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población y desarrollo

Proposal on indicators for follow-up to the goals of the International Conference on Population and Development in Latin America and the Caribbean

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Latin American and Caribbean Demographic Centre (CELADE) –Population Division

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Contents

Tables

Boxes

Figures

Summary

This document is intended to provide a frame of reference for the design and implementation of a system of indicators for use in following up on the goals agreed upon at the International Conference on Population and Development and set forth in the Latin American and Caribbean Regional Plan of Action on Population and Development.

One of the elements taken into consideration in this proposal is the sociodemographic diversity existing in the countries of the region, which makes it difficult to design a uniform system for monitoring progress towards the objectives of the Plan of Action. The Latin American and Caribbean countries are at differing stages in the demographic transition, which means that their age structures are very different as well. Consequently, the steps taken by the countries to fulfil the Plan of Action will be aimed at varying sectors of the population as national priorities change.

A system is proposed at the regional level for comparing the indicators with quantitative targets as a means of evaluating how much progress is being made and identifying socioeconomic or sociodemographic inequalities between different population groups. This system would also provide background information for the design of social policies. The ultimate aim of the system is to serve as a basis for the development of national systems adapted to the circumstances existing in each country. To this end, a number of methodological aspects are discussed with a view to ensuring the system's operational usefulness (the need to set up a ranking system consistent with the

objectives of the different programmes, the need to adopt a typology geared to differing levels of evaluation and monitoring, etc.).

The selection of these indicators was based on their fulfilment of a set of basic criteria (reliability, validity, sensitivity, etc.) and on the range of information available. Consideration was also given to the proposals made by a number of United Nations agencies as one of the outcomes of various conferences held during the 1990s.

Indicators were grouped into three priority areas which were defined in the post-Cairo evaluation conducted for Latin America and the Caribbean in 1998: population and public policy; gender equity, full equality of opportunity, and empowerment for women; and health and reproductive rights, family planning and family welfare. A description of each indicator has also been prepared which covers its definition, sources, quantitative objective if any, sociodemographic breakdown and relevant comments.

Introduction

This document is a preliminary draft of the proposal being prepared by the Latin American and Caribbean Demographic Centre (CELADE) - Population Division of the Economic Commission for Latin America and the Caribbean (ECLAC) in order to generate a system of indicators for follow-up to the goals of the Programme of Action of the International Conference on Population and Development (ICPD) in the countries of Latin America and the Caribbean. CELADE, in close coordination with the United Nations Population Fund (UNFPA), is carrying out a range of activities in response to the resolution adopted by the Ad Hoc Committee on Population and Development of the twenty-eighth session of ECLAC. In that resolution, CELADE was instructed to provide support to countries for developing information systems with indicators that could be used for follow-up and appraisal of the implementation of the Programme of Action and the Latin American and Caribbean Regional Plan of Action on Population and Development. The resolution adopted contains the following provision:

> "Instructs the Latin American and Caribbean Demographic Centre (CELADE) -Population Division of ECLAC and the ECLAC Subregional Headquarters for the Caribbean, in consultation and with the support of the United Nations Population Fund, to give priority to assisting the countries to develop information systems which will include indicators that will allow for adequate follow-up and appraisal of the implementation of the recommendations contained in the Programme of action and the Regional Plan of Action"

> "Instructs the Ad Hoc Committee to follow up on the implementation of the Programme of Action of the International Conference on Population and Development and the Regional Plan of Action on an ongoing and systematic basis, taking as a point of reference the initial proposal for a regional system of indicators prepared by the Latin American and Caribbean Demographic Centre (CELADE) - Population Division of ECLAC, which, taking into account the characteristics of Latin America and the Caribbean, refers to the commitments assumed at the world summits held during the 1990s, especially the International Conference on Population and Development".

This resolution was adopted after CELADE, in response to a resolution of the Open-Ended Meeting of Presiding Officers of the Ad Hoc Committee on Population and Development in December 1998, presented to the Ad Hoc Committee on Population and Development of the twenty-eighth session of ECLAC the document "Sistema de indicadores para el seguimiento y la evaluación de las metas del Programa de Acción de la Conferencia Internacional sobre la Población y el Desarrollo para los países de América Latina y el Caribe. Un primer borrador para análisis" (ECLAC, 2000). The purpose of this document was to move forward with establishing a common basis for the design of a system of indicators, and the result was a set of 37 on which consensus had been reached, plus a few basic elements for defining qualitative indicators.

In order to reflect the particular characteristics of Latin America and the Caribbean, the proposal for a set of indicators for the region should take into account the three key differences between the countries: the stage of mortality and fertility transition that they have reached, the availability of timely and high-quality information sources, and the existence of coordination mechanisms and agencies to be responsible for monitoring compliance with the goals of the Programme of Action. In view of these differences, not all of the goals of the Programme of Action or the Regional Plan of Action have the same priority for each country. The diversity existing in these three areas means that a system has to be designed that will allow for different sub-systems. In order to take into account the specific features of countries, CELADE carried out a survey on "Mecanismos institucionales para el seguimiento del cumplimiento de las metas del Programa de Acción de la CIPD". The information from this survey is complementary to the surveys carried out two years earlier by the United Nations Population Division and by the UNFPA. CELADE also proposed a workshop on diverse national information systems where the countries were able to share their experiences in establishing indicator systems and consider the potential for implementing a set of indicators for follow-up to the goals of the Programme of Action of the ICPD.

In short, taking account of the experience gained, this document has been written to serve as a framework for the design and implementation of a system of indicators for the follow-up to the goals agreed at the ICPD.

Chapter I refers briefly to the main points of the ICPD agreements, the specific short-term objectives and the priority areas defined for Latin America and the Caribbean. It also gives an idea of the regional situation with regard to the institutional mechanisms available in each country and what progress they have made in developing systems of indicators. Chapter II briefly reviews the current diversity in the region with regard to the demographic conditions of the Latin American countries. Chapter III then defines some conceptual and methodological aspects of the indicators, to be taken into account when developing national systems. At this point, some ideas for the implementation of a regional system are mentioned, with a review of some of the lists of indicators produced by United Nations organizations. The following chapter analyses some of the information sources which could provide data for such a system. Lastly, chapter V presents a preliminary list of indicators which is a revised version of the list presented by CELADE in Mexico, in the document referred to above (ECLAC, 2000).

I. The agreements adopted at the International Conference on Population and Development

As a result of the International Conference on Population and Development (ICPD) held in Cairo in 1994, 179 countries signed a set of recommendations and shared goals set out in the Programme of Action adopted at the ICPD (United Nations, 1995). One important aspect of the Programme, compared with those of previous conferences, is that goals expressed in terms of demographic growth have been replaced with goals expressed in terms of the needs of men and women; added to this is the priority given to the empowerment of women and to increasing their participation by offering greater access to education, to health services —including reproductive health services— and to employment opportunities.

Accordingly, the Programme of Action calls for the integration of demographic factors in policies and programmes relating to sustainable development, with special attention given to their impact on population. It also advocates assessing the integration of population issues into development programmes. To this end, Governments should create institutional mechanisms which allow for population dynamics to be taken into account in the decision-making process. One way of achieving this is to strengthen collaboration between the Government, non-governmental organizations and the private sector in social and economic development programmes. In Latin America, the objectives, goals and recommendations for action in the framework of the ICPD Programme of Action were defined for the region by the

ECLAC sessional Ad Hoc Committee on Population and Development. The main actions and meetings of that Committee are summarized in box 1.

The agreements signed by the countries take into account the specific needs and conditions of Latin America and the Caribbean and propose a set of objectives which are presented in the Regional Plan of Action (ECLAC/CELADE, 1996). The specific objectives to be fulfilled in the short term are the following:

- To reduce the death rate among children younger than one year;
- To reduce the childhood mortality rate;
- To increase life expectancy;
- To reduce the maternal mortality rate;
- To reduce the unmet need for contraceptive methods;
- To make primary health care, including reproductive health care, accessible to all individuals;
- To reduce by 50% the differences in infant mortality rates, maternal mortality rates and the unmet need for contraceptives, as observed in different geographical areas and social groups;
- To make information on contraceptive methods and on where to obtain them available to all persons in their reproductive years;
- To incorporate and institutionalize matters related to population in primary and secondary education programmes.

In 1998, the Ad Hoc Committee on Population and Development carried out a review and appraisal of the implementation of the Programme of Action of the International Conference in Latin America and the Caribbean in accordance with the recommendations contained in the Regional Plan of Action. As a result of this review, six priority areas were defined, each of which is related to a set of priorities for action, as shown in box 2.

As a whole, the agreements illustrate a new focus on development, which is based on the needs of individuals and has fundamental goals which include poverty eradication, satisfaction of the basic needs of all the population and the protection of rights; moreover, the empowerment of women has become an essential aspect of development policies. There is recognition of the need to incorporate all sectors of civil society, including the private sector, in order to make progress towards achieving the goals specified in the agreements.

Another aspect to take into account in the implementation and follow-up to the Plan of Action is the existence of national institutional mechanisms responsible for population policies and programmes. In order to gain an overview in this area, CELADE conducted a survey in the countries of the region[1] towards the end of 2000, and the results have already been analysed and published (CELADE-ECLAC, 2001b). Various considerations emerged from this exercise.

[1] Of a total of 30 countries that received the questionnaire, 19 replied, including 15 from Latin America and 4 from the Caribbean (CELADE-ECLAC, 2001b).

Box 1

MEETINGS FOR LATIN AMERICA AND THE CARIBBEAN REGARDING THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT

ECLAC SESSIONAL AD HOC COMMITTEE ON POPULATION AND DEVELOPMENT

3-7 April 2000, Mexico City (twenty-eighth session of ECLAC)
Third meeting of the ECLAC sessional Ad Hoc Committee on Population and Development
Population, Youth and Development System of Indicators for the follow-up to the goals of the ICPD Programme of Action of the ICPD

Twenty-first special session of the General Assembly on the 1994 International Conference on Population and Development New York: 30 June to 2 July 1999 (ICPD+5)

14-15 December 1998 Santiago, Chile.
Open-ended meeting of the Presiding Officers of the ECLAC sessional Ad Hoc Committee on Population and Development.
Latin America and the Caribbean: review and appraisal of the implementation of the Programme of Action of the International Conference on Population and Development.

13-14 May 1998 Oranjestad, Aruba (twenty-seventh session of ECLAC).
Second meeting of the ECLAC sessional Ad Hoc Committee on Population and Development.
Population, reproductive health and poverty. Second report on the follow-up to the Regional Plan of Action.

15-20 April 1996 San José, Costa Rica (twenty-sixth session of ECLAC).
First meeting of the ECLAC sessional Ad Hoc Committee on Population and Development.
Follow-up report on the Latin American and Caribbean Regional Plan of Action on Population and Development.

Latin American and Caribbean Regional Plan of Action on Population and Development

The draft plan approved at the twenty fifth session of ECLAC (Cartagena de Indias, 1994) was supplemented on the basis of the results of the ICPD and consultations with member countries. The final version of the Plan was approved on 1 February 1996.

International Conference on Population and Development (ICPD) Cairo, 1994

29 April-4 May 1993 Mexico City.
Regional Conference on Population and Development.
Latin American and Caribbean Consensus on Population and Development.

Box 2

PRIORITY AREAS FOR IMPLEMENTATION OF THE PROGRAMME OF ACTION OF THE INTERNATIONAL CONFERENCE FOR LATIN AMERICA AND THE CARIBBEAN

a) Population and public policies
- Incorporation of sociodemographic knowledge and data by the institutions responsible for social policy formulation and implementation;
- Strengthening of the intersectoral and inter-agency coordination mechanisms, as well as those between different government bodies;
- Data collection, processing and dissemination systems;
- Ageing of the population;
- International and intraregional migration;
- Family, women heads of households;
- Territorial location;
- Availability of demographic data (disaggregation).

b) Gender equity, full equality of opportunities and empowerment for women
- Gender equity and women's empowerment;
- Women's organizations;
- Legislation and public policies to promote gender equity;
- Combating violence against women and children;
- Education and information on gender equity and equality of opportunity;
- Incorporation of the gender perspective in work with specific groups: indigenous populations and adolescents.

c) Reproductive and sexual health and rights and social equity
- Coverage and quality of reproductive and sexual health services;
- Prevention of unwanted pregnancies;
- Prevention of sexually transmitted diseases, including HIV/AIDS;
- Prevention of maternal mortality;
- Integrated services for reproductive and sexual health;
- Free choice of methods for fertility regulation (quality of services);
- Inclusion of sexual and reproductive health matters in the health sector reform programmes;
- Elimination of barriers to access to reproductive health services for the more socially disadvantaged groups;
- Information, communication and education with regard to reproductive health;
- Improvement of access to sexual and reproductive health services for adolescents.

d) Strengthening the role of civil society
- Involvement of the various actors in promoting the objectives of the Programme of Action;
- Juridical, financial and political conditions which enable the various civil society actors to collaborate with the legislative bodies.

e) International Collaboration
- To strengthen the mechanisms for consultation and coordination of international, multilateral and bilateral organizations among themselves and with governments, thus avoiding the dissipation of external resources and duplication of efforts;
- Measures to implement the 2000 census round.

f) Monitoring the progress made in achieving the objectives of the Programme of Action of the International Conference
- Establishment of integrated mechanisms for the follow-up and evaluation of the objectives agreed at international conferences;
- Design of methodologies and indicators to be used for quantitative and qualitative measurements which incorporate the perspective of the governments as well as that of civil society;
- To create a technical body at the regional level to coordinate the work of the national bodies.

Source: CELADE-ECLAC, 1999.

Firstly, there are very few countries which have an explicit population policy, and thus very few have an official follow-up process. Only two countries have maintained or strengthened their national population councils (Bolivia and Mexico), while in another three countries which do have offices responsible for population issues, these bodies have experienced setbacks in terms of their competencies (Peru, Ecuador and El Salvador). Despite this fact, just over half of the countries which replied to the survey (10 out of 19) have established a coordination mechanism to promote the goals of the Plan of Action. This, together with the fact that not all countries which have an explicit population policy are included in this group, suggests, as noted by the author, that *when the resolutions of an international conference and the corresponding programme of action acquire political importance at the national level, they can mobilize the pertinent organization for follow-up* (CELADE-ECLAC, 2001b).

With regard to the operational aspects of the follow-up, the survey shows that very few countries have systems of specific indicators for this purpose (3 out of 19). Again, here there is no correlation between the existence of these systems and the degree of institutionalization of population issues (whether there is an explicit policy or a coordination mechanism). In short, the existence of formal mechanisms for follow-up to the Plan of Action does not guarantee that such follow-up will be systematic, and therefore specific efforts should be directed to this task (CELADE-ECLAC, 2001b). The above survey shows that, although most countries in the region do not have systems of indicators for follow-up to the ICPD, they do have systems of sociodemographic indicators for follow-up on social policies. It might therefore be more feasible, as a way of establishing national systems such as the one proposed here, to incorporate into the existing national systems those indicators which could show the degree of progress made on the agreements reached in Cairo. In fact it is very probable that some of the indicators in this proposal are already included in the national systems.

Nicaragua and Panama have worked in this area by incorporating a sub-system for the follow-up to the goals of the international conferences, in particular the ICPD, into the design of their national systems for monitoring social policies. The discussions and recommendations which emerged from the Subregional Workshop for Central America on this subject (Nicaragua, 26-27 February 2001) contributed to the progress made in the development of these systems.

Panama is at a very advanced stage of its integrated system of development indicators (SID), which was created with the support of UNFPA. The programme WinR+Plan, developed by CELADE, has been used for presentation of indicators, and the content of the measurements designed for follow-up to the Cairo goals are based on the present proposal. It is hoped that between 2001 and 2002 the system will be completely transferred from the Social Cabinet (the institution responsible for developing the system) to the Statistics and Census Office, in order to guarantee continuity and permanent updating of the SID (Varela, 2001). On the basis of the proposal in Chapter V, CELADE has begun to collect information for the countries of the region, and is also using the WinR+Plan to process the information.

