



Shared Prosperity Dignified Life



World Health  
Organization



Series of SDG Webinars for the Arab Region:  
WHO & UNICEF  
SDG 2.2.1, 2.2.2, 2.2.3, 3.4.2 and 3.5.2

*An Interagency and Experts Collaboration to Improve the Production and Dissemination of SDG Indicators from Official National Sources*

*15 and 16 December*

**Report of the meeting**

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## BACKGROUND

### The need to improve the production and dissemination of reliable comparable and timely data on SDG

In September 2015, the United Nations General Assembly adopted consensus Resolution 70/1: Transforming our world: the 2030 Agenda for Sustainable Development (the 2030 Agenda). The Resolution reaffirms the need for the strengthening of national data systems through “collaboration between national statistical systems and the relevant international and regional organizations to enhance data reporting channels and ensure the harmonization and consistency of data and statistics for the indicators used to follow up and review the Sustainable Development Goals and targets”.

The resolution also urges countries, the specialized agencies, the regional commissions, and the Bretton Woods institutions among others “to intensify their support for strengthening data collection and statistical capacity-building, including capacity-building that strengthens coordination among national statistical offices”. Moreover, the resolution “Urges international organizations to base the global review on data produced by national statistical systems and, if specific country data are not available for reliable estimation, to consult with concerned countries to produce and validate modelled estimates before publication, urges that communication and coordination among international organizations be enhanced to avoid duplicate reports, ensure consistency of data and reduce response burdens on countries, and urges international organizations to provide the methodologies used to harmonize country data for international comparability and produce estimates through transparent mechanisms;”

Five years after the adoption of the 2030 Agenda several countries are facing considerable challenges in monitoring targets in many policy areas. The current COVID-19 pandemic highlights the value of measuring and monitoring: no strategy can be developed, and no measure can be implemented without a proper monitoring and evaluation system.

Many countries in the Arab region are reporting on SDG indicators, however, reporting on progress on many of the SDG indicators, remains limited in the region. Insufficient availability and quality of statistical information on SDG indicators hamper the capacity of policymakers to generate evidence-based and effective policy responses and implement the 2030 Agenda.

Translating these recommendations and resolutions into tangible results is imperative and will require intensive collaboration at the national, regional, and global levels. Regional Commissions' Statistical bodies "are the nexus between the Statistical Commission at the global level and the implementation at the national level of the norms endorsed by the Commission. In the context of the 2030 Agenda, the support provided by the regional commissions to assist the Member States in adapting, implementing, and measuring progress towards the implementation of national development plans is of particular significance as it influences the quality of statistics and methodologies used, as well as the use of new and innovative methodologies and sources of data, known as the transformative agenda for official statistics. The regional commissions carry out activities to strengthen the capacity of Member States to produce, use and dissemination official statistics and also provide a regional platform for sharing experiences and practices in statistics work<sup>1</sup>.”

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<sup>1</sup> Source: Relevance and effectiveness of the statistical work of regional commissions - thematic evaluation of regional commissions, Committee for Programme and Coordination, 57th session, April 2017 (E/AC.51/2017/8)

## Interagency and Experts Collaboration- ESCWA, WHO & UNICEF

In this context, the Economic and Social Commission for Western Asia (ESCWA) implemented an assessment on the availability of country data in the UNSD SDG Global database to identify those less reported by countries and/or less understood by national statistical offices (NSOs), and more estimated by UN Agencies or not reported on. Based on the assessment results, ESCWA in collaboration with relevant custodian agencies will organize virtual capacity development workshops on selected indicators for Arab countries to improve the production and dissemination of SDG indicators from official national sources.

ESCWA, WHO, and UNICEF discussed the organization of a joint webinar to build capacities of Arab countries to produce and use data for four SDG indicators.

### OBJECTIVE- WHY?

The United Nations Economic and Social Commission for Western Asia (UN ESCWA), in collaboration with WHO and UNICEF, custodians of SDG indicators, is organizing a series of webinars on selected SDG indicators that are less produced in the Arab region to create a common understanding among data producers on how to collect, measure and disseminate SDG indicators to increase data production and enhance national data flow to policymakers, other users, and custodian agencies.

The main objectives of the regional training are:

- Enhancing understanding of metadata and nature of data in the UNSD SDG database.
- Improving statistical capacities to stimulate production and use of comparable SDG indicators.
- Strengthening inter-institutional coordination to invigorate production of SDG indicators and data flow.
- Sharing and discussing country challenges in measuring SDG indicators

### TARGET AUDIENCE - WHO?

The meeting was attended by 28 representatives from 14 national statistical offices namely: Algeria, Egypt, Iraq, Kuwait, Lebanon, Libya, Morocco, Oman, Palestine, Saudi Arabia, Somalia, Sudan, Switzerland, and Yemen. Also, there were representatives from WHO.

### SCHEDULE AND LANGUAGE - WHEN?

The regional training was held on 15 and 16 of December from 10:00 A.M. to 12:00 P.M and 10:00 A.M. to 12:15 P.M. respectively Beirut time via Zoom. Facilitation of the workshop was conducted in Arabic/English with simultaneous interpretation in English and Arabic languages.

### OUTCOME- FINDINGS AND RECOMMENDATIONS

The participants from NSOs and other relevant stakeholders were familiarized with concepts, methods including data flow and dissemination channels. The webinar encouraged interactive dialogue and participants were invited to share national experiences in data collection and dissemination including challenges and concerns. Presentations to the meetings were made available in the Arabic and English

languages. A record of the discussions is provided in Annex on Q&A of this report. The full webinar proceedings were recorded to develop training material.

2.2.1 Prevalence of stunting (height for age  $<-2$  standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age and 2.2.2 Prevalence of malnutrition (weight for height  $>+2$  or  $<-2$  standard deviations from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight)

SDGs 2.2.1 and 2.2.2, stunting are defined as height for age less than minus two standard deviations from the median of WHO, severe wasting as a weight for height less than minus three standard deviations, wasting as a weight for height less than minus two standard deviation and overweight as a weight for height greater than two standard deviations.

