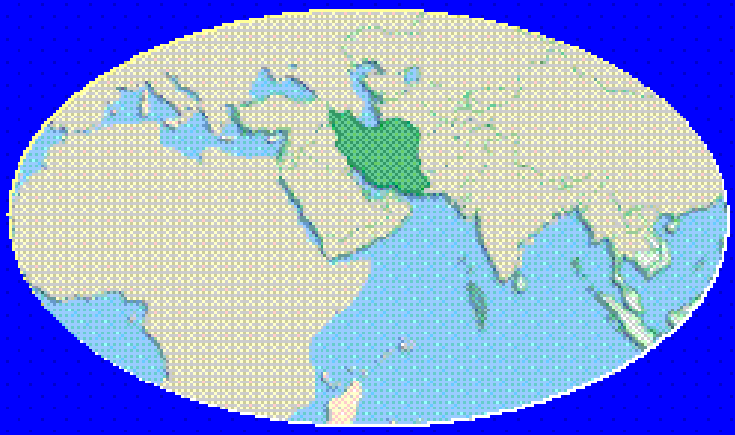
Islamic Republic of Iran

The First Millennium Development Goals Report 2004: Achievements and Challenges



2015
2010
2005
2000

In the name of God,
the Merciful, the Compassionate

The First Millennium Development Goals Report

Islamic Republic of Iran

Prepared by Office of the Deputy for Social Affairs,
Management and Planning Organization

in cooperation with
Institute for Management and Planning Studies and
United Nations in Islamic Republic of Iran

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Foreword by the Head of the Management and Planning Organization

In September 2000 at the United Nations' Millennium Summit, world leaders endorsed a set of time-bound and measurable goals and targets to combat poverty, hunger, diseases, illiteracy, environmental degradation and gender inequality and create a global partnership for development. This global agreement - now known as the Millennium Development Goals (MDGs) - was endorsed by all members of the United Nations. In developing countries, the MDGs are proving their potential to bring together a wide range of opinion- and decision-makers in support of a common development agenda.

The Islamic Republic of Iran pursues the MDGs in a wider Social Development framework. Hence, goals such as poverty alleviation, productive employment, education, health, empowerment of women, environmental protection and international cooperation for development have always been among the goals underscored in I. R. Iran's Five-Year Development Plans (FYDPs) over the past years. In this light, the *First National Report on MDGs* can provide a fresh opportunity for a targeted follow-up to these goals in the aforementioned plans.

The present report has realistically reviewed the country's achievements concerning the targets recommended by the Millennium Declaration and introduced the challenges that lie ahead. In addition, it has tried to provide a link between the challenges cited and the Fourth FYDP on one hand, and those challenges and international development cooperation, on the other.

The major achievements obtained by I. R. Iran concerning the targets specified by the MDG Indicators have so far included as follows. First, a considerable decrease of the population under the extreme poverty and those under the national poverty line as well as a notable reduction in infant and child mortality rates and maternal mortality ratio because of pregnancies and deliveries. Second, a substantial increase in the net enrolment rate in primary schooling and in the ratio of female to male students in tertiary education, the number of childbirths attended by skilled personnel, the ratio of the area protected to maintain biological diversity as well as the proportion of population with remarkable access to safe drinking water, telephone lines and personal computers.

Despite the achievements cited above, there are notable challenges in the way of attaining the targets of the MDGs by 2015, demanding systematic efforts in the upcoming years. The most important challenges include as follows. (a) Reducing both the population under the national poverty line and the poverty gap. (b) Providing the facilities needed for universal primary education in the deprived provinces. (c) Creating job opportunities for women, particularly the educated ones, and their increased participation in the country's decision-making system. (d) Improving qualitatively the maternal health programmes. (e) Seriously confronting HIV/AIDS spread, eliminating malaria and controlling tuberculosis. (f) Preventing environmental degradation. (g) Increasing access to Information and Communication Technology (ICT).

Although the Fourth FYDP (2005-2009) has adopted certain policies to achieve the MDGs, making those policies operational on the basis of the following measures will be important for realizing the targets by 2015. These are as follows: internalizing a pro-poor development strategy in the country's development planning system, identifying carefully the households under the poverty line in order to make well-targeted the subsidies, formulating and implementing strategies needed for accessing to universal primary education based on provincial requirements, expanding job opportunities for women especially the educated ones, extending the coverage of the Integrated Management of Childhood Illness (IMCI) throughout the country, improving the quality of the maternal health, strengthening the implementation of the "Five Year National Strategic Plan on confronting HIV/AIDS" (2002-2007) as well as malaria control programme and paying further attention to environmental considerations in the country's economic growth policies.

Along with the above-said measures, the Deputy for Social Affairs of the Management and Planning Organization (MPO) as the MDG Focal Point in the country can play a prominent role in achieving the goals through the following initiatives. First, making necessary coordination with Statistical Center of Iran (SCI) and other organizations concerned in order to make targeted the statistical processes for calculating the MDGs indicators in years to come. Second, institutionalizing the follow-up of the Millennium Development Goals in the context of the country's FYDPs, and also setting up an appropriate mechanism for better usage of international development cooperation to achieve the MDGs.

In conclusion, I would like to thank the team responsible for the preparation of the Report especially the MPO Deputy for Social Affairs as the National Coordinator, the Research Group and the Editorial Committee for their invaluable efforts to prepare I. R. Iran's First MDGs Report. The Institute for Management and Planning Studies (IMPS) is commended for its effective participation at the Research Group and the Editorial Committee. Also the MPO Bureaus concerned, Ministry of Health and Medical Education, the MPO Economic Studies and International Cooperation Bureau and United Nations Readers Group are appreciated for their comments on final draft of the Report. I sincerely hope this Report provide a suitable ground for institutionalizing the pursuit of the Millennium Development Goals in the country's development plans in the upcoming years.

H. R. Shorakaa

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Foreword by the United Nations Resident Coordinator

189 Heads of State came together at the United Nations Millennium Summit in New York and signed the Millennium Declaration, thereby strongly affirming the commitment and will of their nations and the international community to the achievement of the Millennium Development Goals (MDGs) by 2015. His Excellency President Mohammad Khatami signed the Millennium Declaration on behalf of the Islamic Republic of Iran.