II. Demographic diversity in Latin America in relation to the Programme of Action of the ICPD

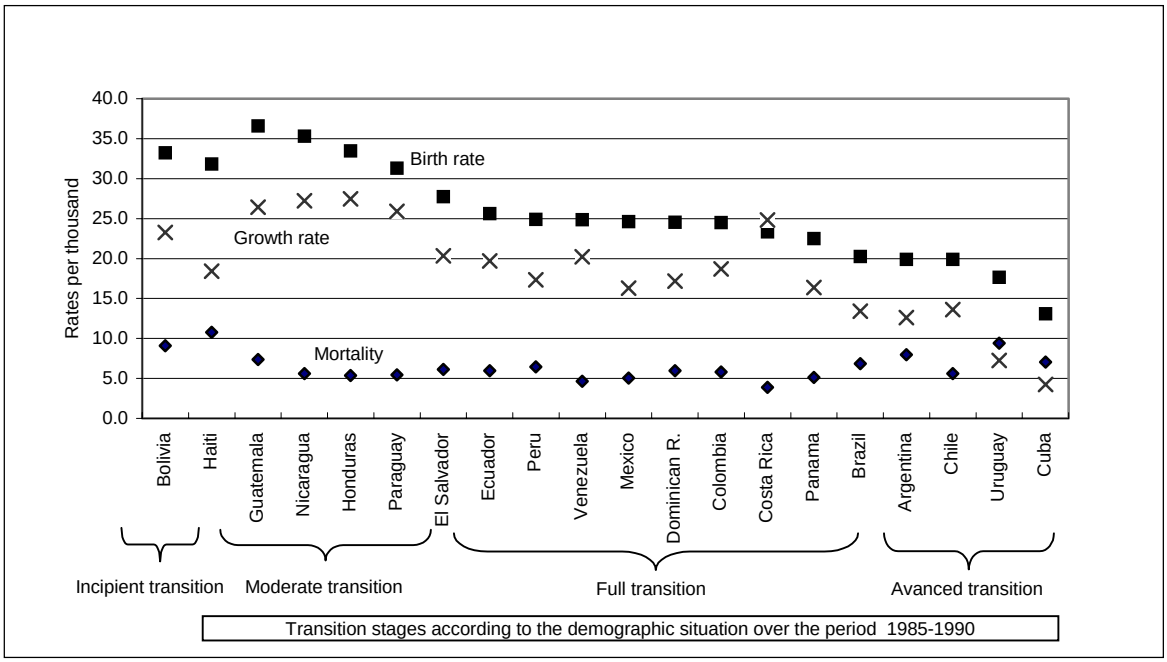
The sociodemographic diversity existing in the countries of Latin America makes it difficult to establish a general method for monitoring the goals of the Programme of Action. Firstly, the countries are in different stages of demographic transition. This means that they are at different points in the process of passing from high levels of mortality and fertility to low levels of mortality and fertility (Chackiel and Villa, 1992). The graph in figure 1 illustrates this situation. It shows the mortality and birth rates and the total growth rate (gross rates per thousand). Although any classification is arbitrary to some degree (so that, for example, some countries are at the borderline between two groups), in general terms and even with the most recent estimates, the different stages of transition that the countries[2] are going through can be identified. The growth rate, which at the beginning of the 1970s was close to 3% on average for Latin America, is now less than 2% in almost all of the countries. The regional picture, however, remains heterogeneous with regard to both the growth rate and its component elements: birth rates, mortality rates, and net migration.

[2] The rates shown are affected by the age structure of the population. Thus, the gross mortality rates in Haiti and Uruguay are of similar magnitude because in the former there is a high mortality rate, particularly in the first few years of life, whereas in the latter, although the level is low, the older composition of its population increases the value of the indicator.

Although since the second half of the twentieth century there have been significant fluctuations in the decline in mortality and fertility rates, there are still significant differences between the countries. In countries at the incipient transition stage, and as an average for the period 1995-2000, life expectancy at birth is less than 60 years, whereas in those at the advanced transition stage it is around 74 years (see table 1). In the case of fertility, the countries at the incipient transition stage have an average total fertility rate of 4.4 children per woman, whereas the countries at the advanced transition stage have an average of 2.4 children per woman. The countries at the moderate and full transition stages have average values within the ranges mentioned, the latter group being the most heterogeneous with regard to demographic indicators (see table 1).

Figure 1

CRUDE MORTALITY AND BIRTH RATES AND TOTAL GROWTH RATE FOR THE PERIOD 1995-2000



Source: Guiomar Bay, 2001.

With regard to the reduction in mortality, the Programme of Action proposed to reduce the infant mortality rate by one third or to 50 deaths per thousand live births and the childhood mortality rate by one third or to 70 deaths per thousand live births by the year 2000. By the year 2005, the infant and childhood mortality rates should be below 50 and 60 deaths per thousand live births respectively. By the year 2015, these values should be 35 and 45. As part of this reduction in mortality, by the year 2005 life expectancy should be above 65 years in the countries with high mortality rates and above 70 years in the countries with lower mortality rates. For the year 2015 these values should be 70 and 75 years respectively (United Nations, 1995).

These objectives of the Programme of Action in fact amount to a single objective relating to mortality reduction, as the measures complement each other. Where mortality is very high, a reduction in infant and childhood mortality is required in order to achieve an increase in life expectancy. Where the infant and childhood mortality rates are low it is likely that an additional reduction in adult mortality is needed in order to achieve the life expectancy goal. Lastly, where infant and childhood mortality were already below the values fixed in the objectives, it is likely that life expectancy was also above the values fixed. Box 3 shows the diversity of situations with regard to infant mortality rates.

Table 1

LATIN AMERICA: SELECTED INDICATORS FOR COUNTRIES ORDERED ACCORDING TO DEMOGRAPHIC TRANSITION PERIOD 1995-2000

Country and stage of demographic transition	Estimate for the period 1995-2000			Estimate for the year 2000		Unmet need for family planning d/
	Life expectancy at birth	Total fertility rate	Death profile index a/	Dependency index b/	Ageing index c/	
Incipient transition						
Bolivia	61.4	4.4	95.8	77.4	10.1	26.1
Haití	57.2	4.4	116.7	78.2	9.2	44.5
Moderate transition						
El Salvador	69.4	3.2	37.7	68.3	14.0	8.2
Guatemala	64.2	4.9	88.6	89.2	8.1	23.1
Honduras	69.8	4.3	83.0	82.1	8.3	11.0
Nicaragua	68.2	4.4	88.8	84.1	7.1	14.7
Paraguay	69.7	4.2	62.0	75.5	8.8	26.1
Full transition						
Brazil	67.9	2.3	29.6	51.4	18.0	7.3
Colombia	70.7	2.8	34.2	59.9	14.4	2.7
Costa Rica	76.5	2.8	12.0	59.9	15.8	---
Ecuador	69.9	3.1	55.8	62.7	13.9	10.0
Mexico	72.4	2.8	35.7	61.0	14.3	14.2
Panama	74.0	2.6	19.7	58.3	17.7	---
Peru	68.3	3.0	55.4	61.8	14.5	12.1
Dominican Republic	71.0	2.8	50.2	60.7	12.9	12.5
Venezuela	72.8	3.0	23.2	62.6	13.1	---
Advanced transition						
Argentina	73.1	2.6	8.4	59.8	35.0	---
Chile	75.2	2.4	7.5	55.3	25.2	---
Cuba	76.0	1.6	2.7	44.5	45.1	---
Uruguay	74.1	2.4	4.7	60.5	52.0	---

Source: ECLAC / CELADE, 2001.

a/ *Death profile index:* this is an approximation, as strictly speaking this index is calculated on the basis of deaths according to causes of death. The ratio used expresses the number of deaths of children for every 100 deaths of older persons. It was calculated as (population aged 0-4/deaths at age 65 and over) *100.

b/ *Dependency index:* expresses the number of potentially inactive persons who have to be supported by every 100 potentially active persons. It was calculated as (population aged 0-14/population aged 65 or over)/(population aged 15064) *100.

c/ *Ageing index:* expresses the number of older adults for each 100 children and young people. It was calculated as (population aged 65 or over/population aged 0-14) *100.

d/ The data are taken from demographic and health surveys: Bolivia DHS 1998, Brazil DHS 1996, Colombia DHS 2000, Ecuador ENDEMAIN 1999, El Salvador FESAL 1998, Guatemala DHS 1999, Haiti DHS 1994, Honduras ENS 1996, Mexico ENPF 1995, Nicaragua DHS 1998, Paraguay ENSMI 1998 (considers only modern contraceptive methods), Peru DHS 1996, and Dominican Republic DHS 1996.

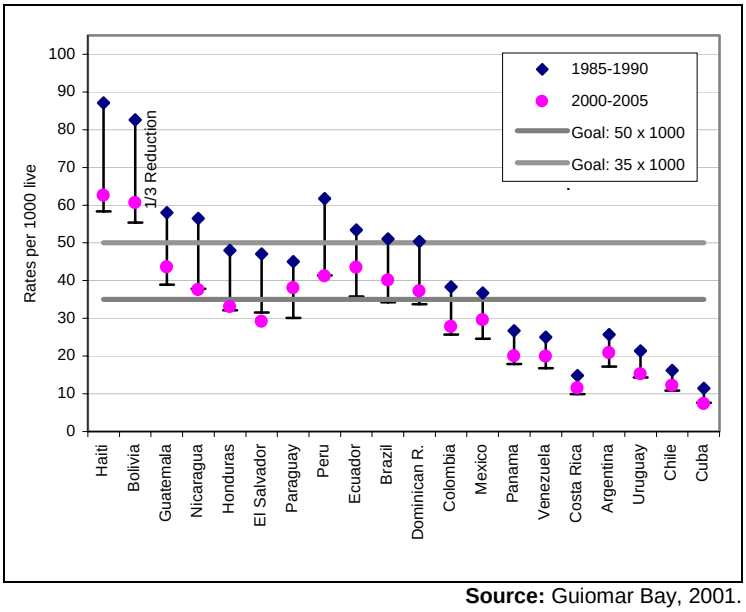
Box 3

PROJECTED INFANT MORTALITY

The graph shows the infant mortality rates for two different periods. The vertical line represents a reduction by one third in relation to the rate for 1985-1990. The parallel lines represent the goals of 50 and 35 per thousand contained in the Programme of Action. The graph illustrates various infant mortality situations. A first group of countries (Panama, Argentina, Venezuela, Uruguay, Chile, Costa Rica and Cuba) had infant mortality rates of less than 35 per thousand in the period 1985-1990. In all of these countries, according to the projected values, there would be a reduction of about one third between the two periods, while their order in relation to each other would remain practically unchanged. In Panama, Argentina and Venezuela, a reduction of one third still seems possible. In Uruguay, Chile, Costa Rica and Cuba, the reduction in infant mortality, if it continued, would progress much more slowly. At the other extreme, Haiti and Bolivia had rates higher than 90 per thousand before 1990. In subsequent years the rates would decline by more than one third, but, according to the projections, will not reach the goal of 50 per thousand. Even if they achieve a reduction of one third before the year 2015, these two countries will still have rates higher than the goal of 35 per thousand.

In the rest of the countries the decline in the projected infant mortality shows a different pattern. Peru, Guatemala and Nicaragua, whose rates were above 60 per thousand, will achieve a reduction of more than the expected one third. In the other countries of this group the projected reduction would not be proportional to the initial levels. Only El Salvador and Honduras would have a reduction of more than one third. In Ecuador and Paraguay, the goal for infant mortality levels would not be achieved, according to their initial levels, and to what the other countries would presumably experience.

PROJECTED CHAGES IN THE INFANT MORTALITY RATE FROM 1985-1990 TO 2000-2005



Source: Guiomar Bay, 2001.

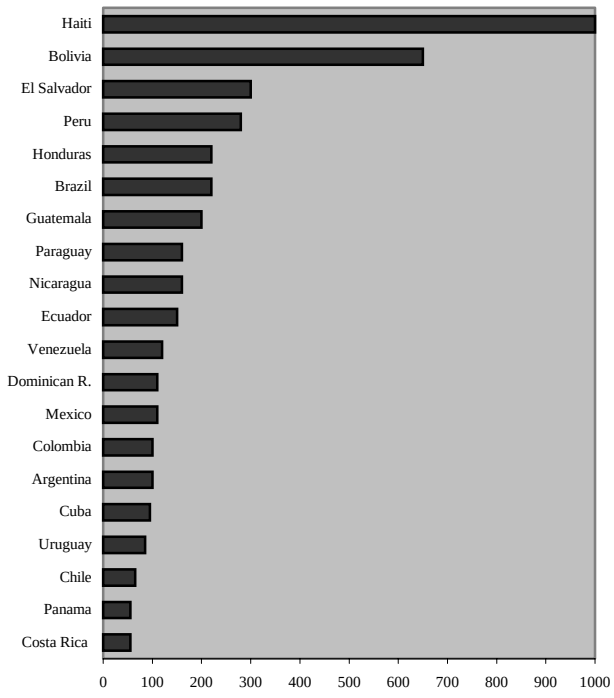
In general, the figure shows, on the one hand, the diversity of situations in connection with one of the goals of the Programme of Action, and on the other hand, the importance of monitoring the changes. It is clear that the decline in infant mortality depends not only on the initial levels but also on other factors which cannot be measured by one indicator alone. The differences in the rates do show, however, the importance of comparing the experience of countries and of identifying the factors explaining the differences in the rate of mortality reduction.

With regard to the goals for maternal mortality (see box 4), reproductive health services and knowledge and availability with regard to contraceptive methods, there is not the same complementarity that was observed in the previous case. No direct relationship has been observed between maternal mortality levels (measured at the national level as the maternal mortality rate) and the actions taken to improve reproductive health services and to improve access to family-planning methods (Stanton and others, in press and United Nations, 2000). This is partly owing to the difficulties inherent in measuring maternal mortality (WHO/UNICEF, 1996), but especially to the diverse situations that are possible with regard to specific actions taken and programme implementation.

Box 4
MATERNAL MORTALITY RATES

The reduction in maternal mortality rates, one of the most important goals of the Programme of Action, also shows differences between the countries of Latin America. The enclosed graph shows the estimates for maternal mortality for the year 1990. In 1990 only Panama and Costa Rica were below the objective of 60 per 100 thousand contained in the Programme of Action. If the rates were reduced by one half by the year 2000 as planned in the Programme of Action, then one half of the countries would have rates below 60 per thousand live births. But even if this reduction had been achieved, one group of countries (Haiti, Bolivia, El Salvador, Peru, Brazil, Honduras and Guatemala) would still have a maternal mortality rate higher than 100. These rates are difficult to estimate however, (WHO/UNICEF, 1996) and thus do not always accurately reflect the scale of what is needed. In 1990, for example, Mexico and the Dominican Republic had a rate of 110 per hundred thousand, but this accounted for 2700 deaths in the former and 220 in the latter country. In the case of Honduras and Guatemala, around the year 1990 the maternal mortality rate was 220 in the former and 200 in the latter. Despite this apparent similarity, in about the same year in Honduras 72% of women received pre-natal services while in Guatemala this percentage was close to 40%. Similarly, in Honduras 45% of births were attended by specialized medical personnel whereas in Guatemala the percentage would be close to 35%.

LATIN AMERICA: MATERNAL MORTALITY RATIO
1990s ESTIMATE
Rate x 100 000



Source: Ross, Stover y Willard, 1999.

In the area of fertility, the goals of the Programme of Action do not refer to specific objectives on how to achieve a specific level of the global rate, but rather to the extent of the population's access to reproductive health services that guarantee information and the opportunity to make a free choice with regard to family planning. From this point of view, it is more important to reduce the unmet need for family planning than to increase the availability of contraceptives. This is one of the objectives of the Programme of Action which it is hoped to achieve in the short term. The unmet need is usually measured as the number of women who do not wish to become pregnant and are sexually active, but not using any contraceptive method. This measurement seeks to reflect the lack of means on the part of couples to plan their family at the time and in the way that they wish (Westoff and Bankole, 2000). In general it has been observed in other countries that the unmet need tends to increase in the first stages of transition when there is an interest in limiting the number of births and then tends to decline (Westoff and Bankole, 2000). This decline is not uniform however as the unmet need consists of contraceptive use for both limiting and spacing

births. It is thus not a measure related exclusively to a "total" reduction in fertility but rather to family-planning decisions (see table 1). Also, the goals of the Programme of Action refer not only to limiting the number of births by women of reproductive age but also to the reproductive and sexual health services available to the population.

