org/economic/ess/food-security-statistics/ess/ - http://unstats.un.org/unsd/mdg/Metadata.aspx?IndicatorId=5 | Undernourishment refers to the condition of people whose dietary energy consumption is continuously below a minimum dietary energy requirement for maintaining a healthy life and carrying out light physical activity with an acceptable minimum body-weight for attained height. Ref | The FAO methodology suffers from several obvious limitations. For one thing, the estimates it produces are only as reliable and accurate as the data used to calculate the food balance sheets, levels of inequality and daily energy requirement cut-off points. For many countries, the reliability of the underlying food balance sheet data and measures of inequality is uncertain. A relatively small variation in just one of these parameters can make a big difference in a country's estimated level of hunger. Furthermore, estimates based on national production and trade figures cannot be used to pinpoint where hunger has become increasingly concentrated in specific geographic areas and socio-economic groups. However national institutions in some countries have been successful in estimating the prevalence of undernourishment in the population at subnational levels, in particular countries participating in the FAO Household Energy Programme for estimating food security statistics. | http://www.fao.org/docrep/005/Y4249E/y4249e06.htm#bm06a |
| Food Consumption Score (FCS) | Outcome | OPTIONAL INDICATOR:<br>A proxy FS indicator combining food frequency and dietary diversity | Household; by location, SES | Score: 0-21 Poor; 21.5-35 Borderline; > 35 Acceptable | Household survey; FSMS | OK, may be difficult to measure accurately | WFP (CFSVA, EFSA) | Emergency & stable | Used to identify food access and consumption problems at the population's level | At the household level, scores are mainly used as proxies of food security; they are correlated to the energy adequacy of intakes, i.e. to the ability of the household to cover basic energy needs of its members. They have been shown to be associated with various other measures of household food security related to access. | | They are not directly related to the nutritional status of household members. | http://home.wfp.org/stellent/groups/public/documents/ena/wfp186895.pdf |
| Dietary Diversity (HDDS) | Outcome | OPTIONAL INDICATOR:<br>Household dietary diversity score (HDDS) | Total population; household and individuals by gender and age, location and SES | The numbers of foods out of 12 groups | Household survey; FSMS | OK; maybe difficult to measure accurately | FANTA, WHO | Emergency & stable | Used to identify food access and consumption problems at the population's level | Correlated with levels of calorific acquisition; tracks seasonal changes in food security and also appears to capture differences in distribution within the household. | The disadvantage of this measure is that the simple form of this measure does not record quantities. If it is not possible to ask about frequency of consumption of particular quantities, it is not possible to estimate the extent to which diets are inadequate in terms of calorific availability. | They are not directly related to the nutritional status of household members. | A valid measure of welfare<br>Ref http://www.foodsec.org/tr/mt/guidelines.pdf |
| Depth of hunger (intensity of food deprivation) | Outcome | OPTIONAL INDICATOR:<br>The intensity of food deprivation indicates how much food-deprived people fall short of minimum food needs in terms of dietary energy. | Total population; by SES and location | Difference between the minimum dietary energy and the average dietary energy intake of the undernourished population (food-deprived). | FAO statistics division | OK; maybe difficult to measure accurately | FAO | Stable situations | Food deprivation is an exogenous factor associated with undernutrition, which is an endogenous factor that becomes an exogenous factor associated with early death. | The intensity of food deprivation is low when it is less than 200 kilocalories per person per day and high when it is higher than 300 kilocalories per person per day. The greater the food deficit, the greater the susceptibility for health risks related to undernutrition. http://www.fao.org/economic/ess/food-security-statistics/en/ | | | |
| Composite Indicators to measure hunger | | | | | | | | | | | | | | |

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| Global Hunger Index | Impact | COMPILED INDICATOR 2:<br>A composite index being the average of child undernutrition, child mortality and the prevalence of undernourishment in total population | Total population | 1. Child undernutrition; 2. Child mortality; 3. Prevalence of undernourishment in total population; each expressed as a percentage and given equal weight. The index varies between a minimum of 0 and a maximum of 100. | See above individual indicators | Relies on reliable and accurate data to calculate indicator | WHO, IFPRI | Stable | Good measure of nutrition outcomes | Higher GHI values indicate more hunger. | | | | |
| Hunger | Impact | To be considered:<br>Composite hunger score | Total population; National and sub-national | 1. Child undernutrition; 2. Food deprivation (Prevalence of undernourishment in total population); 3. Critical food poverty (Income deprivation) | See above individual indicators | Relies on reliable and accurate data to calculate indicator | FAO | Stable | | | | | | |