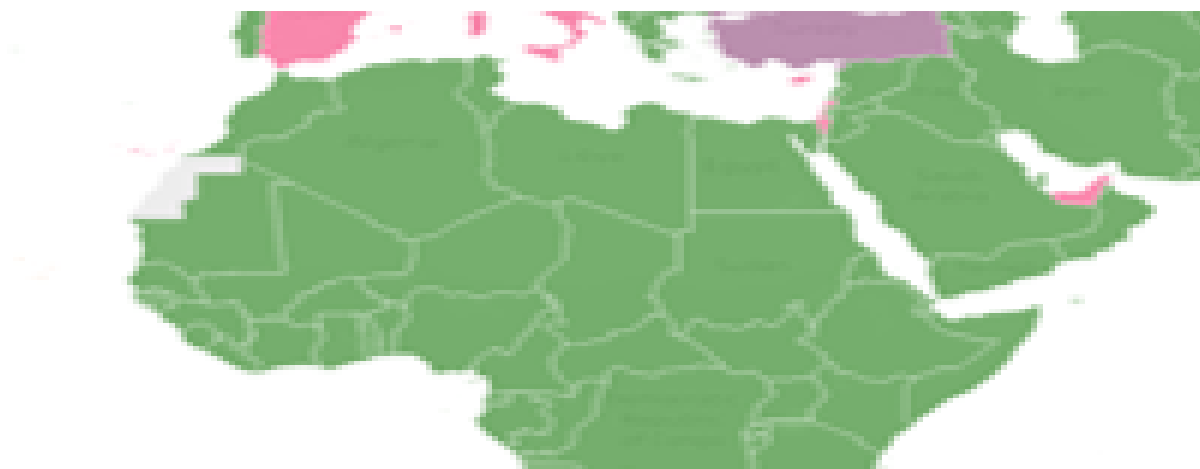
For the majority of countries, nationally representative household surveys constitute the data source. For a limited number of countries data from surveillance systems is used if sufficient population coverage is documented (about 80%). The child's height and weight measurements have to be collected following recommended standard measuring techniques for both data sources. Given the limited number of surveys implemented by countries and the data gaps, the JME group<sup>2</sup> has implemented a new Mixed effect model with random effects for countries to produce comparable estimates for the missing years.

Country data stored in the JME database undergo a systematic review of the primary sources of data (e.g. surveys). A standardized format is used to record information about sampling, training, field teams, equipment, sample coverage, data quality checks (missing values, age distribution, measurement position, digit preferences, implausible values, and standard deviation), estimates and trends, programme context and information, and overall assessment and consensus. This format is used to provide feedback for countries on why a survey is not included in the database.

This systematic review is followed by a country consultation process with SDG focal points to communicate data to be submitted to UNSD.

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<sup>2</sup> JME: Joint Malnutrition Estimates group composed by UNICEF, WHO and the World Bank



For the ESCWA Region, almost 86 per cent of the countries have both stunting and overweight estimates.

Indicators	UNSD SDG Database (C-CA)	UNSD SDG Database (E-M-N-NA-G)	SDG in a national report
2.2.1 Prevalence of stunting (height for age <-2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age	3 (C): Kuwait, Libya, Oman  19 (CA): missing Bahrain, Qatar	3 (E): Iraq, Syrian Arab Republic, Tunisia  21 (M): missing UAE	Qatar, Saudi Arabia  = Algeria, Libya, Oman, Sudan, State of Palestine  ≠ Morocco, Lebanon, Somalia  ≈ Egypt, Iraq, Jordan, Yemen, Tunisia

*C: country data, CA: country adjusted data, E: estimated data, G: global monitoring data, M: modeled data, N: non-relevant data, NA: data nature not available as presented in UNSD SDG database, =: National data same as Country data, ≈: National data nearly same as Country data, ≠National data is not equal to Country data*

Indicators	UNSD SDG Database (C-CA)	UNSD SDG Database (E-M-N-NA-G)	SDG in a national report
2.2.2 Prevalence of malnutrition (weight for height >+2 or <-2 standard deviations from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight)	3 (C): Kuwait, Libya, Oman  19 (CA): missing Bahrain, Qatar	3 (E): Iraq, Syrian Arab Republic, Tunisia  21 (M): missing UAE	Morocco, Comoros, Qatar, Saudi Arabia, Somalia (Overweight)  = Algeria, Libya (Overweight), Iraq, Oman (Wasted), Sudan, Tunisia, State of Palestine  ≠ Egypt, Jordan, Lebanon, Libya (Wasted), Somalia (Wasted), Oman (Overweight)  ≈ Yemen

*C: country data, CA: country adjusted data, E: estimated data, G: global monitoring data, M: modeled data, N: non-relevant data, NA: data nature not available as presented in UNSD SDG database, =: National data same as Country data, ≈: National data nearly same as Country data, ≠National data is not equal to Country data*

### Recommendations for Countries:

- Countries are encouraged to use the data reported on UNSD SDG Database and disseminate it in their VNR and SDG reports.
- Countries are encouraged to nominate focal points from Ministries of Health

- Countries are encouraged to share the reports and raw datasets from national surveys including anthropometry with the JME group through their WHO and UNICEF country offices to be considered for inclusion on its database and in the estimates to be reported to UNSD to track related SDGs. Details on the format and the type of variables needed can be found in Annex 6

#### Recommendations for ESCWA/WHO:

- The JME group can build capacities in countries by providing training on the tools developed (WHO Anthro Survey Analyzer, WHA Global Nutrition Targets Tracking Tool, etc.);

#### 2.2.3 Prevalence of anemia in women aged 15 to 49 years, by pregnancy status (percentage)

The Micronutrients Database in WHO Vitamin and Mineral Information System (VMNIS) is an interactive platform for summarizing data on the micronutrient status of populations from countries Ministries of Health through WHO regional and country offices, National research and academic institutions, non-governmental organizations, organizations of the UN system, reports and peer-review publications generated by partners or implementing partners and peer-review publications found literature search.

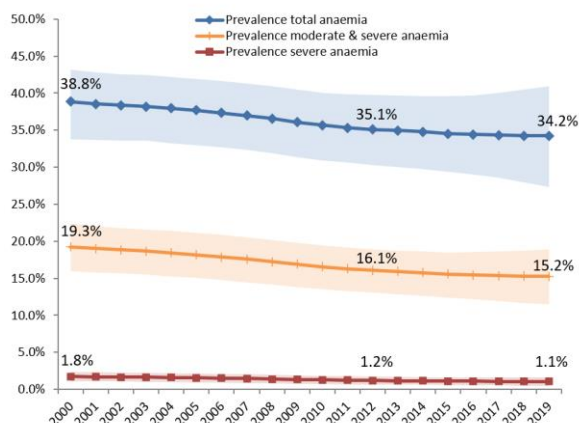
These data are stored in the database based on:

- Sampling frame of a defined population
- Sample representative at national, regional, and 1st admin level
- Population-based, household-based, or facility-based sample (complying with representativeness)
- Cross-sectional sample or baseline assessment of interventions
- Standard, validated data collection techniques and laboratory methodology

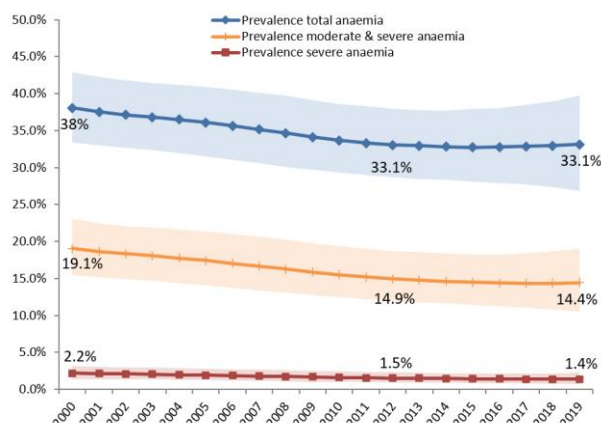
Data from this database as well as individual level data, when available, are then used to monitor progress on SDG 2.2.3 by using a **Bayesian hierarchical mixture** that calculates anemia prevalence estimates for children aged 6-59 months and pregnant and non-pregnant women aged 15-49 years old for each country and year, informed by data from that country and year themselves, if available, and by data from other years in the same country and in other countries with data for similar periods, especially countries in the same region. The resulting estimates are adjusted for altitude and smoking and informed by covariates that help predict blood hemoglobin concentrations (e.g. socio-demographic index, meat supply (kcal/capita), mean BMI for women, and a log of under-five mortality for under-five children).

