CHAPTER I

INTRODUCTION

This handbook is intended to assist UNICEF staff in their work with national counterparts to measure progress toward the Mid-Decade Goals. It is a working document and as such has sections that may be removed and reproduced for specific purposes.

The handbook is a practical, immediate response to requests for guidance as the end of 1995—mid-decade—comes closer. In 1990, at the World Summit for Children, 71 heads of state and government and 88 senior officials from countries around the world pledged themselves to a Declaration and Plan of Action for Children. Based now on the commitments of 158 heads of state, countries around the world have proceeded to develop their own National Programmes of Action (NPA) for Children. Today these National Programmes of Action encompass 9 out of 10 children on earth.

THE MID-DECADE GOALS: BACKGROUND

The Mid-Decade Goals emerged from the first two years of experience, beginning in 1990, with National Programmes of Action. By 1992–93, some of the goals for the year 2000 appeared to be within the reach of many countries by the end of 1995, if the world community would make a concerted effort to that end. Making a measurable difference for children right away, long before the year 2000, has particular urgency. Children and their parents have good reason to be suspicious about promises for improvements in their lives that take 10 years to accomplish.

Accordingly, regional consultations built consensus in 1992 and 1993 around a set of mutually shared goals that could be achieved by mid-decade. At the heart of the process was the Consensus of Dakar, reached by all governments of Africa meeting under the aegis of the Organization for African Unity (OAU). In 1992 the International Conference on Assistance to African Children adopted a set of 13 Mid-Decade Goals, which subsequently received summit-level endorsement by the OAU. While other regional consultations agreed upon a more ambitious set of goals for mid-decade, and have set out to meet them, the real challenges for improving the lives of children and women are in Africa. The Mid-Decade Goals which emerged from Dakar have come to form the moral minimum that all countries need to achieve by the end of 1995 as stepping stones to the goals for the year 2000,[1] and it is those goals that are addressed in this handbook.

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[1]For fuller background, see *Report of the Secretary-General: Implementation of the General Assembly Resolution 45/217 on the World Summit for Children*, A49/326, 46th Session of the General Assembly (New York: United Nations, 1994).

MEASUREMENT OF PROGRESS

Governments that signed the Declaration and Plan of Action for Children also committed themselves to monitoring progress toward the goals and objectives set for the year 2000 in the Plan of Action of the World Summit for Children. The Plan of Action called for each country to "establish appropriate mechanisms for the regular and timely collection, analysis and publication of data required to monitor social indicators related to the well-being of children" (para 34 [v]). Many governments have taken serious steps to do this in their own National Programmes of Action. Measurement of these indicators is an essential part of the process—both for providing information for action and for recognizing improvements. But guidance for doing so has lagged behind demand.

The Plan of Action requests "the assistance of the United Nations . . . to institute appropriate mechanisms for monitoring the implementation of the Plan of Action, using the existing expertise of the relevant United Nations statistical offices, the specialized agencies, UNICEF and other United Nations organs." The annual publication *The Progress of Nations* is one of UNICEF's contributions to that effort. In addition to highlighting how the measurement of progress lags behind action, *The Progress of Nations* has raised the following question: Does the absence of data on the well-being of children reflect an absence of real commitment? Surely, if the vagaries of world financial markets can be reported on a daily basis, then data on children should not be so woefully out-of-date or altogether lacking.

The Mid-Decade Goals have narrowed the information needs to specific areas critical to the survival and development of each child: the right to be protected against the immunizable diseases, to be treated when sick with diarrhoea, to be breastfed, to be well nourished, to be protected against the disorders of iodine and vitamin A deficiencies, to go to school and to have access to water as well as sanitation facilities.[2] Each of the goals is framed within the available resources of each country and the international community.[3]

Yet, recent reviews of data reported by countries to international agencies show that measurement at the national level still lags behind progress and data voids persist. This is demonstrated in Table 1.1, which shows the number of years that have elapsed, on average, between the last national on-the-ground surveys and the year 1994.

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[2] *Human Rights Fact Sheet No. 10*, Convention on the Rights of the Child, Article 24, ISSN 1014-5567 (Geneva: Centre for Human Rights, United Nations, 1990).

[3] Convention on the Rights of the Child, Article 4.

