

## CHAPTER 1

# INTRODUCTION

The purpose of this manual is to assist UNICEF staff, national counterparts and other partners in measuring progress for children through the use of household surveys. It offers a systematic approach to filling gaps in data required for reporting on the situation of children and women 5 years into the millennium, and for setting a baseline from which to measure change in the coming decade and beyond.

The Multiple Indicator Cluster Survey presented in this manual is shaped in large part by the needs arising from recent international agreements: the Millennium Declaration, adopted by all 191 United Nations Member States in September 2000, and the Plan of Action outlined in A World Fit For Children, adopted by 189 Member States at the United Nations Special Session on Children in May 2002. Both of these commitments build upon promises made by the international community at the 1990 World Summit for Children.

In signing these international agreements, governments committed themselves to improving conditions for their children and to monitoring progress towards that end. UNICEF was assigned a supporting role in this task (see Table 1.1).

Many governments have taken substantial steps to accomplish these objectives through national programmes of action. Measuring indicators of progress is an essential part of that process, both to provide information that can guide action and for assessing change. Important experience was gained in the mid- and late-1990s in monitoring the implementation of 13 goals set out in the World Summit for Children Plan of Action. However, even for this limited set of goals, it was quickly recognized that current data on key indicators were lacking in many countries.

### **THE GROWING COMPLEXITY OF THE MONITORING PROCESS**

In an attempt to fill these data gaps, UNICEF developed the Multiple Indicator Cluster Survey (MICS), a household survey that was adapted and administered by some 64 countries in the mid-1990s. Together with data from more routine national sources, the estimates obtained through this first round of MICS helped countries assess how far they had come in their progress for children and where they must go.

The end-decade assessment of the World Summit for Children Plan of Action (in 2000) was based on the full set of 27 goals. The MICS methodology was expanded accordingly (to measure 63 of the 75 indicators) and 67 countries conducted a second round of Multiple Indicator Cluster Survey around the turn of the millennium.

In the five years since the last assessment of progress, the complexity of the monitoring process has grown considerably. The Millennium Declaration, for example, includes a set of eight Millennium Development Goals (MDGs), against which human development is to be measured.

These goals are broken down into 18 targets and 48 indicators, plus a number of additional sub-indicators. Many of these MDG indicators are directly related to children, and UNICEF has been designated as the lead agency to report on global progress towards them.

The World Fit for Children Declaration and Plan of Action contains 21 goals and 99 strategies and actions to achieve them. These goals form the new agenda for action related to children during the first decade of the millennium.

**Table 1.1**  
**A Commitment to Action and UNICEF Response**

The governments that signed the Millennium Declaration and the World Fit for Children Declaration and Plan of Action also committed themselves to monitoring progress towards the goals and objectives they contained:

“We will monitor regularly at the national level and, where appropriate, at the regional level and assess progress towards the goals and targets of the present Plan of Action at the national, regional and global levels. Accordingly, we will strengthen our national statistical capacity to collect, analyse and disaggregate data, including by sex, age and other relevant factors that may lead to disparities, and support a wide range of child-focused research. We will enhance international cooperation to support statistical capacity-building efforts and build community capacity for monitoring, assessment and planning.”

“...We will conduct periodic reviews at the national and subnational levels of progress in order to address obstacles more effectively and accelerate actions....”

A World Fit for Children Plan of Action, paragraphs 60 and 61

The Plan of Action (paragraph 61) also calls for the specific involvement of UNICEF in the preparation of periodic progress reports:

“... As the world’s lead agency for children, the United Nations Children’s Fund is requested to continue to prepare and disseminate, in close collaboration with Governments, relevant funds, programmes and the specialized agencies of the United Nations system, and all other relevant actors, as appropriate, information on the progress made in the implementation of the Declaration and the Plan of Action.”

Similarly, the Millennium Declaration (paragraph 31) calls for periodic reporting on progress:

“...We request the General Assembly to review on a regular basis the progress made in implementing the provisions of this Declaration, and ask the Secretary-General to issue periodic reports for consideration by the General Assembly and as a basis for further action.”

