Data sources guidance for outcome indicators on article 25:

Health

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25.21: Maternal mortality ratio (Sustainable Development Goal indicator 3.1.1), disaggregated by age and disability of the person

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

Link to the metadata related to this Sustainable Development Goal indicator

According to the metadata:

> The Maternal Mortality Estimation Inter-Agency Group maintains an input database consisting of maternal mortality data from civil registration, population-based surveys, surveillance systems, censuses and other specialized studies and surveys. The database is used to determine the number of maternal deaths and, where possible, the number of deaths among all women aged 15–49 years (women of reproductive age) to calculate the proportion of maternal deaths (PM) among women of reproductive age. The maternal mortality rate (MMR) is then calculated as MMR = PM(D/B), where "D" is the number of deaths among women of reproductive age and "B" is the number of live births. The number of live births is based on the World Population Prospects 2019.
>
> Statistical modelling is undertaken to generate comparable country, regional and global level estimates. The model's fit is assessed through cross-validation. Estimates are then reviewed by member States through a country consultation process carried out by the World Health Organization and Sustainable Development Goal focal points. In 2001, the Executive Board of WHO endorsed resolution EB.107.R8, in which it sought 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. Because 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 one or more technical focal persons in each country. It is carried out prior to the publication of estimates. During the consultation period, WHO invites the focal person(s) to review input data sources, methods for estimation and the preliminary estimates. They are encouraged to submit additional data that may not have been taken into account in the preliminary estimates.
>
> Adjustments are made according to the type of data source:
>
> 1. Civil registration and vital statistics, for incompleteness and misclassification of maternal deaths;
>
> 2. Reports that provide "pregnancy-related" mortality, for underreporting of these deaths, as well as overreporting of maternal deaths due to the inclusion of deaths

that are accidental or incidental to pregnancy (thus outside of the definition of maternal mortality).

During the analysis, the focal point also looks for stochastic errors that occur due to the general rarity of maternal deaths, sampling errors in the data source, errors that take place during data collection and processing, and other random errors.

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

Data from the Maternal Mortality Estimation Inter-Agency Group do not include disability. According to the group's 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 censuses, sample or sentinel registration systems, or even specific studies. WHO provides a detailed account of the definition, scope and calculation of the maternal mortality ratio.

A good option is to include disability status in civil registration. Otherwise, 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 previous three years. Doctors reviewed the interview and coded the cause of death. The respondents were not asked about the disability status of the mother, but if that were incorporated, the indicator could be produced.

In the Demographic and Health Survey of Uganda in 2016, which includes disability questions in 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 had been 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 Sustainable Development Goal 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 Sustainable Development Goal indicator

According to the metadata:

> 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, Demographic and Health Surveys, Fertility and Family Surveys, Reproductive Health Surveys, Multiple Indicator Cluster Surveys, Performance Monitoring and Accountability 2020 surveys, and other international survey programmes and national surveys.
>
> For information on the source of each estimate, see "World contraceptive use" from the Department of Economic and Social Affairs.
>
> Data on 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 2000–2019. 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 this could be done if the surveys used to generate these data included related questions. Table 1 presents an example from a survey from Lesotho in which the indicator was generated and the data disaggregated by disability.

Table 1: Percentage of women aged 15–49 years currently married or in a union who are using (or whose partner is using) a contraceptive method, Lesotho, 2018

	No method	Any modern method[a]	Any traditional method[b]	Any method
Total	35.1	64.6	0.4	64.9
Age (years)				
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	–	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	–	39.5
Functional difficulties (age 18–49 years)				
Functional difficulty	41.8	58.2	–	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, 2019).

[a] Female sterilization, male sterilization, intra-uterine device, injectables, implants, contraceptive pill, male condom, female condom or diaphragm/foam/jelly.

[b] Periodic abstinence, withdrawal or other.

25.23: Number of new HIV infections per 1,000 uninfected population, by sex, age and key population (Sustainable Development Goal indicator 3.3.1) 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 Sustainable Development Goal indicator

According to the metadata:

> This information can be obtained by using Spectrum modelling software (which includes disability data) and 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.