The Goals essentially embody the agreed commitments made by the Islamic Republic of Iran and other countries at a range of United Nations Worlds summits and global conferences throughout the 1990s. In this connection, Iran's first Millennium Development Goals Report (MDGR) can now provide a strong momentum to the national development agenda and programmes. With the completion of the MDGR, a new stage in Iran's implementation of the MDGs begins. It is now important that citizens be informed of the report's objectives. They can become aware of how their lives will change for the better, at what pace and along what path. They can also fully understand the problems confronting the communities in which they live, and how they can be a part of the solution. This document should become familiar to everyone concerned with improving social and economic conditions in Iran.

With respect to the Goals, Iran has achieved much in its health sector, and in the establishment of health networks. There have also been great improvements in the education sector. But significant challenges remain with regard to environmental protection and HIV/AIDS, which will require more attention on the part of the state and all stakeholders. By the same token, extreme poverty in Iran is very low; but a considerable percentage of the people live still under the national poverty line.

As indicated above, the Islamic Republic of Iran has signed the Millennium Declaration, which urges states to pay close attention to their governance, human rights and democratization; there are indications that the Iranian authorities are preparing to collaborate in new programmes with the United Nations system in this area. I hope that this baseline report will be followed by practical measures to make real and positive changes in people's lives. The UN system in Iran remains committed to assisting the Iranian Government in its work towards this most important of all goals.

Finally, I should wish to thank the Management and Planning Organisation of Iran, the Institute for Management and Planning Studies, and my colleagues in the United Nations for their valuable contribution in the preparation of this report.

Frederick Lyons
UN Resident Coordinator

PREFACE BY THE EDITORIAL COMMITTEE: I. R. IRAN's MDGs STATUS AT A GLANCE

I.R. Iran's First Report on the Millennium Development Goals sets out the country's achievements, challenges and policies in meeting the goals, targets and indicators recommended at the United Nations Millennium Summit in September 2000 and in the Millennium Declaration adopted at that Summit by a large number of countries.

The Millennium Declaration, the United Nations guidelines on MDG definitions, rational and computing methods of MGDs Indicators as well as the United Nations Development Group guidelines concerning Country Reporting on MDGs have been employed as the basic methodological framework in order to prepare this Report. According to these guidelines, the MDG targets and Indictors, which have been applicable to I. R. Iran, have been identified. The Research Group started the process of data collection in a bid to calculate the Indicators and provide initial drafts on the country's performance of each goal in line with the aforementioned targets and Indicators. The Editorial Committee designed an overall structure for the Report and prepared the final text for each section of the Report on the basis of the initial drafts. The Committee divided the content of each goal into four categories: (1) Progress Achieved, (2) Enabling Policies and Programmes,(3) Major Challenges and Development Cooperation, and (4) Tracking Progress: Monitoring and Evaluation. The UN Readers Group, the MPO Bureaus concerned as well as the Ministry of Health and Medical Education read the final draft and offered their comments. The Editorial Committee incorporated the relevant comments and finalized the First Millennium Development Goals Report of the country. The whole process for the preparation of the Report has been directed by the National Coordinators.

An overview of MDG progress in I.R. Iran reveals that, while the country has realized significant achievements towards meeting the MDG targets, it still faces notable challenges which in turn call for systematic efforts in order to attain the recommended targets by 2015. This Executive Summary briefly describes the achievements already made and challenges that lie ahead. It also suggests priorities for future international cooperation between the Iranian development authorities and the International Development Agencies better to meet the targets of the Millennium Development Goals in forthcoming years. In conclusion, the Summary briefly weighs up the attainment to the goals, the state of national support, existing capacities for data gathering, quality of survey information, statistical tracking, use of data in policy making and monitoring progress.

Goal 1: Eradicate Poverty and Hunger

The Report analyzes the poverty situation in I.R. Iran mainly on the basis of these two indicators - extreme poverty and the national (food) poverty line. The percentage of the population with an income of under $ 1 (PPP) per day has fallen sharply to 0.62 percent in 2002 from 2.24 in 1995. However, once the indicator is estimated on the basis of an income of $2 (PPP) a day, which is closer to the practical minimum for the middle-income countries, more than 6 percent of the population remained in a situation of extreme poverty in 2002, creating a challenge for poverty alleviation. Even so, a more important challenge concerning poverty in I. R. Iran is to reduce the food poverty line, known as the "national poverty line" in the Report. According to the latest data, the food poverty line has significantly decreased from 12.75 percent in 1995 to 8.99 in 2002 for that section of the population unable to take in the minimum threshold of dietary energy set by the nutrition standards. The trend of the poverty gap ratio (1995-2002) reflects that the poor enjoyed a better position, because the gap has narrowed dramatically to 0.113 in 2002 from 0.558 in 1995 (on the basis of $1 PPP per day). The poverty gap ratio for the food poverty line has also been significantly reduced from 4.116 percent in 1995 to 2.238 in 2002. The rise in the share of total consumption of the poorest quintile from 6.8 percent in 1995 to 7.40 in 2002 proves that the poorest households have also benefited from a higher share. Nevertheless, reducing the poverty gap further and increasing the poorest quintile share continue to be notable challenges for the future.

In relation to the eradication of extreme hunger, the Report argues that the percentage of under-fives suffering from underweight has fallen sharply to 10.9 percent in 1998 from 15.8 in 1991. The prevalence of underweight children in rural areas lies at 13.7 percent, some 4.1 percent higher than in urban regions. About 50 percent of underweight rural children live in the Provinces of Sistan-Baluchestan, Khorassan, Hormozgan, Fars and Kerman where a major challenge is to lessen the huge underweight percentage by ensuring the sustained provision of micronutrients or fortified foods.

In order to face with the aforesaid challenges, the Report recommends a pro-poor development strategy that internalizes the poverty alleviation programmes in macro socio-economic policies. To design such a strategy, development planners need to spot carefully those social cohorts who live under the poverty

line, in an effort to propose better-targeted subsidies and other social protections in the context of socio-economic policies. In order to eradicate poverty and hunger, a top priority for future cooperation between Iranian development planners and the United Nations Development Programme (UNDP) could be the transfer of the successful international experiences to initiate the pro-poor development strategy that integrates different poverty and hunger alleviation measures into macro socio-economic policies.

