

SDG indicator metadata

(Harmonized metadata template - format version 1.1)

0. Indicator information (SDG_INDICATOR_INFO)

0.a. Goal (SDG_GOAL)

Goal 3: Ensure healthy lives and promote well-being for all at all ages

0.b. Target (SDG_TARGET)

Target 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

0.c. Indicator (SDG_INDICATOR)

Indicator 3.8.1: Coverage of essential health services

0.d. Series (SDG_SERIES_DESCR)

SH_ACS_UNHC_25 - Universal health coverage (UHC) service coverage index, 2025 methodology [3.8.1]

0.e. Metadata update (META_LAST_UPDATE)

2025-12-12

0.f. Related indicators (SDG_RELATED_INDICATORS)

The universal health coverage (UHC) service coverage index is designed to summarize existing indicators of health service coverage to ensure consistency with the SDGs and other global initiatives and reduce duplication and reporting burden.

Indicator 3.8.1 should always be interpreted together with the other SDG UHC indicator, 3.8.2, which measures financial protection.

0.g. International organisations(s) responsible for global monitoring

(SDG_CUSTODIAN_AGENCIES)

World Health Organization (WHO)

1. Data reporter (CONTACT)

1.a. Organisation (CONTACT_ORGANISATION)

World Health Organization (WHO)

2. Definition, concepts, and classifications (IND_DEF_CON_CLASS)

2.a. Definition and concepts (STAT_CONC_DEF)

Definition:

Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population).

Concepts:

The index of health service coverage is computed as the weighted geometric means of 14 tracer indicators. The 14 indicators are listed below and detailed metadata for each of the components is given in Annex 1. The tracer indicators are as follows, organized by four broad categories of service coverage:

I. Reproductive, maternal, newborn and child health

1. Family planning: Percentage of women of reproductive age (15–49 years) who have their need for family planning satisfied with modern methods (SDG indicator 3.7.1, metadata available [here](#))
2. Pregnancy care: Percentage of women aged 15-49 years with a live birth in a given time period who received antenatal care four or more times
3. Child immunization: Percentage of infants receiving three doses of diphtheria-tetanus-pertussis containing vaccine
4. Child treatment: Percentage of children younger than 5 years with symptoms of acute respiratory infection (cough and fast or difficult breathing due to a problem in the chest and not due to a blocked nose only) in the 2 weeks preceding the survey for whom advice or treatment was sought from a health facility or provider

II. Infectious diseases

5. Tuberculosis: Percentage of incident TB cases that are detected and treated
6. HIV/AIDS: Percentage of adults and children living with HIV currently receiving antiretroviral therapy
7. Malaria: Percentage of population in malaria-endemic areas who slept under an insecticide-treated net the previous night [only for countries with high malaria burden]
8. Water, sanitation and hygiene: Percentage of population using at least basic sanitation services.

III. Noncommunicable diseases

9. Hypertension: Coverage of treatment (taking medicine) for hypertension among adults aged 30-79 years with hypertension (age-standardized estimate) (%)
10. Diabetes: Coverage of treatment (taking medication) for diabetes among adults aged 30 years and over with diabetes (age-standardized estimate) (%)
11. Tobacco: Age-standardized prevalence of adults ≥ 15 years currently using any tobacco product (smoked and/or smokeless tobacco) on a daily or non-daily basis (SDG indicator 3.a.1, metadata available [here](#))

IV. Service capacity and access

12. Hospital access: Hospital beds density, relative to a maximum threshold of 18 per 10,000 population
13. Health workforce: Health workers (medical doctors, nursing and midwifery personnel) per capita, relative to a combined maximum thresholds (overlap with SDG indicator 3.c.1, see metadata [here](#))
14. Health security: International Health Regulations (IHR) core capacity index, which is the average percentage of attributes of 13 core capacities that have been attained (SDG indicator 3.d.1, see metadata [here](#))

2.b. Unit of measure (UNIT_MEASURE)

The indicator is an index reported on a unitless scale of 0 to 100.

2.c. Classifications (CLASS_SYSTEM)

Not applicable

3. Data source type and data collection method (SRC_TYPE_COLL_METHOD)**3.a. Data sources** (SOURCE_TYPE)

Many of the tracer indicators of health service coverage are measured by household surveys. However, administrative data, facility data, facility surveys, and sentinel surveillance systems are utilized for certain indicators. Underlying data sources for each of the 14 tracer indicators are explained in more detail in Annex 1.

In terms of values used to compute the index, values are taken from existing published sources. This includes assembled data sets and estimates from various UN agencies. More details are found in Annex 1.

3.b. Data collection method (COLL_METHOD)

The mechanisms for collecting data from countries vary across the 14 tracer indicators, however in many cases a UN agency or interagency group has assembled and analysed relevant national data sources and then conducted a formal country consultation with country governments to review or produce comparable country estimates. For the universal health coverage (UHC) service coverage index, once this existing information on the 14 tracer indicators is collated, WHO conducts a country consultation with nominated focal points from national governments to review inputs and the calculation of the index. WHO does not undertake new estimation activities to produce tracer indicator values for the service coverage index; rather, the index is designed to make use of existing and well-established indicator data series to reduce reporting burden.

3.c. Data collection calendar (FREQ_COLL)

Data collection varies from every 1 to 5 years across tracer indicators. For example, country data on immunizations and HIV treatment are reported annually, whereas household surveys to collect information on child treatment may occur every 3-5 years, depending on the country. More details about individual tracer indicators are available in Annex 1.

3.d. Data release calendar (REL_CAL_POLICY)

The first release of baseline values for the universal health coverage (UHC) service coverage index took place in December 2017. Updates are released every two years.

3.e. Data providers (DATA_SOURCE)

In most cases, Ministries of Health and National Statistical Offices oversee data collection and reporting for health service coverage indicators.