Country teams use software supported by the Joint United Nations Programme on HIV/AIDS (UNAIDS) to develop estimates annually. The country teams are comprised primarily of epidemiologists, demographers, monitoring and evaluation specialists, and technical partners.

The software used to produce the estimates is Spectrum, developed by Avenir Health, and the Estimates and Projections Package, developed by the East-West Center. The UNAIDS Reference Group on Estimates, Modelling and Projections provides technical guidance on the development of the HIV component of the software.

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

In the Demographic and Health Survey and the Multiple Indicator Cluster Survey, respondents are asked about HIV/AIDS knowledge, attitudes and behaviours, but not about infections. In the Gap Report of 2014, it is noted that data on disability and HIV status are sparse but obtainable. Studies from Cameroon, Kenya and South Africa are cited.

Two studies on a project that would allow for data to be reported for 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 (April 2017), pp. 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)

For the study in Cameroon, 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. They conducted 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 per cent, 95 per cent confidence interval 2.9–5.3) compared with 50 of 739 persons with disabilities (6.8 per cent, 5.0–8.6; conditional odds ratio 1.7; p=0.04).

25.24: Tuberculosis, malaria and hepatitis B incidence per 1,000 population (Sustainable Development Goal indicators 3.3.2, 3.3.3 and 3.3.4) among the population of persons with disabilities compared to others

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

Link to the metadata related to this Sustainable Development Goal indicator

According to the metadata:

> **For tuberculosis**
>
> Details about data sources and methods are available in a publicly available paper on methods used by WHO to estimate the global burden of tuberculosis disease.
>
> National tuberculosis programmes report their annual tuberculosis data to WHO every year between March and June using a standardized online data reporting system maintained by WHO. The system includes real-time checks for data consistency. Estimates of the tuberculosis burden are prepared in July and 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 and September and revisions are made based on feedback. The final set of estimates is reviewed by 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 national malaria control programme are obtained through each country's surveillance system. This includes information on the number of suspected cases, the number of tested cases and the number of positive cases by method of detection and by species, as well as the number of health facilities that report those cases. This information is summarized in a district health information software (DHIS2) application developed for this purpose. Data obtained through representative household surveys are publicly available and included in national demographic household surveys or a Malaria Indicator Survey.
>
> The official focal point for each country is the national malaria control programme at the ministry of health.

If these surveillance systems include questions on disability, the indicators can be disaggregated. For example, the report on the Demographic and Health Survey of 2018 in Nigeria provides the prevalence of malaria among children, based on rapid diagnostics tests administered as part of the survey. Respondents are asked about tuberculosis and hepatitis B vaccination, but not incidence. The survey uses the Washington Group short set of questions

on functioning to identify disability, so the rate of malaria for children over 2 years of age by disability status could be reported.

Table 2 presents an example from the table on malaria contained in the Demographic and Health Survey of 2018 in Nigeria. It does not include disability as a characteristic of either the child or the mother, but if the optional survey module on disability were included, the table could be disaggregated by disability.

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

	Malaria prevalence according to RDT		*Malaria prevalence according to microscopy*	
Background characteristic	**RDT positive (percentage)**	**Number of Children**	**Microscopy positive (percentage)**	**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 and Rockville, Maryland, United States of America, 2019), p. 330.

Note: RDT – rapid diagnostic test.

In the United States of America, the National Health and Nutrition Examination Survey combines interviews and physical examinations. It tests for the hepatitis B virus and tuberculosis. The survey also contains 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). It should be noted that this is different from incidence – incidence refers to

individuals who have ever had the disease, while prevalence refers to those who currently have the disease.

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

	Prevalence (percentage)
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
Born outside the United States	11.9
Born in the United States	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 1,000) between ages 15 and 60 years, disaggregated by sex (World Health Organization indicator), disability and indigenous/ minority background

Level 3: Indicator for which acquiring data is more complex or requires the development of data collection mechanisms that are not currently 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 that draw on the World Population Prospects, 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 Inter-Agency Group for Child Mortality Estimation. More detailed methods are available at the Global Health Observatory of WHO.

