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| INDICATOR\_NUM | METADATA\_CATEGORY | METADATA\_CATEGORY\_DESC | METADATA\_DESCRIPTION |
| III.5 | 1 | Contact point in international agency | Liliana CarvajalStatistics Specialist UNICEF  [lcarvajal@unicef.org](mailto:lcarvajal@unicef.org)  [data.unicef.org](data.unicef.org)  Lale SayHead, SRH Integration in Health Systems (SHS)WHO [sayl@who.int](mailto:sayl@who.int)  [https://www.who.int](https://www.who.int) |
| III.5 | 2 | International agreed definition | \*\*Definition\*\* Proportion of births attended by skilled health personnel \(generally doctors, nurses or midwives but can refer to other health professionals providing childbirth care\) is the proportion of childbirths attended by professional health personnel. According to the current definition \(1\) these are competent maternal and newborn health \(MNH\) professionals educated, trained and regulated to national and international standards. They are competent to: \(I\) provide and promote evidence-based, human-rights based, quality, socio-culturally sensitive and dignified care to women and newborns; \(ii\) facilitate physiological processes during labour and delivery to ensure a clean and positive childbirth experience; and \(iii\) identify and manage or refer women and/or newborns with complications. |
| III.5 | 3 | Method of computation | Numerator:  Number of births attended by skilled health personnel \(doctor, nurse or midwife\) trained in providing quality obstetric care, including giving the necessary support and care to the mother and the newborn during childbirth and immediate postpartum period  Denominator: The total number of live births in the same period.  Definition of skilled health personnel varies between countries. The proportion of births attended by skilled health personnel is calculated as the number of births attended by skilled health personnel \(doctors, nurses or midwives\) expressed as a proportion of the total number of live births in the same period.  In household surveys, such as DHS, MICS and RHS, the respondent is asked about the most recent birth and who helped during childbirth for a period up to five years before the interview. For consistency of reporting, survey customization teams in country are encouraged to review categories of health care providers reported on the previous surveys and ensure comparability. Service/facility records could be used where a high proportion of births occur in health facilities and are therefore recorded. |
| III.5 | 4 | Importance of the indicator in addressing gender issues and its limitation | Having a skilled attendant at the time of delivery is an important lifesaving intervention for both mothers and babies. Not having access to this key assistance is detrimental to women’s health and gender empowerment because it could cause the death of the mother or long-lasting disability, especially in marginalized settings. Achieving universal coverage for this indicator is therefore essential for reducing maternal and newborn mortality.  \*\*Comments and limitations\*\* Births attended by skilled health personnel is an indicator of health care utilization. It is a measure of the health system’s functioning and potential to provide adequate coverage for childbirth. On its own, however, this indicator does not provide insight into the availability or accessibility of services, for example in cases where emergency care if needed. Neither does this indicator capture the quality of care received.  Data collection and data interpretation in many countries is challenged by lack of guidelines, standardization of professional titles and functions of the health care provider, and in some countries by task-shifting. In addition, many countries have found that there are large gaps between international standards and the competencies of existing of health care professionals providing childbirth care. Lack of training and an enabling environment often hinder evidence based management of common obstetric and neonatal complications. |
| III.5 | 5 | Sources of discrepancies between global and national figures | Discrepancies are possible if there are national figures compiled at the health facility level. These would differ from the global figures, which are typically based on survey data collected at the household level. In terms of survey data, some survey reports may present a total percentage of births attended by a skilled health professional that does not conform to the SDG definition \(e.g., total includes provider that is not considered skilled, such as a community health worker\). In that case, the proportion of childbirths by a physician, nurse, or a midwife are totaled, consulted with the country and included in the global database as the SDG estimate.  In some countries where the indicator on skilled health personnel is not actively reported, birth in a health facility \(institutional births\) is used as a proxy indicator. This is frequent in countries in the Latin America region, in European and Central Asian regions, where the proportion of births attended by health professionals is very high. Nonetheless, it should be noted that institutional births may underestimate the percentage of births assisted by skilled health professionals, particularly in cases were home births -assisted by skilled health professionals -are prevalent. |
| III.5 | 6 | Process of obtaining data | National-level household surveys are the main data sources used to collect data for skilled health personnel. These surveys include Demographic and Health Surveys \(DHS\), Multiple Indicator Cluster Surveys \(MICS\), Reproductive Health Surveys \(RHS\) and other national surveys based on similar methodologies. Surveys are undertaken every 3 to 5 years. Data sources also include routine service statistics.  Population-based surveys is the preferred data source in countries with a low utilization of childbirth services, where private sector data are excluded from routine data collection, and/or with weak health information systems. These surveys include Demographic and Health Surveys \(DHS\), Multiple Indicator Cluster Surveys \(MICS\), Reproductive Health Surveys \(RHS\) and other national surveys based on similar methodologies. In MICS, DHS and similar surveys, the respondent is asked about the last live birth and who helped during delivery for a period up to five years before the interview. The surveys are generally undertaken every 3 to 5 years.  Routine service/facility records is a more commons data source in countries where a high proportion of births occur in health facilities and are therefore recorded. These data can be used to track the indicator on an annual basis.  \*\*Collection process\*\* UNICEF and WHO maintain a joint database on Proportion of births attended by skilled health personnel and collaborate to ensure quality and consistency of data sources \(mentioned above\). As part of the data harmonization process and interaction with countries an annual country consultation is conducted by UNICEF. During the country consultation SDG country focal points are contacted for updating and verifying values included in the database and for obtaining new data sources. New data sources are reviewed and assessed jointly with WHO. As part of the process, the national categories of skilled health personnel are verified. The reported data for some countries may include additional categories of trained personnel beyond doctor, nurse and midwife.  UNICEF/WHO database is updated on an annual basis. However, not all countries report new data on annual basis. Countries reporting data from household surveys, may report a new value every 3-5 years, according to their data collection schedule. Data reported from routine administrative source are regularly available on an annual basis. |
| III.5 | 7 | Treatment of missing values | \*\*At country level\*\*  There is no treatment of missing values at country level. If value is missing for a given year, then there is no reporting of that value.  \*\*At regional and global levels\*\*  Missing values are not imputed for regional and global levels. For the latest reported time period, the latest available year in the year range is used for the calculation of regional and global average. |
| III.5 | 8 | Data availability and assessment of countries’ capacity | 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. |
| III.5 | 9 | Expected time of release | Country reported data and global and regional estimates are published annually; in February by UNICEF in the data website [data.unicef.org](data.unicef.org) and by the World Health Organization in May in the [World Health Statistics Report](http://www.who.int/whosis/whostat/en/) and the [WHO Global Health Observatory](https://apps.who.int/gho/data/node.main). UNICEF also reports this indicator in the State of the World’s Children report which is on a bi-annual reporting schedule. |
| III.5 | 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/metadata/files/Metadata-03-01-02.pdf](https://unstats.un.org/sdgs/metadata/files/Metadata-03-01-02.pdf) |