A number of other summit conferences, including the United Nations General Assembly Special Session on HIV/AIDS and the African Summit on Malaria, have defined additional goals, targets and indicators that must be monitored and are sometimes overlapping. The current and third round of the Multiple Indicator Cluster Survey, known as MICS3, attempts to capture a broad

range of data relating to children and women that cover many of these international goals. The survey does not attempt to be exhaustive, but limits its scope to a set of key indicators that can be readily collected through household surveys.

### **MEASURING THE CURRENT SITUATION**

For most global goals, standard monitoring indicators have been defined and are internationally accepted. For the Millennium Development Goals, for example, the General Assembly has agreed upon a set of 48 basic indicators (53 when sub-indicators and composite indicators are treated separately). The current round of MICS can generate data on 21 of the 53 MDG indicators.

The development of a standard set of indicators for tracking progress towards the World Fit for Children goals, however, has presented major challenges. Many of the goals, commitments, strategies and actions laid out in this document do not readily translate into quantitative monitoring indicators. Moreover, developing indicators for the full set of goals and strategies would expand the list to unmanageable proportions. The indicators selected for inclusion in MICS3, therefore, reflect a subset of key elements of the Plan of Action. They cover four major areas represented in the plan (promoting healthy lives, providing quality education, protecting against abuse, exploitation and violence, and combating HIV/AIDS), but do not reflect all elements of that plan. The selection of indicators to be included in MICS3 is based on a set of criteria presented in Table 1.2.

**Table 1.2**  
**Criteria for Inclusion of Indicators in MICS3**

- Relevance to MDG indicators
- Relevance to monitoring the World Fit for Children Declaration and Plan of Action
- Relevance to UNICEF priority areas
- Continuity with the World Summit for Children indicators
- International agreement on indicators
- Previous testing of indicators
- Feasibility of collecting indicators through household surveys
- Does not compromise the quality of data for other indicators

## HOUSEHOLD SURVEYS AS MONITORING TOOLS

The most commonly used tool for collecting social data is the household sample survey. Household surveys are used in all areas of the social sciences, including public policy analysis, which relies heavily on survey data to make informed decisions. Other potential sources of data include population censuses, vital registration systems, routine health service data, epidemiological surveillance sites, and routine education systems. While other sources of data may be available, few are able to cover the range of topics, permit the disaggregation of data, or provide data as quickly or as inexpensive as household surveys.

When these other sources of data are deficient, household sample surveys are the most widely used method for providing data on health and social indicators. Every industrialized country, for example, despite having good routine information systems, has special ongoing survey programmes to provide supplementary information. Such programmes usually consist of extensive health interview surveys and surveys of disease morbidity and disability. Surveys are the best source of data on programme coverage, and on differentials in social indicators. They can also provide breakdowns of information by regional, social or ethnic groupings, which are difficult to obtain from routine data sources.

For some of the indicators that will be needed to assess the situation of women and children, no other sources, aside from the household survey, exist. The only way to obtain nationally representative information on child labour, for example, or on the number of households using iodized salt, or on the nutritional status of young children, is to do a household survey, or to ensure that relevant questions, measurements or tests are included in other survey programmes. Data already collected in other household surveys, such as the Demographic and Health Surveys (DHS), can provide baseline information for some indicators, provided the right questions are asked.

Gaps in the data required for assessing the situation of children and women midway into this decade persist in almost all countries. And few options are available beyond household surveys for closing these gaps. Properly conducted surveys can produce the information needed to meet the rigorous requirements for the end-decade assessment. When linked to improved reporting in routine systems, these surveys offer the best approach for enabling countries to report on the situation of their children, and the progress made since the baseline years of each goal.

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**The quality of data obtained in a survey depends on the proper design of the questionnaire, on the sampling strategy and on good training and supervision of interviewers.**

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## THE ROLE OF MICS3

The MICS3 questionnaires and manual have been developed specifically to obtain data for the 101 indicators listed in Table 1.5 at the end of this chapter. These draw heavily on the experience of the last round of MICS and a review of progress towards the goals of the World Summit for Children. The selection of indicators has been substantially influenced by the more recent Millennium and World Fit for Children Declarations as well as new and emerging areas, particularly the monitoring of HIV/AIDS, malaria and child protection, among others.