Even though the ESCWA region has registered decreasing anemia prevalence rates for pregnant and non-pregnant women between 2000 and 2019 as shown in the graphs below, this region is still ranked five among the seven UN regions in terms of anemia prevalence rate.

### Pregnant women



### Non-pregnant women 15-49 years of age



Indicators	UNSD SDG Database (C-CA)	UNSD SDG Database (E-M-N-NA-G)	SDG in the national report
2.2.3 Prevalence of anemia in women aged 15 to 49 years, by pregnancy status (percentage)	0	10 (E): Bahrain, Egypt, Iraq, Jordan, Lebanon, Morocco, Oman, Somalia, Tunisia, Yemen  11 (M): Algeria, Comoros, Djibouti, Kuwait, Libya, Mauritania, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic, UAE	Jordan

C: country data, CA: country adjusted data, E: estimated data, G: global monitoring data, M: modeled data, N: non-relevant data, NA: data nature not available as presented in UNSD SDG database, =: National data same as Country data, ≈: National data nearly same as Country data, ≠National data is not equal to Country data

### Recommendations for Countries:

- Countries are encouraged to use the data reported on UNSD SDG Database and disseminate it in their VNR and SDG reports.
- Countries are encouraged to nominate focal points from Ministries of Health.
- Countries are encouraged to share the reports and raw datasets from national surveys including anaemia and other micronutrients through their WHO and UNICEF country offices to be considered for inclusion on the database and in the estimates to be reported to UNSD to track related SDG.

### Recommendations for ESCWA/WHO:

- To promote tools and documents to help countries assessing the micronutrient status of their populations, such as the Micronutrient survey manual.



## The WHA Nutrition Targets Tracking Tool

WHO jointly with UNICEF and the European Commission has developed the Global Nutrition Targets Tracking Tool to assist countries in setting their national targets and monitor progress towards 2025 and in the near future towards 2030. This tool enables monitoring progress against SDGs including anthropometric indicators and anemia and the other global nutrition targets: breastfeeding and low birth weight.

This tool is updated yearly and is constituted of 3 modules:

- Module 1: Country Indicator profile. This module helps countries to check their current situation, explore different scenarios from the actual year until 2025 according to their context, monitor progress towards their targets and create their progress report.
- Module 2: Indicator mapping. It is used to compare the latest prevalences and numbers affected with other neighbouring countries (regional), or globally.
- Module 3: Global and regional overview to monitor the country's performance towards targets and compare it with other neighboring countries or globally.

### 3.4.2 Suicide mortality rate

This indicator relates to target 3.4 of the SDGs which is to reduce by one-third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being. It is as well reflected in the WHO General Programme of Work and their mental health action plan. The Suicide mortality rate is defined as the number of suicide deaths in a year, divided by the population, and multiplied by 100 000.

The preferred data source is a well-functioning civil registration and vital statistics system (CRVS) with complete coverage and medical certification of cause of death, coded using the international classification of diseases (ICD-10) (particularly in the case of suicide a coroner or other legal authority is involved). Alternative methods to collect information on causes of death, including suicide, include sample registration systems, hospital data, burial systems, mortuaries, household surveys, clinical autopsy, and others.

For the suicide attempts, the preferred source of data is hospital data and nationally representative population-based surveys such as STEPs Survey and Global School-based Student Health Survey.

Globally, the majority of suicide happen in low-and-middle-income countries with around ¾ of all suicide cases and the highest suicide rates are found in high-income countries. The quality and availability of data on suicide and suicide attempts are poor globally. Only 60 countries have good-quality vital registration data on suicide mortality and 20 countries are known to have gathered national survey data and 3 have national hospital-based suicide attempt data. For the ESCWA Region, suicide rates tend to be low, below the global average. However, the majority of these countries have severe data quality issues or do not have death registration systems. Only Kuwait has good quality data denoting multiple years of national death registration data with high completeness and quality of cause-of-death assignment are available.

The problem of poor-quality mortality data is likely to be related to the under-reporting and misclassification of suicide given the sensitivity and the illegality of suicidal behavior in some countries. Suicides are most commonly found misclassified according to the codes of the 10th edition of the International Classification of Diseases and Related Health Conditions (ICD-10) as “deaths of undetermined intent” (ICD-10 codes Y10-Y34), and also as “accidents” (codes V01-X59), “homicides” (codes X85-Y09) and “unknown cause” (codes R95-R99).

Therefore, WHO has developed the CRVS Strategic Implementation Plan 2021-2025 to accelerate the strengthening of the CRVS system in countries. It provides leadership and guidance to strengthen the capacity of the health sector in countries to notify all births and deaths and ensure that all causes of death are comprehensively assigned and correctly certified.

WHO is as well developing an additional practice manual for establishing and implementing suicide attempt and self-harm surveillance systems.

This indicator is being estimated for 13 countries of the 22 Arab Countries and modelled for another 8. None of these countries has reported the same data in their VNR or SDG national reports.

Indicators	UNSD SDG Database (C-CA)	UNSD SDG Database (E-M-N-NA-G)	SDG in a national report
3.4.2 Suicide mortality rate	0	13 (E): Bahrain, Egypt, Iraq, Jordan, Kuwait, Lebanon, Morocco, Oman, Qatar, Saudi Arabia, Syrian Arab Republic, Tunisia, UAE  8 (M): Algeria, Comoros, Djibouti, Libya, Mauritania, Somalia, Sudan, Yemen	Egypt, Algeria

*C: country data, CA: country adjusted data, E: estimated data, G: global monitoring data, M: modeled data, N: non-relevant data, NA: data nature not available as presented in UNSD SDG database, =: National data same as Country data, ≈: National data nearly same as Country data, ≠ National data is not equal to Country data*

#### Recommendations for Countries:

- Countries are encouraged to use the data reported on UNSD SDG Database and disseminate it in their VNR and SDG reports.
- Countries are encouraged to nominate focal points from Ministries of Health
- Countries are encouraged to conduct the STEPs Survey and Global School-based Student Health Survey

#### Recommendations for ESCWA/WHO:

- ESCWA and WHO to help countries conduct the surveys by providing additional training if needed.

#### 3.5.2 Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol

This indicator falls under target 3.5 to strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. The indicator harmful use of alcohol is defined

according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol.