3.f. Data compilers (COMPILING_ORG)

The World Health Organization, drawing on inputs from other international agencies such as UNICEF, UNAIDS, UN DESA, OECD, Eurostat, World Bank Group.

3.g. Institutional mandate (INST_MANDATE)

WHO support for monitoring the service coverage dimension of Universal Health Coverage (UHC) (target 3.8, indicator 3.8.1 specifically) is underpinned by Resolution WHA69 that requests the Secretariat to track progress towards achieving UHC as part of the SDG 2030 agenda for Sustainable Development.

4. Other methodological considerations (OTHER_METHOD)

4.a. Rationale (RATIONALE)

Target 3.8 is defined as “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all”. The objective is for all people and communities to receive the quality health services they need (including medicines and other health products), without financial hardship. Two indicators have been chosen to monitor target 3.8 within the SDG framework. Indicator 3.8.1 is for health service coverage and indicator 3.8.2 focuses on health expenditures in relation to a household’s budget to identify financial hardship caused by direct health care payments. Taken together, indicators 3.8.1 and 3.8.2 are meant to capture the service coverage and financial protection dimensions, respectively, of target 3.8. These two indicators should be always monitored jointly.

Countries provide many essential services for health protection, promotion, prevention, treatment and care. Indicators of service coverage – defined as people receiving the service they need – are the best way to track progress in providing services under universal health coverage (UHC). Since a single health service indicator does not suffice for monitoring UHC, an index is constructed from 14 tracer indicators selected based on epidemiological and statistical criteria. This includes several indicators that are already included in other SDG targets, thereby minimizing the data collection and reporting burden. The index is reported on a unitless scale of 0 to 100, with 100 being the optimal value.

4.b. Comment and limitations (REC_USE_LIM)

These tracer indicators are meant to be indicative of service coverage, not a complete or exhaustive list of health services and interventions that are required for universal health coverage. The 14 tracer indicators were selected because they are well-established, with available data widely reported by countries (or expected to become widely available soon). Therefore, the index can be computed with existing data sources and does not require initiating new data collection efforts solely to inform the index.

4.c. Method of computation (DATA_COMP)

The calculation of the 3.8.1 indicator requires first standardizing the 14 tracer indicators so that they can be combined into the index, and then computing the index from those values.

The 14 tracer indicators are first all placed on the same scale, with 0 being the lowest value and 100 being the optimal value. For most indicators, this scale is the natural scale of measurement, e.g., the percentage of infants who have been immunized ranges from 0 to 100 percent. However, for a few indicators, conversion and/or rescaling is required to obtain appropriate values from 0 to 100, as follows:

Conversion

The prevalence of tobacco use is converted into prevalence of tobacco non-use, so that an increase means an improvement.

Rescaling

- Rescaling based on a non-zero minimum to obtain finer resolution (this “stretches” the distribution across countries): prevalence of non-use of tobacco is rescaled using a value of 30%, which indicate a realistic range of prevalence levels for the indicator.

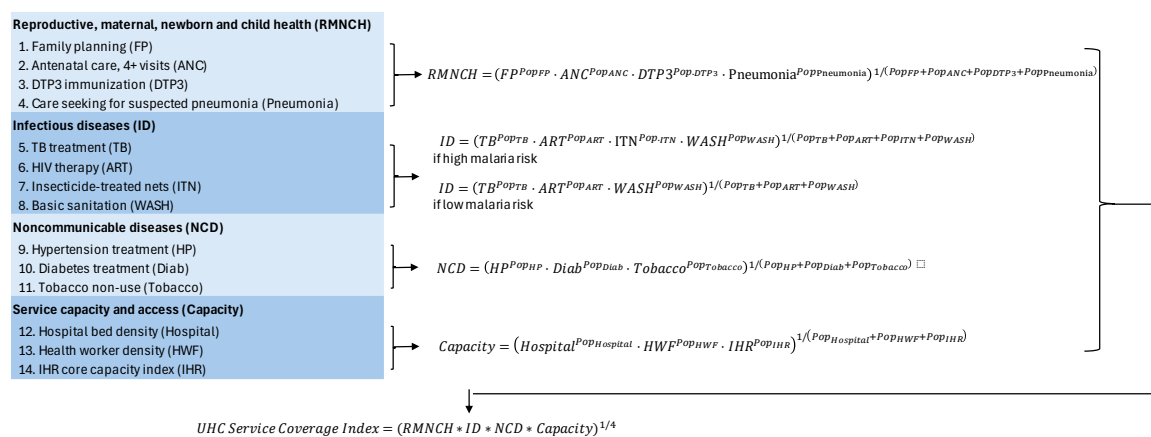
$$\text{rescaled tobacco non-use} = (X - 30)/(100 - 30) * 100$$

- Maximum thresholds for rate indicators: hospital bed density and health workforce density are both capped at maximum thresholds, and values above this threshold are held constant at 100. The hospital bed thresholds is based on values observed across OECD countries (2015

edition of OECD Health Statistics Database) The health workforce threshold is based on the 5th percentile among high-income countries in 2013.

$$\begin{aligned} \text{rescaled hospital beds per 10,000} &= \text{minimum}(100, \text{original value} / 18 * 100) \\ \text{rescaled medical doctors, nursing and midwifery personnel per 1,000} &= \\ &\text{minimum}(100, \text{original value} / 6 * 100) \end{aligned}$$

Once all tracer indicator values are on a scale of 0 to 100, weighted geometric means are computed within each of the four health service areas, and then a geometric mean is taken of those four values. If the value of a tracer indicator happens to be zero or beyond 100, it is set to 1 (out of 100) or 100 (out of 100) respectively before computing the weighted geometric mean in the service area. The following diagram illustrates the calculations. Each tracer is weighted on an indicator specific population based on the denominator of the indicator (noted as “Pop” in the diagram) using United Nations population estimates where applicable. See Annex 1 for denominator definitions and other comparable denominator sources used.



