METHODOLOGICAL APPENDIX

The following pages contain four groups of tables: thirteen of which correspond to indicators of the distance from the aims according to specific commitments, five to advances on the so–called main areas chosen on the methodological bases of the ICC, two which show the changes in aspects related to the situation of women, and three referring to aid and 20/20 commitments.[1] When the information available did not allow us to evaluate advances, we collected the most recent values of the indicators chosen. Wherever possible, a simple and uniform procedure was adopted to develop a fulfilment index which tried to reflect the degree of advances made towards the proposed aim. As in many cases the information available in the countries themselves is more recent than that published by the international organisms, we resolved to note the value the indicator should have in 1996 in order to, within the methodological constraints, see if this is advancing at a rate which will allow the aim to be reached by the year 2000.

The procedure chosen consisted of adopting a common standard of measurement for the distance covered. Given the group of indicators monitored are measured in different units (years of life, percentages, number of persons, etc.) we opted to measure the position in each dimension in relation to the final aim expressed as a value between 0 and 100. In order to do this the value of the 1990 indicators and the «aim value» established in the commitments made were taken, and the average annual rate of growth for the decade was calculated from this. This rate was used to construct a series of annual values or «values due» for the indicators which are contrasted with the «values observed». The contrast was made comparing the distance covered with what should have been covered according to the series constructed. As in some cases there was backward movement in relation to the 1990 situation and in others the aim was achieved before the deadline, we opted to rescale the range of values on a comprehensive scale of 0 to 100. Consequently, the cases of recession which generated negative values take the minimum value 0, while those cases which fulfilled or surpassed the aims take a maximum value of 100. Thus, equal treatment is given to those which remained unchanged from

1990 and those which actually went backwards, and also to those which were fulfilled and surpassed. Another problem was that some aims referred to dates later than the year 2000, and in such cases we chose to draw up the series of due values for this time and assume as an aim for 2000 the value generated by adjusting the distance covered to a decade. The advantage of this is a more simple interpretation of the index as each tenth refers to a year. Thus, for example, if data available for 1993 show a value of 30 percent, then the country is on target,[2] similarly, a lower value would mean that at this rate it will not be fulfilled and a higher value means it will be accomplished early if it continues at the same rate.In some situations the data for 1990 needed to calculate the aim was not available. In these cases we opted for the value available either for that year, the previous or the following one, or even the average of both.Caution must be taken both in interpreting the data and in making comparisons between time periods and nations. For even though the limitations of statistical systems are known it is not worth warning of the drastic changes which are sometimes seen in some indicators from one year to the next, which appear as outrageous values in the index. On occasions this is due to the redefinition of the indicators, or revisions of the statistical procedures, or new estimates or projections, or in coverage, amongst other factors. Thus, for example, the new nation by nation 1996 annual maternal mortality estimates registered an increase of nearly 20% on the previous figures reacting to the fact that a new form of estimation was used with the 1990 data. If these new data are used, obviously, many nations show a significant recession compared with the 1990 value. In this case, for example, we chose to contrast annual values calculated with the old procedure whilst awaiting series generated with the new methodology.

Finally, it should be pointed out that sufficient information was not available to show results for all of the countries on each of the tables below. Moreover, in some cases, no real commitments existed for different countries in different dimensions. Thus, for example, the goal of achieving life expectancy of 60 years had al-

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1   The sources, unless otherwise indicated are: WHO, UNICEF, FAO, UNDP, UNESCO, World Bank and United Nations Centre for Human Settlements (Habitat).
2   For data from 1995 the satisfactory figure would be 50; for 1996, 60 and so on

ready been attained by numerous countries prior to 1990, and the same holds true for the highly developed countries in regard to access to drinking water by the entire population, among other goals. Consequently, given the space limitations, we decided to show on each table only those countries for which sufficient information was available, i.e., we omitted those that did not have a real goal as well as those for which the essential information was not obtained.

Readers interested in having the tables including all countries, as well as the graphs with the data used in preparing this report, can obtain them from our web pages or by electronic mail request.
hhtp:www.chasque.apc.org/socwatch/
e–mail: socwatch@chasque.apc.org

The many limitations of the procedure adopted here include the fact that the indicators chosen develop according to a model of geometric growth. However, it is not necessarily like this in all cases, as it is possible to over or underestimate the real growth in contrast to the due outcome. The diversity of indicators involved makes the adoption of specific procedures very complex, but a certain intuition of this risk in relation to some indicators prevented us from applying the procedure in some of the tables presented below.

INDICATORS OF DISTANCE FROM THE AIMS BY SPECIFIC COMMITMENT

Regarding tables numbered from Commitment1 to Commitment 13, when a value is not provided for the index or for the value that should have been reached by 1996, this is either because no data were available or the value had already been achieved.