**Table 1.3**  
**MICS3 Questionnaire Modules**

<b>Household modules</b>	<b>Modules for children under five</b>
Household Information Panel Household Listing or <i>Extended Household Listing</i> Education Water and Sanitation Household Characteristics <i>ITN (Insecticide-treated Nets)</i> <i>Children Orphaned and Made Vulnerable by HIV/AIDS</i> Child Labour Salt Iodization	Under-five Child Information Panel Birth Registration and Early Learning Vitamin A Breastfeeding Care of Illness <i>Malaria</i> Immunization Anthropometry
<b>Modules for women</b>	<b>Optional modules</b>
Women's Information Panel Child Mortality Tetanus Toxoid Maternal and Newborn Health and <i>Malaria Prevention</i> <i>Marriage/Union and Polygyny</i> Contraception <i>Female Genital Mutilation/Cutting</i> <i>Sexual Behaviour</i> HIV/AIDS	Additional Household Characteristics Security of Tenure and Durability of Housing Child Discipline Source and Cost of Supplies for Insecticide-Treated Nets, ORS Packets, Antibiotics, and Antimalarials Contraception and Unmet Need Attitudes Towards Domestic Violence Child Development Disability Maternal Mortality

*Italics indicate additional modules to be included in all Multiple Indicator Cluster Surveys, where they apply.*

Table 1.3 summarizes the content of MICS3. The content is organized into questionnaire modules, for countries to adopt or omit according to their data needs. Another possible approach, discussed later in this chapter, is incorporating MICS modules or questions into surveys planned by other organizations.

The optional modules shown at the bottom right corner of Table 1.3 should only be included in MICS3 if they are of particular relevance to a country. Likewise, the Maternal Mortality module should only be considered if no reliable national data exist or if data are more than 10 years old, and where a sufficiently large sample size is being used. The Disability module should only be used if there is a specific interest in assessing disability and if a linked, in-depth study, including clinical testing of children, will be done by way of follow-up. The other optional modules can be used at the discretion of each country. The core questionnaires, additional modules and optional modules of MICS3 can be found in Appendix Two. The flow of MICS3 questionnaires and detailed information on the modules are presented in Chapter 3.

The development of the MICS3 questionnaire and manual has drawn on a wide range of organizations. They include the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS, the UN Educational, Scientific and Cultural Organization, the International Labour Organization, the United Nations Statistical Division, the Centers for Disease Control and Prevention (United States), the United States Agency for International Development, MEASURE DHS (ORC Macro International), Johns Hopkins University, John Snow Inc., and others. UNICEF worked with members of various inter-agency MDG monitoring groups and other inter-agency indicator development groups to harmonize methods of measuring priority indicators, wherever possible. These include the Technical Advisory Group of the WHO/UNICEF Joint Monitoring Programme on Water Supply and Sanitation, the Malaria Monitoring and Evaluation Reference Group, HIV-AIDS Monitoring and Evaluation Reference Group, the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global Alliance for Vaccines and Immunization Monitoring and Evaluation Task Force, and the Child Survival Partnership. In particular, UNICEF has worked closely with the Demographic and Health Surveys project to harmonize indicators, questions and methods for analysis, and to coordinate data collection schedules at the country level in order to maximize the usefulness of the two organizations' surveys and avoid duplication of effort.

**Table 1.4**  
**What Multiple Indicator Cluster Surveys Can Do**

- Fortify local-level programme monitoring
- Satisfy national-level needs for goal monitoring
- Perform at low cost
- Produce rapid findings
- Strengthen national capacities for monitoring
- Ensure internationally comparable results

## TAILORING SURVEYS TO INDIVIDUAL COUNTRIES

Every household survey, no matter how simple, incurs costs. The requirements of sample size and proper implementation of fieldwork, data processing, analysis and report writing are demanding. UNICEF country office staff should therefore review the data needs for their country in three steps before deciding whether a Multiple Indicator Cluster Survey is required, and what modules it should contain:

**Step 1:** Review what indicator data, of adequate quality and national coverage, are likely to be available at mid-decade through existing data systems. Do not limit this review to routine data systems, but also include existing and planned surveys.