The different transition stages of the countries have another set of implications, one of the most important being the difference in the age structure of the population (Chackiel, 1999; Schkolnik and Chackiel, 1998), depending on a country's mortality and fertility levels. For example, in countries where the birth and mortality rates are still high, the population aged under 15 accounts for more than 40% of the country's population. In turn, the population over 60 has relatively more weight in countries with low birth and mortality rates. This results in significant differences in the dependency ratio (see table 1). For example, in the year 2000, while in Chile for every 100 potentially active persons there were 55 inactive (potentially dependent) persons, in Guatemala the latter figure was 89. The economic implications of these differences are well-known. Furthermore, this distinction in the relative weight of the different age groups means that the emphasis of policies and programmes to improve the well-being of the population will also be different in the different countries, depending on the stage of demographic transition.

Another example of differences in age structure is seen in the programmes for reducing mortality. Given the relationship between the age structure of the population and the age structure of deaths, in the countries with the highest mortality rates the actions should be designed mostly for the population aged under five years. In the countries with the lowest mortality rates and at a more advanced transition stage, the majority of deaths occur in the adult population and thus the set of actions needed to reduce mortality rates are very diverse, depending on the relative incidence of different diseases. This is reflected to some extent by the ratio of deaths of children to those of older adults,[3] as an approximation to a death profile index, for which figures are shown in table 1. For the year 2000 it is estimated that in the countries at the incipient transition stage there are about 100 or more deaths of children aged under 5 for every 100 deaths of older adults. In the countries at the advanced transition stage, on the other hand, this ratio is less than 9 children for every 100 older persons.

Other examples of the differences deriving from the age structure of the population relate to social security programmes. A reduction in mortality rates means that a greater proportion of people are surviving until their 60s, and are also living for more years after their 60s. The relative size of this group is growing (a phenomenon referred to as population ageing), both because there are more survivors and because, as a result of the decline in fertility, the number of persons in the younger age group (0-15) is growing more slowly. This means that in these countries the group of persons requiring social security services, and especially the pension system, will increase in numbers and duration while the percentage of future contributors to maintaining the system is decreasing, when it is an unfunded pension plan (ECLAC/CELADE/IDB, 1996).

Population ageing is a process which to a greater or lesser extent has begun in all countries of the region. At present, however, there are still differences, as shown by the estimates of the ageing index for the year 2000 (see table 1). While in the majority of the incipient and moderate transition countries there are less than 10 older adults for every 100 children and young people, in countries at the advanced transition stage there are between 25 and 50 older persons.

This regional picture of diversity in the demographic situation means, in terms of monitoring, that the set of actions to be taken by countries to achieve the goals of the Programme of Action should aim at different sectors of the population. The age structure of the population is an

[3] This ratio is associated with the pattern of causes of death, with infectious and parasitic diseases being the most frequent in children, and chronic and degenerative diseases among older persons. The ratio combines, to some extent, the effect of demographic transition and epidemiology.

expression of the demographic transition, whose components —fertility, mortality and migration— present a wide range of variability between the countries of the Region. This is why the proposal for indicators for the follow-up to the goals will take demographic transition into account, in order to distinguish the issues which are more important for one or another country according to the stage that they are going through. Lastly, demographic diversity is compounded by social and economic diversity, which means that in some countries different levels of monitoring will be needed, for example in aspects related to international migration.

III. Methodological aspects of selecting indicators

1. The diversity of actions relating to the goals of the Programme of Action

The main significance of the Programme of Action of the International Conference on Population and Development lies in the change from goals defined in demographic terms to a set of goals and objectives which have the final aim of improving the well-being of the population by satisfying the needs of individual men and women. An essential part of the Programme of Action is the emphasis on reproductive health and women's empowerment. The recognition and extension of the rights of individuals are also particularly important in the goals of the Programme of Action.

This change of emphasis in the Programme of Action means that the policies adopted by countries to attain population and development goals cover different areas and that their implementation therefore requires various kinds of projects and programmes. The objectives of the projects and programmes also change in accordance with national priorities. Moreover, these projects and programmes are closely related to other plans, in particular with those aiming for a poverty reduction. For example, in the case of social investment funds, one of the expected impacts in terms of human capital is the improvement of the education, health and sanitary conditions in which the population lives. This means that the areas which need to be monitored and evaluated in order to determine the education and

health conditions of the population coincide substantially with the goals of the Programme of Action such as for example, access to education, the incidence of certain illnesses, maternal-child health, and others relating to the benefits expected from the investment in education and health infrastructure or access to existing services.

One example of the relationship between poverty reduction and the goals of the Programme of Action is the evaluation of the impact of the Bolivian Social Investment Fund (Pradhan, Rawlings and Ridder, 1998) where the suggested indicators for the final impact on health include infant mortality, childhood mortality, the prevalence and incidence rates of certain diseases and the prevalence of malnutrition. The proposed indicators for intermediate impact include a set of indicators related to the use of health services such as care during pregnancy and childbirth, immunization and knowledge and treatment of diarrhoeal and respiratory disorders. Each of these indicators is linked to specific objectives of the Programme of Action as is the case of infant mortality, childhood mortality, the reduction of maternal mortality, and others relating to health.

Perhaps the best example of the diversity of the actions needed to implement the Programme of Action relates to gender equality and equity —a central aspect of the ICPD Programme of Action. Improvement of the social status of women and their full empowerment requires actions ranging from those that correct the historical marginalization that has generated inequality between men and women in areas such as access to education and employment, to those that protect women from violence and discrimination. The report produced by the National Population Council (CONAPO) on the implementation of the ICPD Programme of Action in Mexico shows the wide range of actions that serve to illustrate the diversity of areas where gender equality and equity need to be promoted (see box 5) (CONAPO, 1999).

Box 5

ACTIONS TAKEN BY CONAPO OF MEXICO IN RELATION TO THE GOALS FOR GENDER EQUALITY AND EQUITY

In the CONAPO report the actions intended to improve the social status of women were classified into seven different areas: education, participation in economic life, women's health, promotion and defence of women's rights, eradication of violence against women, and strengthening the social image of women. With regard to access to education, the report takes note of the projects of the National Institute for Adult Education which provide training for women in *maquila* industries, the launching in 1997 of the programme *Ser padres, una experiencia compartida* aimed at the mothers of families with school-age children and others such as the project *Atención educativa a mujeres* or the compensatory programmes designed for women and particularly indigenous women. As for women's participation in economic life, the report refers to actions such as training for women through the programme *Calidad Integral y Modernización* of the Secretariat of Labour and Social Provision, the programme *Más y mejores empleos para las mujeres en México* intended to have an impact on policies and programmes for generating employment at the national level, the modification of the Social Security Law in order to support working women, and access to credit through the Microfinancing Fund for Rural Women. In order to eradicate violence against women, in 1997 a decree reformed and repealed various provisions of the Civil Code and the Penal Code relating to intra-family violence. With regard to women's empowerment, the *Campaña educar para convivir mejor* on radio and television deals with issues relating to intra-family violence and equal treatment of men and women. In this example, in the case of Mexico, the achievement of gender equity and equality involves actions to reform laws and institutions in such a way as to guarantee rights and opportunities for women, to encourage economic development in such a way as to include women and to take corrective actions against discriminatory practices as well as promoting new values among the population

In each country, the set of actions to be carried out depends on the form in which the lack of opportunity, the non-respect of rights and discrimination occur. From this point of view it is important that the set of indicators is able, not only to highlight the achievements of the projects and programmes implemented but also to identify areas where specific actions are needed. For example, the lack of economic opportunities, the low level of access to education and the intra-family violence to which women are very often subjected results in problems of nutrition and a higher incidence of disease among women.

2. Monitoring and evaluation

This diversity of actions needed to move towards the goals of the Programme of Action means that monitoring and evaluation are of key importance in their follow-up and implementation. The aim of the monitoring activities is to identify trends in specific results over the longer term and in different population groups and geographical areas of a country. The collection of information to document these trends should produce indicators which provide feedback on the efficiency of the various programmes and projects. The follow-up has to be at two levels: at the programme level, where changes in the inputs and products are measured over time, and also at the level of the population where the intermediate and long-term results are measured. Depending on the different versions, monitoring involves a range of different activities for project implementation which range from reports to documentation of the conditions of the population group for which the projects and/or programmes were designed (Valadez and Bambergeer, 1994; Bertrand and others, 1996). Similarly, the monitoring goals include checking on the effectiveness and efficiency of implementation of a project or programme in such a way that corrections can be made during implementation and that the degree of fulfilment of the objectives in relation to the desired results can be assessed. The UNICEF Planning Office (1997) has defined monitoring as the regular supervision of the implementation of an activity to establish that the different actions defined are carried out as planned and that necessary corrective actions can be taken. The World Bank distinguishes between monitoring of results and evaluation of impact (Rubio and others, 2000).

Monitoring of results refers to the measurement that takes place of the effect of the products on the well-being of individuals in order to provide feedback to decision-makers on the effectiveness of the efforts. This monitoring includes the follow-up of changes over time and of differences between different social groups and areas of a country. Evaluation of impact means determining whether the specific actions of the projects and programmes are responsible for the changes observed in the well-being of the population.

Evaluation seeks to demonstrate a previously-defined impact in a more specific manner and requires a more complex methodology such as randomized experiments as well as information which is collected for the express purpose of programme evaluation (Bertrand and others, 1996; Valdez and Rawlings, 1994). While monitoring has the purpose of following over time the change in particular phenomena, evaluation seeks to determine the degree to which the observed changes can be attributed to the implementation of a specific project or programme. This requires measuring changes at the level of the beneficiary groups in the population and at the level of households or individuals. According to the design of the evaluation, comparable data collected at two different times are also needed, or data from a comparable population group that is not participating in the project or programme. The methodology should be such as to isolate the effects of the programme, for which purpose the measurements to be used should be unbiased and unambiguous with regard to the effects of the programme. On the other hand, most of the methods require assumptions to be made about causal relationships between programme inputs and the results.

Then, whether it is a case of formulation, monitoring or evaluation of social projects, it is recommended that systems of indicators are used which were explicitly designed for this purpose, and have also been made compatible with analysis needs (VSO, 1995). One issue that arises with regard to the methodology is the importance of making an analytical distinction between types of indicators. In general terms, it is a matter of having a relatively balanced number of indicators which can be used to cover the characteristics of the inputs, processes and products (or concrete results) of the programmes and projects.

Although a number of similar classifications for indicators[4] are already available, for the particular purposes of monitoring or follow-up activities a set of intermediate and final indicators is now offered for consideration which have been defined according to the objectives established in the programme (Rubio and others, 2000; Bertrand and others, 1996). Final indicators are those that measure the results or impact in respect of the broader goals relating to the well-being of the population. In general the results refer to changes in behaviour of individuals, and so the information for these indicators should come directly from the population for which the actions were designed. These indicators generally change slowly and their development is a product of various factors operating simultaneously. Intermediate indicators are those which measure inputs or products which quantify a result or which contribute to achieving a result and provide a more up-to-date vision of the progress achieved with respect to certain goals. The information for producing these indicators should come from administrative records. If the coverage of these records is inadequate, the information needed may be obtained through surveys.

3. The relation between goals and indicators

As mentioned previously, ideally, the indicators should be selected at the time when the programmes are designed, in such a way that provisions are made to produce or collect the information needed. In other words, when the programme goals are established, the precise measurements which will indicate their fulfilment should be established at the same time. Substantive aspects should be considered in the definition in such a way that the indicator is relevant for the programme, and is accessible in terms of obtaining the information. Box 6 summarizes some of the desirable characteristics of an indicator. A key aspect in the selection of indicators to be included in a system is the specification of the purpose and of the type of indicator needed. Following a logical structure, the definition of each of the indicators should relate to the objectives that are to be attained.

As an example, UNFPA, in defining its four-year programme, has established a series of goals and indicators based on three goals to which the Fund's activities contribute. These goals are the following (United Nations, 2000):

a) All couples and individuals enjoy good reproductive health, including family planning and sexual health, throughout life;

b) There is a balance between population dynamics and social and economic development; and

c) Gender equality and empowerment of women are achieved.

[4] See a comparison made by Vos (1995) between the classification adopted by the author, two others defined by the World Bank and that of the so-called "logical framework".

Box 6
DESIRABLE CHARACTERISTICS OF AN INDICATOR

There are different definitions of an indicator, some of which are the following:

- The indicators specify the quantitative and qualitative detail of a set of objectives. They refer to the situation that will obtain when the objectives are achieved;
- Measurement used to demonstrate the resulting change in a project or programme activity;
- Variables used to measure the progress achieved with regard to the goals;
- Measures or pointers that help to quantify or describe the achievement of results and monitor the progress made towards attaining the goals;
- Variable or measurement which can be used to transmit a direct or indirect message. As long as it is measured correctly, it can be based on quantitative or qualitative information.

It is clear that according to these definitions that an indicator must be able to measure the change in a specific state or situation of the population or of the beneficiaries of a project or programme. For this, a suitable indicator for monitoring the goals should allow for verification of the changes based on observations as close as possible to the beneficiary population and also for the opportunity for consultation by parties interested in the accomplishment of the goals in order to assess the degree of progress achieved. In the case of the goals of the Programme of Action, as indicated above, the set of actions which could contribute to achieving the goals and objectives are extremely diverse as they depend on the particular conditions of each country. Also, as many of the goals are expressed in terms of a state of well-being of the population, indicators have to be found which will be comparable in different contexts.

In addition to comparability, there is another series of characteristics that an indicator should have. These have been defined using different terms but can be summarized as follows (WHO, 1997; UNICEF Planning Office (1997); UNFPA, 1998a; United Nations, 1999a):

Pertinence or usefulness. This is the capacity of the indicator to measure impact in such a way that it responds to policy concerns.

Validity. The indicator measures what it is really intended to measure.

Reliability. The capacity of the indicator to express the same result if it is measured in repeated form or on the basis of different sources.

Comprehensibility or simplicity. It should be expressed in such a way that it is fully comprehensible.

Sensitivity. The capacity of the indicator to measure changes.

Specificity. The capacity of the indicator to measure exclusively those changes in the phenomenon or the result that are intended to be measured.

Accessibility. The information required can be obtained on more than one occasion and at low cost.

These three goals are closely related to another series of issues also dealt with at other world conferences such as those on the environment, social development and women. The three goals as a whole are also intended to contribute to the ultimate aim of poverty eradication and improvement of the quality of life for all.

Together with this definition of the three priority goals, the UNFPA has defined a set of indicators which make it possible to monitor progress in achieving those goals. One of the key requirements of this relationship between indicators and goals is that there exists a set of programmes and projects whose final results will contribute to achieving the goals. Fulfilling this requirement is necessary, but not sufficient, as the programmes and projects carried out in the different areas are not the only ones to contribute to achieving each of the goals. Just as there are other factors in a country which may contribute to achieving the goals, there may also be changes

in the requirements which prevent the projects and programmes contributing to the achievement of the goals.

The plan in box 7 shows the relationship between goals, products, results and indicators as defined by the UNFPA for the area of reproductive health. It shows that there are two different levels of indicators. A first level is for those which consider the achievement of the goal related to the area of reproductive health. These indicators are specific measures at the national level on the assumption that each of the phenomena measured reflects the existence of good reproductive and sexual health. The indicators may be changed as a result of the programmes and projects carried out in the area of reproductive health but may also be changed as a result of changes in other areas. These indicators are referred to as final, as, in general, they are not related to specific projects and/or programmes but which cover the expected changes as a whole.

