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MONITORING ACHIEVEMENT OF SOCIAL GOALS  
IN THE 1990's

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PROPOSED PROGRAMME TO MONITOR THE ACHIEVEMENT OF SOCIAL GOALS  
DURING THE 1990'S

I. Introduction

As planning for the fourth development decade begins, there is increasing consensus on the urgency of statistical needs to monitor progress of developing countries as they strive to meet social and human development goals. WHO and UNICEF have already adopted common goals for health of women and children during the decade of the 1990s. These goals include reduction of mortality, improved nutrition, education of women, control of childhood diseases and more effective water and sanitation standards. (see Annex I). The need to monitor progress in achieving these goals presents a direct challenge to individual countries and international agencies to develop and improve their statistical systems in order to produce timely, reliable and relevant statistical indicators.

While recognizing that it is the responsibility and prerogative of each government to select its own population policies and objectives in view of particular needs and characteristics of a given country and its population situation, UNFPA is also promoting clear and achievable goals for population programmes for the 1990's (see Annex II) within the context of the strategy for the fourth development decade. These goals include deceleration of rapid population growth through reduction of fertility by expanding education and services for family planning; lowering of current levels of maternal, infant and child mortality; and improving the role, status and participation of women. A wide range of information needs has been identified to monitor these goals. These include data on fertility and pregnancy history; knowledge, attitude and practice of contraception; breast-feeding; maternal, infant and child mortality; migration; family formation and dissolution; disability; school enrolment and educational attainment; economic activity; and employment, unemployment and under-employment.

The United Nations preliminary guidelines on social indicators, approved for publication by the Statistical Commission in 1976, and the Handbook on Social Indicators, issued in 1989, provide a general framework and orientation for the development of indicators. Technical documentation on statistics on women, disabled persons and other population groups, and on methods of population and housing censuses, household surveys, and civil registration and vital statistical systems developed by the United Nations over the last ten years, provides extensive technical guidance for basic data collection and for selection of indicators.

In addition to the priority interests of UNICEF and UNFPA noted above, it is expected that as the programme to develop indicators to monitor progress in social and human aspects of development begins to take shape, other United Nations agencies will also want to participate in the identification of key indicators that will require continuing or periodic

measurement in the decade of the 1990s. The implications for data collection for these indicators will then need to be spelled out so that ongoing basic data programmes of all kinds can be drawn on efficiently and effectively for monitoring purposes.

Effective utilization of the statistical indicators by the countries themselves is a major element in order for the programme to be meaningful and worthwhile. While it is thought that all countries will be interested in development indicators (indeed, some have developed their own programme for indicators) that feature social and human goals, as opposed to strictly economic ones, countries will no doubt need to be sensitized to the value and utilization of social indicators. This process can and should take place at meetings of the regional commissions and the Statistical Commission and such fora as the special Working Group meeting on Household Surveys, scheduled to be convened by ECA in October 1989.

#### Use of Existing Data Collection Systems

Data for monitoring various aspects of progress can and must be garnered from a variety of sources, including population censuses, vital and civil registration systems, other administrative record systems, and household sample surveys. The last may hold the most promise for producing the necessary data to derive certain key indicators, although no viable data source would be ruled out. This is due to several factors.

First, continuing or periodic household surveys are excellent for measuring change over relatively short intervals - a critical element in monitoring progress. Second, many of the topics for which indicators are needed have already been well-tested in the field with respect to both survey instrument development and estimation methodology. Hence it is reasonable to promulgate the use of standardized questionnaire modules for a wide array of social, economic, demographic and health-related topics, thus eliminating the need to build a long lead time for instrument testing and development - a process which, while essential for new subject matter, can easily add as little as six months or as much as two years to a survey programme.