Note that in countries with low malaria burden, the tracer indicator for use of insecticide-treated nets is dropped from the calculation.

4.d. Validation (DATA_VALIDATION)

The data obtained to calculate the index have typically already been checked for quality through separated processes. However, a quality assessment is performed before consulting countries (i.e. detection of important outliers or substantial difference between last update and next update for the same year). The index estimates are included in a consultation to obtain country’s feedback. Data are revised as needed for antenatal care coverage and hospital beds densities. The revision of all the other indicators should follow the reporting mechanism already in place.

Information on the validation of the index construction can be found in the following paper:

[https://www.thelancet.com/journals/langlo/article/PIIS2214-109X\(17\)30472-2/fulltext](https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(17)30472-2/fulltext)

4.e. Adjustments (ADJUSTMENT)

Not applicable

4.f. Treatment of missing values (i) at country level and (ii) at regional level

(IMPUTATION)

- **At country level**

The starting point for computing the index is to assemble existing information for each tracer indicator. In many cases, this involves using country time series that have been produced or collated by UN agencies in consultation with country governments (e.g., immunization coverage, access to sanitation, HIV treatment coverage, etc). Some of these published time series involve mathematical modelling to reconcile multiple data sources or impute missing values, and these details are summarized in Annex 1.

After assembling these inputs, there are still missing values for some country-years for some indicators. Calculating the universal health coverage (UHC) service coverage index requires values for each tracer indicator for a country, so some imputation is necessary to fill these data gaps. The current approach involves a simple imputation algorithm. For each indicator:

- If a country has missing values between two years with values, linear interpolation is used to fill missing values for the intervening years
- If a country has historical years with values, but no current value, constant extrapolation is used to fill missing values to the current year
- If a country has no values, a value is imputed. For pneumonia care-seeking, a regression is fit to impute missing values (see Annex 1 for details). For family planning, UN MDG 49 subregions aggregates are used. For all other indicators, a regional median is calculated to impute missing values. By default, regions are based on UN SDG subregions. However, when there are not enough countries within UN SDG subregions with available data, other groupings can be used.

Given the timing and distribution of various health surveys and other data collection mechanisms, countries do not collect and report on all 14 tracer indicators of health service coverage on an annual basis. In addition, monitoring at country level is most suitably done at broader time intervals, e.g., every 5 years, to allow for new data collection across indicators. Therefore, the extent to which imputation has been used to fill missing information should be communicated along with the index value.

- **At regional and global levels**

Any needed imputation is done at country level. These country values can then be used to compute regional and global values.

4.g. Regional aggregations (REG_AGG)

Regional and global aggregates use the denominators of each tracer indicator, predominately from the United Nations population estimates, at the country level to compute a weighted average of each tracer indicator and aggregate sum denominator or weight. These tracer indicator averages and summed weights are used to calculate the index as presented in the diagram under section 4.c for a given region. United Nations population estimates at country level are used to ensure consistency and comparability of estimates within countries and between countries over time.

4.h. Methods and guidance available to countries for the compilation of the data at the national level (DOC_METHOD)

Not applicable

4.i. Quality management (QUALITY_MGMT)

Not applicable

4.j Quality assurance (QUALITY_ASSURE)

Not applicable

4.k Quality assessment (QUALITY_ASSMNT)

See 4.d Validation

5. Data availability and disaggregation (COVERAGE)

Data availability:

Summarizing data availability for the universal health coverage (UHC) service coverage index is not straightforward, as different data sources are used across the 14 tracer indicators. Additionally, for many indicators comparable estimates have been produced, in many cases drawing on different types of underlying data sources to inform the estimates while also using projections to impute missing values.

Time series:

A baseline value for the UHC service coverage index for 2015 across 183 countries was published in late 2017. As part of this process, data sources going back to 2000 were assembled. In 2019, UHC service coverage index were estimates for the years: 2000, 2005, 2010, 2015 and 2017. From 2021, the index is estimated every two years for all countries (i.e. 194 WHO member states).

Disaggregation:

Equity is central to the definition of UHC, and therefore the UHC service coverage index should be used to communicate information about inequalities in service coverage within countries. This can be done by presenting the index separately for the national population vs disadvantaged populations to highlight differences between them.

For countries, geographic location is likely the most feasible dimension for sub-national disaggregation based on average coverage levels measured with existing data sources. To do this, the UHC index can be computed separately by, e.g., province or urban vs rural residence, which would allow for subnational comparisons of service coverage. Currently, the most readily available data for disaggregation on other dimensions of inequality, such as household wealth, is for indicators of coverage within the reproductive, maternal, newborn and child health services category. Inequality observed in this dimension can be used as a proxy to understand differences in service coverage across key inequality dimensions. This approach should be replaced with full disaggregation of all 14 tracer indicators once data are available to do so.

6. Comparability / deviation from international standards (COMPARABILITY)

Sources of discrepancies:

The service coverage index draws on existing, publicly available data and estimates for tracer indicators. These numbers have already been through a country consultation process (e.g., for immunization coverage), or are taken directly from country reported data.

7. References and Documentation (OTHER_DOC)

URL: <https://www.who.int/health-topics/universal-health-coverage>

References: <https://www.who.int/publications/i/item/tracking-universal-health-coverage>
[http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X\(17\)30472-2.pdf](http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(17)30472-2.pdf)
<https://www.who.int/health-topics/universal-health-coverage>

For historical development of methods, see:

<https://www.who.int/publications/i/item/9789241565264>

<https://www.who.int/publications/i/item/monitoring-progress-towards-universal-health-coverage-at-country-and-global-levels-framework-measures-and-targets>
<http://collections.plos.org/uhc2014>

Annex 1: Metadata for tracer indicators used to measure the coverage of essential health services for monitoring SDG indicator 3.8.1.

