Annex 5: Mapping of data sources and creation of a database for Maternal, Newborn, Child and Adolescent Health Policies

Contents

Abbreviations

MCA	Department of Maternal, Newborn, Child and Adolescent Health and Ageing
EWEC	Every Woman Every Child
PRG	Policy Reference Group
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SRH	Department of Sexual and Reproductive Health and Research
WHA	World Health Assembly
WHO	World Health Organization

1. Background

The new Global Strategy on Women's, Children's and Adolescents' Health 2016–2030 (Global Strategy 2.0) emphasizes the need to improve the health of all women, children and adolescents through transformative multisectoral actions which accelerate coverage of interventions, mitigate gender and equity gaps, improve quality of services and allow all women and children to survive and thrive. Such an approach brings to the centre of the discussion the need for countries to endorse and implement policies that allow for these transformations to happen. New and ambitious goals and targets set in the Global Strategy 2.0 will require the presence and utilization of strong, evidence-informed and equity-focused policies. Policies should go beyond mere evidence-based intervention policies, span across the continuum of care for reproductive, maternal, newborn, child and adolescent health (RMNCAH) into a life course approach and reach beyond traditional health system boundaries.

Since 2009 the Department of Maternal, Newborn, Child and Adolescent Health and Ageing (MCA) has administered a Global Policy Survey of World Health Organization (WHO) Member States to track country progress in adopting WHO recommendations in national health policies related to RMNCAH. There have been four rounds to date: 2009–2010, 2011–2012, 2013–2014 and 2016. In addition, the Department of Sexual and Reproductive Health and Research (SRH), as part of monitoring progress on the Global Reproductive Health Strategy approved by the World Health Assembly (WHA) through resolution 57.12, has been tracking policies on sexual and reproductive health and has done so biennially since 2009. The biennial reports are included in the corresponding year during WHA meetings. We now propose to combine efforts and establish a global platform to track the adoption and implementation of essential RMNCAH policies in all countries, with special attention to 81 low- and middle-income countries that account for the highest burden of maternal, newborn and child mortality. We seek to stimulate greater global and national policy dialogue and link this dialogue with the development of country-specific investment plans and accountability for accelerated progress towards the Global Strategy 2.0 goals and targets. By undertaking these activities, we aim to provide a useful source of information for governments, partners and the community-at-large in the challenging path of implementing the new Global Strategy 2.0.

To optimize the approach, the MCA and RHR Departments have established a Global RMNCAH Policy Reference Group (PRG), to advise WHO on the content of the policy tracking and the utilization of related outputs. The first meeting was held in February 2017. This group advised on some potential priority indicators but asked that we provide them with more direction on priorities and what policies are needed prior to recommending a final list of policies to be monitored. They also emphasized the need to streamline the current global policy survey by examining if there are other potential data sources to extract key policies on an ongoing basis, decreasing the need to have a large survey of countries to collect policy information.

To respond to this request, a list of potential policies in RMNCAH has been developed based on the Every Woman Every Child (EWEC) Global Strategy, key global initiatives, and WHO priorities in the area of RMNCAH. In addition, the PRG undertook a mapping of policy tracking for the Global Strategy for Women's, Children's and Adolescents' Health 2030 (GS 2030) in February 2017 which resulted in the identification of 30 RMNCAH policy data sources. Starting with this list and adding additional sources

identified by the MCA Department team, a critical review of potential data sources was undertaken to identify indicators from each source, select sources and indicators for inclusion in a database, and extract and compile data into a single database. This report details the process by which sources and indicators were selected, as well as the methods used to extract data from disparate sources. In addition, it provides key metadata about the indicators in the final database.

2. Source mapping and selection

Based on preliminary analysis conducted by the Global RMNCAH PRG, and individual research, 42 data sources were identified for possible inclusion in the database. Each source was reviewed and assessed to determine:

- If the source provides country-level data
- Type of data (numeric or non-numeric)
- Format of source (e.g. spreadsheet, interactive map, non-database format, etc.)
- If data were collected or compiled (i.e. original data collection undertaken or data compiled from existing sources)
- Method of data collection/compilation
- Frequency of source update
- Year of last update
- Number of countries for which data are available
- Method for assessing data quality
- GS 2030 Action Area(s)
- GS 2030 Objective Area(s)
- Additional notes/relevant observations
- Indicators collected.

The following summary describes the key characteristics of the 42 sources assessed for inclusion in the database:

- Of the 42 sources, 5 did not provide country-level data. These sources generally were indicator guides, proposed frameworks/global strategies or provided information on regional trends.
- Of the 37 sources that provided country-level data, the maximum number of countries listed in a single source was 215. The minimum number of countries listed in a single source was 24.
- Of the 37 sources that provided country-level data, quality of data was validated in a variety of ways; 22 sources did not state how quality of data was verified.
- Of the 37 sources that provided country-level data, 7 of them were document repositories. Document repositories were defined as sources that provided information on a general topic but did not provide information according to a standard list of indicators. This was commonly found for sources that addressed case law, legal matters, compacts and country-level policies by providing a PDF or web link to the original source document.
- Of the 30 sources that provided country-level data and were not document repositories, 19 of them presented data in a spreadsheet format (csv/xlsx). The remaining 11 sources provided data in a variety of formats that included interactive maps, PDFs, weblinks and tables.

Once this information was compiled and organized into a spreadsheet in Excel, it was submitted to the MCA/EME Coordinator at WHO for review. Based on the information on each source, the MCA/EME Coordinator selected sources for inclusion in the database. Based on further review of the sources to cross-reference duplicated indicators across sources, remove sources that presented data in a way that could not be standardized across countries, and include several additional sources to capture specific indicators of interest, a total of 17 sources were selected for final inclusion in the database.

A list of final sources with details can be found in Annex 1: Data sources. Furthermore, the Excel file RMNCAH Source Tracking 10.6.17 details all sources reviewed and final sources selected.

3. Selection of indicators

The final list of indicators available from the selected sources was reviewed by the MCA/EME Coordinator at WHO for indicator selection. At time of selection, if an indicator of interest required hand abstraction, it was included in the final list and alternative means for obtaining the raw data were pursued (see section 4: Data extraction methods for further details).

In total, 348 indicators were selected for abstraction from 16 sources. However, the source total remains at 17 (refer to Annex 1: Data sources), as the MCA/EME Coordinator decided that no indicators should be abstracted from source #10, but it should remain on the list if any indicators needed value verification at a later date.

To provide detailed information on indicator definitions and response options, a data dictionary was created which can be found in Annex 2: Indicator data dictionary. Furthermore, the Word file RMNCAH Data Dictionary 10.6.17 can be referenced to obtain these data. In addition, the Excel file RMNCAH Source Tracking 10.6.17 details all indicators reviewed and final indicators selected.

4. Data extraction methods

To abstract selected indicators, spreadsheets (csv/xlxs) were downloaded from the identified website for each source (refer to Annex 1: Data sources). For sources where spreadsheets were not available (i.e. indicators that would require hand abstraction due to presentation via PDFs, interactive maps, etc.), MCA/EME staff reached out to the respective department at WHO or the United Nations organization responsible for the data to obtain raw data files.

Once the respective spreadsheets were downloaded, data were sorted alphabetically by country name, and country names were matched with ISO3 codes using the VLOOKUP function in Excel. The ISO3 code was used to organize data from all sources. ISO3 codes were obtained from the International Organization for Standardization's online browsing platform at: https://www.iso.org/obp/ui/#search

Three data sources needed no further transformation before they could be used to populate the final database. Data sources that did not require further transformation include:

- Global Analysis and Assessment of Sanitation and Drinking-Water (Source: 3)
- World Policy Analysis Center (Source: 24)
- UNICEF: Monitoring the Situation of Children and Women (Source: 41).

Five sources were publically available in a format that required hand abstraction. The MCA Department team was able to reach out to partners to request data as an Excel file. From the Excel files provided, no further transformation was required for the following data sources:

- MCA Policy Indicators Survey (Source: 16)
- Global status report on violence prevention (Source: 13)
- International Labour Organization: Working Conditions (Source: 38)
- World Health Organization, UNICEF, IBFAN – Marketing of Breast-Milk Substitutes: National Implementation of the International Code Status Report 2016 (Source: 39)
- Food Fortification Initiative (Source: 40).

Eight data sources required additional transformation before they could be used to populate the final database. Data sources that required additional transformation included:

- Global Health Expenditure Database (Source: 9)
- National Health Workforce Account (Source: 18)
- OHCHR Status of Ratification Interactive Dashboard (Source: 19)
- WHO vaccine-preventable diseases: monitoring system (Source: 34)
- Worldwide Governance Indicators (Source: 35)
- OECD Child Family Database and Child Well-Being (Source: 36)

- World Bank: Social Expenditure Indicators (Source: 37)
- World Bank Country and Lending Groups (Source: 42).

The details on data transformation for each source are below.

Global Health Expenditure Database (Source: 9)

Data from this source needed to be transformed from long (multiple rows per country) to wide (one row per country with a column for each indicator). To do so, a pivot table was created with the country as the rows and the indicators as the columns. In addition, the original database used the following notation: empty values are ":", values equal to 0 are "–", and values less than 0.5 are "<". The empty values were converted to blanks, 0 values converted to 0, and values less than 0.5 were converted to 0.5.

National Health Workforce Account (Source: 18)

Data for this source needed to be organized to represent values for the most current year data were reported. To do so, data were sorted alphabetically in ascending order and by year in descending order. Duplicate country entries were then removed, isolating values for the most current year.

OHCHR Status of Ratification Interactive Dashboard (Source: 19)

Data for this source are available in an interactive, colour-coded map. In addition, there is an option to list countries by colour on the left side of the webpage. Country names were selected by colour, copied and pasted into an Excel workbook where the labels based on the map were recorded. This was a manual process, as there was no downloadable file available from the source.

WHO vaccine-preventable diseases: monitoring system (Source: 34)

For the immunization schedule data, a separate tab was created for each vaccine, and the data were copied into each tab from the full schedule based on filtering the full schedule by vaccine description. Any vaccine that contained the corresponding antigen was included on the vaccine-specific tab. Next, a separate tab was created, and a column given for each vaccine indicator. Finally, the VLOOKUP function in Excel was used to populated the indicators with Yes/No for presence of each vaccine in the immunization schedule.

Worldwide Governance Indicators (Source: 35)

Data from this source needed to be transformed from long (multiple rows per country) to wide (one row per country with a column for each indicator). To do so, a pivot table was created with the country as the rows and the indicators as the columns.

OECD Child Family Database and Child Well-Being (Source: 36)

Data for this source needed to be organized to represent values for the most current year data were reported. To do so, data were sorted alphabetically in ascending order and by year in descending order. Duplicate country entries were then removed, isolating values for the most current year.

World Bank: Social Expenditure Indicators (Source: 37)

Data for this source needed to be organized to represent values for the most current year data were reported. To do so, data were sorted alphabetically in ascending order and by year in descending order. Duplicate country entries were then removed, isolating values for the most current year.

World Bank Country Income Group (Source: 42)

Data for this source did not include the Cook Islands and Niue. To obtain their country income group classification, the following source was used: http://who.int/phe/health_topics/outdoorair/databases/country_grouping_2016.pdf?ua=1

5. Database creation

A database repository was created in Excel which contained country names, ISO3 codes, and a column for each indicator with an assigned variable name. Variable names were created for each indicator, except for indicators abstracted from the World Policy Analysis Center (Source: 24). For this source, variable names for indicators were kept the same as the original source to ensure ease of transfer into the database.

Once variable names were established, indicators were then transferred from the original source to

the database using the VLOOKUP function in Excel. Values that were blank in the original source file were transferred into the Excel data repository as 0 and then replaced with a blank. Countries not listed in the original source document were transferred into the Excel data repository as #N/A and then replaced with a blank. Prior to the data transfer, all indicators and corresponding values (categorical variables) were checked for inconsistencies in spelling of response options. For quality control, countries and indicators were randomly checked to ensure appropriate alignment between source, country and indicator value during the data transfer process.

After the data transfer, a data dictionary (Annex 2: Indicator data dictionary) was created to compile:

- Variable Name
- Variable Description
- Variable Values
- Source Name/Number.

For all sources that provided categorical variables, variable values were assigned to each indicator.

The exception was the World Policy Analysis Center (Source: 24), where variable values were kept the same as the original source to maintain integrity of data during the transfer. All numerical values were transferred as is.

Once all data were populated, the Excel database was copied and pasted as values, all #N/A values were converted to blanks, and the Excel database was imported into STATA statistical software. In STATA, all variables were labelled, and all value sets were given numeric labels. Finally, each variable was checked for consistency and correctness of value set labels (numeric and text). The STATA do file RMNCAH_Database_Labels.do can be referenced to obtain the code used for this process.

The final database is available in a number of formats:

- STATA file (RMNCAH-Database.dta)
- Excel file with numeric responses (RMNCAH-database-numeric.xlsx)
- Excel file with text responses (RMNCAH-database-lables.xlsx).

Annex 1: Data sources

Source number	Source name	Source location	Source provides country-level data on RMNCAH indicators	Type of data (numeric or non-numeric)	Source format	Data collected or compiled	Method of data collection/ compilation	Frequency source is updated	Year of last update	Number of countries with data	Method for assessing data quality
3	Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS)	http://www.who.int/water_sanitation_health/monitoring/investments/glaas/en/, http://www.who.int/water_sanitation_health/publications/glaas-report-2017/en/	Yes	Numeric	Spreadsheet (csv/xlsx)	Collected	Survey	Annually	2017	78	All 75 GLAAS country submissions were reviewed for internal consistency, completeness and data entry errors. Countries were contacted through the respective WHO regional and country focal points for clarification and follow-up of any data issues that were identified. Additionally, there was external validation with a key informant questionnaire.
9	Global Health Expenditure Database (GHED)	http://www.who.int/health-accounts/ghed/en/, http://apps.who.int/nha/database	Yes	Numeric	Spreadsheet (csv/xlsx)	Compiled	Reports produced by the World Bank, United Nations Development Programme, OECD, Eurostat, IMF, Development Banks or National Accounts	Annually	2017	193	WHO updates the data annually, taking, adjusting and estimating the numbers based on publicly available reports. The estimates are sent out to Ministries of Health for validation prior to publication, but users are advised that country data may still differ in terms of definitions, data collection methods, population coverage and estimation methods used.
10	World Populations Policy Database	https://esa.un.org/poppolicy/wpp_datasets.aspx	Yes	Numeric	Spreadsheet (csv/xlsx), Interactive map, Graph	Compiled	Government documents/ statements, Laws: judgements, national constitutions, regional and international instruments, Reports produced by the World Bank, United Nations Development Programme, OECD, Eurostat, IMF, Development Banks or National Accounts, Official statements	Every two years	2015	197	Not stated

Source number	Source name	Source location	Source provides country-level data on RMNCAH indicators	Type of data (numeric or non-numeric)	Source format	Data collected or compiled	Method of data collection/ compilation	Frequency source is updated	Year of last update	Number of countries with data	Method for assessing data quality
13	Global status report on violence prevention	http://www.who.int/violence_injury_prevention/violence/status_report/2014/en/; raw data obtained from MCA/EME WHO staff (indicators abstracted for Countdown 2017)	Yes	Numeric	Spreadsheet (csv/xlsx)	Collected	Survey, Consensus meetings, Independent databases	First report of its kind	2014	133	Data for this report were systematically gathered from each country in a four-step process which was led by a government-appointed National Data Coordinator. First, within each country a self-administered questionnaire was completed by respondents from Ministries of Health, justice, education, gender and women, law enforcement and police, children, social development and the interior, and, where relevant, non-governmental organizations. Second, these respondents held a consensus meeting and agreed on the data best representing their country. Third, WHO regional and global violence prevention technical staff validated the final data submitted for each country by checking them against independent databases and other sources. Finally, permission to include the final data in the status report was obtained from country government officials.
16	MCA Policy Indicators Survey	http://www.who.int/maternal_child_adolescent/epidemiology/policy-indicators/en/	Yes	Numeric	Spreadsheet (csv/xlsx), Interactive map, Dashboard, Graph	Collected	Survey	Every two years	2016	122	Not stated
18	National Health Workforce Account	http://who.int/hrh/statistics/en/, http://apps.who.int/gho/data/node.main?showonly=HWF	Yes	Numeric	Spreadsheet (csv/xlsx)	Collected	Survey, Health facility assessments or routine administrative records	Annually	2017	193	Not stated

Source number	Source name	Source location	Source provides country-level data on RMNCAH indicators	Type of data (numeric or non-numeric)	Source format	Data collected or compiled	Method of data collection/ compilation	Frequency source is updated	Year of last update	Number of countries with data	Method for assessing data quality
19	OHCHR Status of Ratification Interactive Dashboard	http://indicators.ohchr.org	Yes	Numeric	Interactive map	Compiled	WHO/UN office or database	Every 6 months	2014	194	Not stated
24	World Policy Analysis Center	http://www.worldpolicycenter.org/topics/health/policies, https://www.worldpolicycenter.org/maps-data/data-download	Yes	Numeric	Spreadsheet (csv/xlsx), Interactive map	Compiled	Laws: judgements, national constitutions, regional and international instruments, National reports on policies and laws to the UN and official global and regional bodies	Not stated	2017	193	To ensure quality and accuracy of data, the following measures are taken: (1) Double coding: Rights, laws and policies are coded independently by two researchers, and their results compared, to reduce the potential for human error or differences in interpretation; (2) Verification of outliers: Nations that are outliers on particular variables are verified using additional sources whenever possible; (3) Databases are periodically updated across countries in a systematic fashion according to a broad review of available sources.
34	WHO vaccine-preventable diseases: monitoring system	http://www.who.int/immunization/monitoring_surveillance/data/en/	Yes	Numeric	Spreadsheet (csv/xlsx)	Compiled	Survey, WHO/UN office or database, Review of grey and academic literature, Consulted local experts, Ministries of Health or related Ministries	Annually	2016	195	(1) Evidence-based: No ad hoc adjustments to reported data have been made; in some instances, data for a country were available from a single source, usually the national reports to WHO. In these instances, in the absence of data from an alternative source, those data were used for the WHO/UNICEF estimate. (2) Country-specific: Each country was reviewed individually, and data were not "borrowed" from other countries. There was no attempt to group countries based on income, development levels, population size or geographic location. The resulting estimates are based only on data from that country.

Source number	Source name	Source location	Source provides country-level data on RMNCAH indicators	Type of data (numeric or non-numeric)	Source format	Data collected or compiled	Method of data collection/ compilation	Frequency source is updated	Year of last update	Number of countries with data	Method for assessing data quality
											(3) Consistent patterns and trends: In cases where no data are available for a given year for a country and antigen, data from earlier and later years were extrapolated and interpolated to estimate coverage for the missing year. In cases where data sources are mixed and show large variation, it was attempted to identify the most likely estimate in consideration of the possible biases in the data. (4) Local knowledge incorporated: Local experts were consulted, and data have been put in the context of local events, both those occurring in the immunization system and more widely occurring events. (5) No averaging: In the event that multiple data points are available for a given country and antigen, averages were not taken automatically. Rather, potential biases in each of the sources were considered and a consistent pattern over time was attempted. (6) No smoothing: While there are frequently general trends, data points were not curved using smoothing techniques. (8) PAB coverage was estimated during a mathematical model. (9) Draft estimates are reviewed by national authorities, and revisions are made based on these comments.

