

Making Pregnancy Safer

Towards the European Strategy for Making
Pregnancy Safer: Improving maternal and
perinatal health



Country profiles: Georgia

Key national indicators for assessing
maternal and perinatal health status

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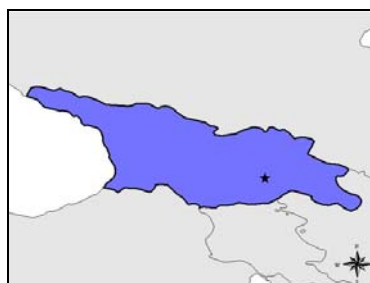
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Facts on maternal and neonatal health in Georgia



Georgia is a country dominated by mountains and rivers, situated in the southern Caucasus and covering an area of 69 700 km². A relatively prosperous republic of the Soviet Union until its dissolution in 1991, Georgia was left vulnerable after independence due to a lack of economic diversification.¹ Economic and political progress has been made since then, but this has been complicated by civil conflicts in certain regions. The economy is currently improving, governmental structures are being reformed, and the privatization process has met with success, supplementing government expenditures on infrastructure, defence, and poverty reduction.² Economic improvement has not benefited all sectors of the population and income inequality is very high.¹ The country moreover suffers from corruption, poor governance and high poverty levels. Georgia has also been heavily over-aided in recent years, which has led to a degree of donor fatigue.³

The Ministry of Labour, Health and Social Affairs is the lead agency for the health care system, implementing government policy on health care and coordinating all activities. Prior to independence, the health system was extremely centralized, leading to unresponsiveness and widespread inefficiencies.¹ The health care system was also severely damaged as a result of the post-independence economic collapse and the drastic reduction in public funding. Decentralization was an early key element of the reform process and has taken place through the devolution of management of the health system to 12 regional health authorities and the privatization of much of the provision of health care.¹ The health system is financed through a social insurance model run by the specially-created State Medical Insurance Company. Levels of state financing are below those required to provide basic care to the population or to maintain the health care facilities themselves. Additional sources of funding are official fees and informal out-of-pocket payments.¹ These are very widespread and many people are deterred from seeking medical services at all because of the high level of out-of-pocket payments charged. The primary health care structure currently in place in Georgia is essentially that inherited from the Soviet era. It is poorly utilized because of the lack of functioning referral processes and many facilities are short of very basic equipment such as thermometers and sterilizers.¹

The perinatal mortality rate in Georgia rose by 7.6% in the period 1994–2004 and, based on the number of live births in 2004, there were 916 perinatal deaths that year. The 2004 perinatal mortality rate is more than double the average in the WHO European Region. There are no figures for neonatal mortality reported to WHO after 1999 but this rate had also increased, by 9.7%, in the period 1994–1999. The neonatal mortality rate per 1000 in 1999 was more than three times the Regional average for the same year and, given the number of live births that year, amounted to 579 neonatal deaths. The maternal mortality ratio fluctuated during the period 1994–2004 but showed an overall increase of 14.3%. The 2004 maternal mortality ratio of 45.28 deaths per 100 000 live births equates to 21 maternal deaths that year and is also more than three times the Regional average. The reported maternal mortality ratio in 2000 was in fact considerably higher than the WHO estimate. However, this was not the case for the perinatal mortality rate, for which the estimate was almost double the reported rate.

¹ Gamkrelidze A et al. *Health care systems in transition: Georgia*. Copenhagen, European Observatory on Health Care Systems, 2002: 4(2) (<http://www.euro.who.int/document/E75489.pdf>, accessed 29 September 2006).

² CIA: The World Factbook [online database]. Washington, DC, Central Intelligence Agency, 2006 (<https://www.cia.gov/cia/publications/factbook/index.html>, accessed 24 August 2006).

³ DFID: Country Profiles: Europe [website]. London, Department for International Development, 2005 (<http://www.dfid.gov.uk/countries/allcountries.asp?view=alpha>, accessed 24 August 2006).

