

# Data sources for outcome indicators on Article 25:

## Health



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## 25.21 Maternal mortality ratio (SDG indicator 3.1.1) disaggregated by age and disability of the person.

*Level 2: Indicator that could be produced with straightforward additions or modifications to existing data collection efforts*

[Link to the metadata related to this SDG indicator](#)

Please see page 14 of the report (<https://www.who.int/reproductivehealth/publications/maternal-mortality-2000-2017/en/>).

The Maternal Mortality Estimation Inter-Agency Group (MMEIG) maintains an input database consisting of maternal mortality data from civil registration, population-based surveys, surveillance systems, censuses, and other specialized studies/surveys. This database is used to determine the number of maternal deaths and where possible the number of deaths among all women of reproductive age (WRA) to calculate the “PM” proportion of maternal deaths among WRA. The MMR is then calculated as  $MMR = PM(D/B)$ ; where “D” is the number of deaths in women aged 15-49 (WRA) and “B” is the number of live births. The number of live births is based upon the World Population Prospects 2019.

Statistical modelling is undertaken to generate comparable country, regional, and global level estimates. The model’s fit is assessed by cross-validation. Estimates are then reviewed with Member States through a WHO country consultation process and SDG focal points. In 2001, the WHO Executive Board endorsed a resolution (EB. 107.R8) seeking to “establish a technical consultation process bringing together personnel and perspectives from Member States in different WHO regions”. A key objective of this consultation process is “to ensure that each Member State is consulted on the best data to be used”. Since the process is an integral step in the overall estimation strategy, it is described here in brief.

The country consultation process entails an exchange between WHO and technical focal person(s) in each country. It is carried out prior to the publication of estimates. During the consultation period, WHO invites focal person(s) to review input data sources, methods for estimation and the preliminary estimates. Focal person(s) are encouraged to submit additional data that may not have been taken into account in the preliminary estimates.

Adjustments are made according to the data source type:

- (1) CRVS, for incompleteness and misclassification of maternal deaths
- (2) reports providing “pregnancy-related” mortality, for underreporting of these deaths, as well as over-reporting of maternal deaths due to inclusion of deaths which are accidental or incidental to pregnancy (thus outside of the definition of maternal mortality).

The analysis also accounts for stochastic errors due to the general rarity of maternal deaths, sampling error in the data source, errors during data collection and processing, and other random error.

The MMR estimates are limited to countries with population of greater than 100 000. Out of 185 countries and territories, 177 have nationally representative data.

The Maternal Mortality Estimation Inter-Agency Group data, available at <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/26>, does not include disability. According to this website, the most reliable source of data on maternal mortality is civil registration, if there is complete coverage and the medical certification contains the cause of death.

Other possible data sources listed by WHO include household surveys, population census, sample or sentinel registration systems, or even specific studies. Key issues about how to calculate the maternal mortality rate, in general, can be found at [https://www.who.int/reproductive-health/topics/monitoring/measuring\\_mmr.pdf](https://www.who.int/reproductive-health/topics/monitoring/measuring_mmr.pdf).

A good option is to include disability status on civil registration. If not, a survey can be used. In 2016, Bangladesh conducted the Maternal Mortality and Health Care Survey across 298,284 households. It included a “verbal autopsy interview” for any household death in the past three years. Doctors reviewed the interview and coded the cause of death. The interviews did not ask about the disability status of the mother, but if that were incorporated, the indicator could be produced.

In the [2016 Uganda DHS](#), which includes disability questions on the overall survey, “data were collected from all female respondents on the survival of their sisters and brothers to obtain an estimate of adult mortality. Questions were included to determine if any of the sisters’ deaths were maternity-related, which permits the estimation of maternal mortality.” However, no questions were asked about the disability status of the mother.

## **25.22 Proportion of women and girls of reproductive age who have their need for family planning satisfied with modern methods (based on SDG indicator 3.7.1) disaggregated by age and disability.**

*Level 1: Indicator for which data are already being produced and reported on in at least some countries*

[Link to the metadata related to this SDG indicator](#)

This indicator is calculated from nationally-representative household survey data. Multi-country survey programmes that include relevant data for this indicator are: Contraceptive Prevalence Surveys (CPS), Demographic and Health Surveys (DHS), Fertility and Family Surveys (FFS), Reproductive Health Surveys (RHS), Multiple Indicator Cluster Surveys

(MICS), Performance Monitoring and Accountability 2020 surveys (PMA), World Fertility Surveys (WFS), other international survey programmes and national surveys.