Total alcohol per capita (15+ years) consumption (APC) is defined as the total (sum of three-year average recorded APC and unrecorded APC adjusted for tourist consumption) amount of pure alcohol consumed per adult (15+ years), in a calendar year, in litres of pure alcohol:

- 1- Recorded alcohol per capita (15+) consumption of pure alcohol is calculated as the sum of beverage-specific alcohol consumption of pure alcohol (beer, wine, spirits, other) from different sources. The priority in the decision tree is given to government national statistics; second are country-specific alcohol industry statistics in the public domain based on interviews or fieldwork; third is the Food and Agriculture Organization of the United Nations' statistical database (FAOSTAT), and fourth is data from alcohol industry statistics in the public domain based on desk review. If in doubt, the Steering Committee can decide to use a preferable source based on consensus and in consultation with the government. If beverage volumes are not available in litres of pure alcohol, they are transformed into litres of pure alcohol. The alcohol content (% alcohol by volume) differs between beer, wine, and spirits.  
To gather the recorded APC data, each country should check with their national statistics office, institute or department and/or ministry or department of finance, taxation, revenue or customs and/or other similar body about the availability of sales or taxation data, or data on production, import, and export by type of alcoholic beverage with an indication of alcohol content.
- 2- The unrecorded alcohol consumption refers to alcohol that is not taxed and is outside the usual system of governmental control, such as home or informally produced alcohol (legal or illegal), smuggled alcohol, surrogate alcohol (which is alcohol not intended for human consumption), or alcohol obtained through cross-border shopping (which is recorded in a different jurisdiction). The priority in the decision tree is given to nationally representative empirical data; second to specific other empirical investigations and third to expert opinion, including special exercise with nominal group technique. To gather this data, each country should check whether the government or a governmental entity has carried out a specific investigation into unrecorded alcohol and made the results available in a report or other document that can be accessed. If not, it is suggested to conduct the WHO STEPwise approach to surveillance (STEPS) survey including the alcohol module. Otherwise, a Delphi survey (nominal group technique) on unrecorded alcohol could be conducted.
- 3- Tourist consumption takes into account tourists visiting the country and inhabitants visiting other countries. Tourism data are derived from Tourism Statistics of the UN Statistics Division.
- 4- Population data is to be derived from UN World Population Prospects, medium variant.

This indicator is collected every four years through the Global Survey on Alcohol and Health in collaboration with WHO regional offices. National counterparts or focal points in all WHO Member States are officially nominated by the respective ministries of health. The survey submissions are checked and whenever information is incomplete or in need of clarification, the questionnaire is returned to the focal point or national counterpart in the country concerned for revision. Data submitted by countries are triangulated with data from key industry-supported data providers and WHO estimates for this indicator are compiled into each country profile which is sent to alcohol focal points or alcohol national

counterparts for validation/endorsement. All the estimates are then incorporated into the Global Status Report on Alcohol, WHO Global Information System on Alcohol and Health, and sent to the UNSD Global Database.

Indicators	UNSD SDG Database (C-CA)	UNSD SDG Database (E-M-N-NA-G)	SDG in a national report
3.5.2 Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol	0	20 (G): missing Sudan, State of Palestine	Morocco, Qatar, Tunisia

*C: country data, CA: country adjusted data, E: estimated data, G: global monitoring data, M: modeled data, N: non-relevant data, NA: data nature not available as presented in UNSD SDG database, =: National data same as Country data, ≈: National data nearly same as Country data, ≠National data is not equal to Country data*

### Recommendations for Countries:

- Countries are encouraged to use the data reported on UNSD SDG Database and disseminate it in their VNR and SDG reports.
- Countries are encouraged to nominate focal points from Ministries of Health
- Focal points are encouraged to consult with other experts from the countries to fill in the survey.

### Recommendations for ESCWA/WHO:

- ESCWA and WHO to approach the two countries with missing data for this indicator to make sure what's the problem and to encourage them to start the process of collecting data.
- WHO to reconsider labeling nature from "Global" to 'Country' or "Country adjusted, as seems appropriate, based on the fact that the indicator is based on country data.

## ATTENDANCE AND EVALUATION

An electronic evaluation was completed during the 2 days webinar. The results were as follows:

An electronic evaluation was completed by 12 participants during Day 1/15 Dec 2022 webinar. The results were as follows:

Q1: How do you rate the overall quality of this Webinar?								
Q2: How successful was the webinar in reaching its intended objectives?								
Q3: How would you evaluate the inputs provided by the presenters in reaching the intended outcome of the webinar?								
Q4: How would you evaluate the overall organization and logistics of the webinar?								
Indicator	Date	# of Submitted Evaluations	Excellent	Good	Fair	Excellent %	Good %	Fair %
	15-Dec-21							
Q1		12	8	4	0	67%	33%	0%
Q2		12	8	4	0	67%	33%	0%
Q3		12	8	4	0	67%	33%	0%
Q4		12	9	3	0	75%	25%	0%

An electronic evaluation was completed by 11 participants during Day 2/16 Dec 2022 webinar. The results were as follows:

Q1: How do you rate the overall quality of this Webinar?								
Q2: How successful was the webinar in reaching its intended objectives?								
Q3: How would you evaluate the inputs provided by the presenters in reaching the intended outcome of the webinar?								
Q4: How would you evaluate the overall organization and logistics of the webinar?								
Indicator	Date	# of Submitted Evaluations	Excellent	Good	Fair	Excellent %	Good %	Fair %
	<b>16-Dec-21</b>							
Q1		11	7	4	0	64%	36%	0%
Q2		11	7	4	0	64%	36%	0%
Q3		11	7	4	0	64%	36%	0%
Q4		11	8	3	0	73%	27%	0%

#### TRAINING CERTIFICATION

Participants who successfully attended the ESCWA SDG webinar were awarded a training certificate by the organizers.

## GROUP PHOTOS

Zoom Meeting

Recording...

Alexandra Fleischmann	Joelle Atallah	Neda Jafar	wedad ALGHARYANI	lubn abd
Lisa Rogers	Elisa Dominguez	Monica Flores Urrutia	Safaa Lazim	zainab ali
Interpreter Lena Menhem	Katia Interpreter	Hessa Alkhashti	Ashwag Hussain	Abdulrahman Ramadan
Interpreter Joce...	Lama alshawi	sajida roor	Afkar Eltaib Aw...	lubn abd
Interpreter Jocelyne Mgh...	Lama alshawi	sajida roor	Afkar Eltaib Awd Elk rim ...	lubn abd
	إيمان العسيري	Latefa ALABDU...	Abdulaziz Almu...	
	إيمان العسيري	Latefa ALABDULHADI --	Abdulaziz Almudaifer	

Chat

هم ضحايا لظروف معينة يجب ان يتحصلوا على علاج في ليبيا يتم حصول عليها من سجلات الوفيات التي تكون مطابقة لسجلات المستشفيات

From Neda Jafar to Everyone:  
thank you very much for your inputs dears

thank you widada very much too

From wedad ALGHARYANI to Everyone:  
thank you

From Monica Flores Urrutia to Everyone:  
I agree with establishing a list of focal points for indicators

Who can see your messages? Recording On

To: Everyone

Type message here...