Goal 2: Achieving Universal Primary Education

Universal primary education has always been a major concern of the development policies of the country. The net enrolment ratio expressed as the ratio of children in the 6-10 age group enrolled in primary schools to the total population of official school-age children steadily rose to 97 percent in 2002 from 85 in 1990. The proportion of pupils starting grade 1 who reach grade 5 increased from 87.1 percent in 1990 to 89.1 in 2002. In addition, the literacy rate for the 15-24 age group for both sexes has progressively enhanced. The rate for men has risen from 92.2 percent to 97.6, while that of women soared from 81.1 percent to 94.7 (1990-2002). In spite of the remarkable progress towards achieving universal primary schooling, meeting the target set for 2015 necessitates coping with some challenges. These include improving the weak economic conditions of the children's families in certain rural areas, making educational programmes more flexible, especially with a view to meeting the regional needs, overcoming geographical difficulties in order to access some rural and tribal regions, overcoming socio-cultural barriers to girls' education in some areas of the country, using international experiences to improve educational procedures and quality evaluation, identifying the illiterate and encouraging their attendance at training classes and furthering private sector participation in literacy campaign.

Goal 3: Promote Gender Equality

Four indicators are introduced here to measure the progress towards gender equality and empowerment of women. *First*, the ratio of female students in primary, secondary and tertiary education rose remarkably to 93.1 percent in 2002 from79.2 in 1990, thanks to the Government's policies set for improving gender equality in education. This rapid rise mainly resulted from the increase in the survival rate of female students at secondary level and more female entrants to higher education. An important achievement here is that the ratio of women to men in tertiary education has shot up to 110.5 percent in 2002 from 37.4 in 1990. Because of such remarkable progress, the Report argues that the target set out in Goal 3 of bridging the gender gap in primary, secondary and tertiary education by 2015 is attainable. *Second*, the ratio of literate women to men in the 15-24 age group has increased by 9.1 percent, rising from 87.9 in 1990 to 97 in 2002. The share of women in waged employment in the non-agricultural sector rose from 10.5 percent in 1990 to 12 in 2002. This rate continued to go up from 1990 to 1998 to reach 15.3 percent, although it then shrank back to stand at 12 percent in 2002. The main reason for this decline stems from an increase in job demands by women, as a result of the greater number of educated women. As a consequence, it poses a challenge for the development planners to create jobs for the educated women. *Third*, the percentage of seats held by women during four terms of the national Parliament increased from 2 percent in the Third Parliament (1988-1991) to 5 in the Sixth Parliament (2000-2003). However, it declined to 4.1 percent in the first year of the Seventh Parliament (2004). Women need to become further involved in management and decision-making positions.

Goal 4: Reduce Child Mortality

Infant and child mortality rates mirror the health status of the most vulnerable cohorts in a country. Three indicators measure progress towards the MDG target of reducing the under-five mortality rate by 2/3 (two-thirds) between 1990 and 2015 in I.R. Iran. *First,* the country has made remarkable progress in decreasing child mortality rate from 68 in1000 live births in 1990 to 36 in 2000, promising that the above target is attainable by 2015. *Second*, I. R. Iran has also made substantial progress in relation to the infant mortality rate, decreasing the rate by over 54 percent, from 52.5 in1000 live births in 1990 to 28.6 in 1000 in 2000. However, there should be further efforts in this regard in order to reach the recommended rate (ca. 17 in 1000 live births) by 2015. *Third*, the proportion of one-year-old children immunized against measles has increased from 85 percent in 1990 to 96 in 2001, showing that there is a reasonable probability that all one-year old children will be immunized against measles by 2015. The major challenges facing the country in reducing child mortality include incorporating the mortality reduction programmes into macro health policies, formulating provincial plans to diminish child and infant mortality rates, reducing neonatal mortality and mobilizing financial resources to realize this MDG target. Increasing the number of the cities to be under the umbrella of the IMCI programme and strengthening implementation of standard protocols for prenatal and postnatal care are among other challenges. Overcoming the above challenges requires developing future international cooperation on

transferring modern technologies to accomplish the programmes concerned, establishing a comprehensive death information registration system for child and infant deaths, introducing new educational methods for improved child nutrition, and identifying the children's burden of diseases.

Goal 5: Improve Maternal Health in the Context of Reproductive Health

The target of Goal 5, improvement of maternal health, is the reduction of the maternal mortality ratio by ¾ (three-quarters) between 1990 and 2015. Its Indicators that evaluate the extent to which the target is reached are the maternal mortality ratio and the proportion of births attended by skilled health personnel. The maternal mortality ratio per 100,000 live births has dropped sharply to 37.4 deaths in 1997 from 91 in 1989 in I.R. Iran. Likewise, the proportion of births assisted by skilled attendants has increased from 70 percent in 1989 to about 90 in 2000. Five major reasons directly affecting the shrinkage in maternal mortality include a decreased fertility rate, an increase in late marriages and childbirths, improved rural women's literacy, better access to emergency health (especially obstetric) services, and broadened provision of maternal and childbirth care due to expanded health networks and centres. Since 'improve maternal health' is addressed in the broader concept of reproductive health, the Report looks at the related reproductive health indicators in I.R. Iran. Most, though not all, of the reproductive health Indicators reveal a remarkable improvement in I. R. Iran. For instance, the contraceptive prevalence rate jumped from 49.6 percent in 1989 up to 73.8 in 2000. Moreover, the adolescent (15-19) fertility rate almost halved from 54 children per 1000 women in 1996 to 26.8 children per 1000 women in 2000.

The major challenges facing the country in relation to maternal health improvement in the context of reproductive health include making operational the standard protocols for providing pregnancy, delivery and post-delivery services, producing sufficient information on the side-effects resulting from pregnancy and childbirth, improving the quality of services rendered by mid-wives, promoting the quality of reproductive health including family planning services, ensuring reproductive health commodity security, creating a comprehensive national system to prevent maternal deaths, establishing an appropriate monitoring system for maternal care programmes, bridging data and information gaps on certain concepts of reproductive health such as the breast and cervical cancer and abortion, and addressing some aspects of reproductive health regarded as sensitive in the past, such as adolescent reproductive health. One priority for development assistance to face the aforementioned challenges includes the transfer of successful international experiences in different aspects concerned.