For information on the source of each estimate, see United Nations, Department of Economic and Social Affairs, Population Division (2020). World Contraceptive Use 2020

Data for the percentage of women of reproductive age (15-49 years) who have their need for family planning satisfied with modern methods are available for 130 countries or areas for the 2000-2019 time period. For 103 countries or areas, there are at least two available data points.

The World Contraceptive Use 2020 data set includes [data on contraceptive use by marital status and age group](#). It does not disaggregate by disability status but could do so if the surveys used to generate these data included related questions. An example of a survey from Lesotho used to generate this indicator that can disaggregate data by disability is presented in table 1.

**Table 1:** Use of contraception (currently married/in union) Percentage of women age 15-49 years currently married or in union who are using (or whose partner is using) a contraceptive method, Lesotho, 2018

	No method	Any modern method <sup>1</sup>	Any traditional method <sup>2</sup>	Any method
Total	35.1	64.6	0.4	64.9
Age				
15-19	54.5	45.2	0.4	45.5
20-24	33.0	66.7	0.3	67.0
25-29	28.7	71.3	0.0	71.3
30-34	28.0	71.9	0.1	72.0
35-39	32.9	67.0	0.1	67.1
40-44	36.5	61.4	2.0	63.5
45-49	60.5	39.5	0.0	39.5
Functional difficulties (age 18-49 years)				
Functional difficulty	41.8	58.2	0.0	58.2
No functional difficulty	34.1	65.5	0.4	65.9

Source: Bureau of Statistics, *Lesotho Multiple Indicator Cluster Survey 2018, Survey Findings Report* (Maseru, Lesotho, 2019).

Notes: <sup>1</sup>Female sterilization, Male sterilization, IUD, Injectables, Implants, Pill, Male condom, Female condom, Diaphragm/Foam/Jelly; <sup>2</sup>Periodic abstinence, Withdrawal, Other.

## 25.23 Number of new HIV infections per 1,000 uninfected population, by sex, age and key population (SDG indicator 3.3.1) and disability.

*Level 1: Indicator for which data are already being produced and reported on in at least some countries*

According to the SDG metadata, this can be obtained from [Spectrum modelling](#) (which does include disability data), household or key population surveys with HIV incidence-testing. Other possible sources include regular surveillance systems among key populations, should people with disabilities be considered a key population.

[Link to the metadata related to this SDG indicator](#)

Country teams use UNAIDS-supported software to develop estimates annually. The country teams are comprised of primarily epidemiologists, demographers, monitoring and evaluation specialists and technical partners.

The software used to produce the estimates is Spectrum—developed by Avenir Health ([www.avenirhealth.org](http://www.avenirhealth.org))—and the Estimates and Projections Package, which is developed by the East-West Center ([www.eastwestcenter.org](http://www.eastwestcenter.org)). The UNAIDS Reference Group on Estimates, Modelling and Projections provides technical guidance on the development of the HIV component of the software ([www.epidem.org](http://www.epidem.org)).

In 2019, 170 countries reported on this indicator without disaggregating by disability.

The DHS and the MICS ask about HIV/AIDS knowledge, attitudes and behaviours, but do not ask about infections. The [United Nations Gap Report, in 2014](#), states that data on disability and HIV status is sparse but obtainable. They cite studies from South Africa, Cameroon and Kenya.