12:06 PM 16/12/2021

## LIST OF ANNEXES

Annex 1: AGENDA

Annex 2: LIST OF ORGANIZERS & PARTICIPANTS

Annex 3: RESOURCES

Annex 4: Q & A

Annex 5: METADATA

Annex 6 – Data Sharing Requirements and Instructions

## Annex 1: AGENDA

Day 1: 15 December		Speakers
10:00 – 10:05 A.M.	Introduction to the Webinar (objective, speakers, and content)	ESCWA – Neda Jafar WHO – Elaine Borghi
10:05 – 11:00 A.M.	<ul style="list-style-type: none"> <li>JME group structure, background, and process to get nutrition data points</li> <li>Nutrition data quality recommendations</li> <li>Tools to support SDG monitoring</li> </ul> <p>2.2.1 Prevalence of stunting (height for age &lt;-2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age Discussion – Q&amp;A</p> <p>2.2.2 Prevalence of malnutrition (weight for height &gt;+2 or &lt;-2 standard deviations from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight) Discussion – Q&amp;A</p>	WHO-UNICEF-WB JME group:  Giovanna Gatica Dominguez (WHO) Richard Kumapley (UNICEF)
11:00 A.M. – 12:00 P.M.	<ul style="list-style-type: none"> <li>Background of anemia estimates</li> <li>Data collection process and methodology for the estimates</li> <li>Tools to support SDG monitoring</li> </ul> <p>2.2.3 Prevalence of anemia in women aged 15 to 49 years, by pregnancy status (percentage) Discussion – Q&amp;A</p>	Monica Flores Urrutia (WHO) Elisa Dominguez (WHO)
Day 2: 16 December		
10:00 – 11:00 A.M.	3.4.2 Suicide mortality rate Discussion – Q&A	WHO - Alexandra Fleischmann
11:00 A.M. – 12:00 P.M.	3.5.2 Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol Discussion – Q&A	WHO - Alexandra Fleischmann
12:00 – 12:15 P.M.	Way Forward and Conclusion	ESCWA – Neda Jafar WHO – Elaine Borghi WHO – Alexandra Fleischmann



## Annex 2: LIST OF ORGANIZERS & PARTICIPANTS

### LIST OF ORGANIZERS

ESCWA	WHO	UNICEF
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## Annex 3: RESOURCES

### SDGs 2.2.1-2.2.2-2.2.3:

- WHO Anthro Survey Analyser: <https://www.who.int/tools/child-growth-standards/software>
- WHO Global Child Malnutrition Database: <https://www.who.int/teams/nutrition-and-food-safety/databases/nutgrowthdb>
- Global Health Observatory for Prevalence of anemia in women of reproductive age (aged 15-49) (%): [https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-anaemia-in-women-of-reproductive-age-\(-\)](https://www.who.int/data/gho/data/indicators/indicator-details/GHO/prevalence-of-anaemia-in-women-of-reproductive-age-(-))
- Micronutrients database. The Vitamin and Mineral Nutrition Information System (VMNIS) (<https://www.who.int/teams/nutrition-and-food-safety/databases/vitamin-and-mineral-nutrition-information-system>)
- Micronutrient survey manual: <https://www.who.int/publications/i/item/9789240012691>
- Global Targets Tracking Tool: <https://www.who.int/tools/global-targets-tracking-tool>
- eLearning Course on the Tracking Tool: <http://nutritionlearning.org/the-global-nutrition-targets-tracking-tool-2/>
- Child anthropometry indicators trends and targets tracking Excel spreadsheet: <http://www.who.int/nutrition/publications/anthropometry-data-quality-report-annex11.xlsx>
- The extension of the 2025 Maternal, Infant and Young Child nutrition targets to 2030: <https://apps.who.int/nutrition/global-target-2025/discussion-paper-extension-targets-2030.pdf?ua=e>
- Global anaemia reduction efforts among women of reproductive age: impact, achievement of targets and the way forward for optimizing efforts. <https://www.who.int/publications/i/item/9789240012202>
- WHO. Haemoglobin concentrations for the diagnosis of anaemia and assessment of severity. Vitamin and Mineral Nutrition Information System. Geneva, World Health Organization, 201 (WHO/NMH/NHD/MNM/11.1) (<http://www.who.int/vmnis/indicators/haemoglobin>.

Pdf) Recommendations for data collection, analysis and reporting on anthropometry indicators in children under 5 years old. World Health Organization & United Nations Children's Fund (UNICEF). (2019). Available in English and Arabic (<https://apps.who.int/iris/handle/10665/324791>)

### SDGs 3.4.2-3.5.2:

- Suicide prevention: [https://www.who.int/health-topics/suicide#tab=tab\\_1](https://www.who.int/health-topics/suicide#tab=tab_1)
- WHO CRVS Strategic Implementation Plan 2021-2025: <https://apps.who.int/iris/rest/bitstreams/1356884/retrieve>
- International Classification of Diseases, Tenth Revision (ICD-10): <https://www.cdc.gov/nchs/icd/icd10.htm>
- Fatal injury surveillance in mortuaries and hospitals: a manual for practitioners: <https://apps.who.int/iris/handle/10665/75351>
- Preventing suicide: a resource for suicide case registration: [https://apps.who.int/iris/bitstream/handle/10665/44757/9789241502665\\_eng.pdf](https://apps.who.int/iris/bitstream/handle/10665/44757/9789241502665_eng.pdf)
- Practice manual for establishing and implementing suicide attempt and self-harm surveillance systems: <https://apps.who.int/iris/handle/10665/208895>
- WHO Global status report on alcohol and health: <https://www.who.int/publications/i/item/9789241565639>

Global information system on alcohol and health: <https://www.who.int/data/gho/data/themes/global-information-system-on-alcohol-and-health>

Annex 4: Q & A

Country /Name	Questions	Answers
<b>Indicator 2.2.3</b>		
ESCWA	How is the data is collected? The through which surveys?	<p>The data is collected from two sources. First, the macronutrient database where a national representative data is included and then this national representative data is scrutinized, whether it has a proper methodological approach, it induces good assessment techniques in hemoglobin, it was adjusted by altitude and then adjusted by smoking status.</p> <p>The methodology acknowledges that not all countries have a lot of data, the fact that conducting a nutrition survey is expensive.</p> <p>Hence this model is used to complete these gaps of data.</p> <p>It can be collected as well from MICS and DHS surveys if it complies with the criteria for inclusion for the estimates and the macronutrient database like a sampling frame of the defined population and having a standard and validated methods in the laboratory methodology.</p>
ESCWA	Since the data collection of this indicator from surveys is costly, we need to get this data from administrative records. What, how and what can we do about it, and how to go about it?	<p>WHO is working with the Department of Data Delivery and impact to see how to triangulate the surveillance data with the survey data. This is hopefully an objective to be achieved. However, for anemia, it's not that easy, because many countries have large surveillance systems and sometimes the methodology is not well reported. No information is provided if the phlebotomists are well trained if they use a portable device or the laboratory, who is providing the data and how routine is this data if the data from the children is when the children go to the doctor and to see how representative is the data?</p> <p>Another example for pregnant women, if they go to their antenatal care checks to see to check if this data is representative, because, for the anemia estimates, data from facility level are only included, for example, for hospitals where the national coverage was at least 80%.</p> <p>WHO is also currently working on some guidance for countries looking at hemoglobin data quality and also in the development of some tools to help with the analysis of the data.</p>
<b>Indicator 3.4.2</b>		