The second level of indicators are defined as intermediate. They summarize the change expected if the projects and/or programmes designed to achieve the objective are successful. As shown in the example, there may be more than one indicator for each result. The indicators at this level may be different to the previous ones as they refer to the results of implementation but not necessarily the impact. In fact, in many cases, there is a time lag between implementation of the project and the impact achieved.

For the indicators to be of practical use, there has to be a hierarchical order for the national indicators which corresponds to the same hierarchical order of the objectives for the different projects and programmes. The ultimate utility of an indicator depends in particular on its capacity to define specific actions. For example, increasing coverage, extending opening hours, reducing the incidence of a certain event, etc.

Lastly, as the goals are not exclusive to one agency and they are often similar or complementary to those of other agencies, a change in the indicators may not always be attributed to the project or programme of a single agency. One important outcome of a system of indicators designed to monitor goal achievement is thus the ability to identify those aspects that require evaluation activities. For example, in the case of the maternal mortality rate, the combination of final and intermediate indicators makes it possible to ask why two countries have a similar maternal mortality rate (the final indicator) but such different levels of prenatal care and birth assistance (intermediate indicators).

A key aspect of this evaluation is the potential for obtaining baseline measurements which describe the conditions at the beginning of a project or programme. This obviously depends on the development of the country in terms of information systems, and the level of disaggregation required. When it is a matter of measuring the status of the population of a country, some of these baseline measurements may be very costly (for example, establishing the nutritional status of children or the precise measurement of maternal mortality in the country in the absence of hospital records), in other cases there are adequate records (for example measuring the height/age ratio of children starting school). Other times the collection of information needed to evaluate the results may be included in the activities of the project or programme itself.

Box 7

EXAMPLE OF THE RELATIONSHIP BETWEEN GOALS, PRODUCTS, RESULTS AND INDICATORS ACCORDING TO THE UNFPA

Strategic objective at the sectoral level	**Indicators and expected trend**
All couples enjoy good reproductive health, including family planning and sexual health, throughout life	Decrease in unmet need for family planning Reduction in maternal mortality rate Increase in the proportion of births assisted by skilled attendants Decrease in number of births among adolescents Decrease in HIV incidence in persons aged 15-24 Decrease in infant mortality rate National mechanisms in place to monitor and reduce sexual violence
Results expected from implementation of the projects and/or programmes	**Indicators and expected trend**
Increase in the availability of comprehensive reproductive health services	Increase in the percentage of service delivery points (SDPs) offering at least three of the following services: modern family-planning methods; maternal health care and assisted delivery; prevention and management of reproductive tract infections including STDs and prevention of HIV/AIDS; management of the consequences and complications of unsafe abortion; information, education and counselling on human sexuality and reproductive health, including family planning.
	Increase in the percentage of STDs which offer information, education, counselling and access to services to adolescents
Improvement in the quality of reproductive health services	Increase in the percentage of SDPs offering at least three modern methods of contraception
	Increase in the percentage of SDPs providing quality reproductive health services in accordance with established protocols
Improvement of the conditions for combating practices prejudicial to women	National policy in place to address practices harmful to women's health
Results of each component	**Indicators defined by quantity, quality and time**
This section refers to the specific components of projects and	Indicators relating to the project inputs and products

4. Comparability in a set of regional indicators

The proposal presented in chapter V is intended as a basis for developing national systems for monitoring the Programme of Action of the ICPD as well as the Regional Plan of Action. The system is thought out at the macro level, that is, at the national level.[5] At this level, it is possible to use the system to compare the indicators with goals in order to evaluate to what extent the desired progress is being made; inequalities between different population groups according to socioeconomic or sociodemographic characteristics as well as between geographical areas within a country can be identified; and reference information is also provided for specific programmes and evaluations in the area of social services.

[5] As mentioned by Vos (1995), the information needs vary according to the level of analysis, which may be at the national (macro) level, sectoral (meso) level or the level of individual programmes and projects (micro level). At the meso level the specific needs of a sector are considered, for example health or education. At this level measurements are made to evaluate the efficiency and effectiveness of the sector, in order to identify measures that will achieve the objectives pertaining to it. At the micro level there is emphasis on the follow-up to project implementation, to ensure that services are accessible to the beneficiary population and to analyse the impact of the project on the living conditions of that population.

In view of the relationship between goals and indicators the problem is how to get from one set of indicators that are of use for projects and programmes to another set which allows for monitoring at the regional level. For this purpose, the indicators should fulfil the following requirements:

1. They should be appropriate to the demographic, economic and epidemiological situation of the country;
2. They should use existing sources of information and particularly those with wide coverage and of reasonable quality;
3. They should be measured many times whether in one source or in different sources;
4. There should be a consensus on their interpretation and any differences should be clarified;
5. They should indicate progress and show up shortcomings so that lessons can be drawn from the experiences of the other countries.

As a result of the various conferences held during the 1990s, countries signed agreements relating to different areas of development and which are implemented by different United Nations agencies. Each agency uses a set of indicators in its programming in order to monitor whether the programmes and projects supported in each country contribute to attaining the goals established in the agreements. In view of this situation, to avoid overburdening the countries with producing information for each of the indicators, efforts have recently been made to unify these proposals. The annex contains a review of some of these proposals and the efforts made to unify them. There is also a comparison of the different sets of indicators.

As can be seen in the annex, there is one set of indicators that is included in almost all the lists. This set of indicators defines the basic conditions, meaning the universality of services, reduction in inequity in health, access to education and the provision of basic services. In general, the indicators included in the lists are those which can be used to sum up the living conditions of the population and the risks to which they are exposed. The indicators most frequently used refer to mortality rates, such as the infant mortality rate, the mortality rate of children aged under 5, life expectancy at birth and the maternal mortality rate. Another set of indicators that is frequently used concerns access of the population to services, for example the net school enrolment rate, literacy, access to potable water, the prevalence of contraceptives and malnutrition in children aged under 5. In general, all the proposals emphasize indicators for conditions at the beginning of life, in other words, the most commonly used indicators refer to the situation in childhood.

IV. Availability of the information

One of the key aspects of the various proposals is that the indicators are calculated on the basis of existing sources. This is a problem as far as comparability is concerned, as the existing sources vary from one country to another in terms of both availability and coverage, and quality. This chapter reviews the availability of existing data in Latin America.

In view of the diversity of the sources described below, it is important to take account of the fact that although certain measures may have the same name, such as in the case of infant mortality, they may be based on very different data. For example, if the infant mortality rate, is calculated from registry data, it is based on the register of deaths of children less than one year old and the register of births. If it is calculated using census information, it is based on mothers' statements concerning live births and deaths of children. If it is calculated directly with data from a survey, it comes from women's statements of dates of birth and death of their children. If there is no underreporting or bias in the sampling or in the collection of information, these measures should be similar in magnitude, as long as the time of reference is comparable (and also, in the case of indirect measurement, if an adequate model is used).

1. Vital statistics

In order to measure the changes that have taken place in countries subsequent to the holding of the International Conference on Population and Development in 1994, it is important that the indicators refer to two moments in time. Where the information is

from a continuous record, such as the register of deaths or births, it is in theory possible to obtain "year-to-year" measurements. The comparability in time of the measurements however is determined by the delay in the production of information and the changes in coverage and the form of recording the information. Not all the countries in Latin America have continuous records which can be used to obtain various measurements that are comparable over time.

The first significant difference between the countries is the delay between recording and the availability of the information. Even if the coverage was complete, in 2000, it would not be possible to measure changes subsequent to 1994 in all countries (see table 2). In most countries, the delay in the availability of the information is about 2 years. With regard to coverage, only five countries have adequate coverage of both births and deaths. In another six countries the record of births is adequate but not that of deaths (see table 2). In other countries, both births and deaths have a degree of under-reporting that is too high to have reliable measurements. In the case of deaths, the degree of under-reporting of deaths in infants less than one year old is higher than the under-reporting of total deaths. Also, it is known that there are significant differences in the coverage of vital statistics between the different geographical areas of a country, in countries where this has been evaluated.

2. Population censuses

Changes in mortality and fertility can be measured reliably and directly from continuous records in only five countries. In the other countries surveys or population censuses are used (see table 2). The questions used to measure childhood mortality or fertility have been included in almost all the population censuses held in Latin America in the 1980s and 1990s, and in those which have already taken place in the year 2000. As shown in table 3, many of them included questions on the birth and survival of children, which can be used to obtain estimates of fertility[6] and deaths in childhood. Some countries' censuses include questions which can be used to obtain estimates of adult mortality such as maternal orphanhood and deaths which occurred in the household in the past twelve months. These questions, however, have not led to the same results as the questions on childhood mortality. In some cases the information has not provided acceptable estimates for adult mortality levels.

The population census does not resolve the problem of timeliness of the information. On the one hand, owing to its complexity and cost, the population census is carried out approximately once in ten years. On the other hand, the measures calculated on the basis of retrospective information refer to a period approximately 2 to 5 years prior to the date of the census. This means that in 2000, the information received will correspond to the last five years of the 1990s for fertility and infant mortality and even earlier for adult mortality.

Despite these limitations, the population census is a very important information source. Firstly, the main advantage of covering these issues in the population censuses is the possibility of disaggregating the demographic estimates by geographical units or by social groups. For example, information on childhood mortality and the characteristics of mothers, fathers, households and housing units that is available in a single source has been used for detailed analyses of childhood mortality in Latin American countries.

In addition, the universal and simultaneous nature of the information collected in the population census means that disaggregated information can be obtained on the economic, social and educational characteristics of the population. Specific questions can be included to measure phenomena which are by their nature difficult to identify. One of these is internal and international

[6] To estimate fertility, there must also be a question on births in the past year.

migration. The population census can provide data on the location and characteristics of the migrants which makes it easier to establish policies to deal with them. The census can also be used to obtain information on other phenomena which are difficult to measure owing to their low frequency among the population such as maternal mortality or disability, although there are some doubts as to the advisability of doing so.

Lastly, the population census should not be seen as an alternative source to surveys but rather as complementary. The sample framework of the surveys generally derives from the population census. In recent years, a series of procedures has been developed to combine the data from the population census with the survey data in such a way as to obtain measures with a greater degree of disaggregation than was possible with the sample used in the survey.[7]

Table 2

AVAILABILITY OF DEMOGRAPHIC INFORMATION IN LATIN AMERICA AND THE CARIBBEAN

Country	Population censuses		Most recent fertility or demographic survey	Vital statistics			
	Year of most recent census	Percentage of omissions		Most recent year available	Percentage of under-reporting (1990-1995)		
					Births	Total deaths	Deaths at under one year
Argentina	1991	0.9		1998	3.4	5.4	6.6
Bolivia	1992	6.7	1998	1995	76.3	a/	b/
Brazil	1991*	2.5	1996	1997	28.1	20.7	47.1
Chile	1992	1.1		1998	1.6	-0.3	5.0
Colombia	1993	11.2	2000	1997	7.3 c/	29.7	65.4
Costa Rica	1984*	5.4	1993	1998	3.5	1.1	3.6
Cuba	1981	0.8	1987	1999	1.1	-2.7	0.7
Ecuador	1990	6.8	1999	1997	-6.1	22.9	54.5
El Salvador	1992	4.4	1998	1994	2.6 d/	30.4 d/	50.9 d/
Guatemala	1994	13.8	1999	1995	0.6 d/	23.1 d/	
Haiti	1982	12.0	1995		-	-	-
Honduras	1988	7.2	1996	1983	1.2 e/	49.2 e/	66.2 e/
Jamaica	1991*		1997				
Mexico	1990*	1.8	1997	1997	-19.1	7.7	33.7
Nicaragua	1995	1.0	1998	1996	28.0	51.3	61.8
Panama	1990*	2.6	1984	1998	4.4	21.9	31.4
Paraguay	1992	7.1	1998	1996	21.6	53.4	73.9
Peru	1993	3.0	1996	1998 f/	-10.7 d/	45.0 d/	57.5 d/
Dominican R.	1993	5.1	1996	1998	36.6	43.2	67.1
T. and Tobago	1990*		1987				
Uruguay	1996	2.3		1998	3.6	1.7	4.7
Venezuela	1990	7.8	1977	1998	1.7	6.7	7.5

* Countries which conducted a census in the year 2000; Jamaica and Ecuador conducted a census in 2001.
Note: Brazil conducted a population count in 1996 and Mexico in 1995.
a/ Last available year 1982.
b/ No information available.
c/ Last available year 1987, under-reporting for the period 1980-1985.
d/ Under-reporting for the period 1985-1990.
e/ Under-reporting for the period 1975-1980.
f/ Excludes the jungle indigenous population, and corrected dates of birth and deaths as of 1990.

[7] In connection with this topic, consult CELADE-ECLAC, 2001c.

Table 3

AVAILABILITY OF DATA IN THE POPULATION CENSUSES TO ESTIMATE ADULT MORTALITY, CHILD MORTALITY AND FERTILITY

(Updated in November 2000)

Country	Maternal orphanhood			eaths in the past twelve months			Children born alive			Surviving children			Date of birth of last child			Births in the year prior to the census			Survivors of those born in the past year or the last live birth		
	1980	1990	2000	1980	1990	2000	1980	1990	2000	1980	1990	2000	1980	1990	2000	1980	1990	2000	1980	1990	2000
Argentina**							1980	1991	2001	1980	1991	2001			2001	1980	1991				
Bolivia**					1992		1976	1992	2001	1976	1992	2001									
Brazil*	1980	1991		1980			1980	1991	2000	1980	1991	2000	1980	1991	2000						2000
Chile							1982	1992		1982	1992			1992		1982					
Colombia**	1985	1993					1985	1993	2000	1985	1993	2000	1985	1993	2000		1993		1985		
Costa Rica*							1984		2000	1984		2000	1981								
Cuba							1981			1981											
Ecuador**		1990	2001				1980	1990	2001	1980	1990	2001	1980	1990				2001	1980	1990	2001
El Salvador		1992			1992			1992			1992			1992						1992	
Guatemala	1981	1994			1994		1981	1994		1981	1994		1981	1994					1981	1994	
Haiti				1982			1982			1982			1982								
Honduras				1988			1988			1988			1988						1988		
Jamaica														1991							
Mexico*							1980	1990	2000	1980	1990	2000	1980	1990	2000						2000
Nicaragua					1995			1995			1995			1995						1995	
Panama*	1980	1990					1980	1990	2000	1980	1990	2000	1980				1990	2000	1980	1990	2000
Paraguay**	1982	1992					1982	1992	2002	1982	1992	2002	1982	1992	2002				1982		
Peru**	1981	1993	2001				1981	1993	2001	1981	1993	2001	1981	1993	2001				1981	1993	2001
Dominican R.	1981	1993			1993		1981	1993		1981	1993		1981	1993					1981	1993	
T. and Tobago								1990						1990							
Uruguay							1985	1996		1985	1996					1985	1996				
Venezuela**							1981	1990		1981	1990					1981	1990				

Source: CELADE, on the basis of official figures.

* Countries which conducted a census in the year 2000.

** For the 2000 round, refers to the questionnaire of the pilot test or experimental census.

3. Fertility and health surveys

Since the first programme of fertility surveys was conducted at the end of the 1970s, which demonstrated the potential for obtaining information on fertility, reproductive health and population dynamics on the basis of a sample of women of child-bearing age, in the majority of the Latin American countries surveys of this type have been carried out on a regular basis. Most of the countries that do not have adequate records have conducted at least three fertility surveys in the past two decades. The wealth of information available in the fertility surveys can be used to explore a great number of issues relating to the process of family planning, reproductive health, maternal health, and child morbidity and mortality. The inclusion of special sections has made it possible to analyse in depth some other issues such as immunization coverage, the use of oral rehydration therapy, knowledge of the transmission of HIV/AIDS, and nutrition in children and mothers. Despite the potential for detailed research on a wide range of issues, the surveys have little potential for disaggregating the information. It is a nationally representative sample of women of child-bearing age (15-49 years). Some of the most recent surveys have increased the scale of the sample to allow estimates for smaller geographical units.

In the majority of countries without adequate records, the fertility and health surveys are used to compare the changes over time of measures relating to population dynamics, and women's and children's health. Most countries have held such surveys at dates both prior and subsequent to the holding of the International Conference on Population and Development. It is not always possible, however, to establish a causal relationship between the change in the indicators obtained from the survey data and the policies and programmes deriving from the ICPD agreements.