Table 1.1 Average age of data on Mid-Decade Goals for developing countries

		Age of data in years (by region)				
Goal	Indicator	Sub-Saharan Africa	South Asia	East Asia and Pacific	Middle East and North Africa	Latin America and the Caribbean
1	Immunization —DPT	1.3	1.4	1.2	1	1.1
	—Measles	1.3	1.4	1.2	1	1.2
	—Polio	1.3	1.4	1.2	1	1.1
	Tetanus toxoid for pregnant women	2.8	1.6	3.9	3	13.6
	TB immunization	1.3	1.4	1.2	4.4	1.9
5	Children receiving adequate vitamin A[a]	⇐ ⇐ Only 4 of 99 countries have data. ⇒ ⇒				
6	Iodized salt consumption[a]	⇐ ⇐ Only 12 of 99 countries have data. ⇒ ⇒				
7	Use of ORT[b] (pre-1993 definition)	2.9	1.3	2.6	2.6	1.3
	Use of ORT[b]: increased fluids and continued feeding[a]	⇐ ⇐ Only 13 of 99 countries have data. ⇒ ⇒				
11	Stunting	9.4	8.7	12.5	10.8	8.1
	Underweight	8.9	8.7	7.9	9.1	7.6
12	Children reaching grade 5	7	8.9	10.6	6.4	7.2
	Entering grade 1 at recommended age	10.6	15.0	12.9	7.5	7.3
	Gross primary school enrollment	5.3	3.9	4.9	3.9	3.3
	Net primary enrollment ratio	8.7	11	8.5	6.1	4.6
13	Access to safe drinking water	4.7	2.9	4.3	4.7	3.2
	Access to sanitary excreta disposal	6.2	5.0	4.3	6.4	4.3

Note: Where no data are available for the period since 1975, the elapsed time for a country indicator is set at 20 years.
[a]Only recently defined.
[b]Oral rehydration therapy.

REPORTING AT MID-DECADE ON THE MID-DECADE GOALS

The Mid-Decade Goals offer an immediate opportunity to close the gap between national-level measurement and actual progress. Not only are the goals widely supported, but it is also generally agreed that progress can be measured in a timely fashion in data-rich and data-poor countries as part of programmatic action to reach the goals. UNICEF has summarized the guidance of the World Health Organization (WHO) for the health goals (which account for 11 of the 13 Mid-Decade Goals) and of UNESCO for the education goal in its *Technical Guidelines for Monitoring the Mid-Decade Goals*.[4]

The remaining mid-decade goal—universal ratification of the Convention on the Rights of the Child—is the most important one. It needs no measurement, only action on the part of national legislatures to ratify the Convention and see that the documents are deposited with the United Nations Legal Office. Of all the Mid-Decade Goals it is the most advanced: 164 countries around the world have now ratified the Convention. Universal ratification requires only 22 remaining countries. There is every reason to hope that by 1995 this Convention will become the first universally ratified treaty of the world community.

The Convention on the Rights of the Child is the foundation for all the goals set at the World Summit for Children, as stated in the Summit's Plan of Action: "The aspirations of the international community for the well-being of children are best reflected in the Convention on the Rights of the Child" (Introduction, para 4).

Each mid-decade goal is quantified and expresses a time-bound target for progress through 1995. The goals are summarised in Table 1.3 (see end of this chapter) and compared with their related goals for the year 2000. Measurable indicators—which all agree can be used feasibly and affordably—are linked to these targets as an integral part of programme delivery. Indicators for these goals serve as summary markers of progress; in some cases they are proxy measures for information that is lacking but is very difficult or costly to collect on a national basis.

THE MID-DECADE REVIEW

An assessment of status on the Mid-Decade Goals is near at hand. The Plan of Action of the World Summit for Children calls upon "the Secretary-General of the United Nations . . . to arrange for a mid-decade review at all levels, of the progress being made toward implementing the Declaration and Plan of Action" (para 35 [iv]). This review necessarily encompasses all national and international goals for children, but it will put special emphasis on the smaller set of Mid-Decade

[4]UNICEF CF/PROG/IC/94-003, Programme Instructions, 15 March 1994.

Goals that emerged from Dakar, and it will draw on national and regional reviews of progress. Such reviews, led in many cases by the head of state, are already under way in different regions. The Secretary-General will make his own report to the United Nations on a special occasion in 1996 after all national governments have made their own reports.

Monitoring Systems for National Reports on the Mid-Decade Goals

There are many different ways to go about monitoring indicators in each goal area. Different systems are summarized in UNICEF's *Technical Guidelines for Monitoring Progress Toward the Mid-Decade Goals*. Each is part of its own national context and has different uses. National Programmes of Action give *prima facie* evidence of the variety of monitoring mechanisms and capacities. Most National Programmes have set up interministerial coordinating bodies for ensuring that goals are monitored across ministries as well as at different levels of government so that current status may be reported in a timely fashion to policy makers.