Libya - Wedad Algharyani	It was mentioned that including death and suicide data is searched for. Is it through special questions in an indirect way in surveys or by obtaining it from hospital records or other ways to obtain it with accuracy and quality in Arabic Countries?	First countries must look at one thing which is the mortality, the deaths from suicide and the other are the suicide attempts, and, to register the data, they must do different kinds of systems, because for the mortality it's the medical certificate, so that's where the attending physician has to fill the international form of medical certification of cause of death according to ICD 10 rules. The other way is to include a set of five questions from the STEP Questionnaire (links provided in the metadata) in any ongoing population survey to collect data on the attempts of the suicide of the whole population as well as some questions from the global student-based school health survey targeting the younger generation.
ESCWA	The problem of the Arab countries relates not only to the suicide mortality rate but to all causes of death due to the CRVS or incompleteness of data. Our records show that Egypt and Algeria have reported on suicide rates but there are no country data captured, and as you mentioned the data could come either from CRVS or from a hospital-based record. The best option now for the ESCWA countries is to attempt to measure this indicator through their population-based surveys until the registries are available. What are the standard questions that we need to include in this in these household-based surveys? Which of ESCWA countries is considered to be a good practice in identifying suicide by applying ICD 10? If there is any and if no, how would WHO and ESCWA	The best strategy for countries is to start building their CRVS not only for suicide mortality but for all causes of death targeting mainly the priority cause of deaths in each country and identifying the main cause of death. Therefore, training must be done for the officers registering the code and cause of death with the help of WHO mortality database colleagues. There is now an action plan for strengthening the CRVS system in countries with some regional initiatives for external causes of death. Countries in the ESCWA region may work together to build an initiative like the ones in America and Asia Regions to develop their mortality registry. A reduced list of ICD 10 may help to start collecting data on several causes of death. For the other option, the hospital-based data, countries can start with piloting one hospital by assigning a trainer or consultant to help emergency doctors where the suicide attempters might be present and afterward scaling it up to other hospitals, regions. For good practice and as already stated in the presentation, Kuwait has good quality data for this indicator which can be contacted to share the experience with other countries.

	help them better recognize the mortality causes of these suicides?	
State of Palestine – Nidal Omar	In Palestine, we rely on police records concerning suicide cases and suicide attempts, and this of course does not cover everything that happens, so we are concerned with the survey and what questions are asked in it.	The police data doesn't have full coverage and it doesn't have the final say but this data is already a good starting point to feed into other sources of data such as the registration system. For example, for some countries like Japan where the data quality is good, they are working on combining data sources and putting them all together, from police records to, national registration systems.

Annex 5: METADATA

Indicators	Data Source	Metadata	Questions
<p>2.2.1 Prevalence of stunting (height for age &lt;-2 standard deviation from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age</p>	<p>Main sources: Demographic and Health Survey (DHS), Multi-Indicator Cluster Survey (MICS), National Nutrition Surveys (NNS), Living Standard Measurement Survey (LSMS)</p> <p>Secondary sources: Administrative records (Ministries of Health) - routine/health facility data</p>	<p>Prevalence of stunting (height-for-age &lt;-2 standard deviations from the median of the World Health Organization (WHO) Child Growth Standards) among children under 5 years of age. Child stunting refers to a child who is too short for his or her age and is the result of chronic or recurrent malnutrition.</p>	<p>UB0. Before I begin the interview, could you please bring (name)'s birth certificate, national child immunization record, and any immunization record from a private health provider, or any other document where the date of birth is officially registered? We will need to refer to those documents. If the mother/caretaker says she knows the exact date of birth and can give it to you without getting the document, ask the respondent to bring the document in any case.</p> <p>UB1. On what day, month and year was (name) born? Probe: What is (his/her) birthday? If the mother/caretaker knows the exact date of birth, also record the day; otherwise, record '98' for the day.</p> <p>Date of birth Don't know day Month Don't know month Year Don't know year</p> <p>UB2. Source of information for date of birth. Several options are possible Birth certificate Birth registration record National child immunization record Private health provider immunization record Mother's report Estimates using calendar of events Other</p> <p>UB3. How old is (name)?</p>



		<p>Probe: How old was (name) at (his/her) last birthday?  Record age in completed years.  Record '0' if less than 1 year.  If responses to UB1 and UB3 are inconsistent, probe further and correct.</p> <p>UB4. Check UB3: Child's age?  Age 0-5  Age 5 or older (go to AN13).</p> <p>UB5. Tell the respondent that you will need to measure the weight and height of the child before you leave the household and a colleague will come to lead the measurement.</p> <p>CHILDREN UNDER 2 YEARS OF AGE</p> <p>AN5. The child is less than 2 years old and should be measured lying down.  Record the result of length measurement as read out by the measurer:  Read the record back to the measurer and also ensure that he/she verifies your record.  Length (cm)  Child refused (go to AN12)  Respondent refused (go to AN12)  Other (specify) (go to AN12)</p> <p>AN6. How was the child actually measured? Lying down or standing up?  Lying down (go to AN11)  Standing up</p> <p>AN7. Record the reason that the child was measured standing up.</p>
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			<p>CHILDREN 2 YEARS OF AGE OR OLDER</p> <p>AN8. The child is at least 2 years old and should be measured standing up. Record the result of height measurement as read out by the measurer: Read the record back to the measurer and also ensure that he/she verifies your record. Height (cm) Child refused (go to AN12) Respondent refused (go to AN12) Other (specify) (go to AN12)</p> <p>AN9. How was the child actually measured? Lying down or standing up? Lying down Standing up</p> <p>AN10. Record the reason that the child was measured standing up</p> <p>AN11. Was the child's hair braided or the child wearing hair ornaments that interfered with measurement? Yes, CHILD'S HAIR BRAIDED OR CHILD WORE HAIR</p>
<p>2.2.2 Prevalence of malnutrition (weight for height &gt;+2 or &lt;-2 standard deviations from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight)</p>	<p>Main sources: Demographic and Health Survey (DHS), Multi-Indicator Cluster Survey (MICS), National Nutrition Surveys (NNS), Living Standard Measurement Survey (LSMS)</p> <p>Secondary sources: Administrative records (Ministries of Health) - routine/health facility data</p>	<p>Child wasting refers to a child who is too thin for his or her height and is the result of recent rapid weight loss or the failure to gain weight. The official MDG indicator is wasting as assessed using weight for height. Wasting can however also be assessed with mid-</p>	<p>UB0. Before I begin the interview, could you please bring (name)'s birth certificate, national child immunization record and any immunization record from a private health provider, or any other document where the date of birth is officially registered? We will need to refer to those documents. If the mother/caretaker says she knows the exact date of birth and can give it to you without getting the document, ask the respondent to bring the document in any case.</p> <p>UB1. On what day, month and year was (name) born? Probe: What is (his/her) birthday? If the mother/caretaker knows the exact date</p>