Table C1 shows that the values of net enrolment in primary school in 1993 in only Afghanistan and Benin were improving at a good rate. In the majority of the countries listed the low rates seen indicate severe limitations in achieving universal participation in primary education and everything seems to indicate, if the data are reliable, that up until then very little progress was made towards reaching this objective.

Table C2 shows changes in life expectancy. Already in 1990 a group of 123 countries had passed the 60 year level. The Maldives, Lesotho and India reached this target in 1995. Pakistan, Bolivia and Namibia advanced rapidly, while Myanmar and Swaziland made adequate improvements.

The 1994 infant mortality data for Colombia, Lesotho, Tonga, Peru and Namibia showed significant improvements, similarly the Dominican Republic, Oman and the Cook Islands advanced in an appropriate way, as shown on **Table C3**.

The data for child mortality of children aged under five years–old on the same table show that South Korea met its aim. They also show a large reduction for a group of 16 countries, while they show Yemen, Egypt, Senegal, Nepal, Botswana, Swaziland,

Honduras, El Salvador and Syria developed in line with the required rate. However, in 29 countries, no improvement was seen or the situation even worsened in relation to 1990. Considering both indicators together it becomes clear that Colombia, Namibia and Peru saw large advances.

According to data on maternal mortality on **Table C4** calculated under the system used before, Nepal and Nigeria, which had had exceptionally high levels, registered large reductions. However, the new estimations show the reduction in Nigeria would have been from 1500 in 1990 to 1000 instead of 800. For Nepal, the previous data indicated 1750 in 1990 and 515 in 1993, while the new estimates indicate 1500 maternal deaths per year. Similarly, Irak and Zimbabwe, which registered 50 and 80, now show 310 and 570 respectively. According to this new system, these two countries have not yet made the advances aimed for. Thus, taking due precautions in relation to this data, **there have been net improvements in only 12 countries**.

Table C5 shows the daily calory intake as an indicator of food security: this commitment does not set out a specific value as a goal.

Table C6 shows the changes in malnutrition in the under–fives and low birth weight babies. Only China was progressing adequately in 1995 according to the first indicator, while 7 countries had made no progress or had even worsened. Planned improvements in birth weights in Malawi and Morocco have met their aims, while only another nine countries advanced at a good rate.

Leaving aside Japan, Kuwait, Mauritius, New Zealand and Singapore who already had 100% coverage, the countries which made the biggest advances in access to health services (as shown on **Table C7**) were Algeria, Burkina Faso, Oman, Thailand and Cameroon. Meanwhile, **there are 50 countries which did not show any improvement whatsoever**.

Table C8 illustrates about reproductive health. As for the commitments to prenatal attention by the year 2015, the nations with a 100 index are those which have fulfilled their aims for the year 2000, but apart from the Cook Islands, Japan and Malta, which had 100% coverage, the other countries with a 100 index also have the value their 1996 indicator should show written in, and must continue advancing to reach their aims for 2015. It can be seen that 11 countries have already reached the level planned for the year 2000, while 5 are keeping up a good pace. Ten countries have reached their 2000 values for attended births, and 5 are advancing as they should. **However, the use of contraceptives is lagging or at a complete standstill in all the nations covered**. Considering the first two indicators together, the Cook Islands, Malawi, Mauritius, Sri Lanka, Thailand, Benin, Burundi, Kiribate, Seychelles and Bangladesh are all progressing at a sufficient rate to fulfil their aims.

Table C9 refers to cases of malaria. Because of lack of data, no index has been calculated.

Table C10 about the elimination or control of illness through data available on children attended, indicates total cover in Canada, Cuba, New Zealand, Seychelles, Singapore and Uganda. This care is developing at a good rate in 8 while **another 20 countries haven't even covered 50%**.

From **Table C11** it can be gathered that four of the countries with available data have total adult literacy, and these are Japan, Finland, Estonia and South Korea. Beyond these, **no adequate advances were seen in any countries between 1990 and 1995**.

Table C12 deals with two variables. Information on access to clean drinking water shows that only 8 countries reported an adequate increase in this indicator outside the nations which already supplied their whole populations. Similarly, no country had total sewerage system coverage, and only 10 were expanding at the desired rate. If both indicators are considered in a composite form only 5 countries (Zimbabwe, Bangladesh, Libya, Botswana and Saudi Arabia) achieved joint advances of the right sort. **26 have either made no improvement or slowed down**.

Table C13, finally, referred to the commitment about improving the availability of housing, illustrates on the number of housing units and of persons per room.