4. Household surveys

The majority of countries have a household survey programme. Although the periodicity of the surveys varies from one country to another, they do take place systematically and there constitute a source of information which provides repeated measures. In view of the more limited sample size, the household surveys have less potential for disaggregation. Also, in some countries the household surveys cover only the urban area or the main cities of the country.

The household surveys have thus far been used in the majority of countries to measure the characteristics and level of economic participation of the population. The household surveys, however, have a number of advantages that have not yet been exploited very much. The first advantage is their institutional aspect. Unlike the population census or the fertility and health surveys, the household surveys in many countries are part of the regular activities of an institution, usually the statistical office, and therefore have a permanent staff and budget. Another advantage of the household surveys is that they offer repeated measures of the structure and many times also of the characteristics of the members of the household. This can be used to monitor changes in the structure of households which are significant for planning social programmes and projects. Another advantage of the household surveys is the information on household income which can be used to identify the population according to poverty levels using the poverty line method or the income method.

Some countries have taken advantage of the potential of the household surveys by including sections to collect information on a specific topic. For example, the inclusion of a set of questions on the situation of older adults, covering aspects such as daily activities and their perception of their own health, would provide information on this group. Processing this data together with the rest of the data from the household surveys would make it possible to characterize more accurately the living conditions and needs of this segment of the population. In view of the costs, an attempt is

made to limit the sections to one or two questions that are not very complex so that they do not require too much interviewing or processing time.

5. Living standards survey

These surveys are part of a programme initiated by the World Bank in the 1980s in order to collect information at the level of households to be used to monitor changes in the living standards of the population and the consequences for households of certain public policies. In Latin America these surveys have been conducted in Nicaragua, Panama, Ecuador, Peru, Jamaica, Guyana, Bolivia and Venezuela.

The survey gathers detailed information on the living conditions of households by means of questions on health care, nutrition, education, consumption and other issues of interest to the countries. In some countries the survey has more specific aims. In Bolivia, for example, the first survey took place in the departmental capitals with the aim of evaluating social investment fund projects. Subsequently the survey was expanded to include populated areas with more than 2,000 inhabitants.

The main use of the survey in many countries has been to measure poverty levels. The detailed information collected in the survey, however, provides some empirical indications of how households respond to economic conditions and what role the government plays in modifying these economic conditions. For this, the standard instrument includes a household questionnaire with questions on health, economic activity, education, economic and other activities, a questionnaire on prices and another which collects information on the service infrastructure available in the community.

6. Continuous or administrative records

In addition to vital statistics, there are other continuous records of a political or administrative nature which can be used to obtain specific indicators. In the area of health, for example, hospital records can be used to establish the prevalence of certain disorders and health service visits. In the case of education, the records in this sector contain, *inter alia*, the numbers attending school at each level, an input needed to calculate school enrolment rates.

The earlier comments on limitations as to the timeliness and quality of vital records also apply, in general, to this information. Thus, countries should make efforts to improve those records which are the traditionally used as a source for particular statistics. There is also a significant potential in administrative records which were not intended for statistical purposes, but with adequate processing could be used for that purpose.

7. Access to aggregated and microdata results[8]

The availability of information sources has implications beyond their use for the calculating indicators. In fact one of the goals of the Programme of Action is to integrate demographic factors into development policies and programmes. For this purpose, the countries' capacity to collect information and research issues related to population and development needs to be strengthened.

An important element for increasing knowledge on population and development issues is timely access to the results of continuous statistics, surveys and censuses. In this regard a

[8] A preliminary version of this section was drafted by Dirk Jaspers, Head of Population Information and Training Area of the CELADE - Population Division of ECLAC.

distinction should be made between aggregate results and the data itself (referred to as microdata, or information at the level of the individual, the household and/or the housing unit).

Although there are countries where the statistical and research results are not disseminated in a very timely manner (in the form of publications), thee has been a substantial improvement in the time of presenting the results. The dissemination of results via the web pages of the national statistical offices has contributed to this.

Despite this progress, there is still only limited access to microdata from the data sources in most countries. This has resulted in the under-use of these sources, although substantial resources have been invested in them. More extensive use would make it possible to research specific issues or to gain information on the situation of specific social groups or of different geographical areas of a country. A better use of these information sources would facilitate a more detail review and evaluation of the quality of the source. Enhanced use would thus generate as a by-product the opportunity to clearly identify the improvements needed in the quality of the data.

Moreover, easier access to the original data and more extensive use would lead to a greater demand for data. Lastly, it would make it possible to create awareness in different sectors of the importance of investing resources in the generation and dissemination of timely and quality information.

Resistance to providing microdata or limited access probably have different causes such as information confidentiality, fear of inappropriate use of the data, databases where the internal consistency has not been verified, lack of sufficient documentation to allow third parties to process the microdata, and also commercial reasons when the investment costs of collecting and processing the information need to be recovered.

Nevertheless, there are situations where despite the fact that the information is widely available, as in the case of the DHS survey programme or in some countries the living standards surveys of the World Bank, their use is still limited. This may be partly due to the complexity of these surveys and the lack of researchers with the appropriate training to use the microdata. It is also likely that easier access to the microdata from different sources (for example, improving their availability in universities or in NGOs) would enhance the national capacity to use these sources for studies which would provide information for decision-making.

In view of the current high demand for the results of population and housing censuses that have taken place or will take place in the current decade, access to the data is of fundamental importance. This demand for information from the population and housing censuses is mostly due to the need for smaller administrative units (municipalities, provincial governments, and others) to have information for planning and prioritizing local development activities. In order to take advantage of the potential for local data use, action must be taken to resolve the problems referred to above.

A significant effort to promote access to and the use of microdata is the development by CELADE of the REDATAM programme. This programme can be used to create census databases, vital statistics, surveys and other sources. The result is a database that is relatively easy to use, that does not need programming to obtain information combining different hierarchical levels of data such as, for example, the housing unit, the household and the individual. As there is a series of database issues, such as survey weightings, or the correlation between segments and housing units, that should be resolved at the time of setting up the database, it does not require a very detailed review of the documentation to be able to obtain information. Also, this system can protect microdata confidentiality through its own format for recording data as well as by restricting access to certain variables or to smaller geographical levels.

V. Preliminary proposal for a set of indicators

The indicators proposed here were grouped in terms of the different priority areas summarized in box 2 and also taking into account the objectives and goals agreed in the regional Plan of Action and at the ICPD. It is a preliminary list and in no way covers all of the issues dealt with at the Conference, but rather some selected aspects which seem important in the country agreements. No doubt each country could enrich the system in accordance with its own needs and characteristics. In view of the above, it seems appropriate to review briefly the aims of each of the priority areas and the objectives and criteria that have been taken into account for this proposal. Generally speaking, the system contains indicators which can be used to assess directly the degree of progress towards some goal defined in the international Programme of Action, or the Regional Plan of Action, and others intended to provide contextual information on the main areas of interest.

1. Priority areas

A. Population and public policies

The general objective in this field is to achieve integration of the demographic components in the design and implementation of development policies and programmes. Strictly speaking, a system of indicators to monitor this objective should include measurements, perhaps of a qualitative nature, which can be used to evaluate to what

extent the information and the sociodemographic analysis are integrated into development strategies. Quite apart from the methodological difficulties and the actual meaning of such measurements, it was considered important at this stage to have a set of indicators which could be described as "contextual", to serve as a basis for describing basic aspects of population issues.

The Regional Plan provides for, *inter alia*, the consideration of "mid- and long-term changes in population age structures in the formulation of social policies...in order to guarantee attention for faster growing and more vulnerable age groups" (ECLAC, 1996). Some indicators are therefore listed in the section on **population growth and structure** which take into account population numbers, growth and structure.

In the context of streamlining and decentralizing the State, there is emphasis on the improvement of data collection, processing and dissemination systems, as well as research on very important aspects for development policies. Importance is attached to the ageing process, the groups of young adults and adolescents, international and intraregional migration, and the family.

Territorial location emerges as a key factor in the search for harmony between the issues of population and sustainable development. For this, the system offers a second group of indicators in the section on **territorial location** which, in addition to providing a basis for establishing the context of the situation in each country, are indicative of the degree of progress towards one of the recommendations of the Regional Plan: "to encourage the diversification of migratory destinations, avoiding population concentrations in large urban nuclei, by developing intermediate cities, on the basis of the examination of their potential". Another group of indicators on **demographic ageing** would offer a general view of that process, which has begun to a greater or lesser degree in all countries of the region. In this section it was considered appropriate to have measurements which indicate the effects of population ageing on family and residential arrangements. Lastly, and as poverty eradication is a central issue in social policies, the system should show the progress made towards eliminating this scourge with the indicators proposed under the heading **Poverty**.

B. Gender equity, full equality of opportunities and empowerment of women

The general objective is to contribute to improving the condition and position of women in society, achieving genuine participation in decision-making, in all spheres of life and on conditions of equality with men. The specific objectives emphasize actions tending to achieve equality of opportunities with regard to employment, with equitable remuneration and combating any form of discrimination against women in the legal, work, social and political areas. For this reason, the majority of the indicators proposed in the section on **equality of employment opportunities** can be used to make a general diagnosis of the situation and the development of the existing inequities in this sector. Some contextual indicators are also included.

Another of the specific objectives is to promote gender equity with regard to education, especially with regard to the presence of women in the medium and higher level of formal education. Most of the indicators included in the section on gender equity in education can be used to monitor the degree of fulfilment of the goals included in the Programme of Action of the ICPD.

With regard to the objectives and recommendations relating to women's health, especially reproductive health, the indicators proposed for the follow-up in this area are included in the following section.

C. Health and reproductive rights, family planning and family well-being

The general objective agreed in the Regional Plan is "to promote and protect the reproductive health and rights of individuals and couples. To protect and support the family in its various forms. To improve the health of the population, particularly reproductive health, and guarantee the right of all couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so".

It is recommended that priority be given to the child population, by strengthening prevention and primary health care services. The indicators in the **health and mortality** group therefore reflect this priority, and some of them can also be used to follow up on the goals.

As for reproductive and sexual health, indicators are included to serve as a basis to evaluate access to risk-free maternity services; family planning, with regard to both supply and demand; sexually transmitted diseases, especially HIV/AIDS. Some of them also constitute the tool for the follow-up of goals. Part of this group, in the area of **sexual and reproductive health**, is a series of indicators to evaluate the legislative framework for the implementation of programmes and policies as well as the existence of the latter. For this set of indicators, it is important that the implementation mode is appropriate to the specific features of each country. All of these indicators will be of use in assessing the degree of progress made towards the goal of making reproductive health accessible "to all individuals of appropriate ages as soon as possible and no later than the year 2015", according to the ICPD Programme of Action.

Adolescents are a group that is particularly affected in this area. The educational component is important as part of a model of integrated reproductive and sexual health services for this age group. Although some of the indicators related to this issue are obtained from disaggregations proposed in the above grouping, the list is expanded with specific indicators for the **sexual health of adolescents**.

2. Contents of the proposal for indicators

The list of indicators included in this chapter contains a series of items for each indicator which are described below:

Definition: Provides the conceptual definition of the indicator, namely the social phenomenon or action that it measures. In some cases, the operational definition or form of calculation is also added, and the form in which it is expressed (in absolute or relative terms, per thousand or as a percentage, etc.);

Goal: This item will appear each time the indicator relates to a goal in the ICPD Programme of Action or the Regional Plan of Action that has been expressed in specific terms, that is, with a quantified objective and a time frame for achieving it. The goal to be measured by the proposed indicator is stated here in order to enhance understanding of the indicator's relevance. In turn, the indicator measurements will facilitate the evaluation by each country of the degree of progress achieved towards this goal.

Source: Refers to the primary sources for obtaining the data to calculate the indicator. If there is more than one, there may be alternative sources (for example in the case of infant mortality) or sources may need to be combined in order to calculate the indicator (for example, the school enrolment rates in the intercensal period).

Disaggregation: Part of the recommendations and objectives of the Regional Plan of Action and the international Programme of Action aim at reducing the existing inequalities between socio-economic or sociodemographic groups (for example, age, sex, ethnicity) as well as disparities within the countries. The variables are therefore specified in such a way as to define the groups or subpopulations for which the indicator will be calculated. It is recommended that each indicator is disaggregated for **urban and rural areas** and for **geographical areas** of interest. It was decided not to refer to this recommendation in relation to individual indicators, as it in fact applies to the entire list. If this item does not appear, the proposed disaggregation unit, where appropriate, is territorial. Also, for countries with an **indigenous population** it is suggested that indicators are included for that population group, especially with regard to health and gender equity. This suggestion applies to other ethnicities as well as other minority groups of interest, such as migrants of a particular origin.

Relevance: although the list includes indicators of interest for all countries of the region, this item refers to the stage of demographic transition reached by each country. When this item does not appear it is understood that the indicator is relevant for all countries. On the other hand, the exclusion of certain groups of countries is based on the national totals, and so for some geographical areas the measurement may be very relevant.

Comments: In some cases there are clarifications as to the usefulness of the indicator in relation to the ICPD objectives; in others, reference is made to aspects of the implementation system for the indicator and to data sources.

A. Population and public policies

A.1. Population growth and structure

Indicator:	**Number of inhabitants**
Definition:	Total number of inhabitants
Source:	Current population estimates and projections; censuses
Disaggregation:	Total and by sex
Comments:	It is important to provide this information with the greatest possible detail, as this indicator provides the denominator for other indicators. It is also recommended that all institutions of the country use the same population projections and estimates.
Indicator:	**Growth rate**
Definition:	This is the growth rate of the population (increase/decrease) as an annual average, over a specific period; it is expressed in terms of every 100 inhabitants.
Source:	Current population estimates and projections; censuses.
Disaggregation:	Total and main age groups (0-14; 15-64; 65 and above).
Comments:	This rate should be obtained from the population projections or estimates.
Indicator:	**Age structure**
Definition:	Relative distribution of the population according to main age groups (0-14; 15-64; 65 and above). Expressed in percentages.
Source:	Current population estimates and projections; censuses.
Disaggregation:	Total and by sex.
Comments:	The information should come from the population projections or population estimates made in the country. It is important that all institutions in the country use the same population projections and

estimates. As noted in the Regional Plan, the inclusion of medium- and long-term changes in the age structures in the design of social policies will improve services for the fastest growing and most vulnerable age groups.

Indicator: **Dependency ratio**
Definition: Expresses the number of economically inactive persons who would have to be supported by active persons. The total level of dependency is calculated from the ratio between the population aged 0-14 plus the population aged 65 and over in relation to the population aged 15-64; a percentage.
Source: Current population estimates and projections. Censuses.
Disaggregation: Total and by age (dependency of young people —the numerator includes only the population aged under 15— and dependency of older adults — the numerator only includes the population aged 65 and above).
Comments: This is a potential ratio as not all the persons aged 15 and under or persons aged 65 and over are out of the labour market, nor are all of those aged 15-59 employed (in fact, the actual rate of dependence is usually higher). Nevertheless, it gives an approximate relationship between the numbers of the work force and the non-working population, an element to take into account in the formulation of employment and social services policies.

Indicator: **Crude birth rate**
Definition: Expresses the frequency at which births occur in a specific population. It is calculated from the ratio of the number of births over a given period to the average population over that period.
Source: Vital statistics and censuses.
Comments: The balance of births and deaths determines the natural growth of the population. The difference between this indicator and the crude mortality rate shows the natural (or vegetative) growth rate of the population. The sources referred to are primary, but it is suggested that the results of national estimates and projections be used, assuming that the basic data has been evaluated.

Indicator: **Crude mortality rate**
Definition: Expresses the frequency at which deaths occur in a given population. It is calculated from the ratio of the number of deaths occurring over a given period to the average population over that period.
Source: Vital statistics and censuses.
Comments: The sources referred to are primary, but it is suggested that the results of national estimates and projections be used, assuming that the basic data has been evaluated.