		<p>upper arm circumference (MUAC).  Child overweight refers to a child who is too heavy for his or her height. The official MDG indicator is overweight as assessed using weight for height. Overweight can however also be assessed with other indicators such body mass index for age. In general BMI for age is not used in the joint dataset but has been considered in absence of any other available estimates.</p>	<p>of birth, also record the day; otherwise, record '98' for day.  Date of birth  Don't know day  Month  Don't know month  Year  Don't know year</p> <p>UB2. Source of information for date of birth. Several options are possible  Birth certificate  Birth registration record  National child immunization record  Private health provider immunization record  Mother's report  Estimates using calendar of events  Other</p> <p>UB3. How old is (name)?  Probe: How old was (name) at (his/her) last birthday?  Record age in completed years.  Record '0' if less than 1 year.  If responses to UB1 and UB3 are inconsistent, probe further and correct.</p> <p>UB4. Check UB3: Child's age?  Age 0-5  Age 5 or older (go to AN13).</p> <p>UB5. Tell the respondent that you will need to measure the weight and height of the child before you leave the household and a colleague will come to lead the measurement.</p> <p>AN1. Measurer's name and number</p>
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			<p>Lying down (go to AN11) Standing up</p> <p>AN7. Record the reason that the child was measured standing up.</p> <p>CHILDREN 2 YEARS OF AGE OR OLDER AN8. The child is at least 2 years old and should be measured standing up. Record the result of height measurement as read out by the measurer: Read the record back to the measurer and also ensure that he/she verifies your record. Height (cm) Child refused (go to AN12) Respondent refused (go to AN12) Other (specify) (go to AN12)</p> <p>AN9. How was the child actually measured? Lying down or standing up? Lying down Standing up</p> <p>AN10. Record the reason that the child was measured standing up AN11. Was the child's hair braided or the child wearing hair ornaments that interfered with measurement? Yes, CHILD'S HAIR BRAIDED OR CHILD WORE HAIR ORNAMENTS THAT INTERFERED WITH MEASUREMENT No AN12. Today's date: Day / Month / Year:</p>
2.2.3 Prevalence of anemia in women aged 15 to 49 years, by	Main sources: Demographic and Health Survey (DHS), Multi-Indicator	Anemia is defined as a hemoglobin concentration less than	1. Asking for consent and explanatory document: Example: As part of this survey, we are asking people all over the country to take an anemia test. Anemia is a serious health

<p>pregnancy status (percentage)</p>	<p>Cluster Survey (MICS), Reproductive Health Survey, Malaria Indicator Survey</p> <p>Secondary sources: Administrative records (Ministries of Health)</p>	<p>120 g/L for non-pregnant women and lactating women, and less than 110 g/L for pregnant women, adjusted for altitude and smoking.</p> <p>The anemia status of women is assessed using blood hemoglobin concentrations. Blood hemoglobin concentrations are typically measured in surveys using the direct cyanmethemoglobin method in a laboratory or with a portable, battery-operated, hemoglobin photometer (using the azide-methemoglobin method) in the field.</p> <p>Testing is voluntary and respondents receive the results of their anemia test immediately, as well as information about how to prevent anemia.</p>	<p>problem that usually results from poor nutrition, infection, or chronic disease. This survey will assist the government to develop programs to prevent and treat anemia.</p> <p>For the anemia testing, we will take a sample from the finger. The equipment used to take the blood is clean and completely safe. It has never been used before and will be thrown away after each test. The blood will be tested for anemia immediately, and the result will be thrown away after each test. The blood will be tested for anemia immediately, and the result will be told to you (and your parent/guardian) right away. The result will be kept strictly confidential and will not be shared with anyone other than members of our survey team.</p> <p>The blood will be tested for anemia immediately, and the result will be told to you right away. The result will be kept strictly confidential and will not be shared with anyone other than members of our survey team.</p> <p>Do you have any questions? You can say yes to the best, or you can say no. It is up to you to decide. Will you take the anemia test?</p> <p>2. Consent granted? Granted Refused</p> <p>3. Is the woman married? Ever-married woman age 15-49 years Other</p> <p>4. What is the pregnancy status of the women? Pregnant Non pregnant Non pregnant lactating Non pregnant non-lactating</p>
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			<p>5. Does the woman smoke?  Yes  No</p> <p>For field workers/ responsible for data collection:  -Identify what type of blood sample is collected  -Make sure to write number of hemoglobin concentrations given by the hemoglobin meter  -Make sure to report the hemoglobin measurement used ( type of hemoglobinmeter or laboratory method)  -Take into account adjustments for smoking and residential elevation above sea level</p> <p>In addition to the questions (410-411:consent and 413:pregnancy status), further information about hemoglobin collection should be known for analysis. Kindly refer to the Micronutrient Survey Manual referred</p> <p>Hemoglobin can be collected using either capillary or venous sampling. (Taken from Micronutrient Survey Manual)</p> <p>Capillary blood from a finger prick is collected by capillary action in a cuvette, which is then placed in the photometer that displays the hemoglobin concentration within one minute. The accuracy of hemoglobin measurement may be improved by pooled capillary or venous blood. For pooled capillary blood, collect 250–500 <math>\mu</math>L small blood collection tube containing an anticoagulant such as EDTA or heparin, gently mixing the blood by inverting the tube several times to prevent clotting, and then filling the cuvette with blood from the blood collection tube.</p>
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		<p>For venous blood, collect 3-5 mL in a vacuum blood collection tube containing an anticoagulant such as EDTA or heparin, gently mixing the blood by inverting the tube several times, and then filling the cuvette with blood from the collection tube for analysis. A comparison of nationally representative surveys measuring hemoglobin using portal hemoglobin meter HemoCue® with capillary (DHS) or venous (BRINDA) samples, showed substantial differences in anemia prevalence estimates, which were consistently lower in venous compared to capillary.</p> <p>The most commonly used method for field-based measurement of hemoglobin in population surveys is photometric determination using a portable haemoglobinometer. The procedure does not require specialized laboratory personnel and the hemoglobinometer may be operated on four AA batteries, which makes it particularly useful in the field. Manuals and tutorial videos for haemoglobinometers are available online, making it easier to follow the proper operation. The portable hemoglobinometer HemoCue® has been validated against traditional hemoglobin laboratory methods and found to have adequate accuracy and precision in controlled settings. The accepted reference method for hemoglobin measurement is the cyanmethemoglobin method.</p> <p>Survey staff with or without phlebotomy experience can be trained to collect capillary blood samples. However, experienced trainers must conduct the training and ensure the use of standardized techniques. For large-scale, population-based surveys, only experienced phlebotomists should collect a venous blood specimen</p>
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<p>3.4.2 Suicide mortality rate</p>	<p>Main sources: Administrative records (Ministry of Health)</p> <p>Secondary sources: Household surveys with a verbal autopsy, and sample or sentinel registration systems.</p>	<p>The Suicide mortality rate is defined as the number of suicide deaths in a year, divided by the population, and multiplied by 100 000</p>	<p><a href="#">STEPs</a> and <a href="#">GSHS</a> (for adolescents)</p>
<p>3.5.2 Alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol</p>	<p>Main sources: For recorded alcohol: Administrative records (NSOs and Institute or department and/or ministry or department of finance, taxation, revenue or customs and/or other similar body about the availability of sales or taxation data, or data on production, import, and export by type of alcoholic beverage with an indication of alcohol content) For unrecorded alcohol: Administrative records (Nationally representative empirical data, specific other empirical investigations, and expert opinion, including special exercise with nominal group technique)</p>	<p>Harmful use of alcohol is defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol. Total alcohol per capita (15+ years) consumption (APC) is defined as the total (sum of three-year average recorded APC and unrecorded APC adjusted for tourist consumption) amount of pure alcohol consumed per adult (15+ years), in a calendar year, in litres of pure alcohol. Recorded alcohol consumption refers to official statistics at the country level (production, import, export, and sales or taxation data), while unrecorded alcohol consumption refers to alcohol that is not taxed and is outside the usual system of governmental control, such as home or informally produced alcohol (legal or illegal), smuggled alcohol, surrogate alcohol (which is alcohol not intended for human consumption), or alcohol obtained through cross-border shopping (which is recorded in a different jurisdiction). Tourist consumption takes into account tourists visiting the country and inhabitants visiting other countries. Positive figures denote alcohol consumption by outbound tourists being greater than alcohol consumption by inbound tourists, negative numbers the opposite. Tourist consumption is based on UN statistics, and data are provided by IHME.</p>	<p><a href="#">Global Survey on Alcohol and Health</a></p> <p><a href="#">For unrecorded consumption of alcohol</a></p>