Goal 6: Combat HIV/AIDS, Malaria and Other Diseases

Another Millennium Development Goal focuses on combating HIV/AIDS, malaria and other major diseases. Its targets address halting by 2015 and beginning to reverse the spread of the major diseases. Some Indicators are specified for assessing progress made in achieving these targets. While prevalence of HIV/AIDS among 15-24 year old pregnant women reported cases was zero in 2003, the prevalence of the condom use rate by married women (15-49) was 9.3 percent in urban and 5.4 in rural areas in 2000. The contraceptive prevalence rate expressed as the percentage of women who are using, or whose sexual partners are using, any form of contraception has increased by about 10 percent, from 64.6 in 1991 to 73.8 in 2000. The total number of registered HIV/AIDS infected cases was calculated as 7,510 by late September 2004, of which 95.1 percent were men. When one overlooks cases were the mode of transmission is unknown (32.7 %), injecting drug use (57.4 %) is the highest mode of transmission responsible for the spread of HIV/AIDS in the country and the next highest mode (6.8 %) is through sexual contact. I. R. Iran is among those countries of the region showing low/moderate malaria endemicity. Good progress has been made in terms of reduction of malaria cases in the country. The prevalence of malaria has fallen sharply to 24.1 cases per 100,000 in 2002 from 103.5 in 1993; however, it has increased to 35.2 cases per 100,000 in 2003. The notification rate of tuberculosis has declined slowly from 24 cases per 100,000 in 1990 to 16 in 2003. Additionally, the percentage of estimated new infectious tuberculosis cases detected and cured under the directly observed treatment short courses (DOTS) exploded from 1 percent in 1995 to 100 in 2001.

There are two major challenges that adversely affect HIV/AIDS spread in the country. *First*, the rapid spread of HIV/AIDS and human trafficking for sex in neighboring countries to the north of I.R. Iran, and narcotics smuggling through eastern borders that affects domestic injecting drug use. *Second*, the cultural and legal consequences of extra-marital sexual behaviours, which keep those suffering from HIV/AIDS hidden since they do not present themselves to the relevant medical centers for treatment. This becomes more important when the young structure of the population and their vulnerability to HIV/AIDS are taken into account. The priorities for employing international development cooperation to face the challenges include the following. (a) Introducing new methods of locating HIV-positive people. (b) Establishing a comprehensive data bank on HIV/AIDS Surveillance. (c) Modifying cultural

and legal approaches that adversely influence the spread of HIV/AIDS. (d) Establishing regional cooperation with the aim of preventing drug trafficking. (e) Providing high quality Anti Retro-Viral medicines (ARVs) and Rapid Diagnostic Kits at a low price to those who need it.

Goal 7: Ensure Environmental Sustainability

A sustainable environment is another Millennium Development Goal, the first target of which deals with integrating the principles of sustainable development into socio-economic policies. Some Indicators evaluates the progress towards this target. These are the proportion of country's land areas covered by forests, which was 4.5 percent in 2001 according to the Food and Agricultural Organization (FAO) definition of forest coverage. If qualitative elements such as forest biomass, removal of superior species through substitution by inferior ones and biodiversity loss are taken into account, the forest destruction trend is also a source of concern. The ratio of the area protected for maintaining biological diversity to total surface area of the country has jumped to 7.11 percent in 2002 from 4.58 in 1997, while based on international standards, the protected zones should cover at least 10 percent of the total surface area of a country. Energy use (kilogram oil equivalent) per $1 GDP (PPP) has increased slightly from 0.309 kilogram in 1990 to 0.338 in 2001. Carbon dioxide emissions per capita have jumped up to 4,681 Kg in 2001 from 4,002 in 1996. Similarly, consumption of ozone-depleting CFCs has increased from 4,500 tons in 1995 to about 6,179 in 2001. Measures need to be taken to slow down the increase in the two Indicators cited above. The second target of Goal 7 tackles the issue of halving the proportion of people without sustainable access to safe drinking water and basic sanitation by 2015. The proportion of the population with sustainable access to an improved water source has increased slowly from 89.6 percent in 1990 up to 93 in 2000. Besides, the percentage of the population with access to the sanitation has significantly increased from 64.3 percent in 1990 to 82.8 in 2000. Despite notable progress towards sustainable development in I.R. Iran, there are still shortcomings, which include the lack of a comprehensive environmental information system and sufficient equipment for continuous monitoring of environmental degradation. A necessary confrontation with the pollutant governmental industries, paying due attention to environmental considerations in macro economic policies, low productivity in energy consumption and the low price of energy carriers are also central policy considerations. The major priorities for development assistance here include internalizing environmental concerns in the development planning model, providing technical advice on protecting biodiversity, natural resource and energy consumption projects as well as setting energy consumption standards.

Goal 8: Develop a Global Partnership for Development

The Eighth Millennium Development Goal aims at exploring ways in which the developed world can assist developing countries in order to achieve the other seven goals through more international development assistance. In the meantime, only four of the suggested targets are applicable in I.R. Iran, which include dealing with the debt problems of developing countries, providing support for a decent work strategy, accessing affordable and essential drugs in developing countries and making available the benefits of new technologies, especially information and communication technologies (ICTs). In line with the above targets, the proportion of debt service as a percentage of exports of goods and services has decreased remarkably in I.R. Iran from 59.2 percent in 1997 to 14.3 in 2002. The unemployment rate among 15-24 year olds was reduced to 19.2 in 1996 from 23.8 percent in 1990 but it rose back up to 28.2 percent in 2002. The number of telephone lines has soared from 4.04 per 100 population in 1990 to 23.2 in 2002; similarly, the number of personal computers per 100 population has more than doubled from 1.96 in 2000 to 4.80 in 2002. The number of Internet users per 100 population was 8.3 persons in 2003. There is no reliable estimate for the proportion of population with access (*one hour's walk*) to affordable and essential medicines on a sustainable basis.