| Household hunger scale | Outcome | OPTIONAL INDICATOR:<br>Based on 3 questions on household food access (HFIAS) - Household Food Insecurity Access Scale | Household; by location, SES | Score 0-1: Little to no household hunger; Score 2-3: Moderate household hunger; Score 4-6: Severe household hunger | Household survey | Relies on reliable and accurate data to calculate indicator | FANTA | Emergency and stable | | | | | | |
| Multisector (underlying) | | | | | | | | | | | | | | |
| Water availability | Output | OPTIONAL INDICATOR:<br>Number of households with access to water | All population; by SES and location | Number of households with at least 15 lpd | National census; Household survey; local area survey | Good | MICS (WASH), JMP (UNICEF/WHO) | Emergencies & Stable | Water availability is easily measured, widely advocated, and has strong links to health outcomes (Roberts). Quantifying the burden of disease associated with inadequate provision of water and sanitation in selected sub-Saharian refugee camps. [J Water Health. 2009] | Access to drinking water and improved sanitation is a fundamental need and a human right vital for the dignity and health of all people. The health and economic benefits of improved water supply to households and individuals (especially children) are well documented. Both indicators are used to monitor progress towards the MDGs. | Information is missing from many developed countries. More needs to be done to address the issues of sustainability and safety in drinking water provision. | | | Cronin AA, Shrestha D, Cornier N, Abdalla F, Ezard N, Aramburo C A review of water and sanitation provision in refugee camps in association with selected health and nutrition indicators--the need for integrated service provision. J Water Health. 2008 Mar;6(1):1-13. |
| Drinking- water source | Output | OPTIONAL INDICATOR:<br>Number of households provided with new / improved drinking water sources in a given year | All population; by SES and location | Total number of households | National census; Household survey; local area survey | Good | MDG 7.8, MICS (WASH), JMP (UNICEF/WHO), WFP | Emergencies & Stable | Yes. WFP (associated with WHZ, WAZ, HAZ) | Access to drinking water and basic sanitation is a fundamental need and a human right vital for the dignity and health of all people. The health and economic benefits of improved water supply to households and individuals are well documented. Use of an improved drinking water source is a proxy for the use of safe drinking water. | Information is missing from many developed countries. More needs to be done to address the issues of sustainability and safety in drinking water provision. | | | Cronin AA, Shrestha D, Cornier N, Abdalla F, Ezard N, Aramburo C A review of water and sanitation provision in refugee camps in association with selected health and nutrition indicators--the need for integrated service provision. J Water Health. 2008 Mar;6(1):1-13. |
| Improved sanitation | Output | OPTIONAL INDICATOR:<br>Access to improved sanitation is the percentage of population with access to improved sanitation in a given year. | All population; by SES and location | Total number of households | National census; Household survey; local area survey | Good; as long as facilities are being utilised | MDG 7.8, MICS (WASH), JMP (UNICEF/WHO), WFP | Emergencies & Stable | Access to drinking water and basic sanitation is a fundamental need and a human right vital for the dignity and health of all people. | | | | | |
| Place for handwashing | Output | OPTIONAL INDICATOR:<br>Number of households with water and soap at specific place for hand washing | All population; by SES and location | Number of households with water and soap at specific place for hand washing / Total number of households x 100 | Household survey; local area survey | OK, as long as have indicator on soap availability | MICS (WASH), JMP (UNICEF/WHO) | Emergencies & Stable | | | | | | |
| Availability of soap | Output | OPTIONAL INDICATOR:<br>Percentage of households with soap anywhere in the household | All population; by SES and location | Percentage of households with soap anywhere in the household / Total number of households x 100 | Household survey; local area survey | OK, as long as soap is utilised | MICS | Stable situations | | | | | | |
| Fuel source (solid fuels) | Output | OPTIONAL INDICATOR:<br>Number of household members in households that use solid fuels as the primary source of domestic energy to cook | All population; by SES and location | Number of household members in households that use solid fuels as the primary source of domestic energy to cook / Total number of household members x 100 | National census; Household survey; local area survey | Good | MDG, MICS | Emergencies & Stable | The use of solid fuels in households is associated with increased mortality from pneumonia and other acute lower respiratory diseases among children as well as increased mortality from chronic obstructive pulmonary disease and lung cancer (where coal is used) among adults. It is also a Millennium Development Goal indicator | Yes. WFP (associated with WHZ, WAZ, HAZ) | | All countries without survey data and with a GNP per capita above US$ 10,500 are assumed to have made a complete transition to cooking with non-solid fuels. | | |