A considerable degree of experience and capability in household surveys has been achieved over the last decade. For example, the National Household Survey Capability Programme (NHSCP), initiated in 1979 in response to a resolution of the Economic and Social Council, and executed since then with the support of UNDP, UNICEF, UNFPA and the World Bank in collaboration with the specialized agencies concerned viz., the ILO, FAO, WHO and UNESCO, is presently in operation in 30 developing countries of Asia, Africa and Latin America. It is expected that by 1991, the country coverage of NHSCP will be extended to 45 countries in all, of which 27 will have attained adequate survey capabilities. Once the basic survey capabilities are established, it would be feasible and logical to establish on that basis continuing survey programmes for the development of indicators, measurement of progress, and assessment of the changes. The World Fertility Survey (WFS), the Contraceptive Prevalence Surveys (CPS) and the Demographic and Health Surveys (DHS), which followed, have also developed the requisite household survey capabilities so vital for organizing a large-scale, cost-effective and timely survey operation that a programme to monitor social progress would entail.

Third, even in countries where surveys have not yet been adequately developed, it may be more practical to develop and organize periodic surveys from the standpoint of timeliness, expense and reliability, to provide the necessary data. This does not mean however, that less attention to the improvement of other data sources such as civil registration or vital statistics systems is advocated. On the contrary support toward their improvement is very much required.

### III. Strategy for Developing a Programme

In view of the manifest need to measure social and human progress in the decade of the 90's, it is proposed that data collection systems dealing especially with demographic and social aspects be promoted and supported in developing countries. The programme, tentatively entitled HOUSEHOLD SURVEY INDICATORS PROGRAMME (HSIP), will be built upon existing household surveys and other data collection systems, to be supplemented by new initiatives to be established wherever needed, and operated in effective coordination with other international survey efforts including NHSCP, DHS and SDA. In detailing the elements of HSIP, it is necessary to look at ways in which this coordination can take place. Of equal importance is the necessity to outline the measurement objectives, to ascertain developing country capability, both at the institutional level and methodologically, and to set priorities accordingly, and to detail the methodological requirements. These matters are discussed in the following paragraphs:

#### A. Measurement Objectives

Looking first at measurement objectives, there are a number of issues here. These include such matters as what measures to estimate, periodicity of measurement, need for subnational and subgroup estimates, etc. Whereas international and national social goals will have identified certain targets for human development in the 1990's, the task of translating these targets into corresponding statistical indicators can be formidable. What must be done is (1) identify those topics which are the most important, and (2) further pare the list to include only those that can be practicably developed, either through household surveys or through other data sources such as vital statistics systems. As mentioned, UNICEF and WHO have already adopted a common list of topics (Annex I) and UNFPA has identified specific population programme goals (Annex II).

On the positive side, it should be noted that one of the major advantages of the household survey approach is that a fairly extensive list of topics can be derived; for this reason it will not be necessary to be overly concerned about developing a very limited list of indicators. Still, it will be essential to settle upon a core set of a limited number of indicators (say 8-10) that is practically manageable from the standpoint of data collection, processing, analysis, dissemination and utilization.

The concerned international agencies will obviously have to coordinate their respective needs on development of the indicators and arrive at some mutual agreement, while individual countries may have competing indicators, engendered by their own priorities with respect to development goals - an eventuality which must be taken into account in the ultimate design of the project in particular countries.

A second issue on objectives is the periodicity or frequency of measurement. There is a clear need to take periodic measurements. This is seen as one of the essential design elements of HSIP since at least some of the indicators, no matter what the final list is determined to be, will require estimates of change in order to draw meaningful conclusions. Closely related to this is the necessity for establishing trends, especially where small changes may not be statistically significant between two successive observations.

A third important measurement objective is the issue of subnational and subgroup estimates and differentials. Individual countries are likely to have a strong interest in regional differences, and in urban-rural comparisons while international agencies will, most likely, be primarily interested in national level estimates, as opposed to subnational. Though it is likely that the sample size for some indicators will be too small to analyze subnational data, particularly estimates of change, with statistical confidence, it is also clear that many other indicators can be reliably estimated subnationally. An example of the former would be maternal or infant mortality - a relatively rare event, in statistical terms, and thus difficult to estimate at the subnational level unless the sample is prohibitively large. An example of the latter would be estimates of access to clean water. Subgroup estimates will also be of key importance, especially such comparisons as male-female and major social or ethnic groups.