Source number	Source name	Source location	Source provides country-level data on RMNCAH indicators	Type of data (numeric or non-numeric)	Source format	Data collected or compiled	Method of data collection/ compilation	Frequency source is updated	Year of last update	Number of countries with data	Method for assessing data quality
35	Worldwide Governance Indicators (WGI)	http://databank.worldbank.org/data/reports.aspx?source=worldwide-governance-indicators	Yes	Numeric	Spreadsheet (csv/xlsx), Interactive map, Chart, Metadata	Compiled	Survey, Expert assessments	Annually	2015	215	Each data source provides a set of empirical proxies for the six broad categories of governance that are measured. These are then combined with the many different measures of corruption into a composite indicator that summarizes their common component. Almost all data sources are available annually, and these annual observations are aligned with the years for the WGI measures. In a few cases data sources are updated only once every two or three years. In this case, data are used that are lagged by one or two years from these sources to construct the estimates for more recent aggregate WGI measures. It is also noted that there are small changes from year to year in the set of sources on which the WGI scores are based. These too are documented online and reflect the reality that the WGI introduces new data sources as they become available, and if necessary on occasion drop existing sources that stop publication or undergo other significant changes that prevent us from continuing their use in the WGI. Wherever possible, these changes are consistently made for all years in the historical data as well, to ensure maximum over-time comparability in the WGI.

Source number	Source name	Source location	Source provides country-level data on RMNCAH indicators	Type of data (numeric or non-numeric)	Source format	Data collected or compiled	Method of data collection/ compilation	Frequency source is updated	Year of last update	Number of countries with data	Method for assessing data quality
36	OECD Child Family Database and Child Well-Being	http://www.oecd.org/els/family/database.htm	Yes	Numeric	Spreadsheet, PDF	Compiled	OECD databases, External organizations	Annually	2015	35	Not stated
37	World Bank: Social Expenditure Indicators	http://pubdocs.worldbank.org/en/722051485367779519/Social-Expenditure-Indicators-portal	Yes	Numeric	Spreadsheet (csv/xlsx)	Compiled	Administrative programme records	Not stated	2015	62	Not stated
38	International Labour Organization: Working Conditions	http://www.ilo.org/global/topics/working-conditions/lang--en/index.htm; raw data obtained from MCA/EME WHO staff (indicators abstracted for Countdown 2017)	Yes	Non-numeric	Spreadsheet (csv/xlsx), PDF file	Compiled	WHO/UN office or database	Every other year	2012	195	Not stated

Source number	Source name	Source location	Source provides country-level data on RMNCAH indicators	Type of data (numeric or non-numeric)	Source format	Data collected or compiled	Method of data collection/ compilation	Frequency source is updated	Year of last update	Number of countries with data	Method for assessing data quality
39	World Health Organization, UNICEF, IBFAN – Marketing of Breast-Milk Substitutes: National Implementation of the International Code Status Report 2016	http://www.who.int/nutrition/publications/infantfeeding/code_report2016/en/; raw data obtained from MCA/EME WHO staff (indicators abstracted for Countdown 2017)	Yes	Non-numeric	Spreadsheet (csv/xlsx), PDF file	Compiled	Survey, WHO/UN office or database, legal databases	Not stated	2014	195	In addition, UNICEF and IBFAN/ICDC reviewed and updated the categorization of countries, utilizing information and documentation received from local IBFAN groups, UNICEF and the WHO database. This allowed a coordinated tripartite review to ensure consistency and alignment of information. All legal measures found were entered into the WHO GINA database, plus the databases of UNICEF and IBFAN/ICDC. Where multiple laws and/or regulations were available, the analysis considered to what extent legal measures were revisions, extensions or replacements of existing laws. For those countries for which translation of their legal measures was not available, information from UNICEF and IBFAN/ICDC was used for categorization purposes. Information on the status of national monitoring mechanisms and processes is based on data provided by 55 countries through completion of the WHO questionnaire on formal monitoring mechanisms.
40	Food Fortification Initiative	http://www.ffinetwork.org/global_progress/index.php; raw data obtained from MCA/EME WHO staff (indicators abstracted for Countdown 2017)	Yes	Non-numeric	Spreadsheet (csv/xlsx), Interactive map	Compiled	Laws: judgements, national constitutions, regional and international instruments	Not stated	2016	108	Not stated

Source number	Source name	Source location	Source provides country-level data on RMNCAH indicators	Type of data (numeric or non-numeric)	Source format	Data collected or compiled	Method of data collection/ compilation	Frequency source is updated	Year of last update	Number of countries with data	Method for assessing data quality
41	UNICEF: Monitoring the Situation of Children and Women	https://data.unicef.org/topic/child-protection/child-marriage/	Yes	Numeric	Spreadsheet (csv/xlsx)	Collected	Survey	Annually	2017	194	As part of the MICS global programme, UNICEF provides technical support and training through a series of regional workshops covering questionnaire content, sampling and survey implementation, data processing, data quality and analysis, report writing, data archiving and dissemination and further analysis. The databases include only statistically sound and nationally representative data from household surveys and other sources. They are updated annually through a process that draws on a wealth of data maintained by UNICEF's network of 140 country offices.
42	World Bank Country and Lending Groups	https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups	Yes	Numeric	Spreadsheet (csv/xlsx)	Compiled	Not stated	Annually	2017	192	

Annex 2: Indicator data dictionary

Variable Name	Variable Description	Variable Values	Source Name/Number
ISO 3			**3-digit ISO code**
Country			**Name of country**
WHO_Region			**Country geographical region (World Bank classification)**
World Bank Country Income Group (wb_ econ)		1: Low-income 2: Middle-income 3: High-income	Country income group classification (World Bank: March 2017) Source: 42
poor_pop	Policies and plans have specific measures to reach vulnerable groups: Poor populations (national)	0: No 1: Yes	Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) Source: 3
remote_pop	Policies and plans have specific measures to reach vulnerable groups: Populations living in remote or hard-to-reach areas (national)	0: No 1: Yes	Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) Source: 3
disab_pop	Policies and plans have specific measures to reach vulnerable population groups: People with disabilities (national)	0: No 1: Yes	Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) Source: 3
female_pop	Policies and plans have specific measures to reach vulnerable groups: Women (national)	0: No 1: Yes	Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) Source: 3
inform_pop	Policies and plans have specific measures to reach vulnerable groups: Populations living in slums or informal settlements (national)	0: No 1: Yes	Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) Source: 3
disease_pop	Policies and plans have specific measures to reach vulnerable populations: Population with high burden of disease (national)	0: No 1: Yes	Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) Source: 3

Variable Name	Variable Description	Variable Values	Source Name/Number
ghed_1a	Total Health Expenditure (THE) as % of Gross Domestic Product (GDP), measured in million current US$		Global Health Expenditure Database (GHED) Source: 9
ghed_1b	Total Health Expenditure (THE) as % of Gross Domestic Product (GDP), measured in current US$ per capita		Global Health Expenditure Database (GHED) Source: 9
ghed_1c	Total Health Expenditure (THE) as % of Gross Domestic Product (GDP), measured as % of THE	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_1d	Total Health Expenditure (THE) as % of Gross Domestic Product (GDP), measured as % of GDP	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_1e	Total Health Expenditure (THE) as % of Gross Domestic Product (GDP), measured as % of General Government Expenditure (GGE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_2a	General Government Health Expenditure (GGHE) as % of Total Health Expenditure (THE), measured in million current US$		Global Health Expenditure Database (GHED) Source: 9
ghed_2b	General Government Health Expenditure (GGHE) as % of Total Health Expenditure (THE), measured in current US$ per capita		Global Health Expenditure Database (GHED) Source: 9
ghed_2c	General Government Health Expenditure (GGHE) as % of Total Health Expenditure (THE), measured as % of THE	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_2d	General Government Health Expenditure (GGHE) as % of Total Health Expenditure (THE), measured as % of Gross Domestic Product (GDP)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_2e	General Government Health Expenditure (GGHE) as % of Total Health Expenditure (THE), measured as % of General Government Expenditure (GGE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_3a	Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE), measured in million current US$		Global Health Expenditure Database (GHED) Source: 9
ghed_3b	Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE), measured in current US$ per capita		Global Health Expenditure Database (GHED) Source: 9
ghed_3c	Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE), measured as % of THE	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_3d	Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE), measured as % of Gross Domestic Product (GDP)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_3e	Private Health Expenditure (PvtHE) as % of Total Health Expenditure (THE), measured as % of General Government Expenditure (GGE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_4a	General Government Health Expenditure (GGHE) as % of General Government Expenditure (GGE), measured in million current US$		Global Health Expenditure Database (GHED) Source: 9
ghed_4b	General Government Health Expenditure (GGHE) as % of General Government Expenditure (GGE), measured in current US$ per capita		Global Health Expenditure Database (GHED) Source: 9

Variable Name	Variable Description	Variable Values	Source Name/Number
ghed_4c	General Government Health Expenditure (GGHE) as % of General Government Expenditure (GGE), measured as % of Total Health Expenditure (THE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_4d	General Government Health Expenditure (GGHE) as % of General Government Expenditure (GGE), measured as % of Gross Domestic Product (GDP)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_4e	General Government Health Expenditure (GGHE) as % of General Government Expenditure (GGE), measured as % of General Government Expenditure (GGE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_5a	External Resources on Health as % of Total Health Expenditure (THE), measured in million current US$		Global Health Expenditure Database (GHED) Source: 9
ghed_5b	External Resources on Health as % of Total Health Expenditure (THE), measured in current US$ per capita		Global Health Expenditure Database (GHED) Source: 9
ghed_5c	External Resources on Health as % of Total Health Expenditure (THE), measured as % of THE	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_5d	External Resources on Health as % of Total Health Expenditure (THE), measured as % of Gross Domestic Product (GDP)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_5e	External Resources on Health as % of Total Health Expenditure (THE), measured as % of General Government Expenditure (GGE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_6a	Out of Pocket Expenditure (OOPS) as % of Total Health Expenditure (THE), measured in million current US$		Global Health Expenditure Database (GHED) Source: 9
ghed_6b	Out of Pocket Expenditure (OOPS) as % of Total Health Expenditure (THE), measured in current US$ per capita		Global Health Expenditure Database (GHED) Source: 9
ghed_6c	Out of Pocket Expenditure (OOPS) as % of Total Health Expenditure (THE), measured as % of THE	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_6d	Out of Pocket Expenditure (OOPS) as % of Total Health Expenditure (THE), measured as % of Gross Domestic Product (GDP)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_6e	Out of Pocket Expenditure (OOPS) as % of Total Health Expenditure (THE), measured as % of General Government Expenditure (GGE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_7a	Out of Pocket Expenditure (OOPS) as % of Private Health Expenditure (PvtHE), measured in million current US$		Global Health Expenditure Database (GHED) Source: 9
ghed_7b	Out of Pocket Expenditure (OOPS) as % of Private Health Expenditure (PvtHE), measured in current US$ per capita		Global Health Expenditure Database (GHED) Source: 9
ghed_7c	Out of Pocket Expenditure (OOPS) as % of Private Health Expenditure (PvtHE), measured as % of Total Health Expenditure (THE)		Global Health Expenditure Database (GHED) Source: 9
ghed_7d	Out of Pocket Expenditure (OOPS) as % of Private Health Expenditure (PvtHE), measured as % of Gross Domestic Product (GDP)		Global Health Expenditure Database (GHED) Source: 9
ghed_7e	Out of Pocket Expenditure (OOPS) as % of Private Health Expenditure (PvtHE), measured as % of General Government Expenditure (GGE)		Global Health Expenditure Database (GHED) Source: 9

Variable Name	Variable Description	Variable Values	Source Name/Number
ghed_8a	Total Health Expenditure (THE) per Capita in US$, measured in million current US$		Global Health Expenditure Database (GHED) Source: 9
ghed_8b	Total Health Expenditure (THE) per Capita in US$, measured in current US$ per capita		Global Health Expenditure Database (GHED) Source: 9
ghed_8c	Total Health Expenditure (THE) per Capita in US$, measured as % of Total Health Expenditure (THE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_8d	Total Health Expenditure (THE) per Capita in US$, measured as % of Gross Domestic Product (GDP)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_8e	Total Health Expenditure (THE) per Capita in US$, measured as % of General Government Expenditure (GGE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_9a	Out of Pocket Expenditure (OOPS) per Capita in US$, measured in million current US$		Global Health Expenditure Database (GHED) Source: 9
ghed_9b	Out of Pocket Expenditure (OOPS) per Capita in US$, measured in current US$ per capita		Global Health Expenditure Database (GHED) Source: 9
ghed_9c	Out of Pocket Expenditure (OOPS) per Capita in US$, measured as % of Total Health Expenditure (THE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_9d	Out of Pocket Expenditure (OOPS) per Capita in US$, measured as % of Gross Domestic Product (GDP)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_9e	Out of Pocket Expenditure (OOPS) per Capita in US$, measured as % of General Government Expenditure (GGE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_10a	General Government Health Expenditure (GGHE) as % of Gross Domestic Product (GDP), measured in million current US$		Global Health Expenditure Database (GHED) Source: 9
ghed_10b	General Government Health Expenditure (GGHE) as % of Gross Domestic Product (GDP), measured in current US$ per capita		Global Health Expenditure Database (GHED) Source: 9
ghed_10c	General Government Health Expenditure (GGHE) as % of Gross Domestic Product (GDP), measured as % of Total Health Expenditure (THE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_10d	General Government Health Expenditure (GGHE) as % of Gross Domestic Product (GDP), measured as % of GDP	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_10e	General Government Health Expenditure (GGHE) as % of Gross Domestic Product (GDP), measured as % of General Government Expenditure (GGE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_11a	Private Insurance as % of Private Health Expenditure (PvtHE), measured in million current US$		Global Health Expenditure Database (GHED) Source: 9
ghed_11b	Private Insurance as % of Private Health Expenditure (PvtHE), measured in current US$ per capita		Global Health Expenditure Database (GHED) Source: 9

Variable Name	Variable Description	Variable Values	Source Name/Number
ghed_11c	Private Insurance as % of Private Health Expenditure (PvtHE), measured as % of Total Health Expenditure (THE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_11d	Private Insurance as % of Private Health Expenditure (PvtHE), measured as % of Gross Domestic Product (GDP)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_11e	Private Insurance as % of Private Health Expenditure (PvtHE), measured as % of General Government Expenditure (GGE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_12a	Public Funds for Health as % of General Government Expenditure (GGE) (excluding external resources), measured in million current US$		Global Health Expenditure Database (GHED) Source: 9
ghed_12b	Public Funds for Health as % of General Government Expenditure (GGE) (excluding external resources), measured in current US$ per capita		Global Health Expenditure Database (GHED) Source: 9
ghed_12c	Public Funds for Health as % of General Government Expenditure (GGE) (excluding external resources), measured as % of Total Health Expenditure (THE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_12d	Public Funds for Health as % of General Government Expenditure (GGE) (excluding external resources), measured as % of Gross Domestic Product (GDP)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_12e	Public Funds for Health as % of General Government Expenditure (GGE) (excluding external resources), measured as % of GGE	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_13a	Public Funds for Health per Capita in Constant 2009 US$, measured in million current US$		Global Health Expenditure Database (GHED) Source: 9
ghed_13b	Public Funds for Health per Capita in Constant 2009 US$, measured in current US$ per capita		Global Health Expenditure Database (GHED) Source: 9
ghed_13c	Public Funds for Health per Capita in Constant 2009 US$, measured as % of Total Health Expenditure (THE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_13d	Public Funds for Health per Capita in Constant 2009 US$, measured as % of Gross Domestic Product (GDP)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_13e	Public Funds for Health per Capita in Constant 2009 US$, measured as % of General Government Expenditure (GGE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_14a	Public funds of national health expenditure, measured in million current US$		Global Health Expenditure Database (GHED) Source: 9
ghed_14b	Public funds of national health expenditure, measured in current US$ per capita		Global Health Expenditure Database (GHED) Source: 9
ghed_14c	Public funds of national health expenditure, measured as % of Total Health Expenditure (THE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_14d	Public funds of national health expenditure, measured as % of Gross Domestic Product (GDP)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_14e	Public funds of national health expenditure, measured as % of General Government Expenditure (GGE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9

Variable Name	Variable Description	Variable Values	Source Name/Number
ghed_15a	Private sources of national health expenditure, measured in million current US$		Global Health Expenditure Database (GHED) Source: 9
ghed_15b	Private sources of national health expenditure, measured in current US$ per capita		Global Health Expenditure Database (GHED) Source: 9
ghed_15c	Private sources of national health expenditure, measured as % of Total Health Expenditure (THE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_15d	Private sources of national health expenditure, measured as % of Gross Domestic Product (GDP)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_15e	Private sources of national health expenditure, measured as % of General Government Expenditure (GGE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_16a	Domestic sources of national health expenditure (General Government Expenditure), measured in million current US$		Global Health Expenditure Database (GHED) Source: 9
ghed_16b	Domestic sources of national health expenditure (General Government Expenditure), measured in current US$ per capita		Global Health Expenditure Database (GHED) Source: 9
ghed_16c	Domestic sources of national health expenditure (General Government Expenditure), measured as % of Total Health Expenditure (THE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_16d	Domestic sources of national health expenditure (General Government Expenditure), measured as % of Gross Domestic Product (GDP)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_16e	Domestic sources of national health expenditure (General Government Expenditure), measured as % of General Government Expenditure (GGE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_17a	Rest of the world funds/External sources of national health expenditure, measured in million current US$		Global Health Expenditure Database (GHED) Source: 9
ghed_17b	Rest of the world funds/External sources of national health expenditure, measured in current US$ per capita		Global Health Expenditure Database (GHED) Source: 9
ghed_17c	Rest of the world funds/External sources of national health expenditure, measured as % of Total Health Expenditure (THE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_17d	Rest of the world funds/External sources of national health expenditure, measured as % of Gross Domestic Product (GDP)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
ghed_17e	Rest of the world funds/External sources of national health expenditure, measured as % of General Government Expenditure (GGE)	Range: 0–100	Global Health Expenditure Database (GHED) Source: 9
pbs_yviol	National population-based surveys for youth violence	0: No 1: Yes 2: Subnational 3: Don't know	Global status report on violence prevention Source: 13
po_polstrag	Problem-oriented policing strategies	0: No 1: Yes 3: Don't know	Global status report on violence prevention Source: 13