As noted earlier, Goal 8 is aimed at facilitating international development cooperation in order to provide access to the other seven goals. Accordingly, a major challenge is building the institutional framework to put in place international cooperation for meeting the Millennium Development Goals. Clearly, a major priority is to help MPO Deputy for Social Affairs (the MDG Focal Point) in order to institutionalize the international cooperation needed to realize the Millennium Development Goals in I.R. Iran. Additionally, it should be borne in mind that further success in meeting the recommended MGD targets through the international development cooperation requires strengthening good governance as well as promoting human rights, especially the rights of children and women.

The Executive Summary ends with two boxes evaluating national performance in relation to the MDGs. Box 1 reveals how far each goal has been achieved and how well they are supported nationally. It reflects that I.R. Iran has been functioning strongly in terms of decreasing poverty and hunger, reducing child mortality and improving maternal health. However, the country has enjoyed a

fair performance on three other goals, namely universal accessing to primary education, improving gender equality and ensuring environmental sustainability. It should be reminded that performance on the HIV/AIDS campaign has been weak but is improving. Hence, there is a need to initiate more efforts in the future to meet the targets of these goals. This Box also demonstrates that the goals have enjoyed different levels of national support. A fair level of support can be observed for eradicating poverty and hunger, accessing primary education, reducing child mortality, improving maternal health and ensuring environmental sustainability, while gender equity as well as fighting HIV/AIDS and other diseases has been weakly advocated. As a consequence, the country requires more enabling policies and programmes in upcoming years for those goals that failed to be supported strongly.

Furthermore, Box 2 reveals the existing monitoring and evaluation capacities to achieve the MDGs. According to this Box, the data gathering capacity, the quality of survey information, the statistical tracking as well as monitoring and evaluation have been fair in the first five goals related to poverty and hunger, primary education, gender equality, child mortality and improve maternal health. However, they have been weak but improving in relation to creating a sustainable environment. Additionally, there has been poor tracking capacity for evaluating the progress on the HIV/AIDS campaign and a sustainable environment. The statistics have been used effectively to create the policies needed for child mortality reduction and maternal health improvement, fairly for universal primary education, gender equity and HIV/AIDS campaign, but weakly with regard to poverty and hunger as well as a sustainable environment. Finally, the MDG Focal Point is requested to provide the necessary coordination between the Statistical Centre of Iran and other related organizations in order to make the statistical processes targeted for calculating the MDG Indicators (especially on the basis of provinces and gender) in the years to come.

Editorial Committee
The First Millennium Development Goals
November, 2004

Box 1: MDGs Status at a Glance

Goals/Targets	Will the Goal/Target Be Met			State of National Support		
	Strong	Fair	Weak but improving	Strong	Fair	Weak but improving
Eradicate Poverty and Hunger Halve the proportion of people living in poverty and those suffering from hunger by 2015	☑				☑	
Achieve Universal Primary Education Ensure that, by 2015, children boys and girls alike, will be able to complete a full course of primary schooling		☑			☑	
Promote Gender Equality and Empowerment Women Eliminate gender disparities in primary and secondary education preferably by 2005, and to all levels of education no later than 2015		☑				☑
Reduce Child Mortality Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	☑				☑	
Improve Maternal Health in the context of Reproductive Health (RH) Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	☑				☑	
Combat HIV/AIDS Have halted by 2015, and begun to reverse, the spread of HIV/AIDS			☑			☑
Ensure Environmental Sustainability Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources		☑			☑	

Box 2: Monitoring and Evaluating Capacity

Goal	Existing Capacity for:														
	Data gathering Capacity			Quality of Survey info.			Statistical Tracking			Use of data in Policy Making			Monitoring and Evaluation		
	Strong	Fair	Weak	Strong	Fair	Weak	Strong	Fair	Weak	Strong	Fair	Weak	Strong	Fair	Weak
Reduce Poverty and Hunger		☑			☑			☑				☑		☑	
Enhance Education		☑			☑			☑			☑			☑	
Promote Gender Equality		☑			☑			☑			☑			☑	
Reduce Child Mortality		☑			☑			☑		☑				☑	
Improve Maternal Health in the RH context		☑			☑			☑		☑				☑	
Combat HIV/AIDS and Other Diseases		☑			☑				☑		☑			☑	
Ensure Environment Sustainability			☑			☑			☑			☑			☑

GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

Target- Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day.

Indicators: (1A) Proportion of population below $1 per day.
(2) Poverty gap ratio.
(3) Share of poorest quintile in national consumption.

Target- Halve, between 1990 and 2015, the proportion of people who suffer from hunger.

Indicators: (4) Proportion of underweight children (under 5 years of age).
(5) Proportion of population below minimum level of dietary energy consumption.

1- Progress Achieved

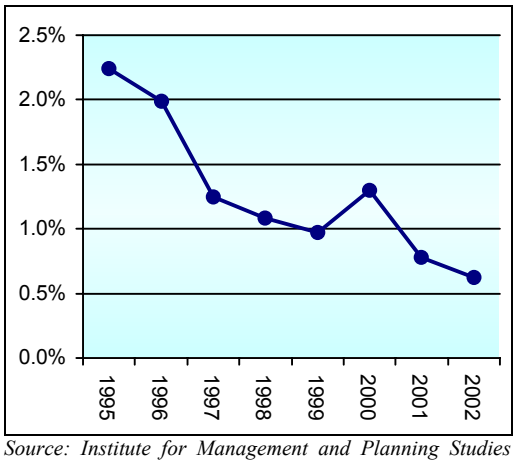
Eradicate Poverty

The growing gap between haves and have-nots is a primary concern. The MDGs were launched with a view to narrowing the gap between the rich and the poor. It is worth noting that poverty is no longer defined as a lack of income below some specific standards of living dubbed the 'poverty line'. Once MDGs are viewed from a holistic perspective, the need to keep an eye on non-economic aspects of poverty becomes more apparent. However, the First Millennium Development Goal concentrates on the eradication of extreme poverty and hunger followed by these two targets: First, to halve, between 1990 and 2015, the proportion of people whose income is less than $1/$2 (PPP) per day. Second, to halve, between 1990 and 2015, the proportion of people who suffer from hunger.