A.2. Territorial location

Indicator: **Degree of urbanization**
Definition: This is the percentage of the population residing in urban areas in relation to the total population. The definition of urban area differs between countries and in some cases also changes from one census to another.
Source: Population estimates and projections; censuses.
Comments: Changes in the population distribution are an indicator of the effects of migration flows. Changes in the location of the population also provide

information on the basic services that the population needs. The ICPD report refers to the need to "adopt strategies for the encouragement of urban consolidation".

Indicator: **Urban population distribution**
Definition: This is a measure of the degree of concentration of the urban population and is calculated from the relative distribution of the urban population according to the size of the localities considered to be urban.
Source: Censuses.
Comments: Each country should define the appropriate classification for small, intermediate and large towns. The following categories have been used in CELADE: 2,000-19,999 inhabitants; 20,000-49,000; 50,000-499,999; 500,000-999,999; and at least 1,000,000 inhabitants.

Indicator: **Primacy of the capital**
Definition: As in the case of the previous indicator, this is also a measure of concentration, complementary and more specific as it expresses the proportion of the urban population concentrated in the capital city.
Source: Censuses.
Comments: In this case it is calculated as the ratio of the population of the capital city (or the city with the greatest population) to the total urban population. An alternative which is sometimes used is to calculate the ratio of the capital city's population to that of the three next largest cities.

Indicator: **Population density in the main urban areas**
Definition: The number of inhabitants per square kilometre in the largest urban areas.
Source: Censuses and administrative records.
Comments: Although it does not have a direct causal link, this indicator is related to some social problems, such as the increase in the marginal sector, the frequency of social disorders, problems of violence and others. If it is calculated in a disaggregated manner for each administrative unit, it provides an indication of the needs of the population in areas such as housing and sanitation.

A.3. Demographic ageing

Indicator: **Percentage of older adults**
Definition: The relative numbers of older adults in the total population. It is calculated from the ratio between persons aged 65 and above and the total population; percentage.
Source: Population estimates and projections. Censuses.
Relevance: Countries at the full and advanced transition stages.
Comments: The ageing threshold, using chronological age as a definition, is generally set at 60 or 65 years, which usually coincides with the legal retirement age.

Indicator: **Ageing index**
Definition: Measures the number of older adults for every 100 children and young persons. It is calculated as the ratio of persons aged 65 and over to persons aged under 15, as a percentage.
Source: Population estimates and projections; censuses.
Relevance: Countries at the full and advanced transition stages.

Comments: This can be used to estimate intergenerational changes resulting from the ageing process. They show the changes in social needs, particularly with regard to health, and in intergenerational transfers.

Indicator: **Percentage of households with older adults**
Definition: Measures the number of households with resident older adults (persons aged 65 and over) in relation to the total of households.
Source: Household surveys and censuses.
Relevance: Countries at the full and advanced transition stages.
Comments: One of the visible expressions of the ageing process is the growing existence of households with an older person resident. This affects the structure of the households and the family arrangements in a more complex way than in the past.

Indicator: **Structure of households with older adults**
Definition: This is the relative distribution of households with older adults according to the type of household. The typology adopted distinguishes between one-person households (only 1 person aged 65 or over); single-generation multi-person households (2 or more older persons); and multi-generation households (at least 1 older person and at least 1 person aged less than 65).
Source: Household surveys and censuses.
Relevance: Countries at the full and advanced transition stages.
Comments: The aim is to provide certain information on the family or residential arrangements of older persons and thus to differentiate, *inter alia*, the service needs of the older adult. To the extent that this information can be obtained from permanent household surveys, the needs of the population aged over 65 can be monitored with greater frequency.

A.4. Poverty

Indicator: **Percentage of population that is poor**
Definition: Measures the incidence of poverty, in this case defined by the income method. It is calculated as the percentage of persons resident in households that are below the poverty line established as a standard for the country.
Source: Household surveys.
Disaggregation: Total; by sex; main age groups (0-14; 15-24; 25-64; and 65 and above); and the sex of the head of the household.
Comments: The issue of poverty eradication is very much linked to the different areas dealt with in both the ICPD and in the Regional Plan. The disaggregation by sex can be used to identify gender inequities.

Indicator: **Percentage of population that is indigent**
Definition: Measures the incidence of indigence, on the basis of the income method. It is calculated as the percentage of persons resident in households whose incomes are insufficient to cover the basic basket of foodstuffs.
Source: Household surveys.
Disaggregation: Total and by sex.
Comments: When it is related to the percentage of the poor population it shows an approximate measure of the degree of poverty.

B. Gender equity, full equality of opportunity and women's empowerment

B.1. Gender equity in education

Indicator:	**Illiteracy rate**
Definition:	Percentage of the population aged over 15 that cannot read a simple text.
Goal:	Reduce the rate of illiteracy for women and men, at least halving it for women and girls by 2005, compared with the rate for 1990.
Source:	Censuses; household surveys.
Disaggregation:	Total, by sex and by main age groups (15-29; 30-49; 50 and above).
Comments:	The level of illiteracy, in addition to providing information on the existence of an effective education system over the long term, or the existence of adult education programmes, is also associated with the degree of access to other services. The disaggregation by age shows the effect of changes in the age structure and changes in the educational system.

Indicator:	**Net primary school enrolment ratio**
Definition:	The number of children enrolled in primary school and of age that officially correspond to this level, as well as the percentage of children of that age in the total population, calculated independently for each sex.
Goal:	By 2010 the net primary school enrolment ratio for children of both sexes should be 90%. Before 2015, there should be universal access to primary education for boys and girls.
Source:	Administrative records and censuses.
Disaggregation:	By sex.
Comments:	For the intercensal period the denominator is obtained from the population estimates and projections. As well as the problems inherent in school enrolment records, the combination of different sources for calculating the ratio sometimes results in inconsistencies (for example ratios above 100%).

Indicator:	**Gap in education**
Definition:	Ratio between the female and male school enrolment rates for the different levels.
Goal:	Eliminate the gender gap in primary and secondary education by 2005.
Source:	Administrative records and censuses. The Regional Plan recommends taking action to encourage women to enter and remain in higher education.
Disaggregation:	Primary, secondary and higher levels.
Comments:	For primary and secondary education the net rates are proposed. The net enrolment ratio for secondary education is calculated as the net enrolment ratio for primary education (previously definied), but taking the population of the age group which offically correspond to the secondary level. For higher education, the gross rates are taken and calculated as total enrolement in the tertiary education regardless of age, expressed as a percentage of the population in the five year age group following on from the secondary school leaving age.

Indicator: **Level of schooling of the population aged 15 to 24**
Definition: The relative distribution of the population aged 15 to 24 according to the level of schooling (the average in completed years of study), calculated independently for each sex.
Source: Household surveys; censuses.
Disaggregation: By sex.
Comments: The ECLAC system of gender indicators uses the following classification for the level of schooling: 0-5 years of study; 6-9; 10-12; 13 or more years of study.

B.2. Equality of employment opportunities

Indicator: **Percentage of households with women heads of household**
Definition: Percentage of households headed by women
Source: Household surveys; censuses.
Disaggregation: Total and by marital status.
Comments: It has been found that households headed by a single woman are more likely to be in conditions of poverty. This identifies a group of women who need better conditions to ease their situation and keep them out of poverty.

Indicator: **Rate of economic participation**
Definition: Measures the degree of participation in the labour market, calculated independently for each sex. It is calculated by establishing the ratio among women (men) who are economically active (defined as those who are working or looking for work) and the total female (male) population, as a percentage. It is measured for the population aged 15 and over.
Source: Household surveys; censuses.
Disaggregation: Main age groups.
Comments: The disaggregation by age used in ECLAC is: 15-24; 25-34; 35-44; 45-59; 60 and above.

Indicator: **Unemployment rate**
Definition: Expresses the level of unemployment in the economically active population, for each sex. It is calculated as a percentage of the total female (male) population that is not working and is actively looking for work in relation to the economically active female (male) population (employed plus unemployed).
Source: Household surveys; censuses.
Disaggregation: Main age groups (15-24; 25-34; 35-44; 45-59; 60 and above).
Comments: The calculation for different age groups can be used to identify the groups of women most affected by unemployment as well as the age groups where there is the greatest inequity.

Indicator: **Percentage of women employed according to qualification**
Definition: Measures the extent of female participation in each occupational category, in accordance with the complexity of the work to be carried out. For each level of occupation the total number of women employed in relation to the total number of people employed is calculated.
Source: Household surveys.
Disaggregation: Total and by occupational levels (manual workers; administrative staff; professional and technical posts; management posts).

Comments: This indicator provides information on the access of women to employment and also on possible discriminatory practices. It is used by the ECLAC system of gender indicators.

Indicator: **Gap by occupational groups**
Definition: Expresses the differential incidence of women employed in a certain occupational group compared to that of men. It is calculated from the ratio of the percentage of women employed in an occupational group to the percentage of men employed in that group. These percentages are obtained by dividing the number of men or women employed in a particular category by the total number of men or women employed.
Source: Household surveys.
Disaggregation: Occupational groups: manual workers; administrative staff; professional and technical staff; management posts.
Comments: The relative distribution by occupational groups - and by sex - is used in the ECLAC gender indicators system.

Indicator: **Gap in the level of income**
Definition: Measures gender differences in relation to the income received for wage labour or independent work. It is calculated from the ratio of average female income to average male income. The average income are obtained, for each sex, by dividing the total of remuneration received for wage labour or independent work by the total number of workers.
Source: Household surveys.
Disaggregation: Level of schooling: 0-3; 4-6; 7-9; 10-12; 13 years and above.
Comments: The indicator contains a certain bias as it needs to be adjusted in relation to the number of hours worked. It is used in the ECLAC system of gender indicators.

Indicator: **Percentage of women in parliament**
Definition: Percentage of women among the members of the legislative authority
Source: Legislative authority.
Comments: This indicator measures the level of opportunity for women's political participation. As an alternative, the existence or otherwise of laws that guarantee a minimum level of representation for women may be considered.

C. Health and reproductive rights, family planning and family well-being

C.1. Fertility and family planning

Indicator: **Number of births**
Definition: Total number of births in a given period.
Source: Population estimates and projections.
Disaggregation: Total; and by five-year age groups of the mothers.
Comments: The percentage of births to adolescent mothers can be obtained from the disaggregation by age groups.

Indicator: **Total fertility rate**
Definition: Average number of children that women will have had by the end of their reproductive life if the current fertility rates by age are applied to them throughout their life.

Source: Vital statistics; censuses; demographic and health surveys.
Disaggregation: Total; by level of schooling; marital status of women of reproductive age; and by specific fertility rates by age.
Comments: It is complementary to the prevalence rate of contraceptives and the maternal mortality rate. It also provides information on possible reproductive health problems (high order birth, births to very young women). When surveys or a complete register of births are available it can be calculated for specific groups of women.

Indicator: **Total desired fertility**
Definition: Expresses the level of fertility that would theoretically be obtained if all unwanted births could be avoided. It is calculated in a similar way to the total fertility rate except that only the wanted births are included. A birth is considered wanted if the number of surviving children at the time of pregnancy is less than the ideal number of children for the woman interviewed.
Source: Demographic and health surveys.
Disaggregation Level of schooling of the mother.
Comments: The contrast of this measure with the observed fertility rate (total fertility rate) indicates the impact of unplanned births on the level of fertility.

Indicator: **Rate of contraceptive use**
Definition: Percentage of women aged 15-49 years who say that they or their partner are using contraceptive methods.
Source: Demographic and health surveys.
Disaggregation: Type of method; level of schooling, marital status and age groups of women of reproductive age.
Relevance: Countries at the incipient, moderate and full transition stages.
Comments: This measure is complementary to the total fertility rate. For greater accuracy, a distinction should be made at least between modern and traditional methods.

Indicator: **Unmet need for family planning**
Definition: Expresses the number of sexually-active women who wish to limit or space the number of children and are not using any contraceptive methods, in relation to the total number of women who are married or have a partner.
Goal: Where there is a gap between contraceptive use and the proportion of individuals expressing a desire to space or limit their families, countries should attempt to close this gap by at least 50% by 2005, without establishing targets or quotas. By the year 2000, they should reduce, by at least 50%, the differences in the unmet need for family-planning services observed between different residential areas, geographical areas and social groups.
Source: Demographic and health surveys.
Disaggregation: Total; by age groups; level of schooling.
Relevance: Countries at the incipient, moderate and full stages of transition.
Comments: In some cases the unmet need may be measured for the total of women of reproductive age (with or without a partner) whereas in others the group of sexually active women is restricted to married women or women with partners. Some countries also distinguish between the need to space births and the need to limit them.

Indicator:	**Availability of contraceptive methods**
Definition:	Percentage of health centres which offer the full range of contraceptive methods officially approved by the programme.
Goal:	Free choice of methods for fertility regulation (provision of quality services).
Source:	Special surveys.
Relevance:	Countries at the incipient, moderate and full transition stages.
Comments:	This indicator should be complemented by the number of contraceptive methods available at the lowest possible levels of service, specifying the different types of methods, so that there is not a false impression of availability.

Indicator:	**Availability of health centres with reproductive health services**
Definition:	Percentage of primary health care establishments where at least three of the following services can be obtained, either directly or by referral: guidance, education and consultation on family-planning; prenatal care, birth care, postnatal care; health services for the newly-born infant and the mother; fertility treatment, treatment for abortion and its consequences; treatment for sexually-transmitted diseases; information, education and communication on sexuality and reproductive health.
Source:	By 2015, all primary health care and family-planning services should be able to offer directly or through referral systems the widest possible range of contraceptive and family-planning methods, essential obstetric services, prevention and treatment of reproductive tract infections, including sexually-transmitted diseases, and barrier methods. By 2005, 60% of establishments should be able to offer these services, and 80% of establishments by 2010.
Source:	Administrative records; special surveys.
Relevance:	Countries at the incipient, moderate and full transition stages.
Comments:	The service components are likely to vary according to the prevailing norms in each country. It is important, however, to assess the availability of family planning and reproductive health within a single centre.

Indicator:	**Quality standards in reproductive health**
Definition:	Measures the existence of quality standards and the extent to which they are applied to reproductive health services. Such standards should cover family-planning information and services, maternal care, prevention and treatment of reproductive tract infections and sexually-transmitted diseases; treatment for abortion complications.
Source:	Special surveys (direct contacts).
Comments:	The existence of national standards which guarantee the quality of services, thus encouraging an increase in their use. In fact, two indicators are suggested, one referring to the existence of standards and another measuring the extent of application of such standards.

C.2. Mother and child care

Indicator:	**Pregnancy services provided by qualified personnel**
Definition:	Percentage of women who were assisted on at least one occasion during pregnancy by trained personnel for reasons relating to pregnancy (with the exclusion of traditional birth attendants).
Source:	Demographic and health surveys.

Disaggregation: Total; age groups at the time of delivery (under 20; 20-34; 35 and above); level of schooling.
Relevance: Countries at the incipient, moderate and full stages of transition.
Comments: In order to make the indicator more specific, traditional birth attendants are excluded and only consultations relating to pregnancy are taken into account. The measurement is made with regard to the woman's last delivery, during a fixed period prior to the survey (3 or 5 years). This measure is related to the prevention of maternal mortality, as this is one of the specific objectives agreed at the ICPD. The indicator can be defined by establishing a greater number of check-ups considered as the minimum necessary to reduce risk.

Indicator: **Births assisted by skilled attendants**
Definition: Births at which the delivery was assisted by health personnel with obstetric training (excluding trained or untrained traditional birth attendants) in relation to the total number of births in a particular period.
Goal: By 2005, in countries where the maternal mortality rate is very high, at least 40% of all births should be assisted by skilled attendants, 50% by 2010 and 60% by 2015.
Source: Demographic and health surveys.
Disaggregation: Total; age groups at the time of delivery (under 20; 20-34; 35 and over); level of schooling.
Relevance: Countries at the incipient, moderate and full transition stages.
Comments: Traditional birth attendants are excluded from this indicator as their level of training is not precisely known and the indicator would be less specific if they were included. The surveys ask about births in the past 5 years. PAHO uses this indicator as a measure of the percentage of the population with access to health services.