Development of Appropriate Monitoring Indicators

UNICEF, working with WHO and UNESCO, has developed *indicators* to measure progress toward these Mid-Decade Goals that permit cross-country comparisons. An indicator is the basic tool for measuring progress, using a commonly agreed-upon definition of a specific situation. Indicators define the data to be collected, so they should be relatively easy to measure and interpret, and should provide valid and reliable information about the objectives they are meant to measure. Ideally, an indicator should also provide useful information to improve programme operations.

The primary indicators have been selected because they can be collected as an integral part of activating national strategies to reach the Mid-Decade Goals. They form a subset of a larger number of indicators already in use for monitoring programs. This subset of indicators to be measured at the national level can provide data that are meant to incite people and policy makers to action. But these data may also be used to monitor programmes at several different levels. The same information may be collected for use by national policy makers and for managing programmes within the health sector, but depending on its planned use, such information may be analysed, interpreted and presented in various ways.

Indicators are indirect or proxy measures of a situation used to monitor and evaluate progress.

Technical Guidelines for Monitoring Progress Toward the Mid-Decade Goals provides further background for these indicators, definitions and common data sources and references. These indicators measure the impact of programmes and generally require techniques, samples and measurement that can be reported only periodically—perhaps at intervals of several years.

The World Health Organization regularly reviews national reports on health, with its *Monitoring of Progress Toward the Goals of Health for All by the Year 2000*. Its latest monitoring of national reports collected data from governments in 1993. A review of those data concluded that many essential indicators are out-of-date or altogether lacking for reporting on the Mid-Decade Goals, further reinforcing initial conclusions drawn in *The Progress of Nations,* in both its 1993 and 1994 releases.

With only one year left until the end of mid-decade, existing data gaps must be filled, especially for the Mid-Decade Goals. WHO and UNICEF share the view that there are ways to do this that will reinforce existing national capacity and strengthen sustained improvements in measurement over the longer term.

In September 1994, the WHO-UNICEF Intersecretariat for the Joint Committee on Health Policy recommended that

> Where data are lacking or out-of-date . . . WHO, UNICEF and other international agencies . . . collaborate across all sectors in assisting countries to monitor progress, using[,] wherever appropriate and feasible[,] multiple indicator surveys.[5]

UNICEF can assist countries in reporting on progress by helping to build in-country monitoring capacity and by identifying and investing in tools that will yield timely information. Priority should be given to methodologies that yield nationally representative results and can stand up to the careful scrutiny required for reporting. National statistical offices are key partners, as are the intersectoral agencies established in National Programmes of Action for monitoring progress toward the Summit goals.

As the information on age of data (Table 1.1) suggests, national capacity to monitor these indicators is still lacking in many areas. For monitoring progress at the national level (for use in advocacy, for overall policy making and for technical and managerial use), the measurement of indicators needs to be consistent, using agreed-upon definitions so that the measures can be used to compare countries and to monitor changes over time. Surveys can, in most settings, complement and strengthen existing reporting systems and fill information gaps for seven of the Mid-Decade Goals, which are discussed in chapter 3.

Choosing a Monitoring Tool

The measurement tools to obtain data on these indicators must meet certain qualifications: the data they produce must be valid and reliable, sensitive to changes and specific to each indicator. The

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[5] UNICEF Executive Directive, "Multiple Indicator Cluster Surveys for the Mid-Decade Goals," CF/EXD/1994-011 (14 November 1994).

indicators must be readily quantifiable, using agreed-upon definitions and reference standards. The data used to calculate each indicator should also be comprehensive, supplying representative national information and appropriate subnational breakdowns as required.

What Are the Tools for Providing Information on These Indicators?

Population census data are important sources of information on the total population, its age structure and its geographical distribution. This information is particularly useful in countries that most need data for setting priorities and for allocating limited resources, because they are also the countries most likely to have incomplete or insufficient information from the *registration of vital events* (births, deaths, marriages, etc.).

Census data can provide *denominators* for indicators; for example, the number of under-fives or the number of children of primary-school age can be estimated from census reports. However, censuses are not carried out by the health sector and usually take place only every 10 years. It can take up to three or more years to produce from census data the information needed by the health sector, so their usefulness for monitoring is limited.

Routine health service data are relatively cheap and easy to collect, but often those responsible for their collection at the local level are not taught how to use the data themselves, are often overburdened by demands to fill in forms and do not receive feedback on how these data are used. For these reasons, the quality of the data collected is often quite low.

Moreover, health service statistics are usually collected for administrative purposes, not for monitoring purposes. Information required on the proper denominators for the indicators are usually not available. Health service statistics can provide information on the number of patients seen, or the number of visits, but they rarely provide information on the entire population at risk, or the total population that is covered by the service. The "population at risk" (for example, the number of live births in a year) can be estimated from census data, if they are up-to-date, and then combined with health service information (for example, the number of children under one year of age immunized in a given year) to measure indicators if the appropriate data have been collected.