In order to explain the situation regarding poverty in I. R. Iran in the context of the MDGs, four indicators are to be analyzed as follows. (1) The proportion of the population that has an income of below $1/$2 (PPP) per day. (1A) The poverty headcount ratio, given as the percentage of the population below the national poverty line(s). (2) The poverty gap ratio that shows how far the poor are beneath the poverty line. (3) The share of poorest quintile in total national consumption.

Graph 1-1 and Table 1-1 show the trends of Indicator 1 along with the PPP Exchange Rate (P0). They both reflect that the percentage of the population under $ 1 (PPP) per day has fallen sharply to 0.62 percent in 2002 from 2.24 in 1995. Although there are no reliable estimates for 1990 as the base year, the trend proves that the target of halving the percentage cited above has been fulfilled.

Graph 1-1: Proportion of population below $1 (PPP) per day.



Source: Institute for Management and Planning Studies (IMPS) (2004).

Since in middle-income countries a poverty line of $2 (PPP) is closer to the practical minimum, Indicator 1(P0) has been calculated also on the basis of a PPP Exchange Rate as for $2 per day. The Indicator has decreased significantly from 13.46 percent in 1995 to 6.21 in 2002, proving that the target of halving the extreme poverty has been realized (See Table 1-1).

Table 1-1: Proportion of population below $1/$2 (PPP) per day (%).

Year	PPP Exchange Rate (Rial)	P0 by $1	P0 by $2
1995	619	2.24	13.46
1996	758	1.99	12.40
1997	845	1.25	9.47
1998	969	1.05	8.29
1999	1185	0.97	7.85
2000	1536	1.30	9.57
2001	1620	0.78	7.33
2002	1963	0.62	6.21

P0: Proportion of population below $1/$2 (PPP) per day.
Source: Institute for Management and Planning Studies (IMPS) (2004).

Indicator 2, the poverty gap ratio (P1), has been estimated on the basis of $1 and $2 (PPP) per day. The trend of Indicator 2 demonstrates that the poverty gap ratio has dramatically dropped to 0.113 in 2002 from 0.558 in 1995 (based on $1 PPP per day). Similarly, on the basis of $2 (PPP) per day, the ratio has fallen from 3.823 percent in 1995 to 1.536 in 2002. Both trends impressively fill the gap between the income levels of the poorest households and the $1/$2 (PPP) thresholds.

Emphasis must be placed on policies aimed at narrowing the poverty gap, mainly because they are crucial requirements for moving from protecting to enabling policies for poverty alleviation.

Table 1-2: Poverty gap ratio (%).

Year	P1 by $1	P1 by $2
1995	0.558	3.823
1996	0.505	3.488
1997	0.279	2.586
1998	0.240	2.158
1999	0.214	1.993
2000	0.246	2.507
2001	0.172	1.812
2002	0.113	1.536

P1: Poverty gap ratio.
Source: Institute for Management and Planning Studies (IMPS) (2004).

Nonetheless, there is a consensus among the experts and officials concerned that the $1 (PPP) per day approach cannot effectively describe the situation of poverty in I. R. Iran. Accordingly, the "Food Poverty Line" (Caloric Approach) has been suggested among others as a tool for estimating the national poverty line (Indicator 1A). The key reason why this approach has been chosen is that it is better designed for the purposes of monitoring and policy-making. Additionally, it also has a close relation with the indicators of the second target of the First Goal: the proportion of underweight children and population below minimum level of dietary energy consumption.

As is revealed in *Table 1-3*, the latest estimation for the Food Poverty Line (Indicator 1A) has significantly declined from 12.75 percent in 1995 to 8.99 in 2002 for the population unable to reach the minimum threshold of dietary energy intake as set by nutritional standards. The poverty gap ratio (P1) for this Indicator has also reduced remarkably from 4.116 percent in 1995 to 2.238 in 2002.

Table 1-3: P0 and P1 Based on Food Poverty Line (%).

Year	National (Food) Poverty Line	
	P0	P1
1995	12.75	4.116
2002	8.99	2.238

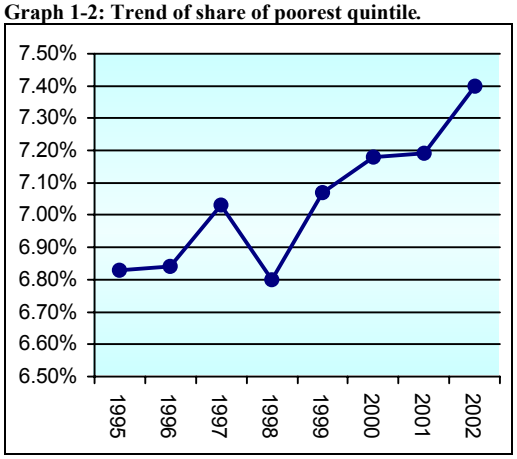
Source: Institute for Management and Planning Studies (IMPS) (2004).

The threatening percentage for nutritional poverty could endanger the health and lower the labour productivity of vulnerable groups. They will then be trapped in a vicious circle of sustainable poverty.

So far, the governmental policies aimed at decreasing the "Food Poverty Line" have been focused on subsidizing energy giving food items, in particular bread, sugar, edible oil, and lipids. Such a policy of subsidies is indiscriminate owing to its non-targeted nature and it will lead to an inappropriate dietary regime.

Graph 1-2 gives the poorest quintile share of total consumption (Indicator 3). The share, rising from 6.83 percent in 1995 to 7.40 in 2002, proves that the poorest households have benefited from higher share of private consumption.

Graph 1-2: Trend of share of poorest quintile.



Source: Institute for Management and Planning Studies (IMPS) (2004).

Eradicate Hunger

As noted earlier, Goal 1 also attaches importance to the target of halving the proportion of the people suffering from hunger between 1990 and 2015. Two indicators that measure progress towards meeting the target are the proportion of underweight children under 5 years of age and the proportion of population below the minimum level of dietary energy consumption.

Table 1-4 indicates the percentage of the underweight children under five years of age has fallen sharply to 10.9 percent in 1998 from 15.8 in 1991. As per this Goal, this indicator should continue to fall to about 8 percent. Thus it can be said that more than 62 percent of the target has been realized.

Table 1-4: Proportion of underweight children under 5 years of age (%).

1991	1995	1998
15.8	15.7	10.9

Source: PBO, NHDR (1999) and MOHME (1998).