**Step 2:** Identify what household surveys are ongoing or planned and can be expected to yield high-quality data that is nationally representative in time for the mid-decade assessment (December 2005). Explore whether these surveys might incorporate MICS3 modules to fill end-decade data gaps.

**Step 3:** If, after other sources have been thoroughly mined, you still expect data gaps, then consider carrying out a Multiple Indicator Cluster Survey. But first explore whether other partners might be interested in sharing the work and the costs it will entail.

Remember that a key aim of the mid-decade assessment is to obtain timely, quality, nationally representative data for assessing the situation of children and women around 2005. If such data are available from other sources, duplicate data collection should be avoided.

However, there may be reasons for including questions in a Multiple Indicator Cluster Survey for which relevant data are already available. For example, education data may be available, but not data on child labour. Because it is important to relate child labour to school attendance, it may be necessary to also collect school attendance data in the MICS3 in order to maximize the usefulness of the child labour data.

Household sample surveys should not be expected to provide reliable subnational reports on these indicators, or to report on change over time, unless these requirements are clearly part of the survey design specifications at the outset. However, when a survey is well conducted, the data supplied should provide valuable information for helping communities and governments understand and monitor their progress, and to plan rationally for the future. Moreover, the results should stand up to scrutiny by governments, other international organizations and communities.

To make sure that happens, it is essential to plan carefully. This manual brings together the best guidance the international community has to offer in doing that. The step-by-step instructions provided here for planning and conducting a Multiple Indicator Cluster Survey are intended to complement and reinforce existing monitoring systems, not replace them.

## KNOWING HOW YOU WILL USE THE RESULTS

Before a final decision is made to conduct a Multiple Indicator Cluster Survey, you should be able to answer the following three questions:

- Why are you doing the survey?
- How do you expect to use the results?
- To whom, and at what level, will the report of results be addressed?

The answers to these questions should help to ensure that the survey will provide useful information for monitoring goals, for influencing policy and programme design, and for encouraging policy makers and programme managers to allocate resources to social priority sectors. What data are needed and how they will be used by policy makers, programme managers, communities and the general public should inform all planning decisions.

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**Make sure it is clear why you are doing the survey and how you will use the results. Then, plan the presentation of your findings alongside the planning of the survey itself.**

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Chapter 2 of this manual contains a list of key decisions that need to be made before a survey is undertaken. UNICEF country representatives, programme managers and national counterparts should read Chapter 2 carefully before starting to plan a survey. It provides advice on what you can expect to gain from a survey and how long it will take to carry out the entire process. Chapter 2 also contains a checklist of items that will need to be budgeted for when doing a national survey.

## BUILDING NATIONAL MONITORING CAPABILITIES

Aside from yielding valuable information, planning and carrying out a survey, and using the results, can strengthen national monitoring capabilities for the future. For this reason, it is important to involve personnel from national institutions, such as medical and public health schools, education and training institutes, and university departments in statistics and social sciences.

Because of the pressure to report results quickly, the information presented in a survey report usually includes only basic findings. However, subsequent analysis of the data can be greatly facilitated by creating a survey microdata file (of household-level data). A microdata file that is well documented and made readily available will allow in-depth analyses to be carried out by specialists in many research institutes, universities and organizations who would otherwise not have access to this data. A small amount of money, together with a microdata file, can generate detailed analyses of the data and lead to further dissemination, via a variety of media, of information about children.

Each country programme is well placed to assess where the strongest entry point may be to help national counterparts. The challenge is to bring together different sectors, organizations and individuals to collaborate in the cost-effective use of a shared tool.

**Table 1.5**  
**Indicators for Monitoring Progress at Mid-Decade**

The following list includes the indicators selected for inclusion in the 2005 round of the Multiple Indicator Cluster Survey. The indicators are primarily those used for monitoring the World Fit for Children Declaration and Plan of Action, but also include indicators for monitoring the Millennium Development Goals and other global commitments. Age ranges indicated with a hyphen include the month or year given as the outer boundary of the range. For example, '6-9 months' includes 6-month-old and 9-month-old children. MDG indicators and indicators that can be estimated only by the inclusion of optional modules are indicated in the last column. The table is reproduced in Appendix One in more detail, including numerators and denominators of each indicator.