It is important to note at the outset what the proposed programme will not do with respect to measurement objectives. HSIP will not be a tool for evaluating the effects of interventions or for establishing causality. These needs, as important as they are, are matters for controlled experiments and evaluation studies. While sample surveys, for example, can measure the levels, trends, differentials and changes in the target population and thus serve a powerful function as a monitoring instrument, they are not well suited to assessing reasons for observed levels or trends.

#### B. Situation in Developing Countries and Type of Support Necessary

To produce the required statistical indicators, countries will have varying degrees of capability to do so. A programme of technical and financial support is envisioned to assist countries to produce indicators. The level of support for a participating country will be dependent upon its need, determined on the basis of institutional infrastructure and methodological sophistication. Donor agencies are expected to be UNICEF, UNFPA and UNDP and perhaps other donor countries under bilateral or multilateral arrangements.

An inventory must be prepared profiling the current status of each country with respect to data collection systems in place or planned, as well as the current availability of data relevant to the production of key indicators. Information on the data collection systems will help assess the capability of each country to collect data relevant to the production of key indicators in the future. The current availability of data will help determine the data that can be produced for establishing the current levels of key indicators. See Annex III for an example of the data collection systems part of such an inventory. With the inventory, three

(perhaps 5) categories of countries could be formulated, to depict their current situation and priority status for UNICEF and UNFPA, plus the amount and type of assistance they would need. Due to the success of programmes such as NHSCP, WFS and DHS, many countries already have adequate household survey systems to produce the necessary data for indicators. Such countries, along with others who might have developed data collection systems on their own, may be categorized as Type I - Strong Capability, and would receive the least amount of external aid under HSIP. These countries are characterized as already having the following characteristics:

- an existing nationwide, continuing household survey programme or other data collection system that can produce indicators readily,
- a reasonably up-to-date sampling frame, and in some cases a master sample for producing national estimates,
- the institutional capacity to take on either survey modules appended to existing surveys or new surveys as necessary.

Type I countries are those that should be able to produce relevant indicators in the shortest time frame, due to their comparative strength methodologically and institutionally. The anticipated kind of assistance that Type I countries would receive would consist of (1) a formulation mission, where needed, to develop the workplan to produce indicators, (2) financial aid to carry out periodic data collections and data processing, and (3) technical assistance for developing the survey instruments for such indicators as child mortality and in developing procedures for constructing estimates and analyzing results.

The Type II countries - Moderate Capability - could be characterized as having some of the characteristics of the Type I countries but not all. For example, a Type II country might have a continuing survey programme, but one which is based on an outdated or incomplete sampling frame or a sampling frame but no continuing survey programme; such a country would require much more development work, and hence development assistance and financial aid, in order to bring it to the level necessary for producing indicators.

The kind of assistance that will be necessary for Type II countries might be (1) a formulation mission to assess the degree of capability and to develop the workplan accordingly and (2) financial aid to shore up infrastructure (such as constructing a master sample) and to carry out periodic data collections and data processing and (3) financial aid in most countries to support technical assistance on using child mortality survey instruments (and perhaps others) and in developing procedures for constructing estimates and analyzing results.

The Type III countries - Least Capability - will be characterized as having very little already established in the way of data collection infrastructure, sampling capability or operational continuing surveys for national data collection. Such countries will obviously require maximum external aid and long lead time before capability can be brought to the level necessary for producing indicators.

Type III countries will no doubt require the greatest amount of assistance - both financial and technical. Due to their relative lack of development, it does not appear likely that Type III countries could begin to produce baseline indicators until the third or fourth year of the programme.

### C. Priorities for Aid to Countries

In setting priorities for selecting the countries that will receive technical and financial assistance, contingent upon their own national requirements and interests of course, size and population density will be considered, as well as rate of population growth. In addition it will be important to cover each of the regions of the world. The Household Survey Indicators Programme would extend, initially, over a 5-year period, 1990-1994. The external aid requirements will have to be determined in respect of each country taking into account its size, type and priority in the above category.