Helping to strengthen routine reports from the health information system, streamlining the amount of information to be collected and assuring that the population census data are tabulated and adjusted to provide appropriate information on denominators for selected indicators make up an important long-term strategy for building in-country monitoring capacity. These two sources—the health information system and the census—should be your first stop when looking for data to measure these indicators. However, the health services do not routinely obtain some of the information required for monitoring the Mid-Decade Goals.

To supplement health service statistics, epidemiological *surveillance sites* are an important data source. As long as the data are collected nationally, or in representative sites across the country,

they can provide useful information on indicators such as immunization, as well as on interventions delivered to certain regions or groups in a population, and they can be particularly useful in providing data on specific diseases. For example, a survey may be necessary to estimate the number of diarrhoea cases treated with oral rehydration salts (ORS), but a sentinel disease surveillance system may provide good data on seasonal patterns of diarrhoeal disease incidence, which can be used to adjust survey estimates of diarrhoea incidence. These systems may also collect information on the occurrence of specific diseases and conditions, such as vitamin A deficiency, goiter and acute respiratory infections, that are too costly to investigate in large-scale surveys.

Household sample surveys are the most widely used method of providing data on health and social indicators when these other sources of data are deficient. Even well-developed health information systems and good registers of vital events serve an important *complementary* role, supplementing routine service statistics with timely data, and with data not usually collected in censuses and at service delivery points (SDPs). Every industrialised country has special ongoing survey programmes, usually very extensive health interview surveys and surveys of disease morbidity and disability, to provide this supplementary information. Surveys are the best source of data on programme coverage, and on differentials in health indicators. They can provide breakdowns of information by regional, social or ethnic groupings which are very difficult to obtain from routine data sources.

No other source exists for some of the information required to monitor the Mid-Decade Goals. For example, the only way to obtain nationally representative information on diarrhoea cases treated with ORT, or on the number of households using iodized salt, or about the nutritional status of young children, is to do a survey, or to ensure that the required questions, measurements or tests are carried out in an ongoing survey programme. Data already collected in household surveys—such as the Demographic and Health Survey (DHS) programme—may be able to provide the baseline information for some indicators, provided the right questions were asked. If such a survey is currently being planned it may be possible to add a module of questions to measure specific indicators of the Mid-Decade Goals.

While large-scale household surveys are not usually carried out routinely, they do provide data that can complement routine statistics, gathered at key points in time. In countries where the health information system leaves many gaps, allocating some programme resources to routine monitoring surveys at the national level may be appropriate. These surveys can be relatively small in scale, because for those countries where data needs are greatest, it is often more important to know the *order of magnitude* for an indicator than to measure it very precisely. This means that a very large survey is often not necessary for providing important basic data at the national level.

Choosing to Monitor Progress with a Survey

Information gaps persist in almost all countries, as already observed. Without new surveys many of these gaps will remain through 1995, limiting any objective assessment of progress. As the end of 1995 approaches, limited options are available beyond simple surveys for closing existing data gaps. Good national estimates of goal indicators can be obtained using modifications of the cluster survey methodology developed by EPI and CDD programme reviews.[6] Properly conducted, these surveys can produce data that will meet the rigorous requirements for reporting on the Mid-Decade Goals. Linked to improved reporting in routine systems, simple rapid surveys can be used for measurement, management and advocacy. They can be used in data-poor countries, and can fill information gaps and improve programme delivery in data-rich countries.

Most countries are likely to find the multiple-indicator surveys[7] immediately useful both for goal monitoring and for influencing—at affordable cost—policy, programme design and resource allocations to social priority sectors. Moreover, most countries can take advantage of substantial national technical capacity developed as a result of extensive experience with cluster surveys. These household cluster surveys are population-based data-gathering systems. They provide a snapshot of the target population at a specific point in time and, if well planned, should give a profile of those most at risk—that is, households that fall outside routine service delivery and reporting systems. The snapshot they present is taken from a sample of households and estimates, and are thus subject to error. Good reports from these surveys make clear the degree of confidence to be placed in the results. Chapter 4 of this handbook tells how to design a survey sampling strategy appropriate to your country's needs and resources.

DECIDING TO CONDUCT A SURVEY: IS THERE A NEED?

Every survey, no matter how simple, incurs costs. Requirements of sample size and proper conduct of the field work are demanding. UNICEF offices should review all the household surveys planned or in progress to see what new information on the Mid-Decade Goals they may produce within two years. Where a survey is in the planning stage, UNICEF can help to focus the survey on information gaps by participating in the survey design and by supporting data analysis that gives priority to reports on indicators of the Mid-Decade Goals. The indicators that can be measured by a national survey are discussed in chapter 3 of this handbook.