Two studies on a project that would allow for data to be reported on this indicator are:

- Pierre De Beaudrap and others, “Prevalence of HIV infection among people with disabilities: a population-based observational study in Yaoundé, Cameroon (HandiVIH)”, *The Lancet HIV*, vol. 4, No. 4 (1 April 2017), p. E161-E168
- Pierre De Beaudrap and others, “HandiVIH—A population-based survey to understand the vulnerability of people with disabilities to HIV and other sexual and reproductive health problems in Cameroon: protocol and methodological considerations”, *BJM Open*, vol. 6, No. 2 (February 2016)

In this project, researchers “used two-phase random sampling to recruit adults with disabilities and a control group matched for age, sex, and residential location from households of the general population.” They recruited 807 persons with disabilities and 807 persons without disabilities from Yaoundé, Cameroon. They did face-to-face interviews and then administered a blood test to identify the prevalence of HIV. They found that “28 of 716 people in the

control population had a positive HIV test result (crude prevalence 3.9%, 95% CI 2.9–5.3) compared with 50 of 739 persons with disabilities (6.8%, 5.0–8.6; conditional odds ratio [OR] 1.7; p=0.04).”

## **25.24 Tuberculosis, malaria and hepatitis B incidence per 1,000 population (SDG indicators 3.3.2, 3.3.3, and 3.3.4) among population of persons with disabilities compared to others.**

*Level 2: Indicator that could be produced with straightforward additions or modifications to existing data collection efforts*

[Link to the metadata related to this SDG indicator](#)

For tuberculosis:

Details about data sources and methods are available in the following publicly available paper: <https://arxiv.org/ftp/arxiv/papers/1603/1603.00278.pdf>

National TB Programmes report every year between March and June their annual TB data to WHO using a standardized online data reporting system maintained at WHO. The system includes real-time checks for data consistency. Estimates of TB burden are prepared in July-August and communicated with countries. In selected countries with new survey data, estimates are updated separately during the year. All estimates are communicated in August-September and revisions are done based on feedback. The final set of estimates is reviewed in WHO before publication in October, for compliance with specific international standards and harmonization of breakdowns for age and sex groups.

For Malaria:

Cases reported by the NMCP are obtained from each country surveillance system. This include among others information on the number of suspected cases, number of tested cases, number of positive cases by method of detection and by species as well as number of health facilities that report those cases. This information is summarized in a DHIS2 application developed for this purpose. Data for representative household surveys are publicly available and included National Demographic Household Surveys (DHS) or Malaria Indicator Survey (MIS).

The official counterpart for each country is the National Malaria Control Program at the Ministry of Health.

For hepatitis, metadata for this indicator is not yet available but has been requested from the custodian agency(ies). Further information can be obtained by contacting [statistics@un.org](mailto:statistics@un.org).

If these surveillance systems include questions on disability, then these indicators could be disaggregated. For example, the 2018 [DHS in Nigeria](#) reports the prevalence of malaria among children, based on rapid diagnostics tests administered as part of the survey. It asks about tuberculosis and hepatitis B vaccination, but not incidence. It uses the WG questions to identify disability, so the rate of malaria for children over 2 by disability status could be reported, although they do not do so.

Table 2 presents an example from the Malaria table in the 2018 Nigeria DHS. It does not have disability as a characteristic of either the child or the mother, but if the optional DHS module on disability was included, this table could be disaggregated by disability.

**Table 2:** Percentage of children age 6-59 months classified in two tests as having malaria, according to background characteristics, Nigeria 2018

Background characteristic	Malaria prevalence according to RDT		Malaria prevalence according to microscopy	
	RDT Positive (%)	Number of Children	Microscopy Positive (%)	Number of Children
Age in months				
6-8	27.5	687	19.1	482
9-11	21.8	598	13.1	448
12-17	30.1	1,450	17.9	1,064
18-23	31.9	1,142	19.7	857
24-35	36.6	2,429	20.1	1,775
36-47	40.5	2,525	24.3	1,856
48-59	42.7	2,519	30.8	1,817
Wealth quintile				
Lowest	57.1	2,115	38.4	1,479
Second	50.3	2,230	33.6	1,572
Middle	38.6	2,398	24.2	1,750
Fourth	25.9	2,377	14.7	1,765
Highest	10.7	2,231	5.7	1,731

Source: National Population Commission and ICF, *Nigeria Demographic and Health Survey 2018* (Abuja, Nigeria, NPC; Rockville, Maryland, USA, ICF, 2019), p. 330

In the United States of America, [the National Health and Nutrition Survey](#) combines interviews and physical examinations. It tests for Hepatitis B and Tuberculosis. It also has disability questions, so it could be used to produce an indicator for prevalence, as can be seen in Table 3, although the report does not currently include it. Note that this is different from incidence - incidence refers to individuals who ever had the disease, while prevalence is those who currently have the disease.