Variable Name	Variable Description	Variable Values	Source Name/Number
home_visit	Programmes to prevent child maltreatment – Home visiting	0: None 1: Limited 2: Larger scale	Global status report on violence prevention Source: 13
child_mar1	Laws against child marriage – Existence	0: No 1: Yes 2: Subnational	Global status report on violence prevention Source: 13
child_mar2	Laws against child marriage – Enforcement	1: Not enforced 2: Limited 3: Partial 4: Full 6: Don't know	Global status report on violence prevention Source: 13
youth_viol1	Programmes to prevent youth violence – Pre-school enrichment	0: None 1: Limited 2: Larger scale 3: Don't know	Global status report on violence prevention Source: 13
youth_viol2	Programmes to prevent youth violence – Life skills and social development training	0: None 1: Limited 2: Larger scale 3: Don't know	Global status report on violence prevention Source: 13
youth_viol3	Programmes to prevent youth violence – Mentoring	0: None 1: Limited 2: Larger scale 3: Don't know	Global status report on violence prevention Source: 13
youth_viol4	Programmes to prevent youth violence – After-school supervision	0: None 1: Limited 2: Larger scale 3: Don't know	Global status report on violence prevention Source: 13
youth_viol5	Programmes to prevent youth violence – School anti-bullying	0: None 1: Limited 2: Larger scale 3: Don't know	Global status report on violence prevention Source: 13
law_ipv1	Laws against intimate partner violence – Law regarding minimum legal age at marriage exists	0: No 1: Yes 2: Subnational	Global status report on violence prevention Source: 13
law_ipv2	Laws against intimate partner violence – According to the law, the minimum legal age of marriage for females	Age in years	Global status report on violence prevention Source: 13

Variable Name	Variable Description	Variable Values	Source Name/Number
law_ipv3	Laws against intimate partner violence – According to the law, the minimum legal age of marriage for males	Age in years	Global status report on violence prevention Source: 13
cps	Implementation of child protection services	0: None 1: Limited 2: Larger scale	Global status report on violence prevention Source: 13
weap1	Laws against weapons on school premises – Existence	0: No 1: Yes 2: Subnational	Global status report on violence prevention Source: 13
weap2	Laws against weapons on school premises – Enforcement	2: Limited 3: Partial 4: Full	Global status report on violence prevention Source: 13
pbs_chilmal	Conduct national population-based survey – Child maltreatment	0: No 1: Yes 2: Subnational 3: Don't know	Global status report on violence prevention Source: 13
mca_1	National policies/strategies that recommend a minimum of 4 ANC visits	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_2	National policies/strategies that recommend an ANC visit in first trimester	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_3	National policies/strategies that recommend the right to access skilled care at childbirth	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_4	National policies/strategies that recommend the presence of birth companion during labour and childbirth	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_5	National policies/strategies that recommend the use of partograph for monitoring active labour	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16

Variable Name	Variable Description	Variable Values	Source Name/Number
mca_6	National policies/strategies that recommend the use of oxytocin for management of third stage of labour	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_7	National policies/strategies that recommend the use of magnesium sulfate for the prevention and treatment of eclampsia	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_8	National policies/strategies that recommend the use of antenatal corticosteroids for preterm labour	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_9	National policies/strategies that recommend the use of ergometrine for management of third stage of labour	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_10	National policies/strategies that recommend the use of misoprostol for management of third stage of labour	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_11	National policies/strategies that recommend the discharge of mother and baby only after 24 hours following childbirth	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_12	National policies/strategies that recommend postnatal contact by trained provider (in <24 hours after birth)	0: No 1: Yes 2: No data 3: Unknown/No answer 5: Partial	MCA Policy Indicator Survey Source: 16
mca_13	National policies/strategies that recommend at least one home visit in postnatal contact	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_14	National policies/strategies that recommend engaging community health worker for postnatal contact	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_15	National policies/strategies that recommend special care for low-birth-weight newborns	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16

Variable Name	Variable Description	Variable Values	Source Name/Number
mca_16	National policies/strategies that recommend Kangaroo Mother Care for low-birth-weight newborns	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_17	National policies allowing midwife and nurse-midwife to administer selected life-saving interventions – Oxytocin for postpartum haemorrhage	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_18	National policies allowing midwife and nurse-midwife to administer selected life-saving interventions – Magnesium sulfate for eclampsia	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_19	National policies allowing midwife and nurse-midwife to administer selected life-saving interventions – Parenteral antibiotics	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_20	National policies allowing midwife and nurse-midwife to administer selected life-saving interventions – Manually remove placenta	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_21	National policies allowing midwife and nurse-midwife to administer selected life-saving interventions – Remove retained products of conception	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_22	National policies allowing midwife and nurse-midwife to administer selected life-saving interventions – Perform assisted vaginal delivery	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_23	National policies allowing midwife and nurse-midwife to administer selected life-saving interventions – Perform newborn resuscitation	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_24	National Essential Medicines List for delivery and newborn care includes key medicines	1: Yes 2: No data 5: Partial	MCA Policy Indicator Survey Source: 16

Variable Name	Variable Description	Variable Values	Source Name/Number
mca_25	National Essential Medicines List for delivery and newborn care includes magnesium sulfate	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_26	National Essential Medicines List for delivery and newborn care includes oxytocin	1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_27	National Essential Medicines List for delivery and newborn care includes misoprostol tablets	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_28	National Essential Medicines List for delivery and newborn care includes ampicillin or amoxicillin injections	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_29	National Essential Medicines List for delivery and newborn care includes gentamycin injection	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_30	National Essential Medicines List for delivery and newborn care includes metronidazole injection	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_31	National Essential Medicines List for delivery and newborn care includes dexamethasone injection	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_32	National Essential Medicines List for delivery and newborn care includes procaine penicillin injection	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_33	National Essential Medicines List for delivery and newborn care includes antenatal corticosteroids	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_34	National Essential Medicines List for delivery and newborn care includes chlorhexidine	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16

Variable Name	Variable Description	Variable Values	Source Name/Number
mca_35	National standard equipment and supplies list for maternal and newborn care includes key equipment	1: Yes 2: No data 3: Unknown/No answer 5: Partial	MCA Policy Indicator Survey Source: 16
mca_36	National standard equipment and supplies list for maternal and newborn care includes manual vacuum aspirator	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_37	National standard equipment and supplies list for maternal and newborn care includes ventouse/forceps	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_38	National standard equipment and supplies list for maternal and newborn care includes partograph	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_39	National standard equipment and supplies list for maternal and newborn care includes self-inflating bag (newborn size) with paediatric masks of different sizes and valves	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_40	National standard equipment and supplies list for maternal and newborn care includes suction pump, catheter and suction bulb	1: Yes 2: No data 3: Unknown/no answer	MCA Policy Indicator Survey Source: 16
mca_41	National standard equipment and supplies list for maternal and newborn care includes oxygen supply	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_42	Policy on notification/review of maternal and newborn deaths – Notification of all maternal deaths within 24 hours	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_43	Policy on notification/review of maternal and newborn deaths: Zero reporting on maternal deaths	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16

Variable Name	Variable Description	Variable Values	Source Name/Number
mca_44	Policy on notification/review of maternal and newborn deaths – Review of all maternal deaths	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_45	Policy on notification/review of maternal and newborn deaths – Review of all still births	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_46	Policy on notification/review of maternal and newborn deaths – Review of all neonatal deaths	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_47	National strategy/plan of action to reduce maternal mortality (at the time of survey)	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_48	National strategy/plan of action to reduce newborn mortality (at the time of survey)	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_49	Conducted specific national review covering maternal health programmes in past two years	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_50	Conducted specific national review covering newborn health programmes in past two years	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_51	User fee waiver in public sector – Antenatal care	0: No 1: Yes 2: No data 3: Unknown/No answer 5: Partial	MCA Policy Indicator Survey Source: 16
mca_52	User fee waiver in public sector – Child birth	0: No 1: Yes 2: No data 3: Unknown/No answer 5: Partial	MCA Policy Indicator Survey Source: 16

Variable Name	Variable Description	Variable Values	Source Name/Number
mca_53	User fee waiver in public sector – Caesarean delivery	0: No 1: Yes 2: No data 3: Unknown/No answer 5: Partial	MCA Policy Indicator Survey Source: 16
mca_54	User fee waiver in public sector – Pharmaceutical and supplies for maternal and newborn care	0: No 1: Yes 2: No data 3: Unknown/No answer 5: Partial	MCA Policy Indicator Survey Source: 16
mca_55	Data reporting period for MCA policy indicators (year)		MCA Policy Indicator Survey Source: 16
mca_chd_1	Implementation of the Integrated Management of Childhood Illness (IMCI) Strategy	0: No 1: Yes 2: No data 4: Not applicable	MCA Policy Indicator Survey Source: 16
mca_chd_2	National clinical guidelines for childcare updated since 2012	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_chd_3	Hospital care guidelines based on 2013 edition of WHO's pocket book for hospital care for children	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_chd_4	National IMCI guidelines based on 2014 WHO generic guidelines	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_chd_5	Guideline on management of pneumonia in community/home by trained provider	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_chd_6	National policy to use community-based health providers	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_chd_7	Updated guidelines to treat chest indrawing at first-level health facilities with antibiotics	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16

Variable Name	Variable Description	Variable Values	Source Name/Number
mca_chd_8	Management of diarrhoea – Use of low-osmolality ORS and zinc	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_chd_9	Management of diarrhoea – Use of community-based health providers	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_chd_10	National policy to use community-based providers to treat malaria	0: No 1: Yes 2: No data 3: Unknown/No answer 4: Not applicable	MCA Policy Indicator Survey Source: 16
mca_chd_11	Policy to use paid community-based providers for pneumonia, diarrhoea and malaria care	0: No 1: Yes 2: No data 3: Unknown/No answer 4: Not applicable	MCA Policy Indicator Survey Source: 16
mca_chd_12	One community-based provider delivering more than one intervention (pneumonia, diarrhoea, malaria)	0: No 1: Yes 2: No data 3: Unknown/No answer 4: Not applicable	MCA Policy Indicator Survey Source: 16
mca_chd_13	Community-based providers trained to manage pneumonia, diarrhoea and malaria in an integrated manner	0: No 1: Yes 2: No data 3: Unknown/No answer 4: Not applicable 5: Partial	MCA Policy Indicator Survey Source: 16
mca_chd_14	National Essential Medicines List for use in children under-five – Paediatric formulation of amoxicillin	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16

Variable Name	Variable Description	Variable Values	Source Name/Number
mca_chd_15	National Essential Medicines List for use in children under-five – Paediatric formulation of co-trimoxazole	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_chd_16	National Essential Medicines List for use in children under-five – Key medicines (tracers)	0: No 1: Yes 2: No data 3: Unknown/No answer 4: Not applicable 5: Partial	MCA Policy Indicator Survey Source: 16
mca_chd_17	National Essential Medicines List for use in children under-five – Oxygen for therapy	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_chd_18	National Essential Medicines List for use in children under-five – Rotavirus vaccination	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_chd_19	Ministry of Health engaged in national CRC implementation and monitoring process	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_chd_20	National strategy/plan of action to reduce child mortality (at the time of survey)	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_chd_21	Conducted specific national review covering child health programmes in past two years	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_chd_22	User fee in public sector for children under-five – Immunization	0: No 1: Yes 2: No data 3: Unknown/No answer 5: Partial	MCA Policy Indicator Survey Source: 16
mca_chd_23	User fee in public sector for children under-five – Sick child visit	0: No 1: Yes 2: No data 3: Unknown/No answer 5: Partial	MCA Policy Indicator Survey Source: 16

Variable Name	Variable Description	Variable Values	Source Name/Number
mca_chd_24	User fee in public sector for children under-five – Pharmaceuticals and supplies for treatment	0: No 1: Yes 2: No data 3: Unknown/No answer 5: Partial	MCA Policy Indicator Survey Source: 16
mca_chd_25	User fee in public sector for children under-five – Wellness and growth monitoring visits	0: No 1: Yes 2: No data 3: Unknown/No answer 5: Partial	MCA Policy Indicator Survey Source: 16
mca_ad_1	National standards for delivery of health services specifically for young people (ages 10–24 years)	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_ad_2	Clearly defined comprehensive package of health services for adolescents	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_ad_3	System in place for regular adolescent-specific training for health providers in first-level facilities	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_ad_4	Adolescents a specific target group in national policies/strategies/plans for sexual and reproductive health and family planning	0: No 1: Yes 2: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_ad_5	Adolescents a specific target group in national policies/strategies/plans for interventions to prevent HIV/AIDS	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_ad_6	Adolescents a specific target group in national policies/strategies/plans for nutritional intervention	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_ad_7	Adolescents a specific target group in national policies/strategies/plans for alcohol use prevention	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16

Variable Name	Variable Description	Variable Values	Source Name/Number
mca_ad_8	Adolescents a specific target group in national policies/strategies/plans for tobacco control activities	0: No 1: Yes 2: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_ad_9	Adolescents a specific target group in national policies/strategies/plans for mental health	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_ad_10	Adolescents a specific target group in national policies/strategies/plans for injury prevention	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_ad_11	Adolescents a specific target group in national policies/strategies/plans for violence	0: No 1: Yes 2: No data 3: Unknown/no answer	MCA Policy Indicator Survey Source: 16
mca_ad_12	Laws and regulations allow minor adolescents to seek the following services without parental/ spousal – Consent contraceptive services except sterilization	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_ad_13	Laws and regulations allow minor adolescents to seek the following services without parental/ spousal consent – Emergency contraception	0: No 1: Yes 2: No data 3: Unknown/No answer 4: Not applicable	MCA Policy Indicator Survey Source: 16
mca_ad_14	Laws and regulations allow minor adolescents to seek the following services without parental/ spousal consent – HIV testing and counselling services	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_ad_15	Laws and regulations allow minor adolescents to seek the following services without parental/ spousal consent – Harm reduction intervention for injecting drug users	0: No 1: Yes 2: No data 3: Unknown/No answer	MCA Policy Indicator Survey Source: 16
mca_ad_16	National strategy or plan of action that specifically addresses adolescent health issues (at the time of survey)	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16

Variable Name	Variable Description	Variable Values	Source Name/Number
mca_ad_17	Budget allocated to support activities planned for adolescent health	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_ad_18	Conducted specific national review covering adolescent health programmes in past two years	0: No 1: Yes 2: No data	MCA Policy Indicator Survey Source: 16
mca_ad_19	User fee waiver in public health sector for older adolescents (15–19 years)	0: No 1: Yes 2: No data 3: Unknown/No answer 4: Not applicable	MCA Policy Indicator Survey Source: 16
nat_wrkfrc1a	Nursing and midwifery personnel density (per 1000 population)		National Health Workforce Account Source: 18
nat_wrkfrc1b	Year of data collection: Nursing and midwifery personnel density (per 1000 population)		National Health Workforce Account Source: 18
nat_wrkfrc2a	Community and traditional health workers density (per 1000 population)		National Health Workforce Account Source: 18
nat_wrkfrc2b	Year of data collection: Community and traditional health workers density (per 1000 population)		National Health Workforce Account Source: 18
nat_wrkfrc3a	Number of nursing and midwifery personnel		National Health Workforce Account Source: 18
nat_wrkfrc3b	Year of data collection: Number of nursing and midwifery personnel		National Health Workforce Account Source: 18
nat_wrkfrc4a	Number of nursing personnel		National Health Workforce Account Source: 18
nat_wrkfrc4b	Year of data collection: Number of nursing personnel		National Health Workforce Account Source: 18
nat_wrkfrc5a	Number of midwifery personnel		National Health Workforce Account Source: 18
nat_wrkfrc5b	Year of data collection: Number of midwifery personnel		National Health Workforce Account Source: 18
nat_wrkfrc6a	Number of community and traditional health workers		National Health Workforce Account Source: 18
nat_wrkfrc6b	Year of data collection: Number of community and traditional health workers		National Health Workforce Account Source: 18

Variable Name	Variable Description	Variable Values	Source Name/Number
nat_wrkfrc7a	Number of community health workers		National Health Workforce Account Source: 18
nat_wrkfrc7b	Year of data collection: Number of community health workers		National Health Workforce Account Source: 18
nat_wrkfrc8a	Number of traditional birth attendants		National Health Workforce Account Source: 18
nat_wrkfrc8b	Year of data collection: Number of traditional birth attendants		National Health Workforce Account Source: 18
nat_wrkfrc9a	Number of licensed qualified obstetricians actively working		National Health Workforce Account Source: 18
nat_wrkfrc9b	Year of data collection: Number of licensed qualified obstetricians actively working		National Health Workforce Account Source: 18
rat_hmn_rght_trts	Number of human rights treaties that have been ratified	0: 0 – 4 1: 5 – 9 2: 10 – 14 3: 15 – 18	OHCHR Status of Ratification Interactive Dashboard Source: 19
edu_free_prim	Is primary education tuition-free? • *Tuition reported* means that the country reports charging tuition in primary school. A country's constitution may state that education is tuition-free, but if the country reports that tuition is charged, it appears as tuition reported. • *Tuition-free* includes cases where no tuition is charged in primary school but there may be other fees. These additional fees cannot be compared across countries, as there is not enough information available.	1: Tuition reported 5: Tuition-free	World Policy Analysis Center Source: 24
edu_comp_prim	Is primary education compulsory?	1: Not compulsory 5: Compulsory	World Policy Analysis Center Source: 24
edu_freecomp_prim	Is primary education tuition free and compulsory? • *Tuition reported* means that the country reports charging tuition in primary school. A country's constitution may state that education is tuition-free, but if the country reports that tuition is charged, it appears as tuition reported. • *Tuition-free* includes cases where no tuition is charged in primary school but there may be other fees. These additional fees cannot be compared across countries, as there is not enough information available.	1: Tuition reported 3: Tuition-free, but not compulsory 5: Tuition-free and compulsory	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
edu_integr	Is inclusive education available for children with disabilities? • In defining the term "children with disabilities" some countries refer to persons with physical disabilities, some refer to persons with mental health conditions or intellectual disabilities, and some discuss persons with disabilities in general. For the purposes of our variable the term "children with disabilities" captures all of these definitions. • *No public special education* means children with disabilities receive no additional support to meet their needs within the public school system. Nongovernmental and other organizations may provide some support for children with disabilities outside the public system. • *Low degree of integration* means that children with disabilities are sent to separate schools within the same public school system. • *At least medium degree of integration* means that children with disabilities may attend the same schools as other students, but not necessarily the same classrooms. • *High degree of integration* means that children with disabilities are able to be taught within the same classroom as other students. • A public school system is a school system that is government-provided and accessible to the general public.	1: No public special education 2: Low degree of integration 4: At least medium degree of integration 5: High degree of integration	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
const_rt_ genprimedu	Do citizens have a general constitutional right to education or a specific constitutional right to primary education? • General right to education means the constitution explicitly mentions a right to education or a right to education at all levels. • Specific right to primary education means the constitution explicitly mentions a right to primary education, a right to education at all levels or a right to education for at least 6 years or until at least age 11. • *Not granted in constitution* means that the constitution does not explicitly mention the right to education or primary education for all citizens. This does not mean that the constitution denies the right to education or primary education, but that it does not explicitly include either of these rights. If the right to education is only guaranteed to specific groups of people, the country will appear as not granting the right to education to all citizens on this variable. • *Aspirational in constitution* means that the constitution protects the general right to education or the specific right to primary education but does not use language strong enough to be considered a guarantee. For example, constitutions in this category might state that the country aims to protect the right to education or intends to provide free primary education. • *Guaranteed in constitution* means that the constitution protects the right to education or primary education in authoritative language. For example, constitutions in this category might guarantee citizens' right to education or make it the State's responsibility to provide primary education. However, constitutions in this category do not guarantee that education is free and/or compulsory. • *Guaranteed compulsory or free* means that the constitution guarantees the right to free or compulsory education, but not both, in authoritative language, either generally or specifically at the primary level. Guaranteed compulsory and free means that the constitution guarantees both the right to free and the right to compulsory education in authoritative language, either generally or specifically at the primary level.	1: Not granted in constitution 2: Aspirational in constitution 3: Guaranteed in constitution 4: Guaranteed compulsory or free 5: Guaranteed compulsory and free	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
const_rt_secedu	Do citizens have a general constitutional right to education or a specific constitutional right to secondary education? • General right to education means the constitution explicitly mentions a right to education or a right to education at all levels. • Specific right to secondary education means the constitution explicitly mentions a right to secondary education, a right to education at all levels or a right to education for at least 6 years or until at least age 11. • *Not granted in constitution* means that the constitution does not explicitly mention the right to education or secondary education for all citizens. This does not mean that the constitution denies the right to education or secondary education, but that it does not explicitly include either of these rights. If the right to education is only guaranteed to specific groups of people, the country will appear as not granting the right to education to all citizens on this variable. • *Aspirational in constitution* means that the constitution protects the general right to education or the specific right to secondary education but does not use language strong enough to be considered a guarantee. For example, constitutions in this category might state that the country aims to protect the right to education or intends to provide free secondary education. • *Guaranteed in constitution* means that the constitution protects the right to education or secondary education in authoritative language. For example, constitutions in this category might guarantee citizens' right to education or make it the State's responsibility to provide secondary education. However, constitutions in this category do not guarantee that education is free and/or compulsory. • *Guaranteed compulsory or free* means that the constitution guarantees the right to free or compulsory education, but not both, in authoritative language, either generally or specifically at the secondary level. • *Guaranteed compulsory and free* means that the constitution guarantees both the right to free and the right to compulsory education in authoritative language, either generally or specifically at the secondary level.	1: Not granted in constitution 2: Aspirational in constitution 3: Guaranteed in constitution 4: Guaranteed compulsory or free 5: Guaranteed compulsory and free	