### D. Methodological Requirements

This section briefly described some of the components which need consideration in the production of monitoring indicators. The ones covered are those of collection method, measurement instruments, data processing, as well as data analysis, outputs and use.

While other means of data collection will be used, it is expected that household sample surveys will be the most common collection method. However, this method encompasses a wide range of possibilities, from small, one-time, data collection covering only one or two indicators, to large, continuous data collection systems with a permanent field staff, associated infrastructure and collecting a wide range of indicators. For reasons of efficiency and effectiveness, the long term preference is to use integrated, continuing household surveys, such as those being supported by NHSCP. At the same time there is a requirement to produce indicators in the immediate to intermediate term, for type III countries as well as those in the type I category. For type III countries, in particular, as well as a number of type II ones, it will be necessary as an intermediate measure to utilize alternatives to the permanent and complex infrastructure demanded by continuing surveys. Such alternatives exist and are being used, for example, by UNICEF and WHO to obtain rapid assessments of child mortality level or immunization coverage. Elapsed times from initial development to production of estimates are from six to nine months.

In order to facilitate the collection of good quality data, and to allow comparability over time and between regions, standardized measurement instruments and related procedures should be used where possible. For a number of indicators, such instruments do exist, for example, for infant and child mortality and for nutritional status. However, for other indicators, such as mortality by cause, or prevalence of respiratory infections, standardized instruments are not easily identified, and some

research and development work will be needed. Even for indicators associated with standardized instruments which have been available for some years, such as infant mortality, there is not necessarily one "best" single measurement instrument.

Standardized measurement instruments have a number of benefits, which not only affect the data collection system, but also have a major impact on the processing of data. With the rapid expansion in the use of computers in data processing, standardized collection instruments facilitate the use of standard, preprogrammed processing modules and packages. Not only does this improve the quality of the output data, it can also result in dramatic improvements in the time taken to produce outputs. This is a critical element when dealing with monitoring data, since the primary purpose of these data are to identify instances where deterioration in human conditions require rapid remedial action. For example, the nutritional status of children can change drastically over a period of three months. Discovering this change only a year or more later can result in many children suffering irreparable damage, which could have potentially been avoided if remedial action had been taken much earlier.

Nevertheless, the timely production of relevant data of reasonable quality does not automatically lead to its use. There are many examples where relevant data have been produced, but no use has been made of them. This can be partly an organization or occupation problem since statistics are frequently produced in one government department but used by another. Furthermore, the producers of data often take the view that once they have produced the data, it is someone else's responsibility to use these data. For these reasons, and others, the communication of data from producer to user and thence their use is often a weak link in a monitoring system. A number of approaches can help such as: better analysis and presentation of data, so that users can more easily understand their meaning; a monitoring team composed of both producers and users; planning ahead as to how proposed data can be used, for example, what action could or should be taken if the maternal mortality rate in a region increases by 5 per cent, 50 per cent or 200 per cent. While approaches like these can improve communication and use of data, this area is likely to be one which requires a considerable degree of flexibility in order to develop effective monitoring within a country.

#### E. Coordination and Management

Coordination must take place on several levels. Each of the concerned international organs of the United Nations system must work together to accept/approve the overall concept and, more specifically, to develop a list of statistical indicators. Coordination must take place among the various programmes already involved in household surveys, notably NHSCP, DHS, SDA. This is necessary not only to avoid duplication of effort within participating countries on survey-taking aspects but to take advantage of the cumulated wealth of expertise and experience which has built up in these programmes for purposes of conceptualizing various details of NHSIP. An early task, for example, for these existing programmes is to develop a first cut at categorizing the countries into the 3 or more types.

Regional commissions will play an important role throughout the process. For example, their expertise would be tapped in refining the list of countries in the three categories. They would also play a key role in mobilizing countries to set the indicators programme in motion and provide technical support and training. In this respect the manpower resources of respective regional commissions will need to be appraised to ensure that they have the requisite capability to undertake the said task.