	<b>Indicator</b>	<b>Description</b>	<b>Comment</b>
<b>HEALTHY LIVES</b>			
1	<b>Under-five mortality rate</b>	Probability of dying between birth and exactly 5 years of age, per 1,000 live births	<b>MDG 13</b>
2	<b>Infant mortality rate</b>	Probability of dying between birth and exactly 1 year of age, per 1,000 live births	<b>MDG 14</b>
3	<b>Maternal mortality ratio</b>	Annual number of deaths of women from pregnancy-related causes, when pregnant or within 42 days of termination of pregnancy, per 100,000 live births	<b>MDG 16</b> <i>OPTIONAL</i>
4	<b>Skilled attendant at delivery</b>	Proportion of births attended by skilled health personnel	<b>MDG 17</b>
5	<b>Institutional deliveries</b>	Proportion of births delivered in a health facility	
6	<b>Underweight prevalence</b>	Proportion of children under five that fall below minus two and below minus three standard deviations from median weight for age of NCHS/WHO reference population	<b>MDG 4</b>
7	<b>Stunting prevalence</b>	Proportion of children under five that fall below minus two and below minus three standard deviations from median height for age of NCHS/WHO reference population	
8	<b>Wasting prevalence</b>	Proportion of children under five that fall below minus two and below minus three standard deviations from median weight for height of NCHS/WHO reference population	
9	<b>Low-birthweight infants</b>	Proportion of live births that weighed less than 2,500 grams at birth	
10	<b>Infants weighed at birth</b>	Proportion of live births that were weighed at birth	

	<b>Indicator</b>	<b>Description</b>	<b>Comment</b>
11	<b>Use of improved drinking water sources</b>	Proportion of population that use improved sources of water	<b>MDG 30</b>
12	<b>Use of improved sanitation facilities</b>	Proportion of population that use improved sanitation facilities	<b>MDG 31</b>
13	<b>Water treatment</b>	Proportion of household members that use water treated to make it safer to drink	
14	<b>Disposal of child's faeces</b>	Proportion of children under 3 years of age whose stools were disposed of 'safely'	
15	<b>Exclusive breastfeeding rate</b>	Proportion of infants less than 6 months of age that are exclusively breastfed	
16	<b>Continued breastfeeding rate</b>	Proportion of children aged 12-15 months and 20-23 months that are currently breastfeeding	
17	<b>Timely complementary feeding rate</b>	Proportion of infants aged 6-9 months that are receiving breastmilk and complementary food	
18	<b>Frequency of complementary feeding</b>	Proportion of infants aged 6-11 months that are breastfed and that received complementary food at least the minimum recommended number of times yesterday	
19	<b>Adequately fed infants</b>	Proportion of infants aged 0-11 months that were appropriately fed (that is, infants aged 0-5 months that were exclusively breastfed and infants aged 6-11 months that were still breastfed and received complementary food at least the appropriate number of times yesterday)	
20	<b>Antenatal care</b>	Proportion of women aged 15-49 years that were attended at least once during pregnancy by skilled health personnel	
21	<b>Contraceptive prevalence</b>	Proportion of women currently married or in union aged 15-49 years that are using (or whose partner is using) a contraceptive method (either modern or traditional)	<b>MDG 19c</b>
22	<b>Antibiotic treatment of suspected pneumonia</b>	Proportion of children aged 0-59 months with acute respiratory infections in the last 2 weeks that are receiving antibiotics	
23	<b>Care seeking for suspected pneumonia</b>	Proportion of children aged 0-59 months with acute respiratory infections in the last 2 weeks that were taken to an appropriate health provider	
24	<b>Solid fuels</b>	Proportion of the population using solid fuels (wood, charcoal, crop residues and dung) as the primary source of domestic energy for cooking	<b>MDG 29</b>