Variable Name	Variable Description	Variable Values	Source Name/Number
const_rt_ highedu	Do citizens have a general constitutional right to education or a specific constitutional right to higher education? • General right to education means the constitution explicitly mentions a right to education or a right to education at all levels. • Specific right to higher education means the constitution explicitly mentions a right to higher education, a right to education at all levels or a right to education for at least 6 years or until at least age 11. • *Not granted in constitution* means that the constitution does not explicitly mention the right to education or higher education for all citizens. This does not mean that the constitution denies the right to education or higher education, but that it does not explicitly include either of these rights. If the right to education is only guaranteed to specific groups of people, the country will appear as not granting the right to education to all citizens on this variable. • *Aspirational in constitution* means that the constitution protects the general right to education or the specific right to higher education but does not use language strong enough to be considered a guarantee. For example, constitutions in this category might state that the country aims to protect the right to education or intends to provide free higher education. • *Guaranteed in constitution* means that the constitution protects the right to education or higher education in authoritative language. For example, constitutions in this category might guarantee citizens' right to education or make it the State's responsibility to provide higher education. However, constitutions in this category do not guarantee that education is free and/or compulsory. • *Guaranteed compulsory or free* means that the constitution guarantees the right to free or compulsory education, but not both, in authoritative language, either generally or specifically at the higher level. • *Guaranteed compulsory and free* means that the constitution guarantees both the right to free and the right to compulsory education in authoritative language, either generally or specifically at the higher level.	1: Not granted in constitution 2: Aspirational in constitution 3: Guaranteed in constitution 4: Guaranteed compulsory or free 5: Guaranteed compulsory and free	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
const_rt_edu_gender	Does the constitution protect the right to education regardless of gender? • The right to education is considered to be protected for girls when the following are explicitly granted to both boys and girls or are granted in general and the constitution states that individuals enjoy rights on an equal basis regardless of gender: the right to education, the right to education at all levels, the right to compulsory education, the right to free education and the prohibition of discrimination in education. • *None-specific to gender* means that the constitution does not explicitly protect the right to education for girls. This does not mean that the constitution denies this right, but that it does not explicitly include it. The country may protect citizens' right to education, but not specifically based on gender. • *Aspirational* means that the constitution protects the right to education for girls but does not use language strong enough to be considered a guarantee. For example, constitutions in this category might state that the country aims to ensure girls have the right to education. • *Specifically guaranteed with exceptions* includes cases where equality in education is guaranteed to both sexes but allows this protection to be curtailed in certain circumstances based on gender. This category does not apply to this variable, as there are no countries that have exceptions to protection against discrimination in education based on gender. • *Broadly guaranteed* means that the constitution guarantees the right to education to citizens and provides general protection against discrimination based on gender but does not specifically protect against discrimination *in education* based on gender. • *Specifically guaranteed* means that the constitution guarantees the right to education and protects against discrimination in education based on gender in authoritative language. For example, constitutions in this category might guarantee protection against discrimination in education based on gender or make it the State's responsibility to ensure this right for boys and girls.	1: Non-specific to gender 2: Aspirational 3: Specifically guaranteed with exceptions 4: Broadly guaranteed 5: Specifically guaranteed	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
const_rt_edu_ethnic	Does the constitution protect the right to education regardless of ethnicity? • The right to education is considered to be protected when the following are explicitly granted on the basis of ethnicity or are granted in general and the constitution states that individuals enjoy rights on an equal basis regardless of their ethnicity: the right to education, the right to education at all levels, the right to compulsory education, the right to free education and the prohibition of discrimination in education. • *None-specific to ethnicity* means that the constitution does not explicitly protect the right to education on the basis of ethnicity. This does not mean that the constitution denies this right, but that it does not explicitly include it. The country may protect citizens' right to education, but not specifically based on ethnicity. • *Aspirational* means that the constitution protects the right to education based on ethnicity but does not use language strong enough to be considered a guarantee. For example, constitutions in this category might state that the country aims to ensure ethnic minorities have the right to education. • *Specifically guaranteed with exceptions* includes cases where equality in education is guaranteed based on ethnicity but allows this protection to be curtailed in certain circumstances based on ethnicity. This category does not apply to this variable, as there are no countries that have exceptions to protection against discrimination in education based on ethnicity. • *Broadly guaranteed* means that the constitution guarantees the right to education to citizens and provides general protection against discrimination based on ethnicity but does not specifically protect against discrimination *in education* based on ethnicity. • *Specifically guaranteed* means that the constitution guarantees the right to education and protects against discrimination in education based on ethnicity in authoritative language. For example, constitutions in this category might guarantee protection against discrimination in education based on ethnicity or make it the State's responsibility to ensure this right.	1: Non-specific to ethnicity 2: Aspirational 3: Specifically guaranteed with exceptions 4: Broadly guaranteed 5: Specifically guaranteed	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
const_rt_edu_relig	Does the constitution protect the right to education regardless of religion? • The right to education is considered to be protected when the following are explicitly granted on the basis of religion or are granted in general and the constitution states that individuals enjoy rights on an equal basis regardless of their religion: the right to education, the right to education at all levels, the right to compulsory education, the right to free education and the prohibition of discrimination in education. • *None-specific to religion* means that the constitution does not explicitly protect the right to education on the basis of religion. This does not mean that the constitution denies this right, but that it does not explicitly include it. The country may protect citizens' right to education, but not specifically on the basis of religion. • *Aspirational* means that the constitution protects the right to education based on religion but does not use language strong enough to be considered a guarantee. For example, constitutions in this category might state that the country aims to ensure religious minorities have the right to education. • *Specifically guaranteed with exceptions* includes cases where equality in education is guaranteed on the basis of religion but allows this protection to be curtailed in certain circumstances based on religion. This category does not apply to this variable, as there are no countries that have exceptions to protection against discrimination in education based on religion. • *Broadly guaranteed* means that the constitution guarantees the right to education to citizens and provides general protection against discrimination on the basis of religion but does not specifically protect against discrimination *in education* based on religion. • *Specifically guaranteed* means that the constitution guarantees the right to education and protects against discrimination in education based on religion in authoritative language. For example, constitutions in this category might guarantee protection against discrimination in education based on religion or make it the State's responsibility to ensure this right.	1: Non-specific to religion 2: Aspirational 3: Specifically guaranteed with exceptions 4: Broadly guaranteed 5: Specifically guaranteed	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
const_rt_anyhlth	Does the constitution take any approach to health? Approaches to health include the right to health, public health or medical services. • *Not granted* means that the constitution does not explicitly mention health protections. This does not mean that the constitution denies these protections, but that it does not explicitly include them. • *Granted to specific groups, not universally* means the constitution explicitly guarantees the right to health, public health or medical services to specific groups, but not to all citizens. Specific groups that are named in constitutions include children, elderly people, poor people, persons with disabilities, women and ethnic minorities. • *Aspirational in constitution* means that the constitution protects the right to health, public health or medical services but does not use language strong enough to be considered a guarantee. For example, the nation will endeavour to provide the right to health or intends to provide medical services. • *Guaranteed in constitution* means that the constitution explicitly guarantees the right to health, medical services or public health to citizens in authoritative language. For example, constitutions in this category might guarantee citizens' right to health or make it the State's responsibility to ensure to protect it.	1: Not granted in constitution 2: Granted to specific groups, not universally 3: Aspirational in constitution 5: Guaranteed in constitution	World Policy Analysis Center Source: 24
const_rt_hlth	Do citizens have a specific right to health? • The right to health includes the right to "health", "health security" and overall well-being". • *Not granted in constitution* means that the constitution does not explicitly mention health protections. This does not mean that the constitution denies these protections, but that it does not explicitly include them. • *Granted to specific groups, not universally* means the constitution explicitly guarantees the right to health, public health or medical services to specific groups, but not to all citizens. Specific groups that are named in constitutions include children, elderly people, poor people, persons with disabilities, women and ethnic minorities. • *Aspirational in constitution* means that the constitution protects the right to health, public health or medical services but does not use language strong enough to be considered a guarantee. For example, the nation will endeavour to provide the right to health or intends to provide medical services. • *Guaranteed in constitution* means that the constitution explicitly guarantees the right to health, medical services or public health to citizens in authoritative language. For example, constitutions in this category might guarantee citizens' right to health or make it the State's responsibility to ensure the protection of the right to health.	1: Not granted in constitution 2: Granted to specific groups, not universally 3: Aspirational in constitution 5: Guaranteed in constitution	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
al_lv_hlth	Can working parents take leave specifically for children's health needs? • Leave for children's health needs incudes leave specifically for children's health needs, including where leave is available only for serious illness, hospitalization or urgent health needs.	1: No leave 3: Yes, unpaid leave 5: Yes, paid leave	World Policy Analysis Center Source: 24
al_bf_breaks	Are mothers of infants guaranteed breastfeeding breaks at work? • If legislation specifies a length of time permitted to breastfeed after the mother returns to work and the mother is also entitled to paid maternal leave, the age shown is the sum of post-birth paid maternal leave and the breastfeeding break entitlement.	1: No guarantee 2: Yes, until child is 1–5.9 months old 4: Yes, until child is 6–11.9 months old 5: Yes, until child is at least 1 year old	World Policy Analysis Center Source: 24
al_bg_6mos	Are working mothers guaranteed paid options to facilitate exclusive breastfeeding for at least 6 months?	1: None 3: Breastfeeding breaks or maternal leave only 5: Both	World Policy Analysis Center Source: 24
al_lv_edu	Can working parents take leave specifically for children's educational needs?	1: No leave 3: Yes, unpaid leave 5: Yes, paid leave	World Policy Analysis Center Source: 24
al_healthoredu_lv	Can working parents take leave to meet children's health and educational needs? • Leave for children's health needs is only leave specifically designated for children's health needs. It does not include cases where leave is available only for serious illnesses, hospitalization or urgent health needs. • Leave for children's educational needs is only leave specifically designated for children's educational needs. There are no countries that only guarantee leave for children's educational needs without also guaranteeing leave for children's health needs. • When leave to meet a child's health needs is made available only to women, it was not included. Our map only shows leave available to both men and women to ensure gender equality. • This variable includes paid and unpaid leave.	1: No leave 3: Education only 4: Leave for health needs only 5: Leave for health and education needs	World Policy Analysis Center Source: 24
cl_genemp	How long are children protected from full-time work? • *Full-time work* is defined as 35 hours of work per week.	Range: 12–18 0: No minimum age	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
cl_haz_minage	Without taking exceptions into account, how long are children protected from hazardous work? • Hazardous work is work that is harmful to children's health or safety. If a country explicitly defined hazardous work in its legislation, its own definition was used. For countries that do not define hazardous work, we use the International Labour Organization's definition: "(a) work which exposes children to physical, psychological or sexual abuse; (b) work underground, under water, at dangerous heights or in confined spaces; (c) work with dangerous machinery, equipment and tools, or which involves the manual handling or transport of heavy loads; (d) work in an unhealthy environment which may, for example, expose children to hazardous substances, agents, or processes, or to temperatures, noise levels, or vibrations damaging to their health; (e) work under particularly difficult conditions such as work for long hours or during the night or work where the child is unreasonably confined to the premises of the employer." • In some cases, there is no minimum age for hazardous work but there is a minimum age for general employment. In these cases, the minimum age for general employment is used based on the assumption that if children are not permitted to work, they will not be permitted to do hazardous work. At the same time, we assume that if hazardous work is not regulated separately, then children will be able to do hazardous work once they reach the minimum working age.	Range: 14–18 0: No minimum age	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
cl_wkpermit_12	What work protections do 12-year-olds have when exceptions to minimum-age protections are considered? • Legal exceptions are cases where the legislation allows children to do work at a younger age under specific circumstances. For hazardous work, we include any exception to the minimum age for hazardous work except "force majeure" (extraordinary circumstances such as war) and "no harm to health, safety and morals" (because in this case the work would no longer be defined as hazardous). For general employment and light work, exceptions include specific types of work, such as agricultural, temporary or seasonal work; exceptions to allow children to work with family members; and exceptions that require only minister or government approval or when the work is deemed indispensable for the child or their family, because these may not be adequately protective in practice. • Hazardous work is work that is harmful to children's health or safety. If a country explicitly defined hazardous work in its legislation, its own definition was used. For countries that do not define hazardous work, we use the International Labour Organization's definition: "(a) work which exposes children to physical, psychological or sexual abuse; (b) work underground, under water, at dangerous heights or in confined spaces; (c) work with dangerous machinery, equipment and tools, or which involves the manual handling or transport of heavy loads; (d) work in an unhealthy environment which may, for example, expose children to hazardous substances, agents, or processes, or to temperatures, noise levels, or vibrations damaging to their health; (e) work under particularly difficult conditions such as work for long hours or during the night or work where the child is unreasonably confined to the premises of the employer." • In some cases, there is no minimum age for hazardous work but there is a minimum age for general employment. In these cases, we assume children are not protected from hazardous work once they reach the minimum age for general employment, because any type of work is permitted at that age. • Work is any employment that is not specified as hazardous or light. Children may only be allowed to work in agriculture or with family members. • The International Labour Organization defines light work as "(a) not likely to be harmful to their health or development; and (b) not such as to prejudice their attendance at school, their participation in vocational orientation or training programs approved by the competent authority or their capacity to benefit from the instruction received." When a country does not explicitly define light work, we consider work "light" when legislation specifies that it cannot harm the child's health or development or interrupt his or her schooling, or when the legislation explicitly identifies work that can be done at a younger age than general employment.	1: Not protected from hazardous work 2: Not protected from general employment 4: Not protected from light work 5: No work permitted	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
cl_wkpermit_14	What work protections do 14-year-olds have when exceptions to minimum-age protections are considered? • Legal exceptions are cases where the legislation allows children to do work at a younger age under specific circumstances. For hazardous work, we include any exception to the minimum age for hazardous work except "force majeure" (extraordinary circumstances such as war) and "no harm to health, safety and morals" (because in this case the work would no longer be defined as hazardous). For general employment and light work, exceptions include specific types of work, such as agricultural, temporary or seasonal work; exceptions to allow children to work with family members; and exceptions that require only minister or government approval or when the work is deemed indispensable for the child or their family, because these may not be adequately protective in practice. • Hazardous work is work that is harmful to children's health or safety. If a country explicitly defined hazardous work in its legislation, its own definition was used. For countries that do not define hazardous work, we use the International Labour Organization's definition: "(a) work which exposes children to physical, psychological or sexual abuse; (b) work underground, under water, at dangerous heights or in confined spaces; (c) work with dangerous machinery, equipment and tools, or which involves the manual handling or transport of heavy loads; (d) work in an unhealthy environment which may, for example, expose children to hazardous substances, agents, or processes, or to temperatures, noise levels, or vibrations damaging to their health; (e) work under particularly difficult conditions such as work for long hours or during the night or work where the child is unreasonably confined to the premises of the employer." • In some cases, there is no minimum age for hazardous work but there is a minimum age for general employment. In these cases, we assume children are not protected from hazardous work once they reach the minimum age for general employment, because any type of work is permitted at that age. • Work is any employment that is not specified as hazardous or light. Children may only be allowed to work in agriculture or with family members. • The International Labour Organization defines light work as "(a) not likely to be harmful to their health or development; and (b) not such as to prejudice their attendance at school, their participation in vocational orientation or training programs approved by the competent authority or their capacity to benefit from the instruction received." When a country does not explicitly define light work, we consider work "light" when legislation specifies that it cannot harm the child's health or development or interrupt his or her schooling, or when the legislation explicitly identifies work that can be done at a younger age than general employment.	1: Not protected from hazardous work 2: Not protected from general employment 4: Not protected from light work 5: No work permitted	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
cl_wkpermit_16	What work protections do 16-year-olds have when exceptions to minimum-age protections are considered? • Legal exceptions are cases where the legislation allows children to do work at a younger age under specific circumstances. For hazardous work, we include any exception to the minimum age for hazardous work except "force majeure" (extraordinary circumstances such as war) and "no harm to health, safety and morals" (because in this case the work would no longer be defined as hazardous). For general employment and light work, exceptions include specific types of work, such as agricultural, temporary or seasonal work; exceptions to allow children to work with family members; and exceptions that require only minister or government approval or when the work is deemed indispensable for the child or their family, because these may not be adequately protective in practice. • Hazardous work is work that is harmful to children's health or safety. If a country explicitly defined hazardous work in its legislation, its own definition was used. For countries that do not define hazardous work, we use the International Labour Organization's definition: "(a) work which exposes children to physical, psychological or sexual abuse; (b) work underground, under water, at dangerous heights or in confined spaces; (c) work with dangerous machinery, equipment and tools, or which involves the manual handling or transport of heavy loads; (d) work in an unhealthy environment which may, for example, expose children to hazardous substances, agents, or processes, or to temperatures, noise levels, or vibrations damaging to their health; (e) work under particularly difficult conditions such as work for long hours or during the night or work where the child is unreasonably confined to the premises of the employer." • In some cases, there is no minimum age for hazardous work but there is a minimum age for general employment. In these cases, we assume children are not protected from hazardous work once they reach the minimum age for general employment, because any type of work is permitted at that age. • Work is any employment that is not specified as hazardous or light. Children may only be allowed to work in agriculture or with family members. • The International Labour Organization defines light work as "(a) not likely to be harmful to their health or development; and (b) not such as to prejudice their attendance at school, their participation in vocational orientation or training programs approved by the competent authority or their capacity to benefit from the instruction received." When a country does not explicitly define light work, we consider work "light" when legislation specifies that it cannot harm the child's health or development or interrupt his or her schooling, or when the legislation explicitly identifies work that can be done at a younger age than general employment.	1: Not protected from hazardous work 2: Not protected from general employment 4: Not protected from light work 5: No work permitted	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
cl_age_ schoolhrs6	Until what age are children protected from working 6 or more hours on a school day? • If legislation specifies that children can only do light work, which by definition should not interfere with schooling, it is assumed that they are protected from working 6 or more hours on a school day. • A nation's stated maximum number of hours permitted on a school day is used whenever available to measure whether children are protected from working 6 or more hours. • When countries do not specify hours of work allowed on a school day, we use the maximum number of hours permitted per day (not specific to a school day) because it is assumed that these regulations will also apply to school days. • When countries state that work is prohibited during school hours but do not specify particular hour limitations, a 6-hour school day is assumed and is combined with data on hours of rest guaranteed at night; the remaining number of hours is used to determine the hours of work permitted on school days.	Range: 12–18 0: No minimum age	World Policy Analysis Center Source: 24
cl_schday_12	How many hours are 12-year-olds legally protected from working on a school day? • A nation's stated maximum number of hours permitted on a school day is used whenever available. • When countries do not specify hours of work allowed on a school day, we use the maximum number of hours permitted per day (not specific to a school day) because it is assumed that these regulations will also apply to school days. • When countries state that work is prohibited during school hours but do not specify particular hour limitations, a 6-hour school day is assumed and is combined with data on hours of rest guaranteed at night; the remaining number of hours is used to determine the hours of work permitted on school days. • *Protected from any work* means that children are not generally permitted to do any type of work. • The International Labour Organization defines light work as "(a) not likely to be harmful to their health or development; and (b) not such as to prejudice their attendance at school, their participation in vocational orientation or training programs approved by the competent authorityor their capacity to benefit from the instruction received." When a country does not explicitly define light work, we consider work "light"when legislation specifies that it cannot harm the child's health or development or interrupt his or her schooling, or when the legislation explicitly identifies work that can be done at a younger age than general employment.	1: 8 or more hours 2: 6–7.9 hours 3: 3–5.9 hours 4: 1–2.9 hours 5: Protected from any work 999: Only light work permitted	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
cl_schday_14	How many hours are 14-year-olds legally protected from working on a school day? • A nation's stated maximum number of hours permitted on a school day is used whenever available. • When countries do not specify hours of work allowed on a school day, we use the maximum number of hours permitted per day (not specific to a school day) because it is assumed that these regulations will also apply to school days. • When countries state that work is prohibited during school hours but do not specify particular hour limitations, a 6-hour school day is assumed and is combined with data on hours of rest guaranteed at night; the remaining number of hours is used to determine the hours of work permitted on school days. • *Protected from any work* means that children are not generally permitted to do any type of work. • The International Labour Organization defines light work as "(a) not likely to be harmful to their health or development; and (b) not such as to prejudice their attendance at school, their participation in vocational orientation or training programs approved by the competent authority or their capacity to benefit from the instruction received." When a country does not explicitly define light work, we consider work "light" when legislation specifies that it cannot harm the child's health or development or interrupt his or her schooling, or when the legislation explicitly identifies work that can be done at a younger age than general employment.	1: 8 or more hours 2: 6–7.9 hours 3: 3–5.9 hours 4: 1–2.9 hours 5: Protected from any work 999: Only light work permitted	World Policy Analysis Center Source: 24
cl_schday_16	How many hours are 16-year-olds legally protected from working on a school day? • A nation's stated maximum number of hours permitted on a school day is used whenever available. • When countries do not specify hours of work allowed on a school day, we use the maximum number of hours permitted per day (not specific to a school day) because it is assumed that these regulations will also apply to school days. • When countries state that work is prohibited during school hours but do not specify particular hour limitations, a 6-hour school day is assumed and is combined with data on hours of rest guaranteed at night; the remaining number of hours is used to determine the hours of work permitted on school days. • *Protected from any work* means that children are not generally permitted to do any type of work. • The International Labour Organization defines light work as "(a) not likely to be harmful to their health or development; and (b) not such as to prejudice their attendance at school, their participation in vocational orientation or training programs approved by the competent authority or their capacity to benefit from the instruction received." When a country does not explicitly define light work, we consider work "light" when legislation specifies that it cannot harm the child's health or development or interrupt his or her schooling, or when the legislation explicitly identifies work that can be done at a younger age than general employment.	1: 8 or more hours 2: 6–7.9 hours 3: 3–5.9 hours 4: 1–2.9 hours 5: Protected from any work 999: Only light work permitted	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
cl_age_ nightrest12	Until what age are children guaranteed 12 hours off from work at night? • *Hours of rest at night* is the number of uninterrupted hours off work at night that children are guaranteed at particular ages. • If legislation specifies only that a child cannot work at night, it is *not* assumed that children have at least 12 hours off at night. • If a country specifies only that work by children and youth is limited to a given number of hours per day, it is not counted as prohibiting night work because the working hours could occur at night. • If only light work is permitted, it is assumed that children have at least 12 hours of nightly rest.	Range: 12–18 0: No minimum age	World Policy Analysis Center Source: 24
cl_nightrest_12	How many hours off from work at night are 12-year-olds guaranteed? • *Hours of rest at night* are the numbers of uninterrupted hours off work at night that children are guaranteed at age 12. • *Not guaranteed* means there is no guarantee of time off specifically at night. If a country specifies only that work by children and youth is limited to a given number of hours per day, it is not counted as prohibiting night work because the working hours could occur at night. • *Less than 10 hours* includes cases where legislation prohibits night work but does not specify the number of hours. • *Protected from working* means children may not do general work at age 12. Light work may be permitted. If legislation specifies children can only do light work which by definition should not interfere with schooling, it is assumed that they are well protected for nightly rest.	1: Not guaranteed 2: Less than 10 hours 3: Only 10–11.9 hours 4: At least 12 hours 5: Protected from working	World Policy Analysis Center Source: 24
cl_nightrest_14	How many hours off from work at night are 14-year-olds guaranteed? • *Hours of rest at night* are the numbers of uninterrupted hours off work at night that children are guaranteed at age 14. • *Not guaranteed* means there is no guarantee of time off specifically at night. If a country specifies only that work by children and youth is limited to a given number of hours per day, it is not counted as prohibiting night work because the working hours could occur at night. • *Less than 10 hours* includes cases where legislation prohibits night work but does not specify the number of hours. • *Protected from working* means children may not do general work at age 14. Light work may be permitted. If legislation specifies children can only do light work which by definition should not interfere with schooling, it is assumed that they are well protected for nightly rest.	1: Not guaranteed 2: Less than 10 hours 3: Only 10–11.9 hours 4: At least 12 hours 5: Protected from working	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
cl_nightrest_16	How many hours off from work at night are 16-year-olds guaranteed? • *Hours of rest at night* are the numbers of uninterrupted hours off work at night that children are guaranteed at age 16. • *Not guaranteed* means there is no guarantee of time off specifically at night. If a country specifies only that work by children and youth is limited to a given number of hours per day, it is not counted as prohibiting night work because the working hours could occur at night. • *Less than 10 hours* includes cases where legislation prohibits night work but does not specify the number of hours. • *Protected from working* means children may not do general work at age 16. Light work may be permitted. If legislation specifies children can only do light work which by definition should not interfere with schooling, it is assumed that they are well protected for nightly rest.	1: Not guaranteed 2: Less than 10 hours 3: Only 10–11.9 hours 4: At least 12 hours 5: Protected from working	World Policy Analysis Center Source: 24
cl_haz_minage_except	How long are children protected from hazardous work when exceptions to minimum-age protections are considered? • Hazardous work is work that is harmful to children's health or safety. If a country explicitly defined hazardous work in its legislation, its own definition was used. For countries that do not define hazardous work, we use the International Labour Organization's definition: "(a) work which exposes children to physical, psychological or sexual abuse; (b) work underground, under water, at dangerous heights or in confined spaces; (c) work with dangerous machinery, equipment and tools, or which involves the manual handling or transport of heavy loads; (d) work in an unhealthy environment which may, for example, expose children to hazardous substances, agents, or processes, or to temperatures, noise levels, or vibrations damaging to their health; (e) work under particularly difficult conditions such as work for long hours or during the night or work where the child is unreasonably confined to the premises of the employer." • In some cases, there is no minimum age for hazardous work but there is a minimum age for general employment. In these cases, the minimum age for general employment is used based on the assumption that if children are not permitted to work, they will not be permitted to do hazardous work. At the same time, we assume that if hazardous work is not regulated separately, then children will be able to do hazardous work once they reach the minimum working age.	Range: 12–18 0: No minimum age	World Policy Analysis Center Source: 24
fb_birthsupp_amt	How much are birth or maternity grants available to first-time parents? • Information is presented on grants available for the first child in order to have a basis for comparison across countries	1: No grant available 2: Less than $50 PPP 3: $50–$149.99 PPP 4: $150–$499 PPP 5: $500 PPP or more	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
fb_modelfam_presch	How much financial assistance is available per month to low-income families with two preschool children per month? • Cash benefits refer to direct financial assistance provided to households by the government, as opposed to other types of assistance such as food stamps or tax. • Our data on family benefits include only cash benefits because we were unable to examine other types of transfers to families, as there was no reliable global data source for this information. • To provide a concrete and comparable image of the financial support offered to families across countries, we calculated benefit levels for sample families with a specified number of children of a specified age. For families with school-age children, the calculation was made based on a family with two 8-year-old children. • When benefits differed according to income level, the lowest income bracket was used, as we were particularly interested in financial support available to families with the greatest need. • Benefits are adjusted for differences in buying power across countries.	1: No known family benefits 2: Less than $20 PPP 3: $20–59.99 PPP 4: $60–149.99 PPP 5: $150 PPP or more	World Policy Analysis Center Source: 24
fb_modelfam_school	How much financial assistance is available per month to low-income families with two school-age children per month? • Cash benefits refer to direct financial assistance provided to households by the government, as opposed to other types of assistance such as food stamps or tax. • Our data on family benefits include only cash benefits because we were unable to examine other types of transfers to families, as there was no reliable global data source for this information. • To provide a concrete and comparable image of the financial support offered to families across countries, we calculated benefit levels for sample families with a specified number of children of a specified age. For families with school-age children, the calculation was made based on a family with two 8-year-old children. • When benefits differed according to income level, the lowest income bracket was used, as we were particularly interested in financial support available to families with the greatest need. • Benefits are adjusted for differences in buying power across countries.	1: No known family benefits 2: Less than $20 PPP 3: $20–59.99 PPP 4: $60–149.99 PPP 5: $150 PPP or more	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
fb_modelfam_teen	How much financial assistance is available per month to low-income families with two teenage children per month? • Cash benefits refer to direct financial assistance provided to households by the government, as opposed to other types of assistance such as food stamps or tax. • Our data on family benefits include only cash benefits because we were unable to examine other types of transfers to families, as there was no reliable global data source for this information. • To provide a concrete and comparable image of the financial support offered to families across countries, we calculated benefit levels for sample families with a specified number of children of a specified age. For families with school-age children, the calculation was made based on a family with two 8-year-old children. • When benefits differed according to income level, the lowest income bracket was used, as we were particularly interested in financial support available to families with the greatest need. • Benefits are adjusted for differences in buying power across countries.	1: No known family benefits 2: Less than $20 PPP 3: $20–59.99 PPP 4: $60–149.99 PPP 5: $150 PPP or more	World Policy Analysis Center Source: 24
fb_ccschsupp	Do families receive benefits for childcare or school costs? • *Means-tested benefits* are only available to families with incomes below a certain level. • *Benefits available without a means test* are available to families without considering their income.	1: No benefits for childcare or school costs 3: Means-tested benefits 4: Benefits available without means test 5: Both with and without a means test	World Policy Analysis Center Source: 24
cm_minage_fem_leg	What is the minimum age of marriage for girls?	Range: 9–21 0: No minimum age	World Policy Analysis Center Source: 24
cm_minage_mal_leg	What is the minimum age of marriage for boys?	Range: 13–22 0: No minimum age	World Policy Analysis Center Source: 24
cm_legal_diff_leg	Is there a gender disparity in the legal age of marriage?	1: No minimum age for girls and boys 2: Girls can be married 3–4 years younger than boys 3: Girls can be married 1–2 years younger than boys 5: No difference in minimum age	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
cm_protect_girl_13	Under what circumstances can a 13-year-old girl be married? • *No restrictions* means that there are no legal restrictions on girls marrying at age 13. • *Can marry with parental consent and/or under religious or customary law* means that girls may be married at age 13 with parental permission and/or under religious or customary law. We do not consider that these requirements are protective of at-risk children. • *Only permitted with court approval or when pregnant* means girls may be married at age 13 only with approval that is likely to be more protective (such as court or social welfare centre approval) or in the case of pregnancy or after the birth of a child. • *Marriage legally prohibited* means that there are no circumstances under which a 13-year-old girl can legally be married.	1: No restrictions 2: Can marry with parental consent and/or under religious or customary law 3: Only permitted with court approval and/or pregnancy 5: Marriage legally prohibited	World Policy Analysis Center Source: 24
cm_protect_girl_15	Under what circumstances can a 15-year-old girl be married? • *No restrictions* means that there are no legal restrictions on girls marrying at age 15. • *Can marry with parental consent and/or under religious or customary law* means that girls may be married at age 15 with parental permission and/or under religious or customary law. We do not consider that these requirements are protective of at-risk children. • *Only permitted with court approval or when pregnant* means girls may be married at age 15 only with approval that is likely to be more protective (such as court or social welfare centre approval) or in the case of pregnancy or after the birth of a child. • *Marriage legally prohibited* means that there are no circumstances under which a 15-year-old girl can legally be married.	1: No restrictions 2: Can marry with parental consent and/or under religious or customary law 3: Only permitted with court approval and/or pregnancy 5: Marriage legally prohibited	World Policy Analysis Center Source: 24
cm_protect_girl_17	Under what circumstances can a 17-year-old girl be married? • *No restrictions* means that there are no legal restrictions on girls marrying at age 17. • *Can marry with parental consent and/or under religious or customary law* means that girls may be married at age 17 with parental permission and/or under religious or customary law. We do not consider that these requirements are protective of at-risk children. • *Only permitted with court approval or when pregnant* means girls may be married at age 17 only with approval that is likely to be more protective (such as court or social welfare centre approval) or in the case of pregnancy or after the birth of a child. • *Marriage legally prohibited* means that there are no circumstances under which a 17-year-old girl can legally be married.	1: No restrictions 2: Can marry with parental consent and/or under religious or customary law 3: Only permitted with court approval and/or pregnancy 5: Marriage legally prohibited	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
cm_protect_boy_13	Under what circumstances can a 13-year-old boy be married? • *No restrictions* means that there are no legal restrictions on boys marrying at age 13. • *Parental consent and/or under religious or customary law* means that boys may be married at age 13 with parental permission and/or under religious or customary law. We do not consider that these requirements are protective of at-risk children. • *Court approval or when pregnant* means boys may be married at age 13 only with approval that is likely to be more protective (such as court or social welfare centre approval) or when there is a pregnancy or birth of a child. • *Marriage legally prohibited* means that there are no circumstances under which a 13-year-old boy can legally be married.	1: No restrictions 2: Can marry with parental consent and/or under religious or customary law 3: Only permitted with court approval and/or pregnancy 5: Marriage legally prohibited	World Policy Analysis Center Source: 24
cm_protect_boy_15	Under what circumstances can a 15-year-old boy be married? • *No restrictions* means that there are no legal restrictions on boys marrying at age 13. • *Parental consent and/or under religious or customary law* means that boys may be married at age 13 with parental permission and/or under religious or customary law. We do not consider that these requirements are protective of at-risk children. • *Court approval or when pregnant* means boys may be married at age 13 only with approval that is likely to be more protective (such as court or social welfare centre approval) or when there is a pregnancy or birth of a child. • *Marriage legally prohibited* means that there are no circumstances under which a 13-year-old boy can legally be married.	1: No restrictions 2: Can marry with parental consent and/or under religious or customary law 3: Only permitted with court approval and/or pregnancy 5: Marriage legally prohibited	World Policy Analysis Center Source: 24
cm_protect_boy_17	Under what circumstances can a 17-year-old boy be married? • *No restrictions* means that there are no legal restrictions on boys marrying at age 13. • *Parental consent and/or under religious or customary law* means that boys may be married at age 13 with parental permission and/or under religious or customary law. We do not consider that these requirements are protective of at-risk children. • *Court approval or when pregnant* means boys may be married at age 13 only with approval that is likely to be more protective (such as court or social welfare centre approval) or when there is a pregnancy or birth of a child. • *Marriage legally prohibited* means that there are no circumstances under which a 13-year-old boy can legally be married.	1: No restrictions 2: Can marry with parental consent and/or under religious or customary law 3: Only permitted with court approval and/or pregnancy 5: Marriage legally prohibited	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
cm_except_pc	Are there exceptions to the general legal minimum age of marriage for girls?	1: No legislated minimum age of marriage 3: Yes, earlier marriage is legal with parental consent 4: Earlier marriage is legal with parental consent only with additional requirements 5: No exceptions to minimum age legislation based on parental consent	World Policy Analysis Center Source: 24
qor_medcare_2	Does the constitution guarantee medical care treatment to women and girls? • The right to medical services includes curative services, health-care services, disease treatment or discussion of the State's responsibility to restore/rehabilitate health. • *No relevant provision* means that the constitution does not explicitly mention the right to medical services for women. This does not mean that the constitution denies this right, but that it does not explicitly include it for women or all citizens. • *General guarantee, not specific to women* means the constitution explicitly guarantees the right to medical services to all citizens but does not explicitly address health protections for women or guarantee that women enjoy equal rights. • *Aspirational for women* means that the constitution protects the general right to medical services for women but does not use language strong enough to be considered a guarantee. For example, the nation intends to provide medical services for women or, within the limit of the State's resources, it will provide health care to citizens, and women enjoy equal rights to men. • *General right to medical care and broad protection from gender discrimination* means that the constitution guarantees the right to medical care treatment to citizens and provides general protection against discrimination based on gender but does not specifically guarantee women a right to medical care treatment. • *Guaranteed to women* means that the constitution explicitly guarantees the right to medical services to women in authoritative language. For example, constitutions in this category might guarantee citizens' right to medical services and guarantee that women enjoy equal social and economic rights to men.	1: No relevant provision 2: General guarantee, not specific to women 3: Aspirational for women 4: General right to medical care and broad protection from gender discrimination 5: Guaranteed to women	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
qor_ publichealth_2	Does the constitution guarantee protection of public health to women and girls? • The right to public health includes the "defence of public health", "access to preventive services", "illness prevention", etc. Each of these can be guaranteed in broad terms, such as the statement of a right to public health, and/or can be phrased more specifically, such as access to immunizations and health education. We considered the broad right to public health to be guaranteed when explicitly stated or when these types of specifics appeared within a broader applicable context. For example, if access to immunizations was mentioned within the context of the protection of public health or disease prevention, the right to public health was considered granted, but if it appeared alone, the overall right to public health was not considered guaranteed. • *No relevant provision* means that the constitution does not explicitly mention the right to public health for women. This does not mean that the constitution denies this right, but that it does not explicitly include it for women or all citizens. • *General guarantee, not specific to women* means that the constitution guarantees the right to public health for citizens but does not include a provision guaranteeing women equal rights broadly. • *Aspirational for women* means that the constitution protects the right to public health for women but does not use language strong enough to be considered a guarantee in addressing the right to public health. For example, the nation will endeavour to protect public health, and women enjoy equal rights to men. • *General guarantee of public health and broad protection from gender discrimination* means that the constitution guarantees the right to public health to citizens and provides general protection against discrimination based on gender but does not specifically guarantee women the right to public health. • *Guaranteed to women* means that the constitution explicitly guarantees the right to public health to women in authoritative language. For example, constitutions in this category might guarantee citizens' right to public health or make it the State's responsibility to ensure the protection of the right.	1: No relevant provision 2: General guarantee, not specific to women 3: Aspirational for women 4: General guarantee of public health and broad protection from gender discrimination 5: Guaranteed to women	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
qor_ anyhealth_2	Does the constitution take any approach to the protection of health for women? • Approaches to health include the right to health, public health or medical services. • *No, none* means that the constitution does not explicitly mention health protections for women. This does not mean that the constitution denies these protections, but that it does not explicitly include them for women or all citizens. • *General approach to health, not specific to women* means that the constitution explicitly guarantees the right to health, public health or medical services to citizens but does not specifically guarantee any of these rights to women or broadly protect women from discrimination. • *Aspirational for women* means that the constitution protects the right to health, public health or medical services for women but does not use language strong enough to be considered a guarantee. For example, the nation will endeavour to provide the right to health for women or the State intends to provide medical services to citizens, and women enjoy equal rights to men. • *General approach to health and broad protection from gender discrimination* means that the constitution guarantees the right to health, public health or medical services to citizens and provides general protection against discrimination based on gender but does not specifically guarantee any approach to health for women. • *Guaranteed to women* means that the constitution explicitly guarantees the right to health, medical services or public health to women in authoritative language. For example, constitutions in this category might guarantee women's right to health or make it the State's responsibility to ensure the protection of public health, and women enjoy equal rights to men.	1: None 2: General approach to health, not specific to women 3: Aspirational for women 4: General approach to health and broad protection from gender and discrimination 5: Guaranteed to women	World Policy Analysis Center Source: 24
dc_benprov	Are benefits available to families with disabilities? • In defining the term "children with disabilities" some countries refer to persons with physical disabilities, some refer to persons with mental health conditions or intellectual disabilities, and some discuss persons with disabilities in general. For the purposes of this database the term "children with disabilities" captures all of these definitions. • Data on family benefits include only government-provided cash benefits. We were unable to examine in-kind transfers to families and tax credits, as there was no reliable global data source for this information. • *No or limited family benefits* includes cases where family benefits are available only in certain circumstances, such as only to specific groups (for example, single parents or orphans), or as benefits to fund specific aspects of life, such as housing or school allowances. • *Means-tested family benefits* are only available to families with incomes below a certain level. There are no family benefits specific to children with disabilities. • *Family benefits that are not means-tested* are family benefits available to families without considering their incomes. There are no family benefits specific to children with disabilities.	1: No or limited family benefits 2: Means-tested family benefits 3: Family benefits are not means-tested 5: Specific benefits for disabled children	World Policy Analysis Center Source: 24