Indicator		Value	Year	Source
DEMOGRAPHY				
Mid-year population (000)		4 474	2005	HFA
Annual population growth rate (%)		-1.1	2004	WHOSIS
Life expectancy at birth (years)	All	76.09	2001	HFA
	Male	73.54	2001	HFA
	Female	78.73	2001	HFA
Live births per 1000 total population (crude birth rate)		10.67	2003	HFA
Total fertility rate		1.4	2003	HFA
Proportion of total fertility attributable to 15–19 year age group		18.7	1998	WHOSIS
Urban population (%)		51	2005	WUP
Female population of reproductive age – 15–49 (000)		1 205	2005	WPP
Number of live births		46 373	2004	HFA
MATERNAL HEALTH				
Maternal mortality ratio per 100 000 live births (latest year)		45.28	2004	HFA
Estimated maternal mortality ratio per 100 000 live births ¹		32	2000	HFA
Reported maternal mortality ratio per 100 000 live births		49.18	2000	HFA
Lifetime chance of dying from maternal causes – 1 in:		1 700	2005	PRB
Abortions per 1000 live births		371.12	2004	HFA
Births to mothers, age < 20 years (% of all live births)		12.79	2003	HFA
Abortions per 1000 live births, age <20 years		115.46	2003	HFA
Caesarean sections as % of live births		16.8	2004	HFA
Births attended by skilled health personnel (%)		97.5	2004	HFA
Women receiving ANC visits (%)	At least 1	91	1999	WHOSIS
	At least 4	WHOSIS
PERINATAL/NEONATAL HEALTH				
Perinatal mortality rate per 1000 births (latest year)		19.76	2004	HFA
Estimated perinatal mortality rate per 1000 births		42	2000	NPM
Reported perinatal mortality rate per 1000 births		20.03	2000	HFA
Early neonatal mortality rate per 1000 live births (latest year) ²		12.1	2004	HFA
Estimated neonatal mortality rate per 1000 live births		25	2000	NPM
Reported neonatal mortality rate per 1000 live births		...	2000	HFA
Low birth weight – less than 2 500g (%)		6	2004	HFA
Congenital syphilis incidence per 100 000		0.0229	2004	HFA
Number of new congenital syphilis cases		1	2004	HFA
HIV/AIDS				
Estimated HIV prevalence rate among adults (15–49) (%)		0.2	2005	UNAIDS
Estimated % of adults (15+) living with HIV who are women ³		<18	2005	UNAIDS
HEALTH CARE FINANCING AND EXPENDITURE				
Total health expenditure as % of gross domestic product, WHO estimates		4	2004	HFA
Total health expenditure, PPP\$ per capita, WHO estimates		193	2004	HFA
Public sector health expenditure as % of total health expenditure, WHO estimates		22.8	2004	HFA
Private households' out-of-pocket payment on health as % of private sector health expenditure		98.3	2004	HFA
HEALTH SYSTEM INFRASTRUCTURE				
Number of midwives (PP) per 100 000		32.71	2004	HFA
Number of physicians per 100 000		489.44	2004	HFA
SOCIOECONOMIC FACTORS				
Poverty headcount ratio at \$1 a day (PPP) (% of population)		7	2003	WDI
Poverty headcount ratio at national poverty line (% of population)		55	2003	WDI
GDP per capita US\$		778	2003	HFA
UNDP Human Development Index rank (out of 177)		100	2003	UNDP
Population with sustainable access to an improved water source (%)	Urban	90	2002	WHOSIS
	Rural	61	2002	WHOSIS

Making Pregnancy Safer	WHO Regional Office for Europe	Country Profiles		
Population with sustainable access to improved sanitation (%)	Urban	96	2002	WHOSIS
	Rural	69	2002	WHOSIS
International migrants as a percentage of the population		4.3	2005	WMS
Female migrants as percentage of all international migrants		37.4	2005	WMS
Literacy rate (%) in population aged 15+	All	100	2003	HFA
	Male	100	2003	HFA
	Female	100	2003	HFA
Female net school enrolment ratio (%)	Primary	92	2004	UNESCO
	Secondary	81	2004	UNESCO
Adult unemployment rate (%) ⁴	Male	13.4	2004	ILO
	Female	11.8	2004	ILO
Gender-related development index		UNDP
Percentage of women who reported physical abuse from a partner in their lifetime ⁵		5	1999	CDC
Percentage of women who reported sexual abuse from a partner in their lifetime ⁵		3	1999	CDC

¹ WHO/UNICEF/UNFPA estimate.

² No data available for neonatal mortality. Early neonatal mortality = neonatal deaths within 0 to 6 full days.

³ Calculated from UNAIDS 2005 estimates of number of adults 15+ living with HIV (5 600) and number of women 15+ living with HIV (<1000).

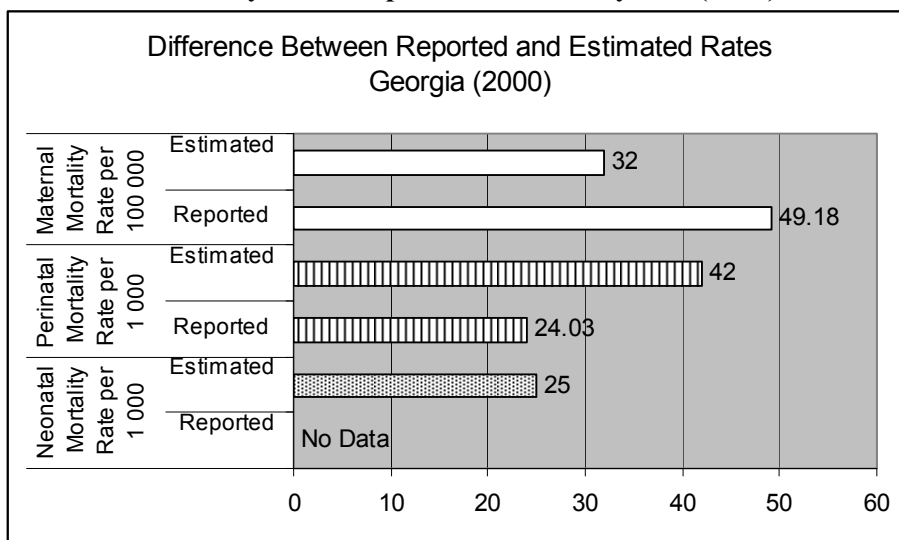
⁴ Persons aged 15 years and over.

⁵ Percentage of women aged 15–44 ever married or in union who reported intimate partner violence (IPV) in their lifetime. IPV is classified into three types (one of which is shown here): verbal, physical or sexual.

Technical notes:

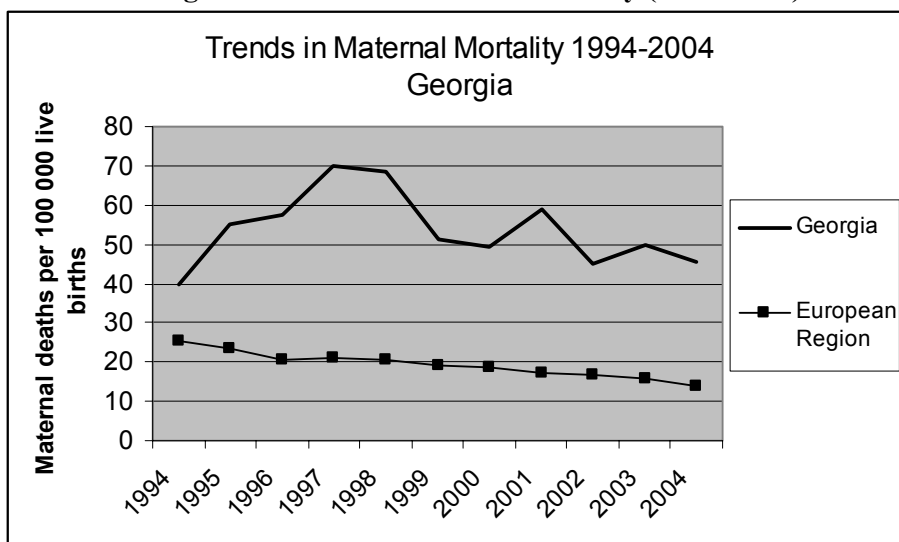
- All figures are for the latest available year as of September 2006 but do not include data where the latest year available is prior to 1990. The exceptions are the reported maternal mortality ratio, neonatal mortality rate and perinatal mortality rate for 2000, which are included to provide a direct comparison with the WHO estimates for the same year.
- The designations employed and the presentation of this material do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries.
- The numbers of maternal, neonatal and perinatal deaths given in the introductory text were calculated using data from the Health for All database as follows: number of live births in a given year /1000 or 100 000 * rate or ratio for the same year.
- For the sake of consistency, the term ‘antenatal’ is used throughout this document, although it should be noted that, in some of the source material, the original term used was ‘prenatal’. The two terms are understood to have the same meaning and be interchangeable.

Georgia 1: Difference between reported and estimated maternal mortality ratio, neonatal mortality rate and perinatal mortality rate (2000)



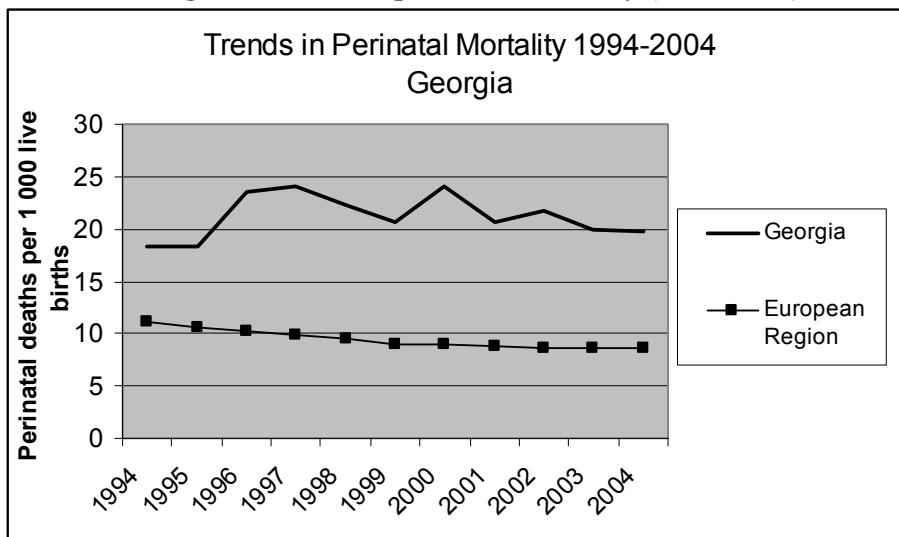
Data source: European Health for All database [online database]. Copenhagen, WHO Regional Office for Europe, 2006 (<http://data.euro.who.int/hfad/> accessed July 2006) and *Neonatal and Perinatal Mortality: Country, Regional and Global Estimates*. Geneva, World Health Organization, 2006.

Georgia 2: Trends in maternal mortality (1994–2004)



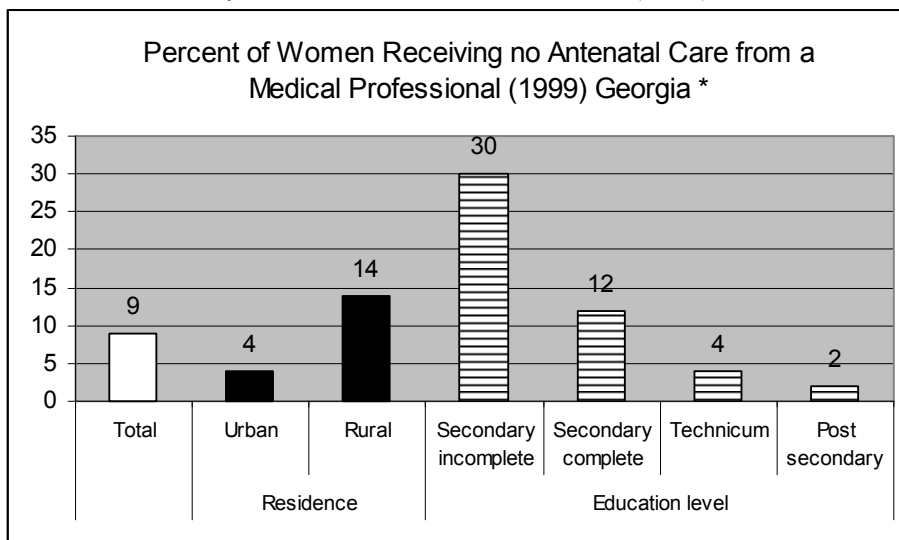
Data source: European Health for All database [online database]. Copenhagen, WHO Regional Office for Europe, 2006 (<http://data.euro.who.int/hfad/> accessed July 2006).

Georgia 3: Trends in perinatal mortality (1994–2004)



Data source: European Health for All database [online database]. Copenhagen, WHO Regional Office for Europe, 2006 (<http://data.euro.who.int/hfad/> accessed July 2006).

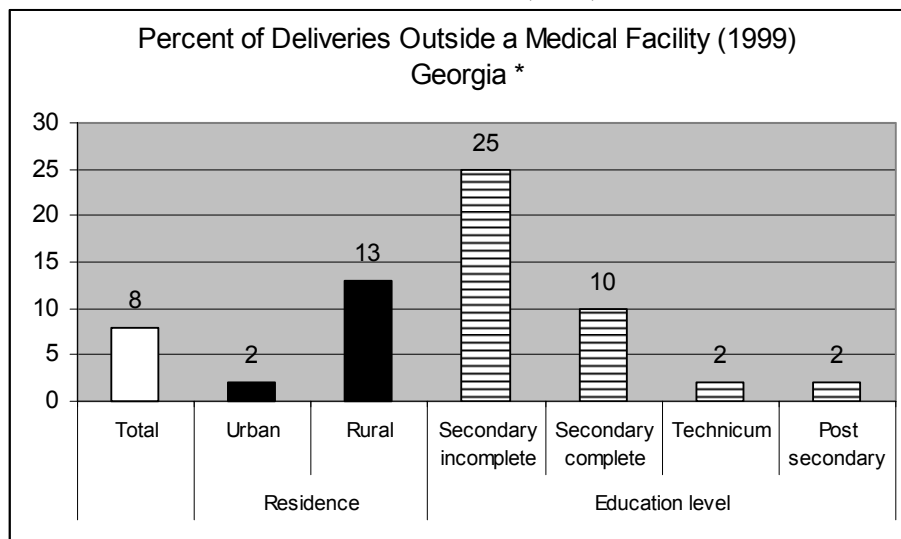
Georgia 4: Percentage of women receiving no antenatal care from a medical professional by residence and education level (1999)



* All live births and still births in last five years. Still births account for less than 2% of sample.

Data Source: *Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report*. Atlanta, GA and Calverton, MD, Centers for Disease Control and Prevention and ORC Macro, 2003 (http://www.measuredhs.com/pubs/pub_details.cfm?ID=410&srchTp=simple, accessed 1 July 2006).

Georgia 5: Percentage of deliveries outside a medical facility by mother’s residence and education level (1999)



* All live births and still births in last five years. Still births account for less than 2% of sample.

Data Source: *Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report*. Atlanta, GA and Calverton, MD, Centers for Disease Control and Prevention and ORC Macro, 2003 (http://www.measuredhs.com/pubs/pub_details.cfm?ID=410&srchTp=simple, accessed 1 July 2006).

Acronyms

- : a source for this data was not found
... : data was missing from a database or report containing this indicator
N/A : indicator is not applicable in the national context

AIDS : acquired immunodeficiency syndrome
ANC : antenatal care
FTE : full-time equivalent
GDP : gross domestic product
HIV : human immunodeficiency virus
IPV : intimate partner violence
LBW : low birth weight
MNH : maternal and neonatal health
PP : physical persons
PPP : purchasing power parity
TB : tuberculosis
UNAIDS : The Joint United Nations Programme on HIV/AIDS
UNICEF : United Nations Children's Fund
UNDP : United Nations Development Programme
UNESCO : United Nations Educational, Scientific and Cultural Organization
UNFPA : United Nations Population Fund

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WDI: World Development Indicators Online [online database]. Washington, World Bank, 2006 (<http://devdata.worldbank.org/dataonline/> accessed July 2006).

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WMS: World Migrant Stock: The 2005 Revision Population Database [online database]. New York, United Nations Department of Economic and Social Affairs Population Division, 2005 (<http://esa.un.org/migration/>, accessed July 2006).

WPP: World Population Prospects: The 2004 Revision Population Database [online database]. New York, United Nations Department of Economic and Social Affairs Population Division, 2004 (<http://esa.un.org/unpp/> accessed July 2006).

WUP: World Urbanization Prospects: The 2005 Revision Population Database [online database]. New York, United Nations Department of Economic and Social Affairs Population Division, 2005 (<http://esa.un.org/unup/> accessed July 2006).

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NPM: *Neonatal and Perinatal Mortality: Country, Regional and Global Estimates*. Geneva, World Health Organization, 2006 (http://www.who.int/reproductive-health/docs/neonatal_perinatal_mortality/text.pdf, accessed 12 February 2007).

UNAIDS: *Report on the Global AIDS Epidemic – Annex 2: HIV and AIDS Estimates and Data, 2005 and 2003*. Geneva, Joint United Nations Programme on HIV/AIDS, 2006 (http://www.unaids.org/en/HIV_data/2006globalreport/default.asp, accessed 8 July 2006).

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Indicator definitions

Indicator	Definition	Source
DEMOGRAPHY		
Mid-year population (000)	Estimate of resident (de jure) population on 1 July of given calendar year. Usually calculated as an average of year-end estimates.	HFA
Annual population growth rate (%)	Self-explanatory.	WHOSIS
Life expectancy at birth (years)	Calculated by WHO Regional Office for Europe for all countries that report detailed mortality data to WHO, using Wiesler's method. Some countries are not able to ensure complete registration of all deaths and births. Therefore, life expectancy calculated using incomplete mortality data is higher than it actually is. In some cases under-registration of deaths may reach 20% and this has to be kept in mind when making comparisons between countries.	HFA
Live births per 1000 total population (crude birth rate)	Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, that, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered live-born. The number of live births includes all live births during the given calendar year, irrespective of registration of the date of birth.	HFA
Total fertility rate	The average number of children that would be born per woman if all women lived to the end of their childbearing years and bore children according to a given set of age-specific fertility rates. It is computed by summing the age-specific fertility rates for all ages and multiplying by the interval into which the ages are grouped.	HFA
Proportion of total fertility attributable to 15–19 year age group (adolescent fertility proportion)	Self-explanatory.	WHOSIS
Urban population (%)	Urban-rural classification of population follows the national census definition and varies from one country or area to another. National definitions are usually based on criteria that may include any of the following: size of population in a locality, population density, distance between built-up areas, predominant type of economic activity, legal or administrative boundaries, and such urban characteristics as specific services and facilities.	WUP
Female population of reproductive age – 15–49 years (000)	Self-explanatory.	WPP
Number of live births	See: Live births per 1 000 total population (crude birth rate).	HFA
MATERNAL HEALTH		
(Reported) maternal mortality ratio per 100 000 live births	A maternal death is death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. There are two alternative sources of information on maternal mortality that are used to calculate this indicator: a) routine mortality data by cause statistics, regularly reported to WHO (in most cases from central statistical offices); b) hospital data reported to ministries of health. Normally, the numbers of maternal deaths from the two sources should be identical, as is the case in most western countries. However, in some countries, mainly in eastern Europe, there are large differences because of national practices of death certification and coding. In such cases, hospital data are more complete/accurate. Since the January 2001 issue of the Health for All database, the maternal mortality rate has been calculated using both types of data (when both figures are reported), taking the larger figure if unequal.	HFA

Indicator	Definition	Source
	Experts argue that, even in countries with good vital registration systems, maternal mortality is actually approximately 50% higher than reported.	
Estimated maternal mortality ratio per 100 000 live births	WHO/UNICEF/UNFPA estimate. WHO and UNICEF, with the participation of UNFPA, have developed an approach to estimating maternal mortality that seeks to generate estimates for countries with no data and to correct available data for underreporting and misclassification. These estimates may differ significantly from national statistics reported by countries to WHO. Estimates for years before and after 2000 may not be comparable because of differences in estimation methods applied.	HFA
Lifetime chance of dying from maternal causes	The probability that a woman will die during her lifetime from causes related to pregnancy and delivery. The measure combines the probability of becoming pregnant and the risk of death from each pregnancy (as measured by the 2000 maternal mortality ratio).	PRB
Abortions per 1000 live births	Total number of induced abortions, irrespective of the method. Abortion is the termination of a pregnancy before the fetus has attained viability. The legal requirements for abortion vary between countries. Usually these requirements are the weight of 500 g or 1000 g or corresponding gestational periods of 22 and 28 weeks.	HFA
Births to mothers, age < 20 years (% of all live births)	See: Live births per 1000 total population (crude birth rate). Age of mother is under 20 years.	HFA
Abortions per 1000 live births, age <20 years	See: Abortions per 1000 live births. Age of pregnant woman is under 20 years.	HFA
Caesarean sections as % of live births	Self-explanatory.	HFA/ WHOSIS
Births attended by skilled health personnel (%)	The proportion of births attended by skilled health personnel is the percentage of deliveries attended by personnel trained to give the necessary supervision, care and advice to women during pregnancy, labour and the post-partum period; to conduct deliveries on their own; and to care for newborns. Skilled health personnel (doctors, nurses or midwives) include only those who are properly trained and who have appropriate equipment and drugs. Traditional birth attendants, even if they have received a short training course, are not to be included.	HFA
Women receiving ANC visits (%)	Percentage of women who utilized antenatal care provided by skilled birth attendants for reasons related to pregnancy at least once during pregnancy among all women who gave birth to a live child in a given time period. Antenatal care includes recording medical history, assessment of individual needs, advice and guidance on pregnancy and delivery, screening tests, education on self-care during pregnancy, identification of conditions detrimental to health during pregnancy, first-line management and referral if necessary. Routine health service statistics: Number of women receiving antenatal care (numerator). Census projections or in some cases vital registration data are used to provide the denominator (numbers of live births). Household surveys: Birth history – detailed questions on the last child or all children a woman has given birth to during a given period preceding the survey (usually 3 to 5 years). The number of births in the survey provides the denominator.	WHOSIS
NEONATAL/PERINATAL HEALTH		
Perinatal mortality rate per 1000 births	Weight-specific (1000 g +) fetal deaths and early neonatal deaths per 1000 births (live births + stillbirths). If weight-specific data are not available, any available data provided according national criteria are used as a proxy.	HFA
Neonatal mortality rate per 1000 live births	The number of deaths in infants under 28 days of age in a year, per 1000 live births in that year. All live births should be included.	HFA
Early neonatal (0 to 6 full days) mortality rate per 1000 live births	The number of deaths in infants 0 to 6 full days of age in a year, per 1000 live births in that year. All live births should be included.	HFA

Indicator	Definition	Source
Estimated neonatal or perinatal mortality rate per 1000 live births	For details see: NPM.	NPM
Percentage of low birth weight (<2500g)	Self-explanatory.	HFA
Percentage of low birth weight (<2500g)	Percentage of live born infants with birth weight less than 2500g in a given time period. Birth weight is the first weight of the foetus or newborn obtained after birth. For live births, birth weight should ideally be measured within the first hour of life before significant postnatal weight loss has occurred and actual weight should be recorded to the degree of accuracy to which it is measured. Low birth weight is defined as less than 2500 g (up to and including 2499 g).	WHOSIS
Congenital syphilis incidence per 100 000	Self-explanatory.	HFA
Number of new congenital syphilis cases	Self-explanatory.	HFA
HIV/AIDS		
Estimated HIV prevalence rate among adults (15–49) (%)	To calculate the adult HIV prevalence rate, the estimated number of adults aged 15–49 living with HIV in 2005 was divided by the 2005 adult population (aged 15–49) and similarly for 2003.	UNAIDS
Estimated % of adults (15+) living with HIV who are women	Percentage of adults living with HIV who are women. Calculated by dividing the estimated number of women 15+ living with HIV by the estimated number of adults 15+ living with HIV, multiplied by 100. These estimates include all people with HIV infection, whether or not they had developed symptoms of AIDS, in 2005.	UNAIDS
HEALTH CARE FINANCING AND EXPENDITURE		
Total health expenditure as % of gross domestic product, WHO estimates	Sum of general government and private expenditure on health. Estimates for this indicator were produced by WHO. The estimates are, to the greatest extent possible, based on the national health accounts classification. The sources include both nationally reported data and estimates from international organizations like the International Monetary Fund, the World Bank, the United Nations and the Organisation for Economic Co-operation and Development. Therefore they may differ somewhat from official national statistics reported by countries.	HFA
Total health expenditure, PPP\$ per capita, WHO estimates	Sum of general government and private expenditure on health. Estimates for this indicator were produced by WHO. The estimates are, to the greatest extent possible, based on the national health accounts classification. The sources include both nationally reported data and estimates from international organizations like International Monetary Fund, the World Bank, the United Nations and the Organisation for Economic Co-operation and Development. They may therefore differ somewhat from official national statistics reported by countries. The purchasing power parity (PPP) is adjusted to the relative domestic purchasing power of the national currency as compared to the US dollar, rather than using the official exchange rate. Multipliers (PPPs) are estimated periodically, using the cost of the standard basket of goods.	HFA

Indicator	Definition	Source
Public sector health expenditure as % of total health expenditure, WHO estimates	Public sector (or general government) expenditure on health is the sum of outlays for health maintenance, restoration or enhancement paid for in cash or in kind by government entities, such as the ministry of health, other ministries, parastatal organizations and social security agencies (without double-counting the government transfers to social security and to extrabudgetary funds). Includes transfer payments to households to offset medical care costs and extrabudgetary funds to finance health. The revenue base of these entities may comprise multiple sources, including external funds. Estimates for this indicator were produced by WHO. The estimates are, to the greatest extent possible, based on the national health accounts classification. The sources include both nationally reported data and estimates from international organizations like International Monetary Fund, the World Bank, the United Nations and the Organisation for Economic Co-operation and Development. They may therefore differ somewhat from official national statistics reported by countries.	HFA
Private households' out-of-pocket payments on health as % of private sector health expenditure	Private households' out-of-pocket payments on health are the direct outlays of households, including gratuities and payments in kind made to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services, whose primary intent is to contribute to the restoration or to the enhancement of the health status of individuals or population groups. These include household payments to public services, non-profit institutions or non-governmental organizations; and non-reimbursable cost sharing, deductibles, co-payments and fees for service. They exclude payments made by enterprises which deliver medical and paramedical benefits, mandated by law or not, to their employees; and payments for overseas treatment.	HFA
HEALTH SYSTEM INFRASTRUCTURE		
Number of midwives (PP) per 100 000	A midwife is a person who has completed a midwifery educational programme duly recognized in the country in which it is located and who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. Only active, practising midwives are included.	HFA
Number of physicians per 100 000	A physician is a person who has completed studies in medicine at the university level. To be legally licensed for the independent practice of medicine (comprising prevention, diagnosis, treatment and rehabilitation), (s)he must in most cases undergo additional postgraduate training in a hospital (from 6 months to 1 year or more). To establish his or her own practice, a physician must fulfil additional conditions. The number of physicians at the end of the year includes all active physicians working in health services (public or private), including health services under other ministries than the ministry of health. Interns and residents, i.e. physicians in postgraduate training, are also included. The number of physicians excludes: physicians working outside the country; physicians on the retired list and not practising or unemployed; physicians working outside health services, e.g. employed in industry, research institutes etc.; dentists (stomatologists), who should be defined as a separate group. Confusion often occurs due to the different meaning of stomatologist in different countries. Stomatologists who are physicians with the specialty of stomatology (oral diseases/surgery) should be included in the number of physicians. In some countries of eastern Europe, the stomatologist is actually a dentist, practising dental care only. In this case, he or she should be excluded from the total number of physicians. National practices in using full-time equivalent and/or physical persons differ, therefore the possibility is given to provide data in both versions.	HFA
SOCIOECONOMIC FACTORS		
Poverty headcount ratio at \$1 a day (PPP) (% of population)	Percentage of the population living on less than \$1.08 a day at 1993 international prices. As a result of revisions in PPP exchange rates, poverty rates cannot be compared with poverty rates reported previously for individual countries. Data showing as 2.0 signifies a poverty rate of less than 2.0%.	WDI
Poverty headcount ratio at national poverty line (% of population)	National poverty rate is the percentage of the population living below the national poverty line. National estimates are based on population-weighted subgroup estimates from household surveys.	WDI

Indicator	Definition	Source
GDP per capita US\$	The total output of goods and services for final use produced by an economy, by both residents and non-residents, regardless of the allocation to domestic and foreign claims.	HFA
UNDP Human Development Index rank	The Human Development Index is a composite index measuring average achievement in three basic dimensions of human development—a long and healthy life, knowledge and a decent standard of living.	UNDP
Population with sustainable access to an improved water source (%)	Percentage of the population with access to an improved drinking water source in a given year. Improved drinking water sources are defined in terms of the types of technology and levels of services that are more likely to provide safe water than unimproved technologies. Improved water sources include household connections, public standpipes, boreholes, protected dug wells, protected springs, and rainwater collections. Unimproved water sources are unprotected wells, unprotected springs, vendor-provided water, bottled water and tanker truck-provided water. Reasonable access is broadly defined as the availability of at least 20 litres per person per day from a source within one kilometer of the user's dwelling. Sustainable access has two components with respect to water: one stands for environmental sustainability, the other for functional sustainability. The former insists on environmental protection through limiting extraction of water to a capacity below what is actually available. The latter reflects programme sustainability in terms of supply and management.	WHOSIS
Population with sustainable access to improved sanitation (%)	Percentage of the population with access to improved sanitation in a given year. Improved sanitation facilities are defined in terms of the types of technology and levels of services that are more likely to be sanitary than unimproved technologies. Improved sanitation includes connection to public sewers, connection to septic systems, pour-flush latrines, simple pit latrines and ventilated improved pit latrines. Not considered as improved sanitation are service or bucket latrines (where excreta is manually removed), public latrines and open latrines. Sustainable access has two components with respect to water: one stands for environmental sustainability, the other for functional sustainability. The former insists on environmental protection through limiting extraction of water to a capacity below what is actually available. The latter reflects programme sustainability in terms of supply and management.	WHOSIS
Improved sanitation facilities, urban (% of urban population with access)	Percentage of the population with at least adequate access to excreta disposal facilities that can effectively prevent human, animal, and insect contact with excreta. Improved facilities range from simple but protected pit latrines to flush toilets with a sewerage connection. To be effective, facilities must be correctly constructed and properly maintained.	WDI
International migrants as a percentage of the population	Estimated number of international migrants divided by the total population, expressed as a percentage.	WMS
Female migrants as percentage of all international migrants	Percentage of female migrants among all international migrants.	WMS
Literacy rate (%) in population aged 15+	Percentage of people aged 15 and above who can, with understanding, read and write a short, simple statement related to their life.	HFA
Female net school enrolment ratio (%)	Number of pupils in the theoretical age group who are enrolled, expressed as a percentage of the same population.	UNESCO

Indicator	Definition	Source
Adult unemployment rate in %	<p>Proportion of the labour force that is unemployed. The unemployed are persons who are currently without work, who are seeking or have sought work recently, and who are currently available for work. The base for these statistics is the labour force (the economically active portion of the population), not the total population. The International Conference of Labour Statisticians adopted the following definition of the unemployed as an international recommendation in 1982:</p> <p>All persons who during the reference period were: (1) “without work”, that is, were not in paid employment or self-employment as specified by the international definition of employment; (2) “currently available for work”, that is, were available for paid employment or self-employment during the reference period; or (3) “seeking work”, that is, had taken specific steps in a specified recent period to seek paid employment or self-employment.</p>	ILO
Gender-related development index	A composite index measuring average achievement in the three basic dimensions captured in the Human Development Index—a long and healthy life, knowledge and a decent standard of living—adjusted to account for inequalities between men and women.	UNDP
Prevalence of violence	Country-specific sources; see table footnotes for definitions where available.	
Prevalence of rape	Country-specific sources; see table footnotes for definitions where available.	