**Table 3:** Age-adjusted prevalence of past or present hepatitis B virus infection among adults aged 18 and over, by sex, race and Hispanic origin, and U.S. birth status: the United States of America, 2015–2018

	Prevalence (%)
Total Population	4.3
Men	5.3
Women	3.4
Non-Hispanic white	2.1
Non-Hispanic black	10.8
Non-Hispanic Asian	21.1
Hispanic	3.8
Non-U.S. born	11.9
U.S. born	2.5

*Source:* Deanna Kruszon-Moran and others, “Prevalence and Trends in Hepatitis B Virus Infection in the United States, 2015–2018”, *NCHS Data Brief*, No. 361 (March 2020), p.1

## **25.25 Probability of dying (per 1000) between ages 15 and 60 years, disaggregated by sex (WHO indicator), disability, and indigenous/minority background.**

***Level 3: Indicator for which acquiring data is more complex or requires the development of data collection mechanisms which are currently not in place***

According to WHO, this indicator draws extensively on available death registration data to assess age-specific mortality rates. Adult mortality rates are derived from life tables which draw on the United Nations World Population Prospects revision, recent and unpublished analyses of all-cause and HIV mortality for countries with high HIV prevalence, vital registration data, and estimates of child mortality from the United Nations Inter-Agency Group for Child Mortality Estimation. More detailed methods are available at <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/64>.

To compute this indicator, the mortality rate by age, sex and disability status is required. One way to do this would be to include disability status as part of the death registration process.

## 25.26 Prevalence of undernourishment (SDG indicator 2.1.1) disaggregated by sex, age and disability.

*Level 2: Indicator could be produced with straightforward additions or modifications to existing data collection efforts*

[Link to the metadata related to this SDG indicator](#)

The ideal source of data to estimate the Prevalence of Undernourishment (PoU) would be a carefully designed and skillfully conducted individual dietary intake survey, in which actual daily food consumption, together with heights and weights for each surveyed individual, are repeatedly measured on a sample that is representative of the target population. Due to their cost, however, such surveys are rare.

In principle, a well-designed household survey that collects information on food acquisitions might be sufficient to inform a reliable estimate of the Prevalence of Undernourishment in a population, at a reasonable cost and with the necessary periodicity to inform the SDG monitoring process, provided that:

- a) All sources of food consumption for all members of the households are properly accounted for, including, in particular, food that is consumed away from home;
- b) Sufficient information is available to convert the data on food consumption or on food expenditures into their contribution to dietary energy intake;
- c) The proper methods to compute the PoU are used, to control for excess variability in the estimated levels of habitual food consumption across households, allowing for the presence on normal variability in the distribution of food consumption across individuals, induced by the differences in energy requirements of the members of the population.

Examples of surveys that could be considered for this purpose include surveys conducted to compute economic statistics and conduct poverty assessments, such as Household Income and Expenditure Surveys, Household Budget Surveys and Living Standard Measurement Surveys. (...)

To inform its estimate of PoU at national, regional and global level, in addition to all household surveys for which it is possible to obtain micro data on food consumption, FAO [Food and Agriculture Organization of the United Nations] relies on:

- a) UN Population Division's World Population Prospects (<https://esa.un.org/unpd/wpp/Download/Standard/Population/>), which provide updated estimates of the structures of the national population by sex and age every two years for most countries in the world;
- b) FAO Food Balance Sheets ([http://faostat3.fao.org/download/FB/\\*E](http://faostat3.fao.org/download/FB/*E)), which provides updated estimates of the national availability of food every year for most countries in the world.

Micro data from household surveys that collect food consumption data are sourced by FAO directly through the National Statistical Agencies' websites, or through specific bilateral agreements.

Collection process:

Official information on food commodity production, trade and utilization used by FAO to compile Food Balance Sheets is provided mainly by Statistical Units of the Ministry of Agriculture. FAO sends out a data collection questionnaire every year to an identified focal point.