As for managing the technical aspects of the programme, it is suggested that the NHSCP Central Coordinating Unit (CCU) of the UN Statistical Office be the Coordinating Unit for HSIP also, because of the perceived close relationship between the proposed programme and NHSCP.

#### F. Initial Developments

The task of monitoring is not an easy one. It is therefore proposed that as an initial activity of the HSIP, pilot projects be launched in several countries. These countries would be selected to ensure representation from all three category types. The primary purpose of these country specific projects is to assess the technical, administrative and practical problems of HSIP. This would provide a substantial knowledge base for the implementation of a viable international programme. Further research and development of data collection, processing and use approaches, as indicated in section D, will be required as support to these pilot projects. The inventory discussed in section B will be further developed in parallel with the pilot project work.

WORLD HEALTH ORGANIZATION  
WHO/UNICEF COMMON GOALS FOR HEALTH DEVELOPMENT OF  
WOMEN AND CHILDREN BY THE YEAR 2000

The goals have been grouped under: Reduction of mortality, Women's education and health, Better nutrition, Control of childhood diseases and Control of the Environment.

1. Reduction of mortality

- 1.1 Reduction by 50% of maternal mortality rates from 1980 levels.
- 1.2 Reduction of 1980 infant mortality rates by at least half or to 50 per 1000 live births, whichever achieves the greater reduction.
- 1.3 Reduction of 1980 under-five mortality rates by at least half or to 70 per 1000 live births, whichever achieves the greater reduction.

2. Women's education and health

- 2.1 Achievement of universal primary education and 80 per cent female literacy.\*
- 2.2 Access by all couples to information and services for child spacing.

3. Better nutrition

- 3.1 Reduction of the rate of low birth weight (2.5 kg) to less than 10%.
- 3.2 Enable all women to exclusively breast-feed their child for four to six months and to continue breast-feeding with complementary food well into the second year.
- 3.3 Virtual elimination of severe malnutrition among under-5 children and reduction by half of moderate malnutrition.
- 3.4 Virtual elimination of iodine deficiency disorders.
- 3.5 Virtual elimination of the blindness and other consequences of vitamin A deficiency.

4. Control of childhood diseases

- 4.1 Global eradication of polio.
- 4.2 Elimination of neonatal tetanus by 1995.
- 4.3 Reduction by 95 per cent in measles deaths and reduction by 90 per cent of measles cases in 1995, compared to pre-immunisation levels as a major step to the global eradication of measles in the longer run.
- 4.4 Reduction by 70 per cent in the deaths due to diarrhoea in children under the age of five years; and 25 per cent reduction in the diarrhoea incidence rate.
- 4.5 Reduction by 25 per cent in the deaths due to acute respiratory infections in children under five years.