	<b>Indicator</b>	<b>Description</b>	<b>Comment</b>
25	<b>Tuberculosis immunization coverage</b>	Proportion of children aged 12-23 months immunized against tuberculosis (with BCG vaccine) by their first birthday	
26	<b>Polio immunization coverage</b>	Proportion of children aged 12-23 months immunized against polio (with oral polio vaccine, or OPV) by their first birthday	
27	<b>DPT immunization coverage</b>	Proportion of 1-year-old children immunized against diphtheria, pertussis and tetanus (DPT) by their first birthday	
28	<b>Measles immunization coverage</b>	Proportion of children aged 12-23 months immunized against measles by their first birthday	<b>MDG 15</b>
29	<b>Hepatitis B immunization coverage</b>	Proportion of children aged 12-23 months immunized against hepatitis B (HepB) by their first birthday	
30	<b>Yellow fever immunization coverage</b>	Proportion of children aged 12-23 months immunized against yellow fever by their first birthday	
31	<b>Fully immunized children</b>	Proportion of children receiving DPT1-3, OPV 1-3, BCG and measles vaccines at the appropriate age	
32	<b>Neonatal tetanus protection</b>	Proportion of children aged 0-11 months protected against neonatal tetanus through immunization of their mother	
33	<b>Use of oral rehydration therapy (ORT)</b>	Proportion of children aged 0-59 months that had diarrhoea in the last 2 weeks and were treated with oral rehydration salts or an appropriate household solution	
34	<b>Home management of diarrhoea</b>	Proportion of children aged 0-59 months that had diarrhoea in the last 2 weeks and that received more fluids and continued feeding	
35	<b>Received ORT or increased fluids, and continued feeding</b>	Proportion of children aged 0-59 months that had diarrhoea in the last 2 weeks and received ORT (oral rehydration salts or an appropriate household solution) or increased fluids, AND continued feeding	
36	<b>Household availability of insecticide-treated nets (ITNs)</b>	Proportion of households with at least one insecticide-treated mosquito net	
37	<b>Under-fives sleeping under insecticide-treated nets</b>	Proportion of children aged 0-59 months that slept under an insecticide-treated mosquito net during the previous night	<b>MDG 22</b>
38	<b>Under-fives sleeping under mosquito nets</b>	Proportion of children aged 0-59 months that slept under a mosquito net during the previous night	
39	<b>Antimalarial treatment (under-fives)</b>	Proportion of children aged 0-59 months with fever in the last 2 weeks that were treated with an appropriate antimalarial within 24 hours of onset	<b>MDG 22</b>

	<b>Indicator</b>	<b>Description</b>	<b>Comment</b>
40	<b>Intermittent preventive malaria treatment (pregnant women)</b>	Proportion of women that received appropriate intermittent, preventive malaria treatment during the last pregnancy	
41	<b>Iodized salt consumption</b>	Proportion of households consuming adequately iodized salt	
42	<b>Vitamin A supplementation (under-fives)</b>	Proportion of children aged 6-59 months that received a high-dose vitamin A supplement in the last 6 months	
43	<b>Vitamin A supplementation (post-partum mothers)</b>	Proportion of mothers that received a high-dose vitamin A supplement before their infant was 8 weeks old	
44	<b>Content of antenatal care</b>	Proportion of women that received selected antenatal care interventions during the last pregnancy (within 24 months)	
45	<b>Timely initiation of breastfeeding</b>	Proportion of women that put their last newborn infant to the breast within 1 hour of birth	
46	<b>Support for learning</b>	Proportion of children aged 0-59 months living in households that provide adequate support for learning and school readiness	
47	<b>Father's support for learning</b>	Proportion of children aged 0-59 months living in households in which the father is engaged in the child's learning activities	
48	<b>Support for learning: children's books</b>	Proportion of households with three or more children's books	<i>OPTIONAL</i>
49	<b>Support for learning: non-children's books</b>	Proportion of households with three or more non-children's books	<i>OPTIONAL</i>
50	<b>Support for learning: materials for play</b>	Proportion of households with materials intended for play	<i>OPTIONAL</i>
51	<b>Non-adult care</b>	Proportion of children aged 0-59 months left alone or in the care of another child (under age 10) in the past week	<i>OPTIONAL</i>