Variable Name	Variable Description	Variable Values	Source Name/Number
fb_modelfam_school_dc	How much financial assistance is available per month to low-income families with one severely disabled school-age child? • Some countries adjust the amount of these benefits based on the age of the child, the family's income, the amount of benefits received through other schemes and/or the nature of the child's disability. For the purposes of comparability, we examine the benefits provided to families in the lowest income bracket with one child with the most severe level of disability at a given age. • To provide a concrete and comparable image of the financial support offered to families across countries, we calculated benefit levels for sample families with a specified number of children of a specified age. For families with a teenage child, the calculation was made based on a family with one 15-year-old child. • *No specific family benefits* includes countries with no family benefit scheme as well as countries with general cash family benefits but no benefits specifically for children with disabilities. • Benefits are only the amount of money targeted towards children with disabilities. If a country has a general cash family benefit and an additional supplement for children with disabilities, we only consider the amount of the supplement. • Benefits are adjusted for differences in buying power across countries.	1: No specific family benefits 2: Less than $100 PPP 3: $100–$199.99 PPP 4: $200–$499.99 PPP 5: $500 PPP or more	World Policy Analysis Center Source: 24
fb_modelfam_teen_dc	How much financial assistance is available per month to low-income families with one severely disabled teenage child? • Some countries adjust the amount of these benefits based on the age of the child, the family's income, the amount of benefits received through other schemes and/or the nature of the child's disability. For the purposes of comparability, we examine the benefits provided to families in the lowest income bracket with one child with the most severe level of disability at a given age. • To provide a concrete and comparable image of the financial support offered to families across countries, we calculated benefit levels for sample families with a specified number of children of a specified age. For families with a teenage child, the calculation was made based on a family with one 15-year-old child. • *No specific family benefits* includes countries with no family benefit scheme as well as countries with general cash family benefits but no benefits specifically for children with disabilities. • Benefits are only the amount of money targeted towards children with disabilities. If a country has a general cash family benefit and an additional supplement for children with disabilities, we only consider the amount of the supplement. • Benefits are adjusted for differences in buying power across countries.	1: No specific family benefits 2: Less than $100 PPP 3: $100–$199.99 PPP 4: $200–$499.99 PPP 5: $500 PPP or more	World Policy Analysis Center Source: 24
pol_immuinj_safty	A policy is being implemented for immunization injection safety	0: No 1: Yes 4: Not applicable	WHO vaccine-preventable diseases: monitoring system Source: 34