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[6]EPI stands for the "Expanded Programme on Immunization." CDD stands for "Control of Diarrhoeal Diseases."

[7]When using an acronym to refer to multiple-indicator surveys, we use MICS (multiple-indicator cluster surveys) to avoid confusion with "management information systems" (MIS).

Before making a decision to do a survey to monitor the Mid-Decade Goals, be sure you have checked to see what other surveys have been done recently, or are planned for the next year. If they employ nationally representative samples, it may be possible to measure the indicators by asking that special tabulations be made from these recent surveys. If a survey is in the planning stage, you may be able to include modules of questions to measure the indicators for which routine data are lacking, and to obtain the cooperation of the survey team to produce the necessary tabulations quickly, as soon as data collection ends.

EXAMPLE:

In Kenya, a national nutrition survey had been conducted in the first part of 1994. There was no need to include measures of the nutrition goals in the monitoring survey planned for the summer of 1994.

Once these other sources of data have been thoroughly mined, you will know what further information gaps exist. Where existing sources of data do not provide representative information needed to calculate an indicator, you may be able to collect it in a special survey. In countries with little data and no other surveys planned, there is good reason to work with governments to design a survey to provide baseline data, point to problems and assist in future assessments. Guidelines for modules to measure indicators of progress for EPI programmes and CDD programmes have proven to be cost-effective and useful tools.[8] These have formed part of the standard training for health programme managers for the past decade, and can provide rapid turnaround from fielding to reporting results.

UNICEF may undertake to support new surveys when:

- All recent data on the subject have been analysed and used.
- No one else is collecting further data or planning to do so in the near future.
- The method proposed is cost-effective and sustainable.
- National monitoring capabilities will be strengthened as a result.

Simple surveys should not be pressed to provide reliable subnational reports on these indicators, nor to report on change over time unless these requirements are clearly part of the survey design specifications at the outset.

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[8] WHO, *The EPI Coverage Survey. Training for Mid-level Managers*, WHO/EPI/MLM/91.10, (Geneva: World Health Organization, 1991); and WHO, *Household Survey Manual. Diarrhoea Case Management, Morbidity and Mortality*, WHO/CDD/SER/86.2 Rev1(1989) (Geneva: World Health Organization, Diarrhoeal Disease Control Programme, 1989).

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

When a survey is well conducted, the results should stand up to close scrutiny by governments, other international organizations and communities. The data supplied by a carefully planned and well-conducted rapid survey should supply valuable information for helping communities and governments to understand and monitor their progress, and to plan for the future rationally.

To make sure that happens, careful planning for the survey is essential. This handbook brings together the best guidance the international community has to offer in doing that. The step-by-step guidance contained in the handbook for planning and conducting a multiple-indicator monitoring survey is intended to complement and reinforce existing systems—not to replace them.

The handbook contains a model of a well-designed survey instrument to use for obtaining the needed information. This standardised questionnaire is a product of a collaborative effort involving many participants, both within and outside UNICEF. It uses a series of question modules designed to provide data for most of the primary indicators of the Mid-Decade Goals. These question modules are found in chapter 3 of this handbook.

The Model Questionnaire can be easily adapted to specific country situations. If, for example, very good and current data already exist for an indicator in a particular country, the relevant module can be dropped. This handbook also offers the user an opportunity to select modules for briefer surveys to fill data gaps or to add to existing survey instruments where measurement plans are already well advanced. They may be combined with other questions that help to illuminate the determinants of current status. In addition to those designed to measure indicators of the Mid-Decade Goals, several other modules are provided, to be included or not at the discretion of the particular country offices and their counterparts. The survey can be implemented at reasonable cost in a variety of country situations.

Before the final decision to conduct a survey is made, you should be able to answer three important 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?*

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 mangers to allocate resources to social priority sectors. What data are needed and how they may be used by policy makers, programme managers, communities and the

general public should inform all planning decisions.

Make certain that all are clear about why you are doing the survey and how you will use the results. Then plan the presentation of findings along with planning of the survey itself.

Chapter 2 of this handbook contains a list of key information and decisions that need to be made before a survey can be undertaken. UNICEF country directors, programme managers, and national counterparts should read this section 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, from planning through implementation to reporting your results. Chapter 2 also contains a checklist of items that will need to be budgeted for when doing a national survey.

WHO IS THIS HANDBOOK FOR?

For any country in which data are altogether lacking, multiple-indicator surveys using cluster sampling provide a means to measure status on most of the Mid-Decade Goals by mounting a rapid, nationally representative survey. The guidance in this handbook is set out to ensure that surveys may be designed and fielded in a way to yield results that will stand up to international scrutiny. The modules have limited aims, but the survey platform does not.