If we look at the combined efforts required to advance in the various areas we can see how slowly the countries have been advancing in general. This can be seen by considering the results of the indices composed as simple averages in the following tables.[3]

INDICATORS OF DISTANCE FROM THE AIMS BY LARGE AREAS

In the case of healthcare, (**Table A1**) Singapore appears to be improving at a good rate although this is greatly influenced by the impact on the composite index of the 100% health coverage already present in 1990. If we were really interested in evaluating the efforts achieved from 1990 onwards we would have to omit the influence of this component, whereby the index for this country would fall to 33.

As regards (**Table A2**) only five countries (Zimbabwe, Bangladesh, Lybia, Botswana and Saudi Arabia) seem to have actually achieved the desired results through recent efforts.

In nutrition (**Table A3**), the index composed by a combination of malnutrition indicators and birth–weight show only Egypt, Guinea, Philippines and Madagascar improved as they should have.

In the case of Education (**Table A4**) an index has not been composed, but the rate of adult literacy, the percentaje of children reaching 5th. grade and the school life expectancy are detailed.

The nations with more than 40% of their population living in poverty (**Table A5**) are, in order of seriousness: Malawi, Bangladesh, Guatemala, Zambia, Bolivia, Tanzania, Ecuador, Lesotho, the Philippines, Vietnam, Kenya, El Salvador, Brazil, Botswana, Madagascar, Ghana, India and Nigeria. Meanwhile income distribution was most unequal in: Brazil, South Africa, Malawi, Guatemala, Zimbabwe, Panama, Chile, Guinea Bissau, Lesotho, the Central African Republic, Kenya, Botswana, Senegal, Honduras, Venezuela, Thailand, Colombia, Puerto Rico, Nicaragua and Mexico.

As to the situation of women, (**Table 6a**) shows that on the health dimension, the index composed by improvements in life–expectancy, attendanded pregnancies and births have only made appropriate advances in Malawi and Mauritius, out of all the countries where information is available. Meanwhile, improvements in women's education (Table 6b) the index composed by literacy and net primary school enrolment shows advances made only in Botswana, Cuba, Mali and Denmark.

EXAMPLES OF SOME INDICATORS OF POLITICAL WILL:

Table O1 illustrated about the countries'expenditure.. Uruguay, Panama, Austria, Netherlands, New Zealand, France, Chile, Costa Rica and Latvia are the ones who allocate the largest share of the government budget to social spending. China, Indonesia and Turkey are the ones that spend least. If we consider that the data take into account only the spending of the central government, which in the majority of cases provides centralized coverage of spending on education, health, social security, etc., the figures would actually be lower if they were expressed in relation to spending by the central government plus state, municipal or local governments where these items do not always account for the same share in the respective budgets.

Table O2 shows how little of AOD aid goes towards fighting poverty.

Table O3 shows that **development aid decreased in real terms in 1995**. According to the June 1996 report by DAC, OECD, while ODA increased 0.1% in current terms between 1994 and 1995, at constant 1994 prices and exchange rates that aid dropped 9.3% in 1995, for the third consecutive year. In 1995, ODA represented 0.27% of GNP of the donor countries, which is the lowest percentage since 1970. **Only four nations fulfilled the 0.7% commitment for that year: Denmark, Netherlands, Norway and Sweden**. Those four countries and Portugal are the ones that allocate more than 0.15% to aid to the least developed countries.

We wanted to create an index composed of the 16 indicators used as indices of advances, but the limited information available made this impossible: information on only 14 of the indicators was available for one country, while the next most well–covered nations could only offer nine of them for similar periods. This will therefore have to remain an objective for the future, with the hope that improvements in the provision of information on the indicators, as proposed by the international organisms, will start to provide fruit within the near future.

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3   In several of the following tables indicators appear which do not become indices as they lack sufficient information. Our intention is to include them afterwards, once the values are published for the previous and following years.

TIME IS LIFE

The reduction of the maternal mortality rate to half the 1990 level is one of the goals agreed to for the year 2000. This year, Social Watch's watch is keeping track of the progress on that goal based on data available in 1995. As seen in the graph, the countries in the 1995 position are those who are on time in goal fulfillment and who, if they continue at their current pace, will achieve the goal by the deadline. The countries who have done better, and who will reach the goal earlier if they keep up their current pace, are the ones positioned after 1995. The countries located between 1990 and 1995 have reduced maternal mortality but not enough to achieve the goal by the end of the millennium without making additional efforts. The countries who in 1994 showed the same rates as in 1990 are positioned at the latter date. Finally, the countries who recorded rates higher than the 1990 ones are positioned before 1990, depending on the magnitude of the setback.