Please send any comments or queries to: uhc_stats@who.int

Tracer area	Family planning
Indicator definition	Percentage of women of reproductive age (15–49 years) currently using a modern method of contraception among those who desire either to have no (additional) children or to postpone the next pregnancy
Numerator	Number of women of reproductive age (15–49 years old) who are currently using, or whose partner is currently using, at least one modern contraceptive method
Denominator	Total demand for family planning (the sum of the number of women using any contraceptive method and the number of women with unmet need for family planning)
Main data sources	Population-based health surveys
Method of measurement	<p>Household surveys include a series of questions to measure the modern contraceptive prevalence rate and need for family planning. The number of women with a need for family planning is defined as the sum of the number of women of reproductive age (15–49 years) and who are currently using, or whose sexual partner is currently using, at least one contraceptive method (modern or traditional), and the number of women of reproductive age with an unmet need for family planning. Unmet need for family planning is the proportion of women of reproductive age (15–49 years) who are fecund and sexually active but who are not using any method of contraception (modern or traditional), and report not wanting any more children or wanting to delay the birth of their next child for at least two years. Included are:</p> <ol style="list-style-type: none"> 1. all pregnant women whose pregnancies were unwanted or mistimed at the time of conception; 2. all postpartum amenorrhoeic women who are not using family planning and whose last birth was unwanted or mistimed; 3. all fecund women who are neither pregnant nor postpartum amenorrhoeic, and who either do not want any more children (want to limit family size), or who wish to postpone the birth of a child for at least two years or do not know when or if they want another child (want to space births) but are not using any contraceptive method. <p>Modern methods include female and male sterilization, the intra-uterine device (IUD), the implant, injectables, oral contraceptive pills, male and female condoms, vaginal barrier methods (including the diaphragm, cervical cap and spermicidal foam, jelly, cream and sponge), lactational amenorrhea method (LAM), emergency contraception and other modern methods not reported separately.</p>

Method of estimation	<p>The United Nations Population Division produces a systematic and comprehensive series of annual estimates and projections of the proportion of need for family planning among women of reproductive age (15-49) satisfied with modern methods. A Bayesian hierarchical model is applied to a comprehensive global dataset of a country-specific data to generate the estimates and projections. The model accounts for differences by data source, sample population, and survey questions. See here for details: https://www.un.org/development/desa/pd/data/family-planning-indicators</p> <p>Data compilation of country-specific survey data in World Contraceptive Use: https://www.un.org/development/desa/pd/node/3285</p>
UHC-related notes	<p>The denominator population used for weighting can also be found also found at the link above.</p>

Tracer area	Pregnancy care
Indicator definition	Percentage of women aged 15-49 years with a live birth in a given time period who received antenatal care four or more times
Numerator	Number of women aged 15–49 years with a live birth in a given time period who received antenatal care four or more times
Denominator	Total number of women aged 15–49 years with a live birth in the same period.
Main data sources	Household surveys and routine facility information systems.
Method of measurement	Data on four or more antenatal care visits is based on questions that ask if and how many times the health of the woman was checked during pregnancy. Household surveys that can generate this indicator include DHS, MICS, RHS and other surveys based on similar methodologies. Service/facility reporting systems can be used where the coverage is high, usually in higher income countries.
Method of estimation	WHO maintains a data base on coverage of antenatal care: http://apps.who.int/gho/data/node.main.ANTENATALCARECOVERAGE4
UHC-related notes	Ideally this indicator would be replaced with a more comprehensive measure of pregnancy care, for example the proportion of women who have a skilled provider attend the birth or an institutional delivery. A challenge in measuring skilled attendance at birth is determining which providers are “skilled”.

Tracer area	Child immunization
Indicator definition	Percentage of infants receiving three doses of diphtheria-tetanus-pertussis containing vaccine
Numerator	Children 1 year of age who have received three doses of diphtheria-tetanus-pertussis containing vaccine
Denominator	All children 1 year of age
Main data sources	Household surveys and facility information systems.
Method of measurement	For survey data, the vaccination status of children aged 12–23 months is collected from child health cards or, if there is no card, from recall by the care-taker. For administrative data, the total number of doses administered to the target population is extracted.
Method of estimation	<p>Together, WHO and UNICEF derive estimates of DTP3 coverage based on data officially reported to WHO and UNICEF by Member States, as well as data reported in the published and grey literature. They also consult with local experts - primarily national EPI managers and WHO regional office staff - for additional information regarding the performance of specific local immunization services. Based on the available data, consideration of potential biases, and contributions from local experts, WHO/UNICEF determine the most likely true level of immunization coverage.</p> <p>For details, see here: https://www.who.int/teams/immunization-vaccines-and-biologicals/immunization-analysis-and-insights/global-monitoring/immunization-coverage/who-unicef-estimates-of-national-immunization-coverage</p>
UHC-related notes	<p>There is variability in national vaccine schedules across countries. Given this, one option for monitoring full child immunization is to monitor the fraction of children receiving vaccines included in their country's national schedule. A second option, which may be more comparable across countries and time, is to monitor DTP3 coverage as a proxy for full child immunization. Diphtheria-tetanus-pertussis containing vaccine often includes other vaccines, e.g., against Hepatitis B and Haemophilus influenza type B, and is a reasonable measure of the extent to which there is a robust vaccine delivery platform within a country.</p>