Variable Name	Variable Description	Variable Values	Source Name/Number
pol_immu_wste	There is a national policy for waste for immunization activities	0: No 1: Yes 4: Not applicable	WHO vaccine-preventable diseases: monitoring system Source: 34
pol_burn	There is a national policy regarding open burning for disposal	0: No 1: Yes 4: Not applicable	WHO vaccine-preventable diseases: monitoring system Source: 34
pol_burial	National policy regarding disposal via burial	0: No 1: Yes 4: Not applicable	WHO vaccine-preventable diseases: monitoring system Source: 34
lne_bdg_immu	There are line items in the national budget specifically for the purchase of vaccines used in routine immunizations	0: No 1: Yes 4: Not applicable	WHO vaccine-preventable diseases: monitoring system Source: 34
immu_fnd_gov	Percentage of total expenditure on vaccines financed by government funds	Range: 0–100 4: Not applicable	WHO vaccine-preventable diseases: monitoring system Source: 34
immu_nitag	Country has a standing technical advisory group (NITAG)	0: No 1: Yes 4: Not applicable	WHO vaccine-preventable diseases: monitoring system Source: 34
advs_grp_tor	Advisory group has formal written Terms of Reference	0: No 1: Yes 4: Not applicable	WHO vaccine-preventable diseases: monitoring system Source: 34
leg_advs_grp	There is a legislative or administrative basis for the advisory group	0: No 1: Yes 4: Not applicable	WHO vaccine-preventable diseases: monitoring system Source: 34
pol_immu_flu	Country has a formal national seasonal influenza vaccination policy	0: No 1: Yes	WHO vaccine-preventable diseases: monitoring system Source: 34
immu_flu_chld	Children are recommended for influenza vaccination	0: No 1: Yes	WHO vaccine-preventable diseases: monitoring system Source: 34
immu_flu_cd	Children with chronic diseases are recommended for influenza vaccination	0: No 1: Yes	WHO vaccine-preventable diseases: monitoring system Source: 34

Variable Name	Variable Description	Variable Values	Source Name/Number
immu_flu_preg	Pregnant women are recommended for influenza vaccination	0: No 1: Yes	WHO vaccine-preventable diseases: monitoring system Source: 34
bcg_nis	BCG part of the National Immunization Schedule	0: No 1: Yes	WHO vaccine-preventable diseases: monitoring system Source: 34
dtp_nis	DTP-containing vaccine is part of the National Immunization Schedule	0: No 1: Yes	WHO vaccine-preventable diseases: monitoring system Source: 34
hepb_nis	HepB is part of the National Immunization Schedule	0: No 1: Yes	WHO vaccine-preventable diseases: monitoring system Source: 34
hib_nis	Hib is part of the National Immunization Schedule	0: No 1: Yes	WHO vaccine-preventable diseases: monitoring system Source: 34
measles_nis	Measles is part of the National Immunization Schedule	0: No 1: Yes	WHO vaccine-preventable diseases: monitoring system Source: 34
ipv_opv_nis	IPV/OPC is part of the National Immunization Schedule	0: No 1: Yes	WHO vaccine-preventable diseases: monitoring system Source: 34
vita_nis	Vitamin A is part of the National Immunization Schedule	0: No 1: Yes	WHO vaccine-preventable diseases: monitoring system Source: 34
rota_nis	Rotavirus is part of the National Immunization Schedule	0: No 1: Yes	WHO vaccine-preventable diseases: monitoring system Source: 34
pneumo_nis	Pneumococcal is part of the National Immunization Schedule	0: No 1: Yes	WHO vaccine-preventable diseases: monitoring system Source: 34
rubella_nis	Rubella is part of the National Immunization Schedule	0: No 1: Yes	WHO vaccine-preventable diseases: monitoring system Source: 34
hpv_nis	HPV conjugate is part of the National Immunization Schedule	0: No 1: Yes	WHO vaccine-preventable diseases: monitoring system Source: 34

Variable Name	Variable Description	Variable Values	Source Name/Number
gov_effectvns	Government effectiveness: Estimate • Government effectiveness captures the perceptions of the quality of public services, the quality of civil service and the degree of its independence from political pressures, the quality of policy formulation and implementation, and the credibility of the government's commitment to such policies. Estimate gives the country's score on the aggregate indicator, in units of a standard normal distribution ranging from approximately -2.5 to 2.5.	Range: -2.5–2.5	Worldwide Governance Indicators Source: 35
pol_stabilty	Political stability and absence of violence/terrorism: Estimate • Political stability and absence of violence/terrorism measures the perceptions of the likelihood of political instability and/or politically motivated violence, including terrorism. Estimate gives the country's score on the aggregate indicator, in units of a standard normal distribution ranging from approximately -2.5 to 2.5.	Range: -2.5–2.5	Worldwide Governance Indicators Source: 35
avg_hoshld_all1	Mean average number of people per household, by all households		OECD Child Family Database and Child Well-Being Source: 36
avg_hoshld_all2	Year data collected: Mean average number of people per household, by all households		OECD Child Family Database and Child Well-Being Source: 36
avg_hoshld_ cpl_chld1	Mean average number of people per household, couple households with children		OECD Child Family Database and Child Well-Being Source: 36
avg_hoshld_ cpl_chld2	Year data collected: Mean average number of people per household, couple households with children		OECD Child Family Database and Child Well-Being Source: 36
avg_hoshld_ sng_chld1	Mean average number of people per household, single-parent households with children		OECD Child Family Database and Child Well-Being Source: 36
avg_hoshld_ sng_chld2	Year data collected: Mean average number of people per household, single-parent households with children		OECD Child Family Database and Child Well-Being Source: 36
age_chld_brth1	Mean age of women at birth		OECD Child Family Database and Child Well-Being Source: 36
age_chld_brth2	Year data collected: Mean age of women at birth		OECD Child Family Database and Child Well-Being Source: 36
chld_por_evrn1	Proportion (%) of children (0–17) living in poor environmental conditions	Range: 0–100	OECD Child Family Database and Child Well-Being Source: 36
chld_por_evrn2	Year data collected: Proportion (%) of children (0–17) living in poor environmental conditions		OECD Child Family Database and Child Well-Being Source: 36
chld_flsh_tlts1	Proportion (%) of children living in households that lack a private flushing toilet	Range: 0–100	OECD Child Family Database and Child Well-Being Source: 36
chld_flsh_tlts2	Year data collected: Proportion (%) of children living in households that lack a private flushing toilet		OECD Child Family Database and Child Well-Being Source: 36

Variable Name	Variable Description	Variable Values	Source Name/Number
adl_fert_rate1	Adolescent fertility rate, births per 1000 women, 15–19 years old		OECD Child Family Database and Child Well-Being Source: 36
adl_fert_rate2	Year data collected: Adolescent fertility rate, births per 1000 women, 15–19 years old		OECD Child Family Database and Child Well-Being Source: 36
chld_dth1	Child death rate due to negligence, maltreatment or physical assault, children 0–19 years, rate per 100 000		OECD Child Family Database and Child Well-Being Source: 36
chld_dth2	Year data collected: Child death rate due to negligence, maltreatment or physical assault, children 0–19 years, rate per 100 000		OECD Child Family Database and Child Well-Being Source: 36
chld_dth_no1	Number of cases of child deaths to negligence, maltreatment or physical assault, children 0–19 years		OECD Child Family Database and Child Well-Being Source: 36
chld_dth_no2	Year data collected: Number of cases of child deaths to negligence, maltreatment or physical assault, children 0–19 years		OECD Child Family Database and Child Well-Being Source: 36
part_frml_chldcre1a	Participant rates (%) for children aged 0–2 years in formal childcare and pre-school services	Range: 0–100	OECD Child Family Database and Child Well-Being Source: 36
part_frml_chldcre1b	Year data collected: Participant rates (%) for children aged 0–2 years in formal childcare and pre-school services		OECD Child Family Database and Child Well-Being Source: 36
part_frml_chldcre2a	Participant rates (%) for children aged 0–2 years in formal childcare and pre-school services, with mother having *not* attained tertiary education	Range: 0–100	OECD Child Family Database and Child Well-Being Source: 36
part_frml_chldcre2b	Year data collected: Participant rates (%) for children aged 0–2 years in formal childcare and pre-school services, with mother having *not* attained tertiary education		OECD Child Family Database and Child Well-Being Source: 36
part_frml_chldcre3a	Participant rates (%) for children aged 0–2 years in formal childcare and pre-school services, with mother having attained tertiary education	Range: 0–100	OECD Child Family Database and Child Well-Being Source: 36
part_frml_chldcre3b	Year data collected: Participant rates (%) for children aged 0–2 years in formal childcare and pre-school services, with mother having attained tertiary education		OECD Child Family Database and Child Well-Being Source: 36
chld_enroll_edu1	Proportion (%) of children aged 3–5 years in pre-primary education or primary school	Range: 0–100	OECD Child Family Database and Child Well-Being Source: 36
chld_enroll_edu2	Year data collected: Proportion (%) of children aged 3–5 years in pre-primary education or primary school		OECD Child Family Database and Child Well-Being Source: 36
hshld_chld1a	Proportion (%) of households with 0 children	Range: 0–100	OECD Child Family Database and Child Well-Being Source: 36
hshld_chld1b	Year data collected: Proportion (%) of households with 0 children		OECD Child Family Database and Child Well-Being Source: 36
hshld_chld2a	Proportion (%) of households with 1 child	Range: 0–100	OECD Child Family Database and Child Well-Being Source: 36

Variable Name	Variable Description	Variable Values	Source Name/Number
hshld_chld2b	Year data collected: Proportion (%) of households with 1 child		OECD Child Family Database and Child Well-Being Source: 36
hshld_chld3a	Proportion (%) of households with 2 children	Range: 0–100	OECD Child Family Database and Child Well-Being Source: 36
hshld_chld3b	Year data collected: Proportion (%) of households with 2 children		OECD Child Family Database and Child Well-Being Source: 36
hshld_chld4a	Proportion (%) of households with 3 or more children	Range: 0–100	OECD Child Family Database and Child Well-Being Source: 36
hshld_chld4b	Year data collected: Proportion (%) of households with 3 or more children		OECD Child Family Database and Child Well-Being Source: 36
hshld_chld5a	Proportion (%) of households with children under 6 years	Range: 0–100	OECD Child Family Database and Child Well-Being Source: 36
hshld_chlb5b	Year data collected: Proportion (%) of households with children under 6 years		OECD Child Family Database and Child Well-Being Source: 36
soc_assis1	Social assistance as a % of GDP	Range: 0–100	World Bank: Social Expenditure Indicators Source: 37
soc_assis2	Year data collected: Social assistance as a % of GDP		World Bank: Social Expenditure Indicators Source: 37
mat_protect	Country has revised the Maternity Protection Convention (No. 183)	0: No 1: Yes 2: Partial	International Labour Organization: Working Conditions Source: 38
cde_brst_sub	Legal status of implementing the International Code of Marketing of Breast Milk Substitutes	0: No 1: Yes 2: Partial	World Health Organization, UNICEF, IBFAN – Marketing of Breast-Milk Substitutes: National Implementation of the International Code Status Report 2016 Source: 39
legis_fort	Legislation on fortification (wheat, rice, maize) Mandatory fortification is defined as legislation that has the effect of requiring fortification with at least iron or folic acid.	0: No fortification 1: Planning 2: Voluntary 3: Mandatory	Food Fortification Initiative Source: 40
child_mar15	Percentage of women aged 20–24 who were first married or in union before the age of 15	Range: 0–100	UNICEF: Monitoring the Situation of Children and Women Source: 41
child_mar18	Percentage of women aged 20–24 who were first married or in union before the age of 18	Range: 0–100	UNICEF: Monitoring the Situation of Children and Women Source:41

Annex 6: Mapping priority policy areas

Background

The new Global Strategy on Women's, Children's and Adolescents' Health 2016–2030 (Global Strategy 2.0) emphasizes the need to improve the health of all women, children and adolescents through transformative multisectoral actions which accelerate coverage of interventions, mitigate gender and equity gaps, improve quality of services and allow all women and children to survive and thrive. Such an approach brings to the centre of the discussion the need for countries to endorse and implement policies that allow for these transformations to happen. New and ambitious goals and targets set in the Global Strategy 2.0 will require the presence and utilization of strong, evidence-informed and equity-focused policies. Policies should go beyond mere evidence-based intervention policies, span across the continuum of care for reproductive, maternal, newborn, child and adolescent health (RMNCAH) into a life course approach and reach beyond traditional health system boundaries.