Microdata of household surveys are generally owned and provided by National Statistical Agencies. When available, data is sourced by FAO directly through the NSA's website. In several cases, when microdata is not available in the public domain, bilateral agreements have been signed, usually in the contexts of technical assistance and capacity development programs.

To obtain this information for children with disabilities, the UNICEF/WG Child Functioning Module that is incorporated in MICS would have to be used.

## **25.27 Prevalence of malnutrition among children under 5 years of age, by type (wasting and overweight) (SDG indicator 2.2.2) and by sex, age and disability.**

*Level 2: Indicator could be produced with straightforward additions or modifications to existing data collection*

[Link to the metadata related to this SDG indicator](#)

For the majority of countries, nationally representative household surveys constitute the data source. For a limited number of countries data from surveillance systems is used if sufficient population coverage is documented (about 80%). For both data sources, the child's height and weight measurements have to be collected following recommended standard measuring techniques (WHO 2008).

Collection process:

UNICEF, WHO and the World Bank group jointly review new data sources to update the country level estimates. Each agency uses their existing mechanisms for obtaining data.

For WHO, see published database methodology (de Onis et al. 2004). For UNICEF, the cadre of dedicated data and monitoring specialists working at national, regional and international levels in 190 countries routinely provide technical support for the collection and analysis of data. For the past 20 years UNICEF has undertaken an annual process to update its global databases, called Country Reporting on Indicators for Goals (CRING). This exercise is done in close collaboration with UNICEF country offices with the purpose of ensuring that UNICEF global databases contain updated and internationally

comparable data. UNICEF country offices are invited to submit, through an online system, nationally representative data for over 100 key indicators on the well-being of women and children, including stunting. The country office staff work with local counterparts to ensure the most relevant data are shared. Updates sent by the country offices are then reviewed by sector specialists at UNICEF headquarters to check for consistency and overall data quality of the submitted estimates and re-analysis where possible. This review is based on a set of objective criteria to ensure that only the most reliable information is included in the databases. Once reviewed, feedback is made available on whether or not specific data points are accepted, and if not, the reasons why. UNICEF uses these data obtained through CRING to feed into the joint dataset. The World Bank Group provides estimates available through the Living Standard Measurement Surveys (LSMS) which usually requires re-analysis of datasets given that the LSMS reports often do not tabulate the stunting data.

The MICS includes a battery of questions about malnutrition and the UNICEF/WG Child Functioning Module. For example, consider the data from the [2017/2108 Ghana MICS survey](#) presented in table 4.

**Table 4:** Percentage of children under age 5 by nutritional status according to three anthropometric indices: weight for age, height for age and weight for height, Ghana

Background Characteristic	Weight for age		Height for age		Weight for height				No. of children under age 5
	Underweight, per cent below		Stunted, per cent below		Wasted, per cent below		Overweight, per cent above		
	-2 SD	-3 SD	-2 SD	-3 SD	-2 SD	-3 SD	+2 SD	+3 SD	
Total	12.6	2.4	17.5	4.8	6.8	1.1	1.4	0.3	8,775
Sex									
Male	14.1	3.2	19.5	5.7	7.8	1.3	1.5	0.2	4,308
Female	11.0	1.6	15.6	3.9	5.9	1.0	1.3	0.3	4,467
Age (in months)									
0-5	11.8	3.4	7.5	2.7	13.4	4.4	3.4	1.1	802
6-11	14.7	4.0	9.6	2.6	14.9	2.7	1.7	0.4	866
12-17	14.0	3.7	14.8	3.3	10.5	2.8	0.7	0.0	819
18-23	18.7	2.6	22.4	6.6	9.9	0.8	0.3	0.0	860
24-5	12.2	2.7	23.1	5.6	4.7	0.3	1.7	0.3	1,729
36-47	12.0	1.4	21.3	6.9	3.1	0.1	1.2	0.2	1,914
48-59	9.0	1.1	15.4	3.3	2.8	0.2	1.0	0.0	1,785

Source: Ghana Statistical Service, *Multiple Indicator Cluster Survey (MICS2017/18) Survey Findings Report* (Accra, Ghana, 2018)

The UNICEF/WG Child Functioning Module identifies children with functional difficulties, beginning at age 2. Thus, the Ghana survey report could have included data on nutrition disaggregated by the child's functional difficulties (age 2-4 years), as presented in table 5.