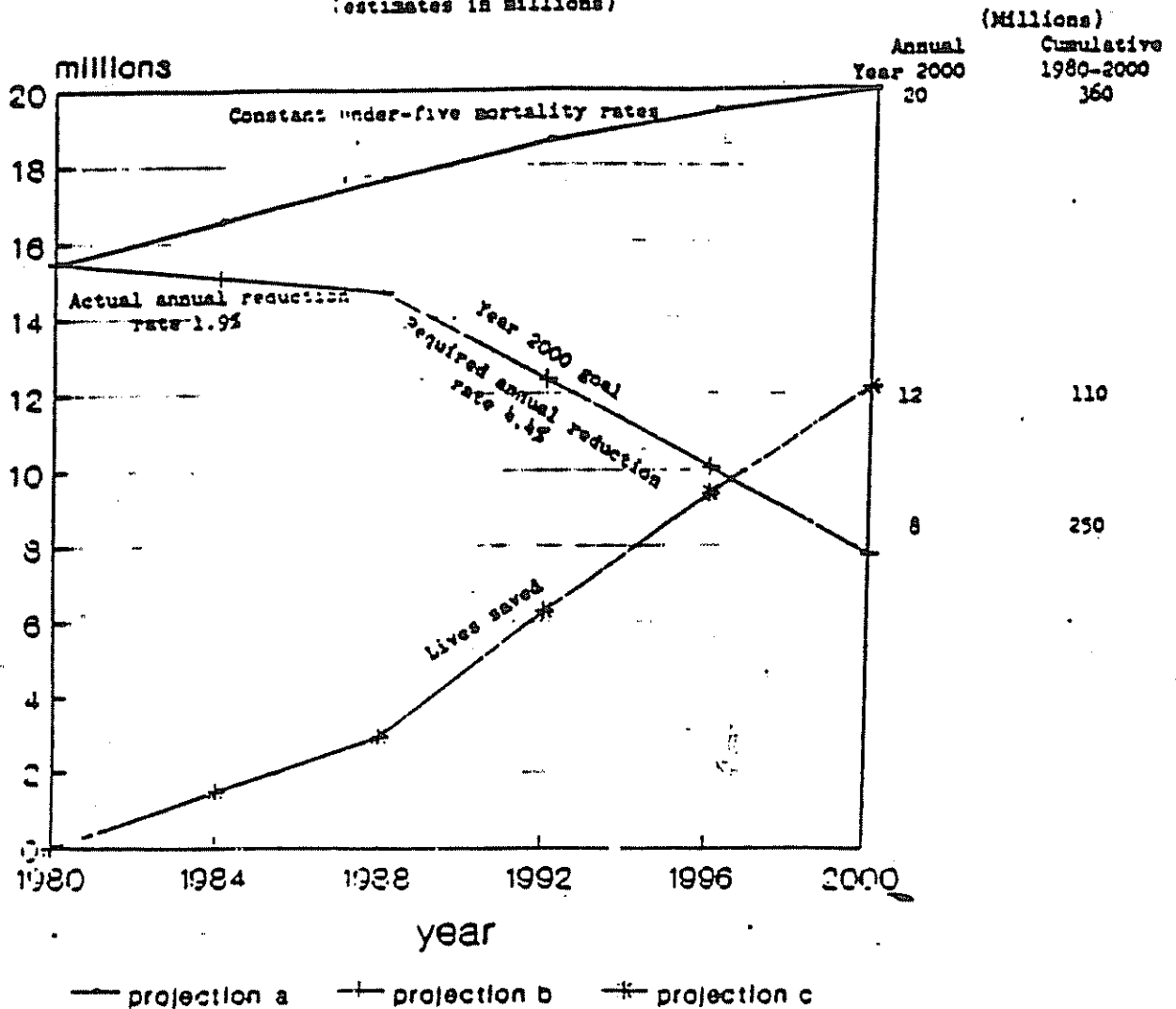
5. Control of the environment

- 5.1 Universal access to safe drinking water.
- 5.2 Universal access to sanitary means of excreta disposal.
- 5.3 Elimination of guinea-worm disease by 1995.
- 5.4 Achievement of a safer and more sanitary environment, with significant reductions of radioactive, chemical and other microbiological pollutants.

\* each country to define the age group.

## GLOBAL ESTIMATED DEATHS AND LIVES SAVED CHILDREN UNDER FIVE YEARS OF AGE 1980 - 2000

(estimates in billions)



The 1980 under-five mortality rates remain constant to the year 2000.

Up to 1988 the under-five mortality rates are as estimated by the United Nations Population Division. From 1988 countries make sufficient progress to reach their CSDR targets by the year 2000 i.e. either an under-five mortality rate of 70 or half their 1980 rate whichever is lower.

i.e. the difference between Projection A deaths and Projection B deaths

ANNEX II

UNFPA GOALS IN THE 1990's

These were enunciated in a recent statement by the Executive Director of UNFPA with an objective to:

- make family planning a development priority, ranked alongside major economic investments, and with an allocation of not less than one per cent of GNP in the countries concerned;
- extend family planning services to 500 million women;
- ensure that no person lives more than one hour's walk away from a health facility providing basic health care and family planning and that no-one lives more than two hours' travelling time from basic emergency facilities;
- ensure that all women pay at least one visit to a health care facility during pregnancy;
- reduce maternal mortality by at least 50 per cent especially in those countries where such mortality is very high (higher than 100 maternal deaths per 100,000 births);
- reduce infant mortality to 50 per 1000 live births - especially in those countries where infant mortality is high;
- expand girls' enrolment in primary school to at least 75 per cent. In countries where girls' enrolment is particularly low, ensure that the ratio of girls to boys in primary school is at least 4:5;
- expand girls' enrolment in secondary school to at least 60 per cent. In countries where girls' enrolment is particularly low, ensure that the ratio of girls' to boys in secondary school is at least 3:5;
- combat women's illiteracy so that at least 70 per cent are able to read and write.

## ANNEX III

### HOUSEHOLD SOCIAL INDICATORS PROGRAMME:

#### STRATEGY FOR COUNTRY INVENTORY AND CLASSIFICATION

##### A - Criteria for inventory and classification.

1. As the HSIP aims essentially at producing on a regular basis a set of key social indicators, the inventory will give consideration to all data sources and systems of information on social and health related aspects of the population.

2. Once the inventory is completed - an iterative process - the following criteria could be applied to classify the countries in a limited number of categories (not more than 5), each corresponding to a specific type of support by the Programme.

- i Priority status of the country for UNICEF (if any).
- ii Priority status of the country for UNFPA.
- iii Demographic surveys carried out in the past (if any), in which year and within which data source (e.g. National, WFS, CPS, DHS, NHSCP, others).
- iv Health and/or nutritional status surveys carried out in the past (if any), in which year and within which data source.
- v Participation in the NHSCP programme or any other similar programme with the objective of national capability building in the field of household surveys.
- vi Completion or coverage rates of deaths and births by the civil registration system.
- vii Planning of a census in the next five years.
- viii Planned participation or formal request for participation in the NHSCP and/or SDA project (Sub-Saharan Africa).
- ix Participation or planned participation in phase 2 of the DHS and/or PAPCHILD Surveys.

##### B - Country Inventory Table

3. The attached table summarizes which previous demographic, health, nutritional status or other type of surveys have been carried out in the last ten years and indicates whether it was of the WFS, CPS, DHS or another kind. It shows the approximate date of the survey and whether the survey was integrated into the NHSCP Programme.

4. The table also gives an outlook on what has been tentatively planned for the next five years, whether it will be a census, a possible DHS or PAPCHILD survey and if the country has formally requested to participate in the NHSCP and/or in the SDA Project.

5. Further analyses taking into account the type and scope of surveys plus the quality and timeliness of data, to ascertain their suitability to compile the final list of agreed-upon indicators is more time-consuming and will require more inputs. That would constitute the next step in preparation of the inventory.













Footnotes

WFS: World Fertility Survey  
CPS: Contraceptive Prevalance Survey  
DHS: Demographic and Health Survey  
SDA: Social Dimensions of Structural Adjustment  
FP/MCH: Family Planning/Maternal Child Health  
TYA: Teenage - Young Adult Family Planning Survey  
NHSCP: National Household Survey Capability Programme

- a) Conducted within NHSCP
- b) FP-MCH (Regional)
- c) Regional
- d) in-depth
- e) Family formation survey
- f) Post-census enumeration survey
- g) Energy survey
- h) Water and Sanitation Survey
- i) Rural Retail Price survey
- j) As of 1 March 1989
- (-) A reasonable anticipation that a census will be held during the decade but there is no established pattern on which to predict a date
- ? Status uncertain
- k) SDA 89 - Target effectiveness date  
SDA (89) - Appraisal mission
- l) with nutritional status module
- m) energy consumption
- n) For subject titles when not indicated please refer E/CN.3/1989/18,  
UN Statistical Commission: 25th Session

U Urban  
R Rural  
X Possible  
P Countries with project proposals  
F Female  
M Male