Since 2009 the Department of Maternal, Newborn, Child and Adolescent Health and Ageing (MCA) has administered a Global Policy Survey of WHO Member States to track country progress in adopting WHO recommendations in national health policies related to MNCAH. There have been four survey rounds to date: 2009–2010, 2011–2012, 2013–2014 and 2016. In addition, the Department of Sexual and Reproductive Health and Research (SRH), as part of monitoring progress on the Global Reproductive Health Strategy approved by the WHA through resolution 57.12, has been tracking policies on sexual and reproductive health and has done so biennially since 2009. The biennial reports are included in the corresponding year during WHA meetings. We now propose to combine our efforts and establish a global platform to track the adoption and implementation of essential RMNCAH policies in all countries, with special attention to 81 low- and middle-income countries that account for the highest burden of maternal, newborn and child mortality (listing available separately). We seek to stimulate greater global and national policy dialogue and link this dialogue with the development of country-specific investment plans and accountability for accelerated progress towards the Global Strategy 2.0 goals and targets. By undertaking these activities, we aim to provide a useful source of information for governments, partners and the community-at-large on the challenging path of implementing the new Global Strategy 2.0.

To optimize the approach, the MCA and SRH Departments have established a Global RMNCAH Policy Reference Group (PRG) to advise WHO on the content of the policy tracking and the utilization of related outputs. The first meeting was held in February 2017. This group advised on some potential priority indicators but asked that we provide them with more direction on priorities and what policies are needed prior to recommending a final list of policies to be monitored. They also emphasized the need to streamline the

current global policy survey by examining if there are other potential data sources to extract key policies on an ongoing basis, decreasing the need to have a large survey to collect policy information.

Several tasks have been accomplished to date. We have developed a list of potential policies in RMNCAH based on the EWEC Global Strategy, key global initiatives, and WHO priorities in the area of RMNCAH, and have completed a survey of the PRG and other experts, including regional health advisors, to develop a list of priority policy areas. We have completed a review of other data sources for collection of these policies and created a database of relevant existing data. However, we still need to need to analyse this database, revise the global policy survey questionnaire based on which data cannot be collected from other databases, administer the survey and analyse the results.

The goal of this document is to analyse the newly created database to help inform the revision of the global policy questionnaire. The following sections provide an analysis of what is available in the newly created global policy database compared to the current MCA questionnaire for maternal and newborn, child and adolescent health. In addition, the following sections lay out a suggestion for what to include in the next round of the global policy survey, taking into account which data can be pulled from existing sources which were compiled into the newly created policy database so as to reduce the reporting burden of countries.

1. Maternal and newborn health

The following table details the policy data available in the newly created policy data set, the questions that were asked in the latest MCA policy questionnaire, and suggestions for what to include in the upcoming MCA policy survey for maternal and newborn health.

No.		Policy data available in another **data set** (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
Section I – Proposed RMNCAH policy areas to be tracked				
1	National legislation that recognizes universal coverage and access to essential health services and to essential medicines	Does the constitution guarantee medical care treatment to women and girls? Does the constitution guarantee protection of public health to women and girls? Does the constitution take any approach to the protection of health for women? Country has revised the Maternity Protection Convention (No. 183)		
2	Overall strategy or plan to improve RMNCAH that is aligned with SDGs targets and supported by adequate level of financial resources		S6. Has the country adopted a national strategy/ plan of action to reduce maternal mortality? S6a. Is it part of another document? S6b. What is the start date? S6c. What is the end date? S7. Has the national strategy/plan of action to reduce maternal mortality been costed? S8. Has the country adopted a national strategy/ plan of action to reduce newborn mortality? S8a. Is it part of another document? S8b. What is the start date? S8c. What is the end date? S9. Has the national strategy/plan of action to reduce newborn mortality been costed?	
3	Package of essential RMNCAH interventions and services is up to date and reflects WHO technical guidelines		**ANC policy** M1. Is there a national policy/policy statement indicating the minimum ANC visits during the normal pregnancy? M2. If yes, how many visits? M3. Does it specify that the first visit should take place during the first 3 months? M4. Year of adoption of the policy?	

No.		Policy data available in another **data set** (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
3 (continued)			**Skilled care at birth policy** M5. Is there a national policy or policy statement on the right of every woman to have access to skilled care at childbirth? M6. If yes, year of adoption of the policy? M7. Is there a national policy or policy statement recommending the presence of a birth companion of choice during delivery? **Place of birth policy** M8. Is there a national policy or policy statement on the place of childbirth? M9. If yes, please indicate recommended place of birth M10. Year of adoption of the policy? **Management of childbirth policy** M11. Does the country have a national policy that recommends the use of magnesium sulfate for the prevention and treatment of eclampsia? M12. If yes, year of adoption of the policy? M13. Is there a national policy/policy statement on the use of antenatal corticosteroids for preterm labour? M14. Is there a national policy for monitoring progress of labour using partograph? M15. Is there a national policy for active management of third stage of labour? If yes, does the national policy recommends the following specific drugs for active management of third stage of labour? M16. Oxytocin Year of adoption of the policy? M17. Ergometrine Year of adoption of the policy? M18. Misoprostol Year of adoption of the policy? **Discharge after birth for mother and newborn policy** M19. Is there a national policy on discharge of mother and the baby after normal childbirth at a facility? M20. If yes, after how many hours? M21. Year of adoption of the policy? M20. For births at home, is there a national policy on the minimum recommended period for the mother and newborn to remain under skilled birth attendant observation? M21. If yes, for how long? M22. Year of adoption of the policy?	

No.		Policy data available in another **data set** (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
3 (continued)			**Postnatal care for mother and newborn policy** M23. Is there a policy recommending postnatal follow-up contacts (visits/reviews) by a trained provider for mother and newborn? If yes, M24. Does it recommend, in case of birth in a health facility, that postnatal care should be received for at least 24 hours after birth? M25. Does it recommend, in case of birth at home, that first postnatal contact should be as early as possible within 24 hours of birth? M26. Does it recommend a minimum number of additional (= after 24 hours of birth) contacts (visits/reviews)? M27. Does it specify that at least one of the recommended contacts should be a home visit? M28. Does it specify if the contacts are for mother and/or newborn? Does it describe who should provide care during the contact(s): M29. Health professional M30. Community health worker (CHW) M31. Year of adoption of the policy? M32. Does the country have national guidelines for postnatal home visits by a trained provider to mothers and/or newborns in the first week after childbirth ("postnatal visits")? M33. If yes, year of adoption of the guidelines? M34. Is there a national policy on special care for low-birth-weight newborns? M35. Is there a national policy that recommends Kangaroo Mother Care for low-birth-weight newborns?	
4	National RMNCAH strategies/plans are linked with the health sector planning cycle and integrated within the overall health sector strategy			
5	RMNCAH financial resources are tracked and annually reported on in disaggregated ways (per population group and per decentralized implementation area)			

No.		Policy data available in another data set (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
6	Standards for quality of care for RMNCAH are aligned with the national package of services for each level of care, and governance mechanisms for implementation are institutionalized			
7	National Essential Medicines List includes life-saving commodities for RMNCAH interventions		Does the national Essential Drugs List include the following drugs indicated for use during pregnancy, childbirth and postpartum care? M37A. Magnesium sulfate M37B. Oxytocin M37C. Misoprostol tablets M37D. Ampicillin or amoxicillin injections M37E. Gentamycin injection M37F. Injection metronidazole M37G. Procaine penicillin injection M37H. Dexamethasone injection M37I. Antenatal corticosteroids M37J. Chlorohexidine	
8	Health information system disaggregates information by gender and age; civil registration and vital statistics (CRVS) systems are aligned with international standards			
Section II – RMNCAH policy areas by technical area				
9	Enforcement of the International Code for Marketing of Breastmilk Substitutes and subsequent relevant World Health Assembly resolutions	Legal status of implementing the International Code of Marketing of Breast Milk Substitutes		

No.		Policy data available in another **data set** (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
10	Maternal and perinatal surveillance and response is institutionalized and regulated		**Maternal deaths** M39A. Is there a national policy requiring all maternal deaths to be notified within 24 hours to a central authority? M39B. If yes, in which year was the policy adopted? M39B2. Does the system require zero reporting? (Zero reporting implies reporting as zero if there are no maternal deaths during the reference period in health administration unit) M39C. Does national policy requires all maternal deaths to be reviewed? M39D. If yes, what year was the policy adopted? M39E. Is there a facility maternal death review (audit) process in place? M39F. Is there a community maternal death review (audit) process in place? M39G. Is there a national panel (committee) to review maternal deaths in place? M39H. If yes, how often does the panel meet? M39I. When did the panel meet last? M39J. Is there a subnational panel (committee) to review maternal deaths in place? **Stillbirths** M40A. Is there a policy that requires all stillbirths (fresh or macerated) to be reviewed? M40B. If yes, in which year was the policy adopted? M40C. Is there a facility stillbirth review (audit) process in place? **Neonatal deaths** M41A. Is there a policy that requires all neonatal deaths (0–28 days) to be reviewed? M41B. If yes, in which year was the policy adopted? M41C. Is there a facility neonatal deaths review (audit) process in place? M41D. Is there a community neonatal death review (audit) process in place?	

No.		Policy data available in another data set (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
	Other maternal- and newborn-specific policies	For each type of violence listed below, please indicate if there is a national action plan for prevention or, if none exists, if there is at least one subnational action plan. 1. Interpersonal violence 2. Child maltreatment 3. Youth violence 4. Intimate partner violence 5. Sexual violence In your country, please indicate which of the following types of laws concerning intimate partner violence exist, indicating whether they are national or, if not, subnational and the extent of enforcement of the laws in those areas where they apply. 1. Domestic or family violence legislation 2. If yes, does it include a law that criminalizes rape in marriage? 3. If yes, does it include a law enabling free entry into marriage and divorce? 4. If yes, does it include a law allowing removal of a violent spouse from the family home? In your country, please indicate which of the following types of laws addressing sexual violence exist, indicating whether they are national or, if not, subnational and the extent of enforcement of the laws in those areas where they apply. 1. Law addressing sexual violence involving intercourse (e.g. rape laws) 2. Laws addressing contact sexual violence (excluding intercourse) 3. Laws addressing non-contact sexual violence		

No.		Policy data available in another data set (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
		Can working parents take leave specifically for children's health needs? Leave for children's health needs incudes leave specifically for children's health needs, including where leave is available only for serious illness, hospitalization or urgent health needs. Are mothers of infants guaranteed breastfeeding breaks at work? If legislation specifies a length of time permitted to breastfeed after the mother returns to work and the mother is also entitled to paid maternal leave, the age shown is the sum of post-birth paid maternal leave and the breastfeeding break entitlement. Are working mothers guaranteed paid options to facilitate exclusive breastfeeding for at least 6 months?		
Section III – Missing RMNCAH policy areas that should be tracked				
13	Existence of subnational plans for countries with large populations/ devolved systems			
14	Existence of an independent national accountability mechanism [with community participation]			
15	Existence of multisectoral governance arrangements/strategies/ action plans			

No.		Policy data available in another **data set** (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
16	Progressive universalism of health financing, with focus on worst-off groups		**Financial protection for women and newborns** F1. Are there fees for health services in the public sector? Are women of reproductive age (15–49 years) exempt from user fees for the following services: F2. Family planning? Antenatal care? F2a. Childbirth (normal delivery)? F2b. Postnatal care for mother? F2c. Caesarean section? F2d. Insecticide-treated bednets? F2e. Pharmaceutical products and/or other medical supplies if required for treatment or delivery? F2f. Immunization services (TT, Rubella)? **Financial protection for children** F3. Are newborns (0–4 weeks) exempt from user fees for the following services: F3a. Postnatal care? F3b. Immunization? F3c. Sick newborn visits? F3d. Insecticide-treated nets? F3e. Pharmaceutical products and/or other medical supplies if required for treatment	

Maternal and newborn health questions from MNCAH policy indicator survey that do not fit this template

Who is allowed to independently perform the following interventions? (Yes/No)

		Midwife	Nurse-Midwife	Medical Assistant
M36M	Assist normal childbirth	Select your answer	Select your answer	Select your answer
M36B	Administer parenteral antibiotics	Select your answer	Select your answer	Select your answer
M36C	Administer uterotonic medicines	Select your answer	Select your answer	Select your answer
M36D	Administer parenteral anticonvulsivants	Select your answer	Select your answer	Select your answer
M38E	Manually remove the placenta	Select your answer	Select your answer	Select your answer
M36F	Remove retained products of conception	Select your answer	Select your answer	Select your answer
M36G	Perform assisted vaginal delivery	Select your answer	Select your answer	Select your answer
M36H	Perform newborn resuscitation	Select your answer	Select your answer	Select your answer
M38I	Kangaroo Mother Care	Select your answer	Select your answer	Select your answer

Are the following supply equipments included in the official MOH standard supply and equipment list?

M38A	Manual vacuum aspirator	Yes No Unknown
M38B	Ventouse/forceps	Yes No Unknown
M38C	Partograph	Yes No Unknown
M38D	Self-inflating bag (newborn size) with paediatric masks of different sizes and valves	Yes No Unknown
M38E	Suction pump, catheter and suction bulb	Yes No Unknown
M38F	Oxygen supply	Yes No Unknown

2. Child health

The following table details the policy data available in the newly created policy data set, the questions that were asked in the latest MCA policy questionnaire, and suggestions for what to include in the upcoming MCA policy survey for child health.

No.		Policy data available in another **data set** (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
Section I – Proposed RMNCAH policy areas to be tracked				
1	National legislation that recognizes universal coverage and access to essential health services and to essential medicines			
2	Overall strategy or plan to improve RMNCAH that is aligned with SDGs targets and supported by adequate level of financial resources		S10. Has the country adopted a national strategy/plan of action to reduce child mortality? If yes, S10a. Is it part of another document? S10a. What is the start date? S10b. What is the end date? S11. Has the national strategy to reduce child mortality been costed?	
3	Package of essential RMNCAH interventions and services is up to date and reflects WHO technical guidelines		**National guidelines for management of childhood illness** C1. Has the country updated the national Integrated Management of Childhood Illness (IMCI) guidelines based on the 2014 WHO Generic Guidelines? C2. If no, in which year was the national IMCI guidelines last updated? C3. Has the country updated the pneumonia guidelines to treat chest indrawing at first-level health facilities with oral antibiotics? **National policy/guidelines on pneumonia case management in communities by trained providers** C5. Does the country have a policy recommending management of pneumonia in the community or at home by a trained provider? If yes, C5. Please specify who are the trained providers C6. Year of adoption of the policy? C8. Does the country have national guidelines on management of pneumonia in the community or at home by a trained provider?	

No.		Policy data available in another data set (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
			National policy/guidelines on diarrhoea case management C9. Does the country have a national policy recommending the use of both low-osmolarity Oral Rehydration Salts (ORS) and zinc for management of diarrhoea? C10. Does the country have a national policy recommending the use of zinc for the management of diarrhoea? C11. Does the country have national guidelines on the use of low-osmolarity ORS? C12. Does the country have national guidelines on the use of zinc for the management of diarrhoea? **National policy on integrated community case management of childhood illness** Does the country have a national policy/policy statement on the use of community-based health providers to deliver one or more of the following child health interventions at home and/or in the community? C13. Home/community management of diarrhoea? C14. Home/community management of pneumonia? C15. Home/community management of malaria? If yes, C16. Please specify who are the community-based providers. C17. Please specify whether the same provider can deliver one or more interventions (pneumonia, diarrhoea, malaria). C18. Please specify whether the community-based providers are trained in management of pneumonia, diarrhoea and malaria cases in an integrated manner (during the same training workshop). **Quality of child health-care services** C20. Has the country updated the hospital care guidelines based on the 2013 edition of the WHO's Pocket book for hospital care for children	
4	National RMNCAH strategies/plans are linked with the health sector planning cycle and integrated within the overall health sector strategy			

No.		Policy data available in another data set (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
5	RMNCAH financial resources are tracked and annually reported on in disaggregated ways (per population group and per decentralized implementation area)			
6	Standards for quality of care or RMNCAH are aligned with the national package of services for each level of care, and governance mechanism for implementation are institutionalized			
7	National Essential Medicines List includes life-saving commodities for RMNCAH interventions		**Commodities related to treatment of diarrhoea and pneumonia in the national Essential Drugs List** Does the national Essential Drugs List include the following drugs indicated for use in children <5 years: C19A. Oral rehydration salts (low-osmolarity ORS)? C19B. Zinc tablets or syrups? C19C. Paediatric formulation of amoxicillin? C19D. Paediatric formulation of cotrimoxazol? C19E. Oxygen for therapy (GAPP-related)? C19F. Rotavirus vaccination?	
8	Health information system disaggregates information by gender and age; civil registration and vital statistics (CRVS) systems are aligned with international standards			
Section II – RMNCAH policy areas by technical area				
11	Ratification of the Convention on the Rights of the Child supported by regular review, reporting and action		**Periodic reporting to the Convention of the Rights of the Child (CRC)** S4. Does the country have a functioning national human rights institution? If yes, S4a. Does its mandate include monitoring fulfilment of the right to health? S5. Is the Ministry of Health engaged in national CRC implementation and monitoring processes?	