In all regions there is a reservoir of national managerial experience to mount the surveys that will contribute to these reports. In EPI alone, over 4,500 coverage surveys and reviews helped build national survey experience in the 1980s, especially in those countries with weaker monitoring systems. In Africa, 1,686 were completed between 1978 and 1991. No region lacks this experience. Most surveys have been managed by nationals. When supported with international assistance, nationals have been an integral part of all survey operations.

From the very start, wide consultation with all those who hold a stake in the results will enhance the survey's impact and acceptance of the findings. This meansinvolving the Ministry of Health, perhaps the Planning Ministry and the Statistical Bureau, as well as nongovernmental organizations (NGOs) working for women and children. Widespread involvement, especially by key national training institutions, such as university public health programs or medical schools and university statistics departments, will also build capacity for future surveys and increase the long-term sustainability of monitoring efforts. All these different constituencies can be brought together to work toward achieving the commitments made by leaders at the World Summit for Children when the survey results are ready to report.

Different sections of the handbook should be read by different members of the survey team. Some sections should be translated, photocopied and given to field staff during their training. Table 1.2 can be used to guide country programme directors, national counterparts and members of the

survey team to the sections they should read.

Table 1.2 Key to contents of the handbook

Section	Contents	Who should read	Need to translate?
Chapter 1: Introduction	Monitoring progress at mid-decade Choosing a monitoring tool Deciding to conduct a survey	Programme director, national counterpart, survey coordinator	
Chapter 2: Decisions to Make Before Starting	Who will the technical resource persons be? What kind of data are required? How big should the survey be? How long will it take? What will it cost?	Programme director, national counterpart, technical resource persons, survey coordinator	
Chapter 3: Designing the Questionnaire	Which indicators will be assessed? What information is required? Target respondents for the different indicators Questionnaire modules	Survey coordinator	
Chapter 4: Choosing the Sample	Principles of sampling Critical decisions for sample size Sample size estimation Alternative sampling strategies	Survey coordinator, technical resource persons	
Chapter 5: Preparing for Data Collection	Logistical arrangements Preparing maps Printing questionnaires Selecting the interviewers Training field staff Arranging for data processing Pilot survey	Survey coordinator, technical resource persons	
Chapter 6: Conducting the Field Work	Choosing households to interview Carrying out interviews Supervising field operations	Survey coordinator, technical resource persons, field supervisors, interviewers	Yes (instructional material
Chapter 7: Processing the Data	Data entry Data checking Evaluating data quality Calculating the estimates	Survey coordinator, technical resource persons	
Chapter 8: Reporting and Using the Survey Findings	Presenting the findings Using the results	Programme director, national counterparts, survey coordinator, technical resource persons	

(table continues on next page)

(Table 1.2, continued)

Appendix 1: Instructions for Interviewers	How to fill in the questionnaire	Survey coordinator, technical resource persons, supervisors and interviewers	Yes
Appendix 2: Anthropometric Techniques	How to weigh and measure children	Survey coordinator, technical resource persons, interviewers, supervisors, measurers	Yes
Appendix 3: Organization and Administration of Data Processing	Managing the data base Running and installing the data entry and analysis programs Obtaining standard errors for cluster surveys Programmer notes	Technical resource persons	
Appendix 4: Definitions of the Indicators	Indicators measured with survey data	Technical resource persons	

NATIONAL CAPACITIES: TODAY AND TOWARD THE YEAR 2000

Assistance from the United Nations Statistical Office, with support from UNFPA, and in consultation with other United Nations agencies, especially the World Health Organization and UNESCO, have helped to build on country experience to prepare this survey instrument for the Mid-Decade Goals. Under the guidance of the Planning and Coordination Office, all relevant technical clusters within UNICEF and the Evaluation and Research Office have also contributed to the question modules.

This handbook was developed in response to a clear demand by countries and field offices. In August of 1994, a global workshop on the multiple-indicator surveys was hosted by UNICEF Bangladesh in Dhaka, where an interagency team, supported by Bangladesh's Bureau of Statistics as well as by regional and international centers of excellence, prepared all UNICEF regional advisers in monitoring and evaluation to put in place regional support for such surveys.

When many gaps still exist in the information needed for monitoring, helping countries in the process of planning and carrying out a survey is an important way to strengthen national monitoring efforts for the future. That is why it is important to involve personnel from national institutions such as medical and public health schools, health worker training institutes, university statistics departments and social science departments. The effort put into building survey capacity

will increase over time when a pool of trained individuals is being developed.

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, as has been done in Bangladesh and Kenya, to collaborate in the cost-effective use of a shared tool.