Tracer area	Child treatment
Indicator definition	Percentage of children younger than 5 years with symptoms of acute respiratory infection (cough and fast or difficult breathing due to a problem in the chest and not due to a blocked nose only) in the 2 weeks preceding the survey for whom advice or treatment was sought from a health facility or provider
Numerator	Number of children younger than 5 years with symptoms of acute respiratory infection (cough and fast or difficult breathing due to a problem in the chest and not due to a blocked nose only) in the 2 weeks preceding the survey for whom advice or treatment was sought from a health facility or provider
Denominator	Number of children younger than 5 years with symptoms of acute respiratory infection (cough and fast or difficult breathing due to a problem in the chest and not due to a blocked nose only) in the 2 weeks preceding the survey
Main data sources	Household surveys
Method of measurement	The indicator is captured by household surveys including DHS, MICS and other national population-based surveys and is intended for use in high under-5 mortality settings to monitor efforts to reduce mortality from acute respiratory infections (including pneumonia) which are a leading cause of death for children under the age of 5 years. The Child Health Accountability Tracking Technical Advisory Group (CHAT TAG), convened by WHO and UNICEF, has ratified this indicator and is working to standardize its use across household surveys. WHO/UNICEF maintains a database of country-level observations from household surveys that can be accessed here: https://data.unicef.org/topic/child-health/pneumonia/
Method of estimation	UNICEF and WHO maintain a data base on this indicator and work on ensuring that values presented are comparable, using the same indicator definition.
UHC-related notes	This indicator is not typically measured in higher income countries with well-established health systems. For countries without observed data, coverage was estimated from a regression that predicts coverage of care-seeking for symptoms of acute respiratory infection (on the logit scale), obtained from the WHO data base described above, as a function of the log of the estimated under-five all-causes mortality rate, which can be found here: https://www.who.int/data/gho/data/themes/mortality-and-global-health-estimates For consistency and comparability of the denominator within countries and between countries over time, estimates of children under 5 years old from United Nations population estimates are used for the weighting instead of the defined denominator listed in this table.

Tracer area	Tuberculosis treatment
Indicator definition	Percentage of incidence TB cases that are detected and treated in a given year
Numerator	Number of new and relapse cases detected and treated in a given year
Denominator	Number of incident TB cases for the same year
Main data sources	Facility information systems, surveillance systems, population-based health surveys with TB diagnostic testing, TB register and related quarterly reporting system (or electronic TB registers)
Method of measurement	<p>This indicator requires two main inputs:</p> <p>(1) The number of new and relapse TB cases diagnosed and treated in national TB control programmes and notified to WHO in a given year.</p> <p>(2) The number of incident TB cases for the same year, typically estimated by WHO.</p> <p>The final indicator = (1)/(2)</p>
Method of estimation	<p>Estimates of TB incidence are produced through a consultative and analytical process led by WHO and are published annually. These estimates are based on annual case notifications, assessments of the quality and coverage of TB notification data, national surveys of the prevalence of TB disease and information from death (vital) registration systems. Estimates of incidence for each country are derived, using one or more of the following approaches depending on available data:</p> <ol style="list-style-type: none"> 1. incidence = case notifications/estimated proportion of cases detected; 2. incidence = prevalence/duration of condition; 3. incidence = deaths/proportion of incident cases that die. <p>Dynamic and statistical models were introduced to produce estimates for 2020 and 2021 that account for the major disruptions to the provision of and access to TB diagnostic and treatment services that have occurred in the context of the coronavirus (COVID-19) pandemic.</p>
UHC-related notes	One can access the WHO estimates here, including the denominator used for weighting: http://www.who.int/tb/country/data/download/en/

Tracer area	HIV treatment
Indicator definition	Percentage of adults and children living with HIV currently receiving antiretroviral therapy (ART)
Numerator	Number of adults and children who are currently receiving ART at the end of the reporting period
Denominator	Number of adults and children living with HIV during the same period
Main data sources	Facility reporting systems, sentinel surveillance sites, population-based surveys
Method of measurement	<p>Numerator: The numerator is generated by counting the number of adults and children who received ART at the end of the reporting period. Data can be collected from facility-based ART registers or drug supply management systems. These are then tallied and transferred to cross sectional monthly or quarterly reports which will then be aggregated for national totals. Patients receiving ART in the private sector and public sector should be included in the numerator.</p> <p>Denominator: Data on the number of people with HIV infection may come from epidemic models and population-based surveys or, as is common in sub-Saharan Africa, surveillance systems based on antenatal care clinics.</p>
Method of estimation	<p>Estimates of antiretroviral treatment coverage among people living with HIV for 2000-2018 are derived as part of the 2019 UNAIDS' estimation round.</p> <p>To estimate the number of people living with HIV across time in high burden countries, UNAIDS in collaboration with countries use an epidemic model (Spectrum) that combines surveillance data on prevalence with the current number of patients receiving ART and assumptions about the natural history of HIV disease progression. Since ART is now recommended for all individuals living with HIV, monitoring ART coverage is less complicated than before, when only those with a certain level of disease severity were eligible to receive ART. Estimates of ART coverage can be found here: https://www.who.int/data/gho/data/indicators/indicator-details/GHO/estimated-antiretroviral-therapy-coverage-among-people-living-with-hiv(-)</p>
UHC-related notes	<p>Comparable estimates of ART coverage in high income countries, in particular time trends, are not always available.</p> <p>The denominator population used for weighting can be found here : https://www.who.int/data/gho/data/indicators/indicator-details/GHO/estimated-number-of-people--living-with-hiv</p>