Indicator: **Availability of centres with obstetric services**
Definition: The number of centres that provide essential obstetric services per 500,000 inhabitants. Essential services imply the availability of skilled personnel and the equipment needed for emergency obstetric services.
Source: Administrative records.
Relevance: Countries at the incipient, moderate and full transition stages.
Comments: The definition of essential obstetric services may vary and include different elements, according to the standards of each country.

Indicator: **Malnutrition in children aged under 5**
Definition: Measures the level of chronic malnutrition in childhood. It is calculated from the percentage of children aged under five with a height/age ratio of less than minus two standard deviations from the reference median.
Goal: By the year 2000, reduce moderate and severe levels of malnutrition to half of the value for 1990.
Source: Demographic and health surveys; special surveys.
Disaggregation: Total and by sex.
Relevance: Countries at the incipient, moderate and full transition stages.
Comments: This is associated with poor food, poor economic conditions and a high prevalence of chronic infections. Unlike emaciation, chronic malnutrition cannot be remedied in the short term, and thus has long-term consequences for individuals and the population. A high prevalence indicates structural problems with regard to access to adequate food.

Indicator:	**Measles vaccination coverage**
Definition:	Percentage of children aged one year (12-23 months) vaccinated against measles.
Source:	Demographic and health surveys; continuous records.
Comments:	This is a measure of immunization coverage. It is important to evaluate the source from which the measure is taken and the form of calculation. For example, this percentage is often affected by errors in the stated age of the children vaccinated. Significant differences in coverage have been observed for the same period of time when different sources are used. Registers usually have offer better coverage than do demographic and health surveys.
Indicator:	**Complete vaccination coverage**
Definition:	Percentage of children to receive all the recommended vaccinations during the first year of life. It is calculated from the ratio of children aged one year (12-23 months) who have been vaccinated against tuberculosis (BSG), diphtheria, pertussis and tetanus (DPT), polio and measles, with regard to the total of children of the same age.
Source:	Demographic and health surveys; continuous records.
Comments:	In recent years the measles vaccination has been substituted by the triple viral vaccination, which is given at 12 months. Some countries have thus begun to exclude it from the calculation for this indicator. Vaccinations for DPT and polio are considered complete if the three respective doses have been received.
Indicator:	**Health coverage**
Definition:	Expresses the number of people who are affiliated to a social security system (public or private), with regard to the total number of persons in a given period.
Source:	Household surveys, demographic and health surveys; living-standards surveys.
Disaggregation:	Total, by sex and by age groups (0-14; 15-49; and 50 and above).
Comments:	This indicator is a measure of access to health, including reproductive health.

C.3. Mortality

Indicator:	**Life expectancy at birth**
Definition:	Average number of years that a person would be expected to live if subject throughout their life to the mortality conditions by age observed over the period studied.
Source:	Population estimates and projections.
Goal:	For the year 2000, to attain a life expectancy of 70 years or, at least, to gain eight years with respect to the 1990 value. Countries with low death rates should continue efforts to improve health services to reduce mortality rates even more.
Disaggregation:	Total and by sex.
Comments:	Although the changes in life expectancy are very sensitive to changes in the infant mortality rate, where the latter is low, the direct calculation of life expectancy can indicate changes in adult mortality. Although it can be approximated indirectly, an adequate register of deaths is required for this calculation.

Indicator:	**Infant mortality rate**
Definition:	Measures the mortality rate for the first year of life. It is calculated from the ratio of the number of deaths of those aged under one year over a certain period and the number of live births over the same period, per thousand.
Goal:	To reduce by a third by the year 2000 the mortality rates among children younger than one year with respect to the 1990 values; or to 50 deaths per 1,000 live births, if that is a lower mortality rate. By the year 2005 the rate should be less than 50 per 1,000 live births, and by 2015 the rate should be less than 35 per 1,000 live births. To reduce, by at least 50%, the differences between infant mortality rates observed among different residential areas, geographical areas and social groups.
Source:	Vital statistics; censuses; demographic and health surveys.
Disaggregation:	Total, by sex and by the mother's level of schooling (the latter is used as an approximation to distinguish different social groups).
Relevance:	National level and subpopulations: countries at the incipient, moderate and full transition stages; subpopulations in all countries.
Comments:	This indicator, in addition to being directly related to an objective of the Programme of Action, has the advantage that it can be calculated for smaller geographical areas and for different socioeconomic groups. It may be estimated indirectly with data obtained from censuses and surveys, which can be used to estimate the infant mortality rate for different groups.

Indicator:	**Mortality rate in childhood (for the under-5s)**
Definition:	Expresses the probability of dying before completing the first 5 years of life. In practice it is calculated from the ratio between the number of deaths in the population aged 0 to 4 years and the total of live births over the period studied, per thousand.
Goal:	To reduce by a third by the year 2000 the mortality rates among children under five, with respect to the 1990 values; or to 70 deaths per 1,000 live births, if that is a lower mortality rate. By the year 2005 the rate should be less than 60 per 1,000 live births, and by 2015 the rate should be less than 45 per 1,000 live births.
Source:	Vital statistics; censuses; demographic and health surveys.
Disaggregation:	Total and by sex.
Relevance:	National level and subpopulations: countries at the incipient, moderate and full transition stages; subpopulations, all countries.
Comments:	As in the case of the infant mortality rate, it can be calculated for smaller areas and for specific groups. Although the causes are also multiple, some vertical actions have an impact, such as immunization and oral rehydration therapy. When calculated separately for each sex, it can be used to indicate possible discriminatory practices against girls, such as a greater tendency to treat illnesses in boys.

Indicator:	**Maternal mortality rate**
Definition:	Annual number of deaths by maternal causes for every 100,000 births.
Goal:	For the year 2000, to reduce maternal mortality rates by at least 50% with respect to the 1990 values, as well as the differences observed between different residential areas, geographical areas and social groups. To achieve a further one-half reduction by 2015.

Source: Vital statistics.
Relevance: Countries at the incipient, moderate and full stages of transition.
Comments: This indicator is difficult to calculate as it requires adequate codification of the causes of death. Owing to the low number of maternal deaths in relation to the total population, indirect estimates have very wide margins of error.

C.4. Sexually transmitted deseases and AIDS

Indicator: **Rate of prevalence of HIV in pregnant women**
Definition: The percentage of pregnant women receiving prenatal care who have taken the relevant test and are HIV-positive.
Source: Continuous records.
Disaggregation: Total and by age groups.
Comments: It is useful to restrict this indicator to urban areas or large cities, in order to avoid bias in the testing process. This indicator can be used to monitor progress in prevention and reduction of HIV infection.

Indicator: **Prevalence of HIV in the population of reproductive age**
Definition: The percentage of HIV-positive persons among the population of reproductive age in a specific period.
Source: Continuous records.
Disaggregation: Total; by sex; and by age groups.
Comments: This indicator should be calculated in the most disaggregated form possible. Ideally, rather than one rate there should be 14 prevalence rates (for each five-year age group among the population aged 15-49, and by sex) so that they can be used to monitor adequately any change in the pattern of infection.

Indicator: **Existence of a national plan to combat RTIs and STDs**
Definition: Existence of a national strategic plan to prevent and control reproductive tract infections (RTIs) and sexually-transmitted diseases, including HIV/AIDS. It refers to the existence of specific policies and programmes to combat ITRs and STDs.
Source: Special surveys.
Comments: It is also important for the national coordination mechanism to initiate specific actions at the national level both for services and in the area of prevention. Indicators may therefore be added which can reflect the actions carried out by each country.

C.5. Basic sanitation

Indicator: **Access to potable water**
Definition: Measures the number of persons with access to potable water, in relation to the total population.
Source: Censuses; household surveys; demographic and health surveys.
Comments: The type of access should be defined, according to the different types of existing supply, to include those which provide potable water within the home. This indicator is associated with the health conditions of the population. A lack of safe water is related to various causes of morbidity and mortality in a country. When it is calculated for smaller

administrative areas, it gives information on access to basic services of the population.

Indicator: **Access to sanitation services**
Definition: Measures the number of persons with access to adequate health services, with regard to the total population. For the urban population a home connected to the sewerage system is considered adequate; in rural areas a connection to a septic tank is also considered adequate.
Source: Censuses; household surveys; demographic and health surveys.
Comments: This indicator and the indicator for access to potable water, are complementary measures for maintaining basic sanitation, which reduces the risk of morbidity and mortality among the population (especially among children).

C.6. Sexual health of adolescents

Indicator: **Fertility rate of mothers aged 15-19**
Definition: Expresses the total of births to mothers aged 15-19 for every thousand women aged 15-19 in the population over a given period.
Source: Population estimates and projections.
Comments: This indicator is important because in this age group a significant proportion of pregnancies are unwanted, and are high-risk pregnancies.

Indicator: **Percentage of adolescent mothers**
Definition: Measures the proportion of adolescent women who are mothers. It is calculated from the ratio of women aged 15-19 who have already delivered at least one live child or who are pregnant for the first time at the time of the survey, in relation to the total number of women in this age group, as a percentage.
Source: Demographic and health surveys.
Disaggregation Total and level of schooling.
Comments: Although this indicator is highly correlated with the adolescent fertility rate, it has the advantage of the potential for disaggregation according to social characteristics and geographical location, as the information is from surveys.

Indicator: **Knowledge of contraceptive methods**
Definition: Measures the degree of knowledge of contraceptive methods among adolescents. It is calculated from the ratio between the population aged 15-19 who know of at least one contraceptive method and the population in this age group, as a percentage.
Source: Demographic and health surveys.
Disaggregation Total; by sex; and by level of schooling.
Comments: In some cases, the information can be disaggregated for sexually active young people and young people without sexual experience. This indicator can also be calculated for each type of method.

Indicator: **Knowledge of the fertile period**
Definition: It is calculated from the ratio of women aged 15-19 who identify correctly the fertile period within their menstrual cycle in relation to the total of women in this age group, as a percentage.
Source: Demographic and health surveys.
Disaggregation Total, and by level of schooling.

Comments:	A lack of knowledge of the physiology of reproduction, of contraceptive methods and the means of preventing sexually-transmitted infections, are a risk factor for healthy and safe sexual health in adolescents.
Indicator:	**Awareness of STI prevention**
Definition:	Measures the numbers of adolescents (aged 15-19) who are aware that the condom can prevent sexually transmitted infections (STIs) and AIDS, in relation to the total numbers in that age group.
Source:	Demographic and health surveys.
Disaggregation	Total; by sex and by level of schooling.
Comments:	Although it is a specific indicator for awareness in relation to STIs, it has been observed empirically that it can be used to discriminate between different groups of young people. In any case, a possible alternative is to calculate an indicator of average awareness, based on the weighting of a series of items on awareness relating to prevention and to forms of transmission of STIs, especially HIV/AIDS.
Indicator:	**Centres with sexual and reproductive health services for adolescents**
Definition:	Percentage of the total of health centres which offer counselling and sexual and reproductive health care services for adolescents.
Source:	Special surveys.
Comments:	This information should be complemented with a measure which can be used to evaluate the quality of the services offered.

Note: Some of the indicators listed in other sections which are disaggregated by age groups can be used to supplement the above section (using the information for the age group 15-19). The indicators are: number of births; rate of contraceptive use; unmet need for family planning; desired fertility rate; pregnancy services by skilled personnel; birth care by skilled personnel; HIV prevalence rate in pregnant women.

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Annex

A COMPARISON OF THE PROPOSALS FOR INDICATORS FOR FOLLOW-UP TO THE WORLD CONFERENCES

• Common country assessment (United Nations)

This is an effort by the United Nations to bring together the different lists of indicators so as to have a set of indicators which show the progress achieved by countries in resolving development problems and identifying possible areas of action on the part of the United Nations system.

The list was constructed with the idea that the indicators would reflect the living conditions of the population in relation to human rights and the standards and principles of the United Nations. Thus, the indicators report on the situation with regard to food security, health, including reproductive health, education, access to justice, security of person, gender equality, and other universally recognized rights and principles. The selection was made according to four components: indicators relating to the conventions and agreements of the world conferences; conference and convention indicators relating to governance and political and civil rights; indicators relating to economic and demographic conditions, and lastly, thematic indicators which in special circumstances provide further insight into particular issues (such as the problem of drug trafficking).

The indicators were selected from the various existing lists on the criterion that the indicators should not impose an additional burden on the countries. In accordance with this principle, the indicators should be constructed from existing data sources, in order to obtain reliable and systematic measures. For the indicators to serve as a basis for comparison at the international level, they should also be clear and easy to interpret, and provide a measure of progress towards common goals and objectives.

Another important criterion for selecting indicators is their potential for disaggregation so that, in addition to giving an idea of the country's situation with regard to certain goals, they also reflect the situation of specific groups. Each of the indicators, where appropriate, may thus be disaggregated by sex, urban and rural areas, different geographical levels, and specific groups, such as indigenous peoples or adolescents.

In each country the selection of the indicators should involve not only the United Nations but also the government, civil society, the private sector, the donor community and the Bretton Woods institutions. The aim of this collaboration is to generate a common understanding among the sectors with regard to the situation of the country and to key aspects of development. It is hoped that this process will result in an analysis of the challenges of development and particularly those problems affecting the poorest sectors of the population. There should also be an evaluation of priority needs as well as national capacity and the progress made with respect to the agreements, on the basis of a shared data base. Lastly, in view of the fact that the information needed to construct the indicators is not available in all countries, the process of preparing the indicators should have the result of identifying the information needs.

- **Organisation for Economic Cooperation and Development**

The Development Assistance Committee of the Organisation for Economic Cooperation and Development (OECD) selected a set of goals from conferences of the United Nations which relate to key aspects of economic development, social well-being, and environmental sustainability. The main concern of the OECD is sustainable development and thus a significant set of indicators is included relating to the environment and the country's economic conditions. This proposal also contains a substantial set of indicators relating to the formation of human capital particularly with regard to health and education. The set of 29 indicators is organized as indicators of: economic well-being; social development; environmental sustainability and regeneration; and general indicators on population and on economic growth.

The indicators were selected in such a way that information would be available for all countries. The OECD suggests interpreting the indicators as a single interrelated set covering key aspects of development. Where appropriate, the indicators should be disaggregated by sex to measure gender equity. The list, however, is not designed for disaggregation by areas or groups within each country.

- **Minimum National Social Data Set**

The United Nations Statistical Commission has defined a minimum data set relating to the social conditions of a country. This set of 15 indicators refers basically to the population's health and economic conditions, and access to adequate housing, and tries to cover the goals of various world conferences simultaneously. According to the resolution of the Committee on Economic and Social Affairs, these indicators should be considered as a minimum set to which others should be added according to national needs and circumstances.

- **Basic Social Services for All**

With the aim of disseminating the objectives of the conferences a working group of the Department of Economic and Social Affairs of the United Nations has defined a set of 11 indicators relating to the basic services to which the population should have access. These indicators, although mostly referring to access to basic services, also include mortality indicators such as infant mortality, childhood mortality, life expectancy and maternal mortality. The indicators give an idea of the universality of services, and the decrease in equity with regard to health, access to education and basic services.

- **United Nations Population Fund Programming Indicators**

With the aim of defining the countries' cooperation needs and the financing required by the programmes, the United Nations Population Fund (UNFPA) defined a set of indicators which form part of the logical framework used in the organization of cooperation activities. This list is structured according to the areas of UNFPA activities: reproductive health; population and development; information, education and communication. The emphasis is on those indicators related to reproductive health and gender equality. The indicators are related to three final aims: all couples and individuals are to enjoy reproductive health, including family planning and sexual health throughout their lives; there is a balance between population dynamics and economic and social development; and the achievement of gender equity and women's empowerment.

- **Indicators for population and reproductive health programmes (UNFPA)**

In addition to this reduced set of indicators chosen for programming purposes, the UNFPA has developed a list of indicators for population and reproductive health programmes. This set of indicators attempts to cover the vast majority of agreements reached at the International Conference on Population and Development. In view of the fact that the indicators may have limitations, and that the set may include both indicators which measure impact and indicators which measure a process, the UNFPA report proposes that groups of indicators be selected to reflect the situation in relation to a particular problem and to monitor the results of the actions taken.