This small window of opportunity will shortly close for those who postpone strategic work-planning for 1995. This handbook contains the technical guidance needed to assist in each step of this process, from deciding whether to do a survey to actually conducting and reporting on one.

Box 1.1

WHAT MULTIPLE-INDICATOR SURVEYS CAN DO

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

TABLE 1.3

WORLD SUMMIT FOR CHILDREN: A COMPARISON OF GOALS AND INDICATORS FOR THE YEARS 1995 AND 2000

Year 2000 Goal	Year 2000 Goal Indicators	1995 Mid-Decade Goal (MDG)	MDG Indicators
Maintenance of a high level of immunization coverage (at least 90% of children under one year of age by the year 2000) against diphtheria, pertussis, tetanus, measles, poliomyelitis, tuberculosis, and against tetanus for women of child-bearing age.	Proportion of children immunized against diphtheria, pertussis and tetanus (DPT3) before their first birthday. Proportion of children immunized against measles before their first birthday. Proportion of children immunized against poliomyelitis (OPV3) before their first birthday. Proportion of children immunized against tuberculosis before their first birthday. Proportion of pregnant women immunized against tetanus. Proportion of children protected against neonatal tetanus through immunization of their mother.	(1) Elevation of immunization coverage of six antigens of the Expanded Programme on Immunization to 80% or more in all countries.	All indicators as in column 2 (Year 2000 Goal Indicators).
Elimination of neonatal tetanus by 1995.	Annual number of cases of neonatal tetanus.	(2) Same as Year 2000 Goal.	Same as Year 2000 Goal Indicator. Proportion of districts reporting neonatal tetanus cases.

Year 2000 Goal	Year 2000 Goal Indicators	1995 Mid-Decade Goal (MDG)	MDG Indicators
Reduction by 95% in measles deaths and reduction by 90% of measles cases compared with pre-immunization levels by 1995, as a major step to the global eradication of measles in the longer run.	Annual number of under-five deaths due to measles. Annual number of cases of measles.	(3) Same.	Same. Same.
Global eradication of poliomyelitis by the year 2000.	Annual number of cases of polio.	(4) Elimination of polio in selected countries and regions.	Same. Proportion of districts reporting polio cases.
Virtual elimination of vitamin A deficiency, and its consequences, including blindness.	Proportion of children 2 to 6 years of age who are nightblind. Proportion of children 6 months to 6 years of age with serum vitamin A below 20 micrograms/dl. Proportion of lactating women with breast milk vitamin A below 30 micrograms/dl (or less than 8 micrograms/gram of milk fat).	(5) Virtual elimination of vitamin A deficiency. *(At least 80% of all children under 24 months of age in areas with vitamin A deficiency receive adequate vitamin A.)*	Proportion of children under 24 months of age receiving adequate vitamin A (in vitamin A–deficient areas).

Year 2000 Goal	Year 2000 Goal Indicators	1995 Mid-Decade Goal (MDG)	MDG Indicators
Virtual elimination of iodine deficiency disorders.	Proportion of population in iodine-deficient areas consuming adequately iodized salt. Proportion of children 6 to 11 years of age with goitre of any grade (palpable and visible combined). Median value of the concentration of urinary iodine in school children should be greater than 10 micrograms/dl of urine. Proportion of newborns (cord blood or aged 3 days to 3 weeks) with serum TSH levels above 5 mIU/L.	(6) Universal iodization of salt in IDD-affected countries.	Proportion of households consuming adequately iodized salt according to agreed criteria: (1) in the whole country and (2) in areas known to be at high risk of IDD.
Reduction by 50% in the deaths due to diarrhoea in children under the age of five years and 25% reduction in the diarrhoea incidence rate.	Proportion of diarrhoea episodes in under-fives treated with ORT (increased fluids) and continued feeding. Annual number of under-five deaths due to diarrhoea. Average annual number of episodes of diarrhoea per child under five years of age.	(7) Achievement of 80% usage of ORT (increased fluids) and continued feeding as part of the programme to control diarrhoeal diseases.	Proportion of diarrhoea episodes in under-fives treated with oral rehydration salts (ORS) and/or recommended home fluids (pre-1993 ORT definition). Proportion of diarrhoea episodes in under-fives treated with ORT (increased fluids) and continued feeding. Proportion of population that has a regular supply of ORS available in their community.