According to the latest available data (Anthropometric Nutritional Indicators Survey 1998), one out of every nine children under five years of age is below the weight required for this age. Of this 10.9 percent, almost 8.7 percent are underweight as a result of malnutrition, and the remaining 2.2 due to their metabolic problems. The prevalence of under-weight children in rural areas is 13.7 percent, which is higher than the figure (9.6) for urban regions. About 50 percent of underweight rural children live in the provinces of Sistan-Baluchestan, Khorassan, Hormozgan, Fars and Kerman. Furthermore, nearly half of the underweight urban children live in Tehran, Khorasan, Khuzestan, Esfahan and Sistan-Baluchestan provinces.

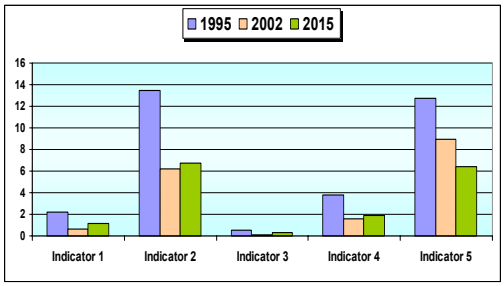
The decline in the percentage of underweight children (Indicator 4) is influenced by expansion of health services. Improvements can also be attributed to increased parental awareness, as seen also in the declining birth rate. The proportion of the population below the minimum level of dietary energy consumption (Indicator 5) is actually the same as P0 of the "Food Poverty Line." This has been estimated as 8.99 percent in 2002.

Box 1-1 and Graph 1-3 show the targeted poverty and hunger indicators (based on the MDGR Guidance Note, 2003) in 1995 and 2002. They also reveal where the Indicators should be in 2015 according to the Guidance Note. They clearly demonstrate that the target of halving the indicators have been so far fulfilled or might be met by 2015.

Box 1-1: Reducing poverty and hunger, 1995-2015 (%).

Indicators	1995	2002	2015
1)Proportion of population below $1PPP	2.24	0.62	1.12
2)Proportion of population below $2PPP	13.46	6.21	6.73
3)Poverty Gap Ratio by $1 PPP	0.56	0.11	0.28
4)Poverty Gap Ratio by $2 PPP	3.82	1.54	1.91
5)Proportion population below minimum level of dietary energy consumption	12.75	8.99	6.37

Graph 1-3: Reducing poverty and hunger, 1995-2015 (%).



2- Enabling Policies and Programmes

Combating poverty has been one of the most important objectives in the FYDPs in I. R. Iran over the past decades. A review of the most recent FYDPs offers an insight into programmes undertaken to reduce poverty from the national perspective.

The most significant measures taken in the Third FYDP to fight poverty include providing special programmes in the employment, housing and educational sectors for the poor as well as non-insurance support. These programmes seek to place an emphasis on creating the necessary facilities for people in need of care and attention, increasing their capabilities and self-reliance, and pensioning off those needy and unable to work. The coverage of the population by support organizations and groups (permanent services) has now increased from 4.7 million in 2000 to 5.5 in 2003. Similarly, the ratio of households with access to employment benefits from support agencies to the total number of households covered by support services grew from 15.9 percent in 2000 to 20 in 2002. The Government has also made reproductive health and family planning services free of charge and widely accessible through the primary health care system, which has resulted in decreased fertility and population growth rate. This results in reducing the dependency ratio and consequently influences the family income, per capita GDP and poverty rate.

In line with the Third FYDP, the Ministry of Social Welfare has been established to give the promise of harmonizing all social welfare activities under the same umbrella.

Moreover, the Iranian Government has adopted a more comprehensive approach in an effort seriously to fight poverty in its Fourth FYDP (2005-2009). Accordingly, in order to establish social justice and alleviate poverty, the Government is required to take the following measures through efficient and well-targeted resources allocation, especially in terms of improving the current subsidy system. These are as follows. (1) Effective expansion of the social security system to cover people in

all walks of life. (2) Implementation of tax regulations aimed at achieving a fair redistribution of income. (3) Annual estimates of absolute (extreme) and relative poverty line(s), and organization of social protection programmes designed to reduce the number of the population falling below the poverty line(s), focusing particularly on the lowest three deciles. (4) Creation of jobs for the poor and providing them with job training programmes. (5) Promotion of the participation of NGOs and charity institutions in poverty alleviation programmes. (6) Ensuring of nutritional safety and sufficiency to meet the requirements of the proper food basket by improved intake of micronutrients. (7) Increase in social insurance coverage. (8) Building of low cost residential units and offering specific housing facilities for those in the most need.

3- Major Challenges and Development Cooperation

Major challenges

The MDG approach tends to address poverty in the context of both of the extreme poverty ($1/$2 PPP per day) and the national poverty line(s). I.R. Iran has enjoyed success in reducing the extreme poverty; therefore, thanks to the low percentage of the population under the extreme poverty, the main challenge facing the country is to reduce the proportion (8.99 percent) of the population living under the Food Poverty Line. To meet this objective, there are some other major challenges to be addressed as set out below. (1) Poverty alleviation requires a higher economic growth rate and economic stability, which entails further employment opportunities and maintains the purchasing power. It means that a pro-poor growth policy in I. R. Iran ought to focus on generating more jobs for the poor and preserving their purchasing power. (2) Poverty reduction also needs to ensure equity in the distribution of gains and pains associated with macro-economic change. (3) A major challenge here is consequently to recognize with care those social cohorts that live below the poverty line, in a bid to design better targeted subsidies and other social supports. (4) Poverty alleviation policies should also aim at protecting vulnerable people in earthquake-prone regions. (5) Impoverishment caused by the want of effective health insurance coverage should also be prevented. (6) Poverty reduction requires maintaining the relatively low levels of fertility and population growth despite the large cohort of young people entering reproductive age. Slow population growth opens a "demographic window" of opportunity for economic growth and poverty reduction, as the ratio of dependants to working age population. (7) Poverty reduction policies should aim at promoting equity of access to basic health services for all vulnerable groups including children and mothers. (8) Poverty eradication when the community is engaged is a successful approach to fighting poverty; this involvement requires more attention in forthcoming years.