Unlike other lists which emphasize the potential for international comparability, this UNFPA proposal includes a significant number of intermediate or process indicators, namely those that provide information on programme implementation. Owing to this emphasis on programmes and project administration, administrative sources are needed, and thus not all the indicators can be measured in all countries.

- **Evaluation of the Goals of the World Summit for Children (UNICEF)**

UNICEF has designed a list of 54 indicators for the purpose of measuring the progress achieved in relation to 27 goals ten years after the holding of the World Summit for Children. The indicators refer in particular to health and education conditions in childhood. Some of the proposed indicators can be used in monitoring more than one of the goals. For example, the prevalence of a low weight/age ratio is an indicator for the reduction of severe and moderate malnutrition, child health care and nutrition, and enhancing infant development. The UNICEF list contains an important set of indicators which refer to the rights of the child, the management of infant diseases, malaria, and a set of indicators on knowledge of and exposure to HIV infection. A significant number of indicators of access to services is also included.

- **Other proposals for indicators**

There are other significant proposals for indicators which were already referred to in the preliminary document on indicators presented at the ECLAC session in Mexico, in 2000. One of these is the set of indicators for monitoring reproductive health that was developed by WHO. The Latin American and Caribbean Women's Health Network (LACWHN) has also proposed a set of indicators for follow-up to the goals of the Programme of Action. A first assessment of the goals of the ICPD Programme of Action using the indicators was carried out for five countries: Brazil, Chile, Colombia, Nicaragua and Peru. The LACWHN proposal is important because it includes a series of qualitative indicators. Lastly, a set of gender indicators to provide follow-up for the goals of the Beijing Platform for Action has been developed by ECLAC at the request of the Regional Conference on Women in Latin America and the Caribbean. The list was drawn up with the aim of covering as many issues as possible on the basis of existing sources.

INDICATORS SUGGESTED BY DIFFERENT ORGANIZATIONS FOR EVALUATION OF COUNTRIES AND OF FOLLOW-UP TO THE SUMMITS

Indicator	CCA 1/	OECD 2/	MNSDS 3/	BSSFA 4/	CELADE 5/	UNFPA (MYFF) 6/	UNICEF 7/	UNFPA 8/
Population and demographic growth								
Intersectoral mechanisms to review development and sectoral plans.						X		
Percentage of the population in rural and urban areas, and in the main cities.					X			X
Growth rate in urban areas (%).								X
Population density in main urban areas.					X			X
Dependency rate by age 9/.					X			X
Percentage of households composed exclusively of persons aged over 65.					X			
Percentage of births to mothers born abroad aged 15-24.					X			
Growth rate of the population and of per capita GNP.						X		X
Number of inhabitants and age structure 10/.	X		X	X	X			X
Percentage of population aged: (i) Under 15 years (ii) 60 years and above.								X
Total fertility rate.	X	X			X			X
Crude mortality rate.								X
Net annual migration rate.								X
Average age of the population.								X
Crude birth rate.								X
Average number of children wanted.								X
Health and Mortality								
Percentage of population with access to primary health care services.	X			X	X			X
Prevalence of HIV in the population aged 15-49 by sex and age 11/.	X						X	X
Rate of HIV prevalence in pregnant women aged under 25 receiving prenatal care in capital cities or major urban areas 12/.	X	X			X	X		
Infant mortality rate.	X	X	X	X	X	X	X	X
Mortality rate of children aged under 5, by sex.	X	X	X	X	X		X	X
Life expectancy at birth, by sex.	X	X	X	X	X	X		X
Reproductive Health								
Fertility rate in women aged 15-19 13/.						X	X	X
Percentage of health centres at the primary health care level offering a range of reproductive health services, either directly or through referrals.					X			X

Indicator	CCA 1/	OECD 2/	MNSDS 3/	BSSFA 4/	CELADE 5/	UNFPA (MYFF) 6/	UNICEF 7/	UNFPA 8/
Existence of quality standards for reproductive health services.					X	X		X
Services offering primary health care, public and private. Modern family planning methods.					X	X		X
Services offering at least three modern contraceptive methods.						X		
Number of health centres offering essential obstetric services.					X	X	X	X
Services offering primary health care, public and private. Treatment of RTI/STD [14/].						X		X
Services offering primary health care, public and private. Information, education, and counselling on sexual matters, including family planning.						X		X
Unmet need for family planning [15/].					X	X		X
Prevalence of syphilis in mothers attending a prenatal clinic [16/].					X			X
Percentage of health centres with counselling services in sexual and reproductive health for adolescents.					X	X		
Percentage of adolescents knowledgeable about key sexual and reproductive health issues.					X			
Existence of sex education programmes for adolescents in the formal education system.					X	X		
Existence of intersectoral coordination entities for the population and sexual and reproductive health programmes.					X			
Maternal mortality rate [17/].	X	X	X	X	X	X	X	X
Percentage of births assisted by skilled health personnel, excluding trained or untrained traditional birth attendants [18/].	X	X			X	X	X	X
Percentage of women attended, at least once during pregnancy, by skilled health personnel (excluding trained or untrained traditional birth attendants) for reasons relating to pregnancy.					X		X	X
Contraceptive prevalence rate [19/].	X	X	X		X		X	X
Legislation or policy that prohibits provision of family planning services [20/].								X
National policy for the provision of reproductive health care in: (i) family planning services: (ii) maternal care; (iii) STD/RTI programmes.								X
Provisions for: (i) enquiries into maternal deaths; (ii) special measures to reduce maternal mortality.								X
National strategic plan to prevent and control RTIs and STDs, including HIV/AIDS.								X
Provision to protect the basic rights of persons infected with HIV with regard to: (i) employment (ii) marriage/divorce (iii) travel.								X
Legislation on a minimum age for marriage, by sex [21/].								X
Percentage of the population within one hour's walk from an SDP with family planning services.								X

Indicator	CCA 1/	OECD 2/	MNSDS 3/	BSSFA 4/	CELADE 5/	UNFPA (MYFF) 6/	UNICEF 7/	UNFPA 8/
Percentage of SDPs with: (i) sterilized instruments (ii) uncontaminated water.								X
Percentage of women who have been offered family planning services postpartum (up to 6 weeks postpartum).								X
Percentage of clients consulted about their: (i) reproductive intentions (ii) concerns about contraceptive methods.								X
Availability of contraceptives in the past six months.								X
Percentage of women who developed obstetric complications during delivery and received emergency obstetric care.								X
Percentage of hospitals able to perform caesarians and blood transfusions.								X
Percentages of deliveries by caesarian.								X
Percentage of pregnant women having prenatal care who received: (i) iron/folate (100 tablets) (ii) tetanus vaccine (two doses).								X
Percentage of pregnant women who received maternal services and expressed satisfaction with: (i) prenatal services (ii) birth services (iii) postnatal services.								X
Percentage of health personnel who received in-service training in the past two years.								X
Prevalence of urethral discharge in men aged 15-49 years.								X
Percentage of SDPs that have condoms available.								X
Percentage of SDPs offering PAP testing in secondary or tertiary facilities.								X
Percentage of clients satisfied with RTI services.								X
Percentage of health workers who received in-service training in the past two years.								X
Annual number of: (i) legal abortions (ii) estimated illegal abortions.								X
Percentage of obstetric/gynaecological admissions due to abortion complications.								X
Percentage of women receiving abortion care [22/].								X
Availability of in-service training for post-abortion family planning counselling for health personnel.								X
Prevalence of sterility in women aged 20-44 years [23/].								X
Estimated prevalence of genital mutilation of women.								X
Food security and nutrition								
Percentage of children aged under 5 suffering from malnutrition [24/].	X	X		X	X		X	
Percentage of population with a dietary energy supply less than the minimum level (calorie intake in the context of the food balance).	X							X
Percentage of income spent on food by the poorest quintile of households.	X							

Indicator	CCA 1/	OECD 2/	MNSDS 3/	BSSFA 4/	CELADE 5/	UNFPA (MYFF) 6/	UNICEF 7/	UNFPA 8/
Daily per capita calorie consumption.								X
Education								
School enrolment rate in primary and secondary education, by sex [25/].	X	X		X	X	X	X	X
Percentage of pupils who begin the first grade and reach the fifth grade.	X	X					X	
Literacy rate in the adult population, by sex [26/].	X	X		X	X	X	X	X
Literacy rate in the age group 15-24.	X	X						
Average years of schooling, by sex.			X					X
Percentage of the population with complete primary education, by sex.								X
Gender equality and women's empowerment								
National mechanisms for monitoring and reducing sexual violence.						X		
Practices harmful to women [27/].						X		
Reports of sexual abuse by a close relative.					X			
Information on gender issues aimed specifically at men.						X		
Percentage of women parliamentarians.	X					X		X
Literacy in indigenous women aged 15-34.					X			
Ratio of girls to boys among primary and secondary school students [28/].	X	X			X			
Percentage of women in non-agricultural paid employment.	X				X			
Ratio of illiterate women /illiterate men among the population aged 15-24.		X						
Proportion of births by sex.								X
Implementation of policies for: (i) eradicating female genital mutilation (ii) eradicating prenatal selection by sex and selective abortion by sex.								X
Prevalence of practices that weaken and inhibit development, by sex (proportion).								X
Level of gender empowerment [29/].								X
Child Health								
Percentage of those aged less than one year vaccinated against measles.	X						X	
Proportion of children aged 5-14 who are working [30/].	X						X	
Employment								
Employment to population ratio (formal and informal sector).	X		X					
Unemployment rate by sex.	X		X		X			X

Indicator	CCA 1/	OECD 2/	MNSDS 3/	BSSFA 4/	CELADE 5/	UNFPA (MYFF) 6/	UNICEF 7/	UNFPA 8/
Informal sector employment as a percentage of total employment.	X							
Labour participation rate, by sex.								X
Percentage of female labour.								X
Percentage of workers in the non-agricultural sector, by sex.								X
Income and Poverty								
Percentage of households headed by women.					X			X
Poverty headcount ratio (percentage of population with an income of less than US$1 per day).	X	X						X
Poverty headcount ratio (percentage of population with income below the national poverty line).	X							
Poverty gap ratio.	X	X						
Share in national consumption of the poorest quintile of the population.	X	X						
Per capita family income (quantity and distribution).			X					
Monetary value of the minimum food basket.			X					
Housing and basic household amenities and facilities								
Number of persons per room, or average floor area per person.	X		X	X				X
Percentage of the population with access to safe drinking water and sanitation	X	X	X	X	X		X	X
Percentage of the population with access to adequate sanitation	X		X				X	X
Percentage of the population with electricity.								X
Environnment								
Carbon dioxide emissions (per capita).	X	X						
Biodiversity: land area protected.	X	X						
GDP per unit of energy use.	X	X						
Arable land per capita.	X							X
Percentage change in square kilometres of forest land in the past 10 years.	X	X						
Percentage of the population relying on traditional fuels for energy use.	X							X
Countries with effective sustainable development processes (national environmental plans).		X						
Deforestation rate.								X
Drug control and crime prevention								
Area under illegal cultivation of coca, opium poppy and cannabis.	X							

Indicator	CCA 1/	OECD 2/	MNSDS 3/	BSSFA 4/	CELADE 5/	UNFPA (MYFF) 6/	UNICEF 7/	UNFPA 8/
Seizures of illicit drugs.	X							
Prevalence of drug abuse.	X							
Number of crimes per 100.000 inhabitants.	X							
Economy								
GNP per capita (in United States dollars and PPP dollars).	X	X	X					X
External debt (in United States dollars) as a percentage of GNP.	X	X						
Decadal growth rate of GNP per capita (in United States dollars).	X					X		
Gross domestic savings as a percentage of GNP.	X							
Share of exports in GDP.	X							
Share of foreign direct investment (FDI) flows in GDP.	X	X						
Percentage of public expenditure on social services.	X							X
Foreign aid as a percentage of GNP.		X						
Trade as a percentage of GNP		X						
Legal framework of countries								
Status of ratifications of, reservations to and reporting obligations under international human rights instruments.	X							
Status of follow-up to the concluding observations of the United Nations human rights treaty bodies.	X							
Periodicity of free and fair elections.	X							
Recognition in law of the right to freedom of expression, association and assembly.	X							
Recognition in law of guarantees for independent and impartial judiciary and fair trial.	X							
Recognition in law of the right to seek judicial remedies against state agencies and officials.	X							
Recognition in law of the prohibition of gross violations of human rights affecting the security of person.	X							
Access for state institutions and NGOs to census and survey databases [31/].					X	X		

Notes:

1/ Common country assessment (CCA).
2/ Organization for Economic Cooperation and Development.
3/ Minimum national social data set.
4/ Basic social services for all.
5/ Latin American and Caribbean Demographic Centre. Proposal presented to the Committee on Population and Development of the twenty-eighth session of ECLAC.
6/ United Nations Population Fund (Multi-year Funding Framework).
7/ Set of indicators to measure progress at the end of the decade.
8/ Indicators for population and reproductive health programmes.
9/ (i) Total infant dependency rate; (ii) infant dependency rate; (iii) dependency rate for older adults. There are differences in the age range used to define the population of older adults. The United Nations uses 60 years and over.

10/ In general, a classification by ages will also be required to determine certain groups, for example, older persons; the definition should be contextual. In the proposal for a minimum set of social indicators, the structure by sex and age of ethnic groups is also included when appropriate and feasible.

11/ The definition of the ages for this indicator vary. In the common country assessment (CCA) only adults are referred to, whereas the UNFPA proposal refers to the prevalence for adolescent men and women. The prevalence in the population aged 15-49 years is used by UNAIDS.

12/ UNAIDS uses the total of pregnant women receiving prenatal care, disaggregated for urban and rural areas.

13/ For programming purposes, UNFPA uses the number of births to women aged 15-49.

14/ Reproductive tract infections, syndrome diagnosis, treatment and follow-up of contacts. Gonorrhoea, chlamydia, HIV, candidiasis, bacterial vaginosis, and iatrogenic infections resulting from medical procedures such as abortion or IUD insertion.

15/ Percentage of married women of reproductive age who wish to postpone or stop births and are not using any method of contraception.

16/ The UNFPA has proposed the percentage of pregnant women tested for syphilis who visit prenatal clinics and the prevalence of RPI/STD in women who visit gyneacological clinics.

17/ Some lists refer to a “ratio”, but the term used here is maternal mortality “rate”.

18/ Some definitions are less restrictive and refer only to “qualified health personnel”, “trained health personnel”, “skilled personnel”.

19/ The definition proposed by UNFPA specifies the prevalence of use of each method.

20/ Legislation or policies which prohibit the provision of family planning services to: (i) unmarried persons; (ii) persons under a certain age; and (iii) without the consent of a spouse or parents.

21/ (i) Is there a legal minimum age? (ii) What is the legal minimum age? (iii) Is the legal minimum age respected?

22/ (i) Who have had a legal abortion and are referred for post-abortion counselling and family planning; (ii) who were treated for abortion-related complications; (iii) who were referred for post-abortion counselling and family planning.

23/ Percentage of women aged 20-44 years who (i) have never been pregnant or (ii) have had at least one pregnancy, and wish to become pregnant, are not using contraceptives and have not become pregnant in the past two years.

24/ The exact measurement of malnutrition varies between low weight in children of pre-school age, low weight/age ratio, or chronic malnutrition.

25/ Refers to the enrolment rate in primary and secondary education calculated separately for each sex. In some cases the indicator refers only to primary enrolment.

26/ Persons aged over 15 are considered to be adults.

27/ Including sexual violence, lack of education and opportunities, and poor nutrition for girls, as well as other practices relating to marriage, childbirth and puerperium.

28/ Some definitions refer only to secondary education.

29/ This measure used by UNDP refers to the degree of success in achieving gender equality and equity through women's empowerment.

30/ In some cases this refers only to those aged under 15 years.

31/ National database on population disaggregated by sex with plans for updating it at regular intervals.

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