No.		Policy data available in another data set (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
	Other child-specific policies	For each type of violence listed below, please indicate if there is a national action plan for prevention or, if none exists, if there is at least one subnational action plan. 1. Interpersonal violence 2. Child maltreatment 3. Youth violence 4. Intimate partner violence 5. Sexual violence In your country, please indicate which of the following types of laws concerning child maltreatment exist, indicating whether they are national or, if not, subnational and the extent of enforcement of the laws in those areas where they apply. 1. Ban on corporal punishment of children 2. Laws against statutory rape 3. Laws against child marriage 4. Laws against female genital mutilation In your country, is there a law governing the minimum legal age of marriage? What is the minimum age of marriage for girls? What is the minimum age of marriage for boys? Is there a gender disparity in the legal age of marriage? Under what circumstances can a 13/15/17-year-old girl be married? Under what circumstances can a 13/15/17-year-old boy be married? Are there exceptions to the general legal minimum age of marriage for girls? A policy is being implemented for immunization injection safety There is a national policy for waste for immunization activities There is a national policy regarding open burning for disposal		

No.		Policy data available in another data set (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
		National policy regarding disposal via burial There are line items in the national budget specifically for the purchase of vaccines used in routine immunizations Country has a standing technical advisory group (NITAG) Advisory group has formal written Terms of Reference There is a legislative or administrative basis for the advisory group Country has a formal national seasonal influenza vaccination policy Children are recommended for influenza vaccination Children with chronic diseases are recommended for influenza vaccination BCG is part of the National Immunization Schedule DTP-containing vaccine is part of the National Immunization Schedule HepB is part of the National Immunization Schedule Hib is part of the National Immunization Schedule Measles is part of the National Immunization Schedule IPV/OPC is part of the National Immunization Schedule Vitamin A is part of the National Immunization Schedule Rotavirus is part of the National Immunization Schedule Pneumococcal is part of the National Immunization Schedule Rubella is part of the National Immunization Schedule HPV conjugate is part of the National Immunization Schedule		

No.		Policy data available in another data set (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
Section III – Missing RMNCAH policy areas that should be tracked				
13	Existence of subnational plans for countries with large populations/ devolved systems			
14	Existence of an independent national accountability mechanism [with community participation]			
15	Existence of multisectoral governance arrangements/strategies/ action plans			
16	Progressive universalism of health financing, with focus on worst-off groups		**Financial protection for children** F1. Are there fees for health services in the public sector? F4. Are children under the age of 5 years exempt from user fees for the following services: F4a. Immunization? F4b. Sick child visits? F4c. Insecticide-treated bednets? F4d. Well child visits and growth monitoring? F4f. Pharmaceutical products and/or other medical supplies if required for treatment?	

Child health questions from MNCAH policy indicator survey that do not fit this template

Service Delivery for Maternal, Newborn and Child Health

515	Does the country implement the Integrated Management of Childhood Illness (IMCI) strategy? If yes,	Yes No Unknown
515a	are all the districts (or equivalent administrative areas) of the country targets for IMCI implementation in first-level health facilities? If no,	Yes No Unknown
515b	how many districts are targets for IMCI?	number
515c	Number of districts having initiated IMCI training for first-level health workers	number
515d	Proportion of first-level health facilities with at least one health worker who cares for children trained in IMCI	Percentage **OR** <25% 25–49% 50–74% 75% or more unknown
515e	Proportion of first-level health facilities with at least 60% of health workers who care for children trained in IMCI	Percentage **OR** <25% 25–49% 50–74% 75% or more unknown
515f	Year of data (IMCI implementation across districts reported above)	Year
515g	Does the national Integrated Management of Childhood Illness (IMCI) clinical guideline include the first week of life?	Yes No Unknown

3. Adolescent health

The following table details the policy data available in the newly created policy data set, the questions that were asked in the latest MCA policy questionnaire, and suggestions for what to include in the upcoming MCA policy survey for adolescent health.

No.		Policy data available in another **data set** (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
Section I – Proposed RMNCAH policy areas to be tracked				
1	National legislation that recognizes universal coverage and access to essential health services and to essential medicines			
2	Overall strategy or plan to improve RMNCAH that is aligned with SDGs targets and supported by adequate level of financial resources		**Existence of costed national strategies and plans of action** S12. Does the country have a national strategy/ plan of action that specifically addresses adolescent health issues? If yes, S12a. Start date: S12b. End date: S13. Has the national strategy/plan of action for adolescent health been costed? **Existence of national policy/strategy documents specific to the health of adolescents** Does the country have national policy/strategy documents specific to adolescents or young people (10–24 years) or are adolescents or young people cited as a specific target group for defined interventions/activities in a national policy/strategy document for the following health issues? A1. Sexual and reproductive health, including adolescent pregnancy prevention A2. HIV/AIDS A3. Nutrition A4. Diet and physical activity A5. Tobacco A6. Alcohol A7. Substance use A8. Mental health A9. Injury prevention A10. Violence	

No.		Policy data available in another data set (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
			The country has a functional national adolescent health programme A11. Has budget been allocated to support activities planned for adolescent health? A12. Is there a record/report of activities implemented in the past financial year? A13. Is there a designated adolescent health unit in the Ministry of Health or a designated person for coordinating the adolescent health programme at national level?	
3	Package of essential RMNCAH interventions and services is up to date and reflects WHO technical guidelines		**The country has national standards for delivery of health services to young people** A14. Are there national standards for delivery of health services specifically for young people (ages 10–24 years)? If yes, do these standards include the following: A15. A clearly defined comprehensive package of health services? A16. Within the past 2 years, have quality and coverage measurement surveys been conducted to monitor the implementation of these adolescent health standards? A17. Is there a continuous professional education system in place for primary health care clinicians and/or nurses to receive adolescent-specific training?	
4	National RMNCAH strategies/plans are linked with the health sector planning cycle and integrated within the overall health sector strategy			
5	RMNCAH financial resources are tracked and annually reported on in disaggregated ways (per population group and per decentralized implementation area)			
6	Standards for quality of care for RMNCAH are aligned with the national package of services for each level of care, and governance mechanism for implementation are institutionalized			

No.		Policy data available in another data set (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
7	National Essential Medicines List includes life-saving commodities for RMNCAH interventions			
8	Health information system disaggregates information by gender and age; civil registration and vital statistics (CRVS) systems are aligned with international standards			
Section II – RMNCAH policy areas by technical area				
12	School health policy areas in regards to health education and school health services			
	Other adolescent-specific policies	For each type of violence listed below, please indicate if there is a national action plan for prevention or, if none exists, if there is at least one subnational action plan. 1. Interpersonal violence 2. Child maltreatment 3. Youth violence 4. Intimate partner violence 5. Sexual violence		
Section III – Missing RMNCAH policy areas that should be tracked				
13	Existence of subnational plans for countries with large populations/ devolved systems			
14	Existence of an independent national accountability mechanism [with community participation]			
15	Existence of multisectoral governance arrangements/strategies/ action plans			
16	Progressive universalism of health financing, with focus on worst-off groups		**Financial protection for adolescents** F1. Are there fees for health services in the public sector? F5. Are older adolescents (15–19 years) exempt from user fees for all health care?	

No.		Policy data available in another data set (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
			If no, are adolescents or school-going adolescents exempt from user fees for the following health services: F5a. Outpatient care visits? F5b. Inpatient care visits? F5c. HIV testing and counseling? F5d. Contraceptives? F5e. Pharmaceutical products and/or other medical supplies if required for treatment? F5f. Mental heath (rehabilitation for drug abuse)?	

Adolescent health questions from MNCAH policy indicator survey that do not fit this template

Provisions are made in laws or regulations legally allowing minors to consent to medical interventions

(In law, the term "minor" is used to refer to a person who is under the age at which one legally assumes adulthood and is legally granted rights afforded to adults in society. Depending on the jurisdiction and application, this age may vary but is usually marked at either 18, 20, or 21).

A18	What is the legal age of majority in the country??	
	For unmarried adolescents, does the country have laws or regulations that allow underage (minor) adolescents to provide consent to the following services without parental consent? If yes, at what age?	Report age in years
A19	Contraceptive services except sterilization?	Yes No Unknown
A20	If yes, at what age?	Report age in years
A21	Emergency contraception?	Yes No Unknown
A22	If yes, at what age?	Report age in years
A23	HIV testing and counselling services?	Yes No Unknown
A24	If yes, at what age?	Report age in years
A25	Harm reduction interventions for injecting drug users (needle exchange, opiate substitution therapy)?	Yes No Unknown
A26	If yes, at what age?	Report age in years
A27	HIV care and treatment?	Yes No Unknown
A28	If yes, at what age?	Report age in years

	For married adolescents, does the country have laws or regulations that allow married and underage (minor) adolescents to provide consent to the following services without spousal consent?		
A29		Contraceptive services except sterilization?	Yes No Unknown
A39		Emergency contraception?	Yes No Unknown
A31		HIV testing and counselling services?	Yes No Unknown
A32		HIV care and treatment?	Yes No Unknown
A33		Harm reduction interventions for injecting drug users (needle exchange, opiate substitution therapy)?	Yes No Unknown

Availability of nationally representative data on heath outcomes in adolescents

8.B.1	Do you have a national estimate of the all-cause mortality rate in adolescents?		Yes No Unknown
		If yes, provide the latest year for which the estimate is available	Year
8.B.2	Do you have a national estimate of main causes of death in adolescents?		Yes No Unknown
		If yes, provide the latest year for which the estimate is available	(Before 2000, 2000–2004, 2005.....2015)
8.B.3	Do you have a national estimate of main causes of morbidity in adolescents?		Yes No Unknown
		If yes, provide the latest year for which the estimate is available	(Before 2000, 2000–2004, 2005.....2015)

4. Cross-cutting RMNCAH

No.		Policy data available in another data set (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
Section I – Proposed RMNCAH policy areas to be tracked				
1	National legislation that recognizes universal coverage and access to essential health services and to essential medicines	Does the constitution take any approach to health? Approaches to health include the right to health, public health or medical services. • *Not granted* means that the constitution does not explicitly mention health protections. This does not mean that the constitution denies these protections, but that it does not explicitly include them. • *Granted to specific groups, not universally* means the constitution explicitly guarantees the right to health, public health or medical services to specific groups, but not to all citizens. Specific groups that are named in constitutions include children, elderly people, poor people, persons with disabilities, women and ethnic minorities. • *Aspirational in constitution* means that the constitution protects the right to health, public health or medical services but does not use language strong enough to be considered a guarantee. For example, the nation will endeavour to provide the right to health or intends to provide medical services. • *Guaranteed in constitution* means that the constitution explicitly guarantees the right to health, medical services or public health to citizens in authoritative language. For example, constitutions in this category might guarantee citizens' right to health or make it the State's responsibility to ensure to protect it.	**Right to universal access to health services enshrined in national legislation** S1. Does the State's constitution or national legislation recognize the right to the highest attainable standard of health? S2. Is universal coverage/access to essential health services and to essential medicines clearly recognized in the constitution or national legislation? S3. Is the right to health explicitly recognized in national health policies, strategies or plans, including those related to maternal, newborn, child and adolescent health?	

No.		Policy data available in another data set (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
		Do citizens have a specific right to health? • The right to health includes the right to "health", "health security", and "overall well-being". • *Not granted in constitution* means that the constitution does not explicitly mention health protections. This does not mean that the constitution denies these protections, but that it does not explicitly include them. • *Granted to specific groups, not univer*sally means the constitution explicitly guarantees the right to health, public health or medical services to specific groups, but not to all citizens. Specific groups that are named in constitutions include children, elderly people, poor people, persons with disabilities, women and ethnic minorities. • *Aspirational in constitution* means that the constitution protects the right to health, public health or medical services but does not use language strong enough to be considered a guarantee. For example, the nation will endeavour to provide the right to health or intends to provide medical services. • *Guaranteed in constitution* means that the constitution explicitly guarantees the right to health, medical services or public health to citizens in authoritative language. For example, constitutions in this category might guarantee citizens' right to health or make it the State's responsibility to ensure the protection of the right to health.		
2	Overall strategy or plan to improve RMNCAH that is aligned with SDGs targets and supported by adequate level of financial resources			

No.		Policy data available in another data set (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
3	Package of essential RMNCAH interventions and services is up to date and reflects WHO technical guidelines			
4	National RMNCAH strategies/plans are linked with the health sector planning cycle and integrated within the overall health sector strategy		**Periodic reviews of maternal, newborn and child health programmes** S14. Has the country conducted a specific national programme review process for MNCAH in the past 2 years? If yes, S14a. Does it cover maternal health? S14b. Does it cover newborn health? S14c. Does it cover child health? S14d. Does it cover adolescent health? S14e. When did the last programme review take place? S14f. Are the findings and recommendations of specific MNCH programme reviews taken into account during national health sector reviews? G5i. Does the country have a national RMNCH scorecard? If yes, how often are the RMNCH scorecards released?	
5	RMNCAH financial resources are tracked and annually reported on in disaggregated ways (per population group and per decentralized implementation area)			
6	Standards for quality of care for RMNCAH are aligned with the national package of services for each level of care, and governance mechanisms for implementation are institutionalized			
7	National Essential Medicines List includes life-saving commodities for RMNCAH interventions			

No.		Policy data available in another data set (exact definition)	MCA policy questionnaire (exact wording of questions)	Suggested questions
8	Health information system disaggregates information by gender and age; civil registration and vital statistics (CRVS) systems are aligned with international standards		**Types of disaggregated data captured by the national Health Information System (HIS)** S16. Are the data presented in the national HIS disaggregated by age? If yes, are the age-disaggregated data available for the following age groups? S16a. 10–14 years S16b. 15–19 years S16c. 10–19 Years	
Section III – Missing RMNCAH policy areas that should be tracked				
13	Existence of subnational plans for countries with large populations/ devolved systems			
14	Existence of an independent national accountability mechanism [with community participation]		**Community involvement in national maternal newborn and child health programmes** G11a. Is there a national policy/strategy to ensure engagement of civil society organization representatives in national-level planning of MNCAH programmes? G11b. Is there a national policy/strategy to ensure engagement of civil society organization representatives in periodic review of national programmes for MNCAH?	
15	Existence of multisectoral governance arrangements/strategies/ action plans			
16	Progressive universalism of health financing, with focus on worst-off groups			

Annex 7: Countries that completed the 2018–2019 SRMNCAH Policy Survey by WHO region

African Region

Algeria
Angola
Benin
Botswana
Burkina Faso
Burundi
Cabo Verde
Cameroon
Chad
Congo
Côte d'Ivoire
Democratic Republic of the Congo
Equatorial Guinea
Eritrea
Eswatini
Ethiopia
Gabon
Gambia
Ghana
Guinea
Guinea-Bissau
Kenya
Lesotho
Liberia
Madagascar
Mali
Mauritania
Mauritius
Mozambique
Namibia
Niger
Nigeria
Rwanda
Senegal
Sierra Leone
South Africa
South Sudan
Togo
Uganda
United Republic of Tanzania
Zambia
Zimbabwe

Region of the Americas

Antigua and Barbuda
Argentina
Barbados
Belize
Bolivia (Plurinational State of)
Brazil
British Virgin Islands*
Chile
Colombia
Costa Rica
Cuba
Dominica
Dominican Republic
Ecuador
El Salvador
Grenada
Guatemala
Guyana
Haiti
Honduras
Mexico
Nicaragua
Panama
Paraguay
Peru
Saint Kitts and Nevis
Suriname
Trinidad and Tobago
Uruguay
Venezuela (Bolivarian Republic of)

Eastern Mediterranean Region

Afghanistan
Djibouti
Egypt
Iraq
Jordan
Lebanon
Morocco
Occupied Palestinian territory*
Oman
Pakistan
Saudi Arabia
Somalia
Sudan
Syrian Arab Republic
United Arab Emirates
Yemen

European Region

Albania
Armenia
Austria
Azerbaijan
Bulgaria
Croatia
Cyprus
Czechia
Denmark
Estonia
Finland
France
Georgia
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
The former Yugoslav Republic of Macedonia
Turkey
Turkmenistan
Uzbekistan

South-East Asia Region

Bangladesh
Bhutan
Democratic People's Republic of Korea
India
Indonesia
Maldives
Myanmar
Nepal
Sri Lanka
Thailand
Timor-Leste

Western Pacific Region

Australia
Brunei Darussalam
Cambodia
China
Cook Islands
French Polynesia*
Guam*
Lao People's Democratic Republic
Marshall Islands
Micronesia (Federated States of)
Mongolia
Palau
Philippines
Singapore
Vanuatu
Viet Nam
Wallis and Futuna Islands*

* Country completed the survey but was not included in the analyses within this report. Region-specific reports will be made available and may include data from non-Member States that responded to the survey.

Annex 8: Countries that completed the 2018–2019 SRMNCAH Policy Survey by World Bank income group

Classifications based on World Bank country income classifications as of June 2018.

Low income

Afghanistan
Benin
Burkina Faso
Burundi
Chad
Democratic People's Republic of Korea
Democratic Republic of the Congo
Eritrea
Ethiopia
Gambia
Guinea
Guinea-Bissau
Haiti
Liberia
Madagascar
Mali
Mozambique
Nepal
Niger
Rwanda
Senegal
Sierra Leone
Somalia
South Sudan
Syrian Arab Republic
Tajikistan
Togo
Uganda
United Republic of Tanzania
Yemen
Zimbabwe

Lower middle income

Angola
Bangladesh
Bhutan
Bolivia (Plurinational State of)
Cabo Verde
Cambodia
Cameroon
Congo
Côte d'Ivoire
Djibouti
Egypt
El Salvador
Eswatini
Georgia
Ghana
Honduras
India
Indonesia
Kenya
Kyrgyzstan
Lao People's Democratic Republic
Lesotho
Mauritania
Micronesia (Federated States of)
Mongolia
Morocco
Myanmar
Nicaragua
Nigeria
Occupied Palestinian territory*
Pakistan
Philippines
Republic of Moldova
Sri Lanka
Sudan
Timor-Leste
Uzbekistan
Vanuatu
Viet Nam
Zambia

Upper middle income

Albania
Algeria
Armenia
Azerbaijan
Belize
Botswana
Brazil
Bulgaria
China
Colombia
Cook Islands†
Costa Rica
Cuba
Dominica
Dominican Republic
Ecuador
Equatorial Guinea
Gabon
Grenada
Guatemala
Guyana
Iraq
Jordan
Kazakhstan
Lebanon
Maldives
Marshall Islands
Mauritius
Mexico
Namibia
Paraguay
Peru
Romania
Russian Federation
Serbia
South Africa
Suriname
Thailand
The former Yugoslav Republic of Macedonia
Turkey
Turkmenistan
Tuvalu
Venezuela (Bolivarian Republic of
Wallis and Futuna Islands*†

High income

Antigua and Barbuda
Argentina
Australia
Austria
Barbados
British Virgin Islands*
Brunei Darussalam
Chile
Croatia
Cyprus
Czechia
Denmark
Estonia
Finland
France
French Polynesia*
Guam*
Israel
Italy
Latvia
Lithuania
Luxembourg
Malta
Monaco
Norway
Oman
Palau
Panama
Poland
Portugal
Saint Kitts and Nevis
San Marino
Saudi Arabia
Singapore
Slovakia
Slovenia
Spain
Sweden
Trinidad and Tobago
United Arab Emirates
Uruguay

* Country completed the survey but was not included in the analyses within this report. Region-specific reports will be made available and may include data from non-Member States that responded to the survey.

† Not an official World Bank income classification.