Tracer area	Malaria prevention
Indicator definition	Percentage of population in malaria-endemic areas who slept under an ITN the previous night.
Numerator	Number of people in malaria-endemic areas who slept under an ITN.
Denominator	Total number of people in malaria endemic areas.
Main data sources	Data on household access and use of ITNs come from nationally representative household surveys such as Demographic and Health Surveys, Multiple Indicator Cluster Surveys, and Malaria Indicator Surveys. Data on the number of ITNs delivered by manufacturers to countries are compiled by Milliner Global Associates, and data on the number of ITNs distributed within countries are reported by National Malaria Control Programs.
Method of measurement	Many recent national surveys report the number of ITNs observed in each respondent household. Ownership rates can be converted to the proportion of people sleeping under an ITN using a linear relationship between access and use that has been derived from 62 surveys that collect information on both indicators.
Method of estimation	Mathematical models can be used to combine data from household surveys on access and use with information on ITN deliveries from manufacturers and ITN distribution by national malaria programmes to produce annual estimates of ITN coverage. WHO uses this approach in collaboration with the Malaria Atlas Project. Methodological details can be found in pages 122-123 of the World Malaria Report 2021: https://www.who.int/publications/i/item/9789240040496 .
UHC-related notes	WHO produces comparable ITN coverage estimates for 40 of the 47 malaria endemic countries or areas of sub-Saharan Africa. The islands of Mayotte (for which no ITN delivery or distribution data were available) and Cabo Verde (which does not distribute ITNs) were excluded, as were the low transmission countries of Eswatini, Namibia, Sao Tome and Principe, and South Africa, for which ITNs comprise a small proportion of vector control. Analyses were limited to populations categorized by NMPs as being at risk. For other countries, ITN coverage is not included in the UHC service coverage index due to data limitations.

Tracer area	Water, sanitation and hygiene
Indicator definition	Percentage of population using at least basic sanitation services, that is, improved sanitation facilities that are not shared with other households
Numerator	Number of people using basic sanitation services as well as those using safely managed sanitation services. Improved sanitation facilities include flush/pour flush toilets connected to piped sewer systems, septic tanks or pit latrines; pit latrines with slabs (including ventilated pit latrines), and composting toilets
Denominator	Total population
Main data sources	Population-based household surveys and censuses
Method of measurement	Data on improved sanitation facilities are routinely collected in household surveys and censuses. These data sources may also collect information on sharing of sanitation facilities are shared among two or more households, and on emptying of on-site sanitation facilities. Household-level responses, weighted by household size, are used to compute population coverage.
Method of estimation	The WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP) is responsible for SDG reporting on drinking water, sanitation and hygiene (WASH) and has produced regular estimates of coverage of the population using at least basic sanitation services since 2000. The JMP assembles, reviews and assesses national data collected by statistics offices and other relevant institutions including sectoral authorities. Linear regression is used to provide estimates of the population using improved sanitation facilities, as well as the proportion practising open defecation. Regressions are also made to estimate the population using improved sanitation facilities connected to sewers and septic tanks; these are constrained to not exceed the estimates for total improved facilities. The proportion of the population sharing sewer and non-sewered sanitation facilities is estimated by making a linear regression on all available data on sharing from household surveys and censuses. Basic sanitation services are calculated by multiplying the proportion of the population using improved sanitation facilities by the proportion of improved sanitation facilities which are not shared among two or more households. Separate estimates are made for urban and rural areas, and national estimates are generated as weighted averages of the two, using population data from the most recent report of the United Nations Population Division. The most recent household survey or census available for most countries was typically conducted two to six years ago. The JMP extrapolates regressions for two years beyond the last available data point. Beyond this point the estimates remain unchanged for up to four years unless coverage is below 0.5 per cent or above 99.5 per cent, in which case the line is extended indefinitely. For more information see https://washdata.org/monitoring/methods/estimation-methods
UHC-related notes	The SDG global indicator of “proportion of population using safely managed sanitation services” (SDG 6.2.1a) is an expanded version of the MDG indicator, which additionally considers safe management of excreta along the entire sanitation chain, including treatment and disposal This indicator is not used for UHC monitoring due to lower data availability.

Tracer area	Prevention of cardiovascular disease
Indicator definition	Coverage of treatment (taking medicine) for hypertension among adults aged 30-79 years with hypertension (age-standardized estimate) (%)
Numerator	Number of adults aged 30-79 years who took medication for hypertension
Denominator	Number of adults aged 30-79 years with hypertension (defined as having systolic blood pressure \geq 140 mmHg, diastolic blood pressure \geq 90 mmHg, or taking medication for hypertension)
Main data sources	Population-based surveys and surveillance systems
Method of measurement	Data sources recording measured blood pressure are used (self-reported data are excluded). If multiple blood pressure readings are taken per participant, the first reading is dropped and the remaining readings are averaged. Whether medication is taken for hypertension may be assessed using questions worded as variations of “Are you currently taking any medicines, tablets, or pills for high blood pressure?” or “In the past 2 weeks, have you taken any drugs (medication) for raised blood pressure prescribed by a doctor or other health worker?” In studies that gather information on prescribed medicines, survey information may be used to establish that the purpose of taking a blood pressure-lowering drug was specifically to treat hypertension.
Method of estimation	Full details of input and data methods are available at: NCD Risk Factor Collaboration (NCD-RisC). Worldwide trends in hypertension prevalence and progress in treatment and control from 1990 to 2019: a pooled analysis of 1201 population-representative studies with 104 million participants. The Lancet S0140-6736(21)01330-1 (https://www.thelancet.com/article/S0140-6736(21)01330-1/fulltext). A total of 1,201 population-based studies that included measured blood pressure and data on blood pressure treatment in 104 million individuals aged 30–79 years were used to estimate trends in hypertension and hypertension diagnosis, treatment and control from 1990 to 2019. Age-standardized estimates are produced by applying the crude estimates to the WHO Standard Population.
UHC-related notes	The denominator population used for weighting can also be found at the Lancet article provided above.