Concerning hunger and malnutrition, the major challenge is to decrease the huge percentage (about 50) of underweight children living in the aforementioned provinces, currently demanding immediate attention.

National priorities for development cooperation

International development agencies can assist the country to overcome the aforesaid challenges in framework of the following initiatives. (1) Designing a pro-poor development strategy that internalizes the poverty alleviation measures in macro socio-economic policies. (2) Preparing a comprehensive "Poverty Map" to recognize the deprived social groups. (3) Predicting preventive measures to support those vulnerable groups living in the disaster-prone areas. (4) Designing a special programme for vulnerable rural children in order to prevent their malnutrition in the aforementioned provinces. (5) Reviewing the correlation between the population and poverty in the country. (6) Establishing a national MDG monitoring mechanism and assessing national capacities for MDG implementation.

4- Tracking Progress in Eradicate Poverty and Hunger: Monitoring and Evaluation.

Supervisory Mechanisms	Evaluation			
	Strong	Fair	Weak but improving	Weak
Access to goal				
Capacity for data/information collection and assessment				
Follow-up, supervision and analysis				
Capacity for application of data analysis in policy-making and planning				
Presentation of necessary mechanisms in financial resource allocation				

Note: *Supervisory factors are evaluated with due attention to capacities and measures included in the Five Year Development Plans (FYDPs) and the use of statistical analysis in policy-making.*

GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

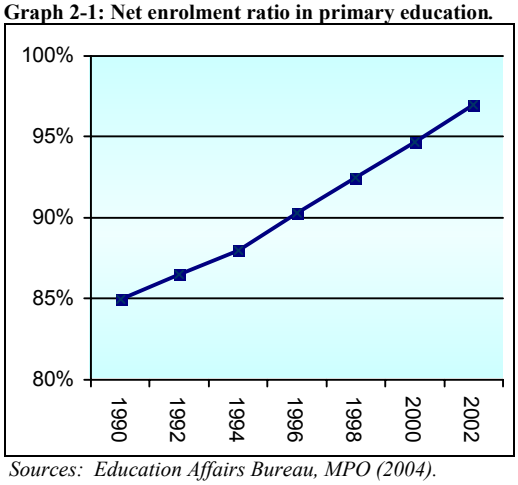
Target- Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling.

Indicators: (6) Net enrolment ratio in primary education.
(7) Proportion of pupils starting grade 1 who reach grade 5.
(8) Literacy rate of 15-24 year olds.

1- Progress Achieved

Based on the MDG approach, three indicators are used to evaluate the achievement of universal primary education, namely: the net enrolment primary education, the proportion of pupils starting grade 1 who reach grade 5 and the literacy rate among 15-24 year olds. The net enrolment ratio for primary education is the ratio of children of the 6-10 age group enrolled in primary schools to the total official population of school age children. A critical target for education planners is to pave the way for fully completing school attendance coverage of the 6-10 age group by 2015, strongly emphasizing various universal goals including the MDGs and EFA (Education for All).

Graph 2-1: Net enrolment ratio in primary education.



Sources: Education Affairs Bureau, MPO (2004).

The above *graph* indicates that I. R. Iran has achieved marked progress in this area. The net enrolment ratio (Indicator 6) rose steadily to 97 percent in 2002 from 85 in 1990 *(see technical note)*. Progress towards this Indicator proves the target of primary pupils' full enrolment has been largely accomplished. This outstanding progress is mainly contributed by the special priority given to universal education during the past decade as envisaged in the Second and Third FYDPs of the country.

Meanwhile, the remaining 3 percent gap in covering all primary school pupils should be bridged through coping with the following: Improving access to the primary education in very remote regions, promoting the economic situation of poor families using their children as income earners and removing some attitudinal obstacles in certain areas. The provinces most adversely affected by the above problems are Sistan-Baluchestan, Kordestan, Hormozgan, Ilam, Khuzestan, Western Azarbayejan and Kohgiluyeh-Boyer Ahmad.

To overcome such issues, the Third and Fourth FYDPs have designed particular programmes including: distance and correspondence learning, establishment of boarding schools, the development of educational infrastructures, and the modification of some cultural attitudes. Furthermore, the Ministry of Education has cooperated with the Management and Planning Organization (MPO) to formulate a National Action Plan on Education for All (2004), a goal of which is to enhance countrywide access to primary schooling for 6-10 age group.

The second Indicator (Indicator 7) to measure achieving universal primary education is the proportion of pupils starting grade 1 who reach grade 5, known as the survival rate to grade 5. The indicator increased from 87.1 percent in 1990 to 89.1 in 2002 as shown by *Table 2-1*.

Table 2-1: Pupils starting grade 1 who reach grade 5 (%).

1990	1992	1994	1996	1998	2000	2002
87.1	87.8	88.4	88.8	89.3	89.5	89.1

Source: Education Affairs Bureau, MPO (2004).

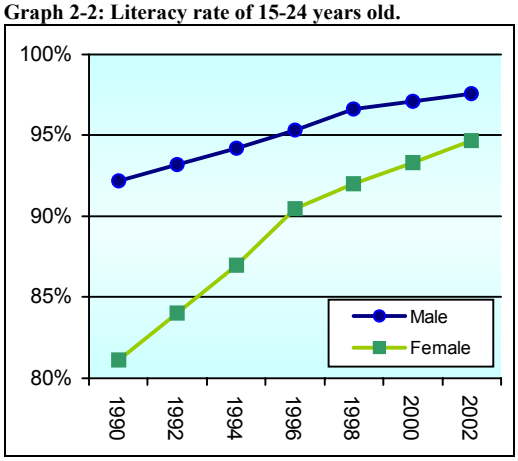
In terms of the educational system, the most significant reasons why some 10 percent of the pupils cannot reach grade 5 include the following. (a) The language barriers experienced by those children whose mother tongue is not the formal educational language of I. R. Iran (i.e. Farsi), particularly in the regions where local languages are predominantly spoken and (b) the low quality of educational methods and resources. Another challenge here is to improve the examination procedures in certain areas. Thus, one of the challenges facing the educational system is to raise its quality and make evaluation and

examination systems more flexible. The need to overcome such challenges has been underlined in the Third and Fourth FYDPs.

The third indicator (Indicator 8) to assess universal primary schooling is the literacