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| INDICATOR\_NUM | METADATA\_CATEGORY | METADATA\_CATEGORY\_DESC | METADATA\_DESCRIPTION |
| III.6 | 1 | Contact point in international agency | Alison Commar  Technical Officer  WHO  [[commara@who.int](mailto:commara@who.int)](mailto:commara@who.int)  [[www.who.int/tobacco/en/](www.who.int/tobacco/en/)](http://www.who.int/tobacco/en/)  Tibor Szilagyi  Team Leader  WHO-FCTC  [[szilagyit@who.int](mailto:szilagyit@who.int)](mailto:szilagyit@who.int)  [untobaccocontrol.org/intro/](untobaccocontrol.org/intro/) |
| III.6 | 2 | International agreed definition | \*\*Definition\*\* The indicator is defined as the percentage of the population aged 15 years and over who currently use any tobacco product \(smoked and/or smokeless tobacco\) on a daily or non-daily basis.  \*\*Concepts\*\* Tobacco use means use of smoked and/or smokeless tobacco products. “Current use” means use within the previous 30 days at the time of the survey, whether daily or non-daily use.  Tobacco products means products entirely or partly made of the leaf tobacco as raw material intended for human consumption through smoking, sucking, chewing or sniffing.   “Smoked tobacco products” include cigarettes, cigarillos, cigars, cheroots, bidis, pipes, shisha \(water pipes\), roll-your-own tobacco, kretek and any other form of tobacco that is consumed by smoking.  "Smokeless tobacco product" includes moist snuff, creamy snuff, dry snuff, plug, dissolvables, gul, loose leaf, red tooth powder, snus, chimo, gutkha, khaini, gudakhu, zarda, quiwam, dohra, tuibur, nasway, naas, naswar, shammah, toombak, paan \(betel quid with tobacco\), iq’mik, mishri, tapkeer, tombol and any other tobacco product that consumed by sniffing, holding in the mouth or chewing.  Prevalence estimates have been “age-standardized” to make them comparable across all countries no matter the demographic profile of the country. This is done by applying each country’s age-and-sex specific prevalence rates to the WHO Standard Population. The resulting rates are hypothetical numbers which are only meaningful when comparing rates obtained for one country with those obtained for another country. |
| III.6 | 3 | Method of computation | A statistical model based on a Bayesian negative binomial meta-regression is used to model prevalence of current tobacco use for each country, separately for men and women. A full description of the method is available as a peer-reviewed article in The Lancet, volume 385, No. 9972, p966–976 \(2015\). Once the age-and-sex-specific prevalence rates from national surveys were compiled into a dataset, the model was fit to calculate trend estimates from the year 2000 to 2030. The model has two main components: \(a\) adjusting for missing indicators and age groups, and \(b\) generating an estimate of trends over time as well as the 95% credible interval around the estimate. Depending on the completeness/comprehensiveness of survey data from a particular country, the model at times makes use of data from other countries to fill information gaps. To fill data gaps, information is “borrowed” from countries in the same UN sub-region. The resulting trend lines are used to derive estimates for single years, so that a number can be reported even if the country did not run a survey in that year. In order to make the results comparable between countries, the prevalence rates are age-standardized to the WHO Standard Population.  Estimates for countries with irregular surveys or many data gaps will have large uncertainty ranges, and such results should be interpreted with caution.  \*\*Disaggregation\*\*: by sex |
| III.6 | 4 | Importance of the indicator in addressing gender issues and its limitation |  |
| III.6 | 5 | Sources of discrepancies between global and national figures | WHO estimates differ from national estimates in that they are \(I\) age-standardised to improve international comparability and \(ii\) calculated using one standard method for all countries. Infrequent surveys or unavailability of recent surveys lead to more reliance on modelling.   As the data set for each country improves over time with addition of new surveys, recent estimates may seem inconsistent with earlier estimates. WHO estimates undergo country consultation prior to release. |
| III.6 | 6 | Process of obtaining data | Prevalence rates by age-by-sex from national representative population surveys conducted since 1990:   * officially recognized by the national health authority; * of randomly selected participants representative of the general population; and * reporting at least one indicator measuring current tobacco use, daily tobacco use, current tobacco smoking, daily tobacco smoking, current cigarette smoking or daily cigarette smoking.   Official survey reports are gathered from Member States by one or more of the following methods:   * reporting system of the WHO FCTC; * review of surveys conducted under the aegis of the Global Tobacco Surveillance System; * review of other surveys conducted in collaboration with WHO such as STEPwise surveys and World Health Surveys; * scanning of international surveillance databases such as those of the Demographic and Health Survey \(DHS\), Multiple Indicator Cluster Survey \(MICS\) and the World Bank Living Standards Measurement Survey \(LSMS\); and * identification and review of country-specific surveys that are not part of international surveillance systems.   Reports either downloaded from websites or emailed by national counterparts. WHO shares and makes public the methodologies for its estimates through the WHO global report on trends in tobacco use 2000-2025 and the WHO Report on the Global Tobacco Epidemic. The WHO estimates undergo country consultation prior to publication. |
| III.6 | 7 | Treatment of missing values | \*\*At country level \*\*  For countries with less than two national surveys completed in different years since 1990, no estimate is calculated, since no trend can be determined. For countries with data from two or more surveys, data gaps, if any, are filled as described in the Computation Method.  \*\*At regional and global levels\*\*  Countries where no estimate can be calculated are included in regional and global averages by assuming their prevalence rates for men and women are equal to the average rates for men and women seen in the UN subregion1 in which they are located. Where fewer than 50% of a UN subregion’s population was surveyed, UN subregions are grouped with neighbouring subregions until at least 50% of the grouped population has contributed data to the region’s average rates. |
| III.6 | 8 | Data availability and assessment of countries’ capacity |  |
| III.6 | 9 | Expected time of release | Biennial release via the WHO Global Report on Trends in Tobacco Smoking 2000-2025, the WHO Global Health Observatory and the Implementation Database of the WHO FCTC. |
| III.6 | 10 | Data source | Data and metadata were extracted from Global SDG Indicators Database on 28 May 2021.  For more information, please go to the following:   * [[https://unstats.un.org/sdgs/indicators/database/](https://unstats.un.org/sdgs/indicators/database/)](https://unstats.un.org/sdgs/indicators/database/]() * [[https://unstats.un.org/sdgs/metadata/files/Metadata-03-0a-01.pdf ](https://unstats.un.org/sdgs/metadata/files/Metadata-03-0a-01.pdf)](https://unstats.un.org/sdgs/metadata/files/Metadata-03-0a-01.pdf ]() |