Tracer area	Management of diabetes
Indicator definition	Coverage of treatment (taking medication) for diabetes among adults aged 30 years and over with diabetes (age-standardized estimate)
Numerator	Number of adults aged ≥ 30 years with diabetes who are currently taking glucose-lowering medication
Denominator	Total number of adults aged ≥ 30 years with diabetes, defined as fasting plasma glucose (FPG) ≥ 7.0 mmol/L, glycated haemoglobin (HbA1c) $\geq 6.5\%$, or taking medication for diabetes
Main data sources	Population-based surveys and surveillance systems
Method of measurement	Whether medication is taken for diabetes may be assessed using questions worded as variations of “Are you currently taking insulin for diabetes?” or “In the past two weeks, have you taken any drugs (medication) for diabetes prescribed by a doctor or other health worker?” Fasting plasma glucose (FPG) and/or haemoglobin A1c (HbA1c) levels are used to identify individuals who have raised blood sugar but are not being treated for diabetes. FPG levels are determined by taking a blood sample from participants who have fasted for at least 8 hours.
Method of estimation	Data observations based on FPG or HbA1c are harmonised to obtain comparable estimates that reflect both biomarkers. A Bayesian hierarchical model is then fitted to these data to calculate age-sex-year-country specific prevalences, which accounts for national vs. subnational data sources, urban vs. rural data sources, and allows for variation in prevalence across age and sex. Age-standardized estimates are then produced by applying the crude estimates to the WHO Standard Population. Further details can be found here: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(24)02317-1/fulltext
UHC-related notes	The denominator population used for weighting can also be found at the Lancet article provided above.

Tracer area	Tobacco control
Indicator definition	Age-standardized percentage of the population aged 15 years and over who currently use any tobacco product (smoked and/or smokeless tobacco) on a daily or non-daily basis.
Numerator	Estimated number of adults 15 years and older who currently use any tobacco product (smoked and/or smokeless tobacco) on a daily or non-daily basis
Denominator	Total number of adults 15 years and older
Main data sources	Household surveys
Method of measurement	Tobacco products include cigarettes, pipes, cigars, cigarillos, waterpipes (hookah, shisha), bidis, kretek, heated tobacco products, and all forms of smokeless (oral and nasal) tobacco. Tobacco products exclude e-cigarettes (which do not contain tobacco), “e-cigars”, “e-hookahs”, JUUL and “e-pipes”.
Method of estimation	A statistical model based on a Bayesian negative binomial meta-regression is used to model prevalence of current tobacco use for each country, separately for men and women. A full description of the method is available as a peer-reviewed article in <i>The Lancet</i> , volume 385, No. 9972, p966–976 (2015). Once the age-and-sex-specific prevalence rates from national surveys were compiled into a dataset, the model was fit to calculate trend estimates from the year 2000 to 2025. The model has two main components: (a) adjusting for missing indicators and age groups, and (b) generating an estimate of trends over time as well as the 95% credible interval around the estimate. Depending on the completeness/comprehensiveness of survey data from a particular country, the model at times makes use of data from other countries to fill information gaps. When a country has fewer than two nationally representative population-based surveys in different years, no attempt is made to fill data gaps and no estimates are calculated. To fill data gaps, information is “borrowed” from countries in the same UN subregion. The resulting trend lines are used to derive estimates for single years, so that a number can be reported even if the country did not run a survey in that year. In order to make the results comparable between countries, the prevalence rates are age-standardized to the WHO Standard Population. Estimates for countries with irregular surveys or many data gaps will have large uncertainty ranges, and such results should be interpreted with caution.
UHC-related notes	Prevalence of tobacco non-use is computed as 1 minus the prevalence of tobacco use. The indicator is then rescaled based on a non-zero minimum to obtain finer resolution : rescaled tobacco non-use = $(X-30)/(100-30)*100$.

Tracer area	Hospital access
Indicator definition	Hospital beds per capita, relative to a maximum threshold of 18 per 10,000 population
Numerator	Number of hospital beds (should exclude labor and delivery beds)
Denominator	Total population
Main data sources	Administrative systems / Health facility reporting system
Method of measurement	Country administrative systems are used to total the number of hospital beds, which are divided by the total estimated population, and multiplied by 10,000.
Method of estimation	<p>Using available data, the indicator is computed relative to a threshold value of 18 hospital beds per 10,000 population. This threshold is below the observed OECD high income country minimum (since year 2000) of 20 per 10,000 (OECD Health Statistics database, 2015 edition) and tends to correspond to an inpatient hospital admission rate of around 5 per 100 per year. This indicator is designed to capture low levels of hospital capacity; the maximum threshold is used because very high hospital bed densities are not necessary an efficient use of resources. The indicator is computed as follows, using country data on hospital bed density (x), which results in values ranging from 0 to 100:</p> <ul style="list-style-type: none"> • Country with a hospital bed density $x < 18$ per 10,000 per year, the indicator = $x / 18 * 100$. • Country with a hospital bed density $x \geq 18$ per 10,000 per year, the indicator = 100.
UHC-related notes	This indicator is used as proxy for the full coverage of inpatient care services. An alternative indicator could be hospital in-patient admission rate, relative to a maximum threshold. However, that indicator is currently not reported widely across regions, in particular the African Region. In countries where both hospital beds per capita and in-patient admission rates are available, they are highly correlated.