Year 2000 Goal	Year 2000 Goal Indicators	1995 Mid-Decade Goal (MDG)	MDG Indicators
Empowerment of all women to breastfeed their children exclusively for four to six months and to continue breast-feeding, with complementary food, well into the second year.	Proportion of infants less than four months (120 days) of age who are exclusively breastfed. Proportion of children 20 to 23 months of age who are breastfeeding. Proportion of infants 6 to 9 months of age (180 to 299 days) who are receiving breast milk and complementary food. Proportion of all hospitals and maternity facilities which are "baby-friendly" according to global BFHI criteria.	(8) Ending and preventing free and low-cost supplies of breast milk substitutes in all hospitals and maternity facilities. Having target hospitals and maternity facilities achieve "baby-friendly" status in accordance with BFHI global criteria.	Proportion of hospitals and maternity facilities targeted for BFHI by end of 1995. Proportion of hospitals and maternity facilities that have been officially designated as "baby-friendly" in accordance with global criteria.
Elimination of guinea-worm disease (dracunculiasis) by the year 2000.	Annual number of cases of dracunculiasis in the total population. Number of villages with any cases of dracunculiasis.	(9) Interrupt guinea-worm disease (dracunculiasis) transmission in all affected villages by the end of 1995.	Same. Number of villages with any cases of dracunculiasis in the last year.
		(10) Ratification of the Convention on the Rights of the Child (CRC) by all countries.	Depositing the Instruments of Ratification with the United Nations Legal Office.

Year 2000 Goal	Year 2000 Goal Indicators	1995 Mid-Decade Goal (MDG)	MDG Indicators
Between 1990 and the year 2000, reduction of severe and moderate malnutrition among under-five children by half.	Proportion of under-fives who fall below minus 2 standard deviations from median weight for age of NCHS/WHO reference population.	(11) Reduction of 1990 levels of severe and moderate malnutrition by one-fifth (1/5) or more.	Same.
	Proportion of under-fives who fall below minus 3 standard deviations from median weight for age of NCHS/WHO reference population.		Same.
	Proportion of under-fives who fall below minus 2 standard deviations from median height for age of NCHS/WHO reference population.		Same.
	Proportion of under-fives who fall below minus 3 standard deviations from median height for age of NCHS/WHO reference population.		Same.
	Proportion of under-fives who fall below minus 2 standard deviations from median weight for height of NCHS/WHO reference population.		
	Proportion of under-fives who fall below minus 3 standard deviations from median weight for height of NCHS/WHO reference population.		

Year 2000 Goal	Year 2000 Goal Indicators	1995 Mid-Decade Goal (MDG)	MDG Indicators
Universal access to basic education, and achievement of primary education by at least 80% of primary school-age children through formal schooling or non-formal education of comparable learning standard, with emphasis on reducing the current disparities between boys and girls.	Proportion of children entering first grade of primary school who eventually reach grade 5. Number of children enrolled in primary school who belong in the relevant age group, expressed as a percentage of the total number in that age group (net enrollment). Proportion of children of primary-school-entry age who enter grade 1 at that age. Proportion of children aged 10 to 12 years reaching a specific level of learning achievement in literacy, numeracy and life skills.	(12) Strengthen Basic Education so as to achieve reduction by one-third of the gap between: (a) primary school enrollment and retention rates in 1990 and universal enrollment and retention in primary education of at least 80% of school-age children, and (b) primary school enrollment and retention rates of boys and girls in 1990.	Same. Same. Same. Number of children enrolled in primary school expressed as a percentage of the total number of children of primary-school age (gross enrolment). *(All above indicators by gender.)*
Universal access to safe drinking water.	Proportion of population with access to an adequate amount of safe drinking water located within a convenient distance from the user's dwelling.	(13) Increase water supply and sanitation so as to narrow the gap between the 1990 levels and universal access by the year 2000 of water supply by one-fourth and of sanitation by one-tenth. *(It is important that the definitions pertaining to access, adequate amount, safe and sanitary facilities be reported on for the indicators.)*	Same *(but expressed in absolute numbers and as a percentage of the total population).*
Universal access to sanitary means of excreta disposal	Proportion of population with access to a sanitary facility for human excreta disposal in the dwelling or located within a convenient distance from the user's dwelling.		Same *(but expressed in absolute numbers and as a percentage of the total population).*

Year 2000 Goal	Year 2000 Goal Indicators	1995 Mid-Decade Goal (MDG)	MDG Process Indicators for HQ, RO and CO Use
Reduction by one-third in the deaths due to acute respiratory infections in children under five years.	Annual number of under-five deaths due to acute respiratory infections. Proportion of pneumonia cases seen at health facilities which receive standard case management.	***For countries that are implementing ARI:*** Strengthening health facilities capability for case management of pneumonia	Proportion of children under five years of age, with an acute respiratory infection needing assessment, who are taken to an appropriate health provider. Proportion of all health facilities that have a regular supply of free or affordable antibiotics and a trained worker and are thus able to give correct pneumonia case management.