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

25.26: Prevalence of undernourishment (Sustainable Development Goal indicator 2.1.1), disaggregated by sex, age and disability

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

Link to the metadata related to this Sustainable Development Goal indicator

According to the metadata:

> The ideal source of data to estimate the prevalence of undernourishment would be a carefully designed and skilfully conducted individual dietary intake survey, in which actual daily food consumption, together with heights and weights for each surveyed individual, is 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 Sustainable Development Goal monitoring process, provided that:
>
> 1. 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;
>
> 2. Sufficient information is available to convert the data on food consumption or on food expenditures into their contribution to dietary energy intake;
>
> 3. The proper methods to compute the prevalence of undernourishment are used to control for excess variability in the estimated levels of habitual food consumption across households, allowing for the presence of 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 those conducted to compute economic statistics and to assess poverty, such as Household Income and Expenditure Surveys, household budget surveys and Living Standards Measurement Studies.
>
> To inform its estimate of the prevalence of undernourishment at national, regional and global levels, in addition to all household surveys for which it is possible to obtain microdata on food consumption, the Food and Agriculture Organization of the United Nations (FAO) relies on:

1. World Population Prospects of the Population Division, Department of Economic and Social Affairs, which provides updated estimates of the structures of a national population by sex and age every two years for most countries in the world;

2. Food balance sheets of FAO, which provide updated estimates of the national availability of food every year for most countries in the world.

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 ministries of agriculture. FAO sends out a data collection questionnaire every year to an identified focal point.

Microdata from household surveys are generally owned and provided by national statistical offices. When available, data are sourced by FAO directly through the websites of the national statistical offices. In several cases, where microdata are not available in the public domain, bilateral agreements have been signed, usually in the contexts of technical assistance and capacity development programmes.

To obtain this type of information for children with disabilities, the Washington Group/United Nations Children's Fund (UNICEF) Module on Child Functioning that is incorporated into the Multiple Indicator Cluster Survey would have to be used.

25.27: Prevalence of malnutrition among children under 5 years of age, by type (wasting and overweight) (Sustainable Development Goal indicator 2.2.2), sex, age and disability

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

Link to the metadata related to this Sustainable Development Goal indicator

According to the metadata:

For the majority of countries, nationally representative household surveys constitute the data source. For a limited number of countries, data from surveillance systems are used if sufficient population coverage is documented (about 80 per cent). For both data sources, the child's height and weight measurements are to be collected following recommended standard measuring techniques (WHO, *WHO Child Growth Standards: Training Course on Child Growth Assessment* (Geneva, 2008)).

Collection process

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

For WHO, see the published database methodology (de Onis and others, "Methodology for estimating regional and global trends of childhood malnutrition", *International Journal of Epidemiology*, vol. 33, No. 6 (December 2004), pp. 1260–1270). For UNICEF, the cadre of dedicated data and monitoring specialists working at national, regional and international levels in 190 countries routinely provides technical support for the collection and analysis of data. For the past 20 years, UNICEF has undertaken an annual process of updating its global databases called "Country reporting on indicators for the Goals". 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. Country office staff work with local counterparts to ensure that the most relevant data are shared. Updates sent by the country offices are then reviewed by sector specialists at UNICEF headquarters to check for the consistency and overall data quality of the submitted estimates and to carry out reanalysis 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 have been accepted and, if not, the reasons why. UNICEF uses these data obtained through "Country reporting on indicators for the Goals" to feed into the joint data set. The World Bank Group provides estimates available through Living Standards Measurement Studies, usually requiring the reanalysis of data sets given that the stunting data are often not tabulated in the study reports.

Multiple Indicator Cluster Surveys include a series of questions about malnutrition and the Washington Group/UNICEF Module on Child Functioning. As an example, data from the Ghana Multiple Indicator Cluster Survey 2017/18 are presented in table 4.

Table 4: Percentage of children under 5 years of age 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*				Number of children under 5 years of age
	Underweight (percentage below)		Stunted (percentage below)		Wasted (percentage below)		Overweight (percentage 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, *Ghana Multiple Indicator Cluster Survey 2017/18: Survey Findings Report* (Accra, 2018).