		Computation method: Numerator: The sum of the amount of recorded alcohol consumed per capita (15+ years), average during three calendar years, in litres of pure alcohol, and the amount of three-year average unrecorded alcohol per capita consumption (15+ years), during a calendar year, in litres of pure alcohol, adjusted for tourist consumption. Denominator: Midyear resident population (15+ years) for the same calendar year, UN World Population Prospects, medium variant.	
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## Annex 6: Data Sharing Requirements and Instructions

### Data sharing requirements and instructions UNICEF-WHO-WB Joint Child Malnutrition Estimates (JME)<sup>3</sup>

#### Why share child malnutrition data with the JME group?

The JME Working Group regularly conducts extensive searches for new data sources containing child malnutrition estimates based on different mechanisms, but this process is not fully exhaustive and key sources might be missed. The SDG country consultation processes provide key opportunities to obtain sources that have not previously been considered by the JME Working Group. Sharing data not yet reflected in the JME database will allow all available country data to be considered in SDG reporting.

#### How your data will be used?

Once shared by national focal points, the source information undergoes a process of quality assessment and review as described in Section 3 of the country consultation background document. When individual-level data are made available, the three-agency group recalculates estimates using a standard approach (re-analysis) (see Section 3 of the country consultation background document), in order to generate estimates that adhere to the standard indicator definition. The use of standard tools<sup>1</sup> or codes<sup>2</sup> provide a variety of data quality outputs which allow for a thorough review to be performed. For those sources meeting the inclusion criteria, the respective child malnutrition estimates are included in the JME database. All data included in this database are used to generate country modelled estimates for stunting and overweight as well as regional and global estimates for stunting, wasting and overweight (see Section 3 of the country consultation background document).

The JME group releases the country, regional and global estimates annually through a variety of dissemination products including a Key Findings Report, a series of databases and other products. In addition to being the official estimates used to monitor SDG Target 2.2, the JME estimates are also used in the WHO Global Database on Child Growth and Malnutrition and to monitor the World Health Assembly 2012 Global Nutrition Targets, the WHO General Program of Work for 2018–2023, and in global reports such as the [Global Nutrition Report](#) and the [State of Food Security and Nutrition in the World report](#).

#### Which type of information is needed?

Although the majority of data sources are nationally representative surveys, anthropometric data collected through national surveillance systems are also considered. The type of information required is:

**Final report** (in Word or PDF) including<sup>3</sup>:

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<sup>1</sup> WHO Anthro Survey analyser - <https://www.who.int/childgrowth/software>.

<sup>2</sup> UNICEF STATA code (available upon request)

<sup>3</sup> Recommendations for data collection, analysis and reporting on anthropometric indicators in children under 5 years old (Chapter 3). <https://www.who.int/publications/i/item/9789241515559>.

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<sup>3</sup> Section 3 also applies for the data sharing requirements for the WHO Micronutrients database

**Full methodological details:** covering sampling design and methods, equipment used, training and data collection procedures in the field.  
**Results:** including response rates, malnutrition estimates and data quality outputs.

**Microdata** (i.e. individual-level dataset), including a variables dictionary. The file should include the following variables:

Minimum variables required for all sources<sup>4</sup>:

Date of birth and date of measurement: The day, month and year should be available; the day should be in numeric, integer format (e.g. 3 or 31), month either in numeric, integer format (e.g. 1 or 12) or as a string (Mar or March) and the year as a 4 digit numeric, integer (e.g. 1990).

Sex: Numeric, integer or string. E.g. male/1/"M"/"m" and female/2/"F"/"f"

Weight: Numeric, float value (in kilograms). Weights should be provided with one decimal  
e.g. 30.1.

Length or height: Numeric, float value (in centimetres). Length or height measurements should be provided with one decimal e.g. 55.4.

Measurement position for length/height: Numeric, integer or string. To indicate whether the measurement was taken in the standing or recumbent position. If this information is missing, the code for reanalysis will assume that the measurement position was recumbent if child's age was <24 months and standing if child's age is ≥24 months.

Additional variables required for two-stage design surveys:

Strata and Cluster (Primary Sampling Unit – PSU): Numeric integer. If not provided, it will be assumed that all children belong to the same strata/cluster.

Sampling weight: Numeric float. If sampling weights are not provided, the sample will be assumed to be self-weighted, i.e. the sampling weight equals one.

Additional optional variables:

Team: Numeric integer. Whenever provided, this variable is used for performing data quality assessment stratified.

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<sup>4</sup> For the WHO Micronutrients database, data on the micronutrient status is being collated for all population groups, and data for the following additional variables are requested:

- Pregnancy status (e.g. if the woman is pregnant, lactating, not pregnant and, not pregnant and not lactating)
- Fasting state of the individual
- Whether the individual smokes or not
- When haemoglobin data is collected, the elevation of household residence of the individual
- Numerical variables for the concentrations of the micronutrients analysed (e.g. haemoglobin, C-reactive protein, alpha (1)- acid glycoprotein, retinol, retinol binding protein, serum ferritin, soluble transferrin receptor, urinary iodine, zinc, folate, vitamin B12)

Stratification variables for equity monitoring:

Residence type: Numeric integer or string., e.g. “Rural” or “Urban”.

Geographical region: String or numeric integer. If geographical region variable is numeric, please provide the value labels in the variables dictionary.

Wealth quintiles: Ordinal numeric integer in ascending order or string E.g. 1, 2, 3, 4, 5; or Q1, Q2, Q3, Q4, Q5; If wealth quintile variable is numeric, please provide the value labels in the variables dictionary,

Mother’s education: Numeric integer or string. Recommended values: “None”, “Primary”, “Secondary” and “Higher”. Any number of categories or values are accepted provided the variables dictionary clearly describes each category.