<b>Indicator</b>	<b>Description</b>	<b>Comment</b>
<b>EDUCATION</b>		
52	<b>Pre-school attendance</b> Proportion of children aged 36-59 months that are attending some form of organized early childhood education programme	
53	<b>School readiness</b> Proportion of children in first grade that attended some form of pre-school the previous year	
54	<b>Net intake rate in primary education</b> Proportion of children of primary-school entry age that enter school at that age	
55	<b>Net primary school attendance rate</b> Proportion of children of primary-school age attending primary or secondary school	<b>MDG 6</b>
56	<b>Net secondary school attendance rate</b> Proportion of children of secondary-school age attending secondary school or higher	
57	<b>Children reaching grade five</b> Proportion of children entering first grade of primary school that eventually reach grade five	<b>MDG 7</b>
58	<b>Transition rate to secondary school</b> Proportion of children that were in the last year of primary school during the previous school year that attend secondary school	
59	<b>Primary completion rate</b> Number of children of any age that are attending the last grade of primary education (excluding the repeaters) as a proportion of children of the age corresponding to the last grade of primary school	<b>MDG 7b</b>
60	<b>Adult literacy rate</b> Proportion of women aged 15-24 years that are able to read a short simple statement on their everyday life	<b>MDG 8</b>
61	<b>Gender parity index</b> Ratio of proportion of girls to proportion of boys in primary and secondary education	<b>MDG 9</b>

Indicator	Description	Comment
<b>CHILD PROTECTION</b>		
62 <b>Birth registration</b>	Proportion of children aged 0-59 months whose births are reported registered	
63 <b>Prevalence of female genital mutilation/cutting (FGM/C)</b>	Proportion of women aged 15-49 years that report undergoing female genital mutilation/cutting	
64 <b>Prevalence of extreme form of FGM/C</b>	Proportion of women aged 15-49 years that report undergoing an extreme form of female genital mutilation/cutting (such as infibulation)	
65 <b>FGM/C prevalence among daughters</b>	Proportion of women aged 15-49 years that report at least one daughter who has undergone female genital mutilation/cutting	
66 <b>Approval for FGM/C</b>	Proportion of women aged 15-49 years favouring the continuation of female genital mutilation/cutting	
67 <b>Marriage before age 15, before age 18</b>	Proportion of women aged 15-49 years that were first married/in union by exact age 15 and proportion of women aged 20-49 years that were first married/in union by exact age 18	
68 <b>Young women aged 15-19 currently married/in union</b>	Proportion of women aged 15-19 years that are currently married/in union	
69 <b>Spousal age difference</b>	Proportion of women aged 15-19 years and 20-24 years currently married/in union with a spousal age difference of 10 or more years	
70 <b>Polygyny</b>	Proportion of women aged 15-49 years in a polygynous union	
71 <b>Child labour</b>	Proportion of children aged 5-14 years involved in child labour activities	
72 <b>Labourer students</b>	Proportion of children aged 5-14 years involved in child labour activities that are attending school	
73 <b>Student labourers</b>	Proportion of children aged 5-14 years attending school that are involved in child labour activities	
74 <b>Child discipline</b>	Proportion of children that (1) experience only non-violent punishment; (2) experience psychological aggression as punishment; (3) experience minor physical punishment; (4) experience severe physical punishment	<i>OPTIONAL</i>