Note: SD – standard deviation.

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

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

Background characteristic	Weighted (percentage)	Number of children under 5 years of age	
		Weighted	Unweighted
Child's functional difficulties (2–4 years of age)			
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 (Sustainable Development Goal 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 Sustainable Development Goal indicator

According to the metadata:

> National-level household surveys are the main data sources used to collect data on skilled health personnel and skilled birth attendants. These surveys include Demographic and Health Surveys, Multiple Indicator Cluster Surveys, reproductive health surveys and national surveys based on similar methodologies. The surveys are undertaken every three to five years. For mainly industrialized countries (where 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 category of qualified personnel) and both collaborate to ensure the consistency of data sources.
>
> Before a country's data are accepted into the joint global databases, UNICEF and WHO implement 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 the estimates for some countries may therefore 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.

If disability questions are included in the surveys used, this indicator can be easily disaggregated. Table 6 presents an example from the Multiple Indicator Cluster Survey in Bangladesh.

Table 6: Percentage distribution of women aged 15–49 years with a live birth within the last two years by a person providing assistance at delivery of the most recent live birth, and percentage of most recent live births delivered by Caesarean section, Bangladesh, 2019

	Skilled attendant					Delivery assisted by any skilled attendant
	Medical doctor	Nurse/midwife	Paramedic/ medical assistant/ sub-assistant community medical officer	Family welfare visitor	Community skilled birth attendant/ private community skilled	
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, 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 Sustainable Development Goal 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 Sustainable Development Goal indicator

According to the metadata:

> Current data on the indicator are mainly derived from nationally representative Demographic and Health Surveys. Data sources increasingly include Multiple Indicator Cluster Surveys and Generations and Gender Surveys, as well as other country-specific surveys.

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

Relevant country-specific surveys

Data for Sustainable Development Goal 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 indicator 5.6.1, specifically women of reproductive age (15–49 years) who are currently married or in a 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 be representative at (at least) one administrative level below the national level.

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

In order to generate data for Sustainable Development Goal indicator 5.6.1, all three questions must be included in the survey. The three questions listed in the definition section of the metadata are generic questions that can be used in country-specific surveys. For the first and the second questions, these should include distinct categories of women making decisions themselves, and of women making decisions jointly with their husbands or partners.

Currently, a total of 57 countries have at least one survey with data on all three questions, which are necessary for calculating Sustainable Development Goal 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 Sustainable Development Goal indicator 5.6.1. The United Nations Population Fund 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 worldwide.

If the optional questions on disability are included in the Demographic and Health Survey, producing this indicator is straightforward. If the Multiple Indicator Cluster Survey is used, disability questions are part of the core questionnaire. Other surveys could also produce the indicator if disability questions are included.

In the 2018 Demographic and Health Survey of Nigeria, data were collected on women's abilities to negotiate sexual relations with their husbands, contraceptive use and reproductive health care. However, even for countries that include disability modules in their surveys, such as the Demographic and Health Survey of Nigeria, no reports were found that disaggregated information on this subject.

25.30: Annual rates of involuntary hospitalization 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 is aimed 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 Convention on the Rights of Persons with Disabilities. The data collected will depend on what is considered and recorded as "voluntary" and "involuntary" hospitalization.

In some jurisdictions, "voluntary" admission may entail consent substituted by a third party, such as a guardian, which conflicts with the standards of the Convention 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 are 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 frequently asked question No. 4 of the indicators on the Convention).

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 on the application of the Mental Health Act in England, a sample of which is presented in table 7, in particular concerning formal detentions in hospitals (also referred to as being "sectioned").

Table 7: Detentions under the Mental Health Act 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
Age (years)			
17 and under	1,241	11,954,618	10.4
15 and under	433	10,748,458	4.0
16–17	808	1,206,160	67.0
18 and over	47,624	44,022,560	108.2
18–34	15,991	12,402,844	128.9
35–49	12,270	10,907,309	112.5
50–64	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* (2019), table 1b.