**Table 5:** Nutrition disaggregated by the child's functional difficulties (age 2-4 years)

Background Characteristics	Weighted per cent	Number of under 5 children	
		Weighted	Unweighted
Child's functional difficulties (age 2-4 years)			
Has functional difficulty	10.8	593	551
Has no functional difficulty	89.2	4,903	4,862

Source: Ghana Statistical Service, *Multiple Indicator Cluster Survey (MICS2017/18) Survey Findings Report* (Accra, Ghana, 2018)

## 25.28 Proportion of births attended by skilled health personnel (SDG indicator 3.1.2). disaggregated by age and disability of the individual giving birth.

**Level 1: Indicator for which data are already being produced and reported on in at least some countries**

[Link to the metadata related to this SDG indicator](#)

National-level household surveys are the main data sources used to collect data for skilled health personnel SBA. These surveys include Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), Reproductive Health Surveys (RHS) and national surveys based on similar methodologies. The surveys are undertaken every 3 to 5 years. For mainly industrialized countries (where the coverage is high), data sources include routine service statistics.

UNICEF and WHO maintain joint databases on skilled attendance at delivery (e.g. doctor, nurse or midwife or any additional qualified category) and both collaborate to ensure the consistency of data sources. These surveys include Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), Reproductive Health Surveys (RHS) and national surveys based on similar methodologies. The surveys are undertaken every 3 to 5 years. For mainly industrialized countries (where the coverage is high), data sources include routine service statistics.

Before acceptance into the joint global databases, UNICEF and WHO undergo a country consultation that consists of an updating and verification process that includes correspondence with field offices to clarify any questions regarding estimates. During this process, the national categories of skilled health personnel are verified, and so the estimates for some countries may include additional categories of trained personnel beyond doctors, nurses, and midwives.

Data are available for over 170 countries.

The lag between the reference year and actual production of data series depends on the availability of the household survey for each country.

As long as disability questions are included in the surveys used, this indicator can be easily disaggregated. Table 6 presents an example from the [MICS in Bangladesh](#).

**Table 6:** Per cent distribution of women age 15-49 years with a live birth in the last 2 years by person providing assistance at delivery of the most recent live birth, and percentage of most recent live births delivered by C-section, Bangladesh, 2019

	Skilled Attendant					Delivery assisted by any skilled attendant
	Medical doctor	Nurse/ Midwife	Paramedic/ Medical assistant (MA)/ SACMO	Family Welfare Visitor (FWV)	Community skilled birth attendant (CSBA/ PCSBA)	
Total	43.3	11.4	0.2	0.9	3.1	59.0
Age at most recent live birth						
Less than 20	43.5	13.3	0.4	1.2	4	62.3
20-34	44.4	11.1	0.2	0.8	2.9	59.4
35-49	32.5	9.0	0.2	0.8	2.5	45.0
Functional difficulties (age 18-49)						
Has functional difficulty	40.2	7.7	0.7	1.9	2.5	53.1
Has no functional difficulty	43.3	11.5	0.2	0.8	3.1	58.9

Source: Bangladesh Bureau of Statistics and UNICEF Bangladesh, *Progotir Pathey, Bangladesh Multiple Indicator Cluster Survey 2019, Survey Findings Report* (Dhaka, Bangladesh, 2019), p. 115

## **25.29 Proportion of women and girls who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (based on SDG indicator 5.6.1) by age and disability.**

*Level 1: Indicator for which data are already being produced and reported on in at least some countries.*

[Link to the metadata related to this SDG indicator](#)

Current data on the indicator are mainly derived from nationally representative DHS. Data sources increasingly include MICS and GGS, and other country-specific surveys.

Data is collected in line with the methodology used for the relevant national survey.

### Relevant country-specific surveys

Data for SDG indicator 5.6.1 may be collected through existing country-specific surveys. For existing national household surveys, it must be ascertained that the sampling design does not systematically exclude subgroups of the population that are important to SDG 5.6.1, specifically, women of reproductive age (15-49) that are currently married or in union. Surveys that cover only certain population subgroups, such as women who speak the dominant language or women from the main ethnic group, may exclude the experiences of a large number of women. Data on the ethnicity and religion of the survey participants should be collected whenever available. The survey should have a large sample size (usually between 5,000 and 30,000 households), be nationally-representative, and representative, at least, at one administrative level below the national level.