Indicator	Description	Comment	
<b>HIV/AIDS</b>			
75	<b>Prevalence of orphans</b>	Proportion of children aged 0-17 years that are orphans	
76	<b>Prevalence of vulnerable children</b>	Proportion of children aged 0-17 years that have a chronically ill parent or that live in a household with a chronically ill adult or where an adult died in the past year	
77	<b>School attendance of orphans versus non-orphans</b>	Ratio of current school attendance among orphans to that of non-orphans in the age range of 10-17 years	<b>MDG 20</b>
78	<b>Children's living arrangements</b>	Proportion of children aged 0-17 years that live in a household but are not living with a biological parent	
79	<b>Malnutrition among children orphaned and made vulnerable by HIV/AIDS</b>	Ratio of underweight prevalence in children aged 0-59 months who are orphaned and made vulnerable by HIV/AIDS (OVC) to underweight prevalence among non-OVCs aged 0-59 months	
80	<b>Early sex among children orphaned and made vulnerable by HIV/AIDS</b>	Proportion of children aged 15-17 years that are orphaned or made vulnerable by HIV/AIDS (OVC) that have had sex before age 15 compared to non-OVCs aged 15-17 years that have had sex before age 15	
81	<b>External support to children orphaned and made vulnerable by HIV/AIDS</b>	Proportion of orphans and vulnerable children whose households received free basic external support in caring for the child	
82	<b>Comprehensive knowledge about HIV prevention among young people</b>	Proportion of young women aged 15-24 years that both correctly identify ways to prevent the sexual transmission of HIV and that reject major misconceptions about HIV transmission	<b>MDG 19b</b>
83	<b>Condom use with non-regular partners</b>	Proportion of young women aged 15-24 years reporting the use of a condom during sexual intercourse with their last non-regular sex partner in the last 12 months	<b>MDG 19a</b>
84	<b>Age at first sex among young people</b>	Proportion of women aged 15-19 years that had sex before age 15	
85	<b>Higher risk sex in the last year</b>	Proportion of women aged 15-24 years that have been sexually active in the last 12 months and have had sex with a non-marital, non-cohabiting partner during the same period	
86	<b>Attitude towards people with HIV/AIDS</b>	Proportion of women aged 15-49 years expressing accepting attitudes towards people with HIV/AIDS	
87	<b>Women who know where to be tested for HIV</b>	Proportion of women aged 15-49 years that know where to get an HIV test	
88	<b>Women who have been tested for HIV</b>	Proportion of women aged 15-49 years that have been tested for HIV	

	<b>Indicator</b>	<b>Description</b>	<b>Comment</b>
89	<b>Knowledge of mother-to-child transmission of HIV</b>	Proportion of women aged 15–49 years that correctly identify means of HIV transmission from mother to child	
90	<b>Counselling coverage for the prevention of mother-to-child transmission of HIV</b>	Proportion of women aged 15–49 years that gave birth and received antenatal care and report that they received counselling on HIV/AIDS	
91	<b>Testing coverage for the prevention of mother-to-child transmission of HIV</b>	Proportion of women aged 15–49 years that gave birth in the previous 2 years and received antenatal care and report that they received the results of an HIV test	
92	<b>Age-mixing among sexual partners</b>	Proportion of young women aged 15–24 years that had sex in the preceding 12 months with a partner that was 10 or more years older than they were	
<b>Additional indicators</b>			
93	<b>Security of tenure</b>	Proportion of urban household members living in households that lack formal documentation for their residence or that feel at risk of eviction	<i>OPTIONAL</i>
94	<b>Durability of housing</b>	Proportion of urban household members living in dwellings that are not considered durable	<i>OPTIONAL</i>
95	<b>Slum household</b>	Proportion of urban household members living in slum housing	<b>MDG 32</b> <i>OPTIONAL</i>
96	<b>Source of supplies</b>	Proportion of children (or households) for whom the following supplies were obtained from public providers: insecticide-treated mosquito nets, oral rehydration salts, antibiotics and antimalarials	<i>OPTIONAL</i>
97	<b>Cost of supplies</b>	Median cost of the following supplies obtained from public and private providers: insecticide-treated mosquito nets, oral rehydration salts, antibiotics and antimalarials	<i>OPTIONAL</i>
98	<b>Unmet need for family planning</b>	Proportion of women that are currently married/in union that have an unmet need for contraception	<i>OPTIONAL</i>
99	<b>Demand satisfied for family planning</b>	Proportion of total demand for contraception (defined as current use of contraception, plus unmet need for contraception) currently satisfied	<i>OPTIONAL</i>
100	<b>Attitudes towards domestic violence</b>	Percentage of women who believe a husband/partner is justified in beating his wife/partner in various circumstances	<i>OPTIONAL</i>
101	<b>Child disability</b>	Percentage of children aged 2–9 years with at least one disability reported by their mother or caretaker	<i>OPTIONAL</i>