Tracer area	Health workforce
Indicator definition	Health workers (medical doctors, nursing and midwifery personnel) per capita, relative to a combined maximum threshold
Numerator	Number of medical doctors, nursing and midwifery personnel
Denominator	Total population
Main data sources	<p>In response to the Sixty-ninth World Health Assembly (WHA69.19), an online National Health Workforce Accounts (NHWA) data platform was developed to facilitate national reporting. In addition to the reporting, the platform also serves as an analytical tool at the national/regional and global levels. Since its launch in November 2017, Member States are called to use the NHWA data platform to report health workforce data. Complementing the national reporting through the NHWA data platform, additional sources such as the National Census, Labour Force Surveys and key administrative national and regional sources are also employed and validated by the countries. Most of the data from administrative sources are derived from published national health sector reviews and/or official country reports to WHO offices.</p>
Method of measurement	<p>Countries are encouraged to adopt a progressive NHWA implementation approach building on multistakeholder engagement at national and sub-national levels. National focal points share the data with WHO through the online NHWA data platform. The platform hosted in WHO, is built to facilitate data reporting on the indicators listed in the NHWA Handbook and data sharing across all the 3 levels of WHO.</p> <p>Health workforce data can be accessed on the NHWA data portal: https://apps.who.int/nhwportal/</p>
Method of estimation	<p>Using available data, the indicator is computed relative to a threshold value of 6 medical doctors, nursing and midwifery personnel per 1,000 population which is the 5th percentile across densities from high income countries in 2013 (baseline year used for health workforce in the Sixty-ninth World Health Assembly (WHA69.19)). This rescaling is done in the same way as that for the hospital bed density indicator described above, resulting in indicator values that range from 0 to 100. Using country data on medical doctors, nursing and midwifery personnel per 1000 population (x), the indicator would be computed as:</p> <ul style="list-style-type: none"> • Country with $x < 6$ per 1000 per year, the indicator = $x / 6 * 100$. • Country with $x \geq 6$ per 1000 per year, the indicator = 100.
UHC-related notes	<p>It should be noted that measuring coverage in all health areas is difficult and the optimal level for these indicators is unknown and they do not relate to a specific need for services. Despite this fact, low levels for these indicators are indicative of poor access to and use of essential health services.</p>

Tracer area	Health security
Indicator definition	<p>International Health Regulations (IHR) core capacity index, which is the average percentage of attributes of all core capacities that have been attained at a specific point in time.</p> <p>The second edition SPAR tool has been expanded from 13 to 15 capacities. The 15 core capacities are (1) Policy, legal and normative instruments to implement IHR; (2) IHR Coordination and National Focal Point Functions; (3) Financing; (4) Laboratory; (5) Surveillance; (6) Human resources; (7) Health emergency management (8) Health Service Provision; (9) Infection Prevention and Control; (10) Risk communication and community engagement; (11) Points of entry and border health; (12) Zoonotic diseases; (13) Food safety; (14) Chemical events; (15) Radiation emergencies.</p> <p>The 13 core capacities of the first edition of the IHR State Parties Annual Assessment and Reporting Tool are (1) Legislation and financing; (2) IHR Coordination and National Focal Point Functions; (3) Zoonotic events and the Human-Animal Health Interface; (4) Food safety; (5) Laboratory; (6) Surveillance; (7) Human resources; (8) National Health Emergency Framework; (9) Health Service Provision; (10) Risk communication; (11) Points of entry; (12) Chemical events; (13) Radiation emergencies.</p> <p>Both SPAR questionnaires (1st and 2nd editions) use a five-level scoring with indicators based on five cumulative levels to measure the implementation status for each capacity. For each indicator, the reporting State Party is asked to select which of the five levels best describes the State Party's current status. To move to the next level, all capacities described in previous levels should be in place for each indicator.</p> <p>For the years 2010 to 2017, Member States used the IHR monitoring questionnaire. The questionnaire is divided into thirteen sections, one for each of the eight core capacities, PoE and four hazards. Individual questions are grouped by components and indicators in the questionnaires. States Parties can provide additional information on the questions in the comment boxes. Responses to the questions include marking one appropriate value (Yes, No, or Not Known) or the appropriate percentages. For statistical purposes, the "Not Known" value will be computed as a "No" value. The IHR monitoring questionnaire includes the following: IHR01. National legislation, policy and financing; IHR02. Coordination and National Focal Point communications; IHR03. Surveillance; IHR04. Response; IHR05. Preparedness; IHR06. Risk communication; IHR07. Human resources; IHR08. Laboratory; IHR09. Points of entry; IHR10. Zoonotic events; IHR11. Food safety; IHR12. Chemical events; IHR13. Radio nuclear emergencies.</p>
Numerator	Number of attributes attained
Denominator	Total number of attributes
Main data sources	Key informant survey
Method of measurement	Key informants report on attainment of a set of attributes for each of the core capacities using a standard WHO instrument. This instrument is based on a self-assessment and self-reporting by the State Party. There are three datasets based on the different tools to collect data for SPAR. For the period 2010 to 2017, the questionnaire, known as the IHR monitoring questionnaire, is divided into thirteen sections, one for each of the eight core capacities, PoE and four hazards and information on the status of implementation for each capacity. The IHR monitoring questionnaire (2010

	<p>to 2017) was replaced by the IHR State Parties Self-Assessment Tool – SPAR, published in July 2018 also known as SPAR 1st edition. The States Parties used the questionnaire from the 2018 – 2020 SPAR reporting cycle. The current questionnaire replaced the SPAR 1st edition and was used by the Member States for 2021. Under each capacity, the indicators were either retained, replaced or added. Historical trends based on the data for similar capacity titles may be taken with caution.</p>
Method of estimation	<p>The score of each indicator level is classified as a percentage of performance along the “1 to 5” scale. e.g. for a country selecting level 3 for indicator 2.1, the indicator level will be expressed as: $3/5 \times 100 = 60\%$</p> <p>CAPACITY LEVEL The level of the capacity is expressed as the average of all indicators. e.g. for a country selecting level 3 for indicator 2.1 and level 4 for indicator 2.2. Indicator level for 2.1 will be expressed as: $3/5 \times 100 = 60\%$, indicator level for 2.2 will be expressed as: $4/5 \times 100 = 80\%$ and capacity level for 2 will be expressed as: $(60+80)/2 = 70\%$</p>
UHC-related notes	<p>Countries began reporting IHR core capacity attainment to WHO for the year 2010. The earliest available IHR score for each country is used for all years 2000-2009.</p> <p>Total population from the United Nations population estimates are used for the weighting instead of the defined denominator listed in the table.</p>