Surveys on unrelated topics may not be good candidates for the incorporation of the SDG 5.6.1 questions. The sensitivity of the topics addressed in health surveys, in particular, those examining women's health, making them a feasible instrument for incorporating questions on women's experience of decision making in sex relations, use of contraceptive, and health care for themselves.

In order to generate data for SDG 5.6.1, all three questions must be included in the survey. The three questions in the Definition section provides generic questions that can be used in country-specific surveys. For the first and the second questions, these should include distinct categories for women making decisions herself, and women making decisions jointly with her husband/partner.

Currently, a total of 57 countries have at least one survey with data on all the 3 questions above which are necessary for calculating Indicator 5.6.1. The 57 countries with data are distributed as follows:

Central Asia and Southern Asia (5)

Eastern Asia and South-eastern Asia (5)

Northern America and Europe (2)

Western Asia and Northern Africa (2)

Latin America and the Caribbean (7)

Sub-Saharan Africa (36)

Several other countries have only one or two of the three questions needed to calculate Indicator 5.6.1. UNFPA engages with major international and regional survey programmes, as well as national and international organizations and agencies to incorporate the questions in relevant household surveys with a view to covering all countries on a global scale.

As long as the optional DHS questions on disability are included, producing this indicator is straightforward. If the MICS is used, disability questions are part of the core questionnaire. Other surveys could also produce the indicator, as long as disability questions are included.

The 2018 [DHS of Nigeria](#) collected data on women’s abilities to negotiate sexual relations with their husband, contraceptive use and reproductive healthcare. However, even for countries that include disability modules in their surveys, such as the DHS of Nigeria, no reports were found that disaggregated information on this subject.

## **25.30 Annual rates of involuntary hospitalisation per 100 000 individuals in the general population.**

***Level 1: Indicator for which data are already being produced and reported on in at least some countries***

This indicator aims at tracking the rates of involuntary hospitalization over time and can contribute to the development of strategies to prevent and end coercion in mental health, in accordance with the CRPD. In the present case, the data collected will depend on what is considered and recorded as “voluntary” and “involuntary” hospitalisation.

In some jurisdictions, “voluntary” admission may entail consent substituted by a third party, such as a guardian, which conflicts with CRPD standards of free and informed consent and the exercise of legal capacity. Third-party authorization should be registered but not counted as “voluntary”.

Data on involuntary hospitalization is scarce and inconsistent across countries. To attain a fuller picture of the practices beyond the official statistics, it is important to use indicators, together with other monitoring tools, in consultation with persons with psychosocial disabilities and their representative organizations (see FAQ no. 3 of CRPD human rights indicators).



Data can be collected from administrative records pertaining to the hospital intake of patients, where the numerator is involuntary admissions and the denominator is all admissions. The National Health Service of the United Kingdom of Great Britain and Northern Ireland produces [annual statistics about application of the Mental Health Act](#) in England, a sample of which is available in table 7, in particular concerning formal detentions in hospitals (also referred to as being “sectioned”).

**Table 7: Detentions under the Mental Health Act of 1983, by age group and gender, 2018-19**

	Number of detentions	Base Population	Crude rate per 100,000 population
All	49,988	55,977,178	89.3
17 and under	1,241	11,954,618	10.4
15 and under	433	10,748,458	4.0
16 to 17	808	1,206,160	67.0
18 and over	47,624	44,022,560	108.2
18 to 34	15,991	12,402,844	128.9
35 to 49	12,270	10,907,309	112.5
50 to 64	9,374	10,533,154	89.0
65 and over	9,989	10,179,253	98.1
All genders (where recorded)	48,828	55,977,178	87.2
Male	25,285	27,667,942	91.4
Female	23,543	28,309,236	83.2

Source: NHS Digital, “[Mental Health Act Statistics, Annual Figures 2018-19](#)”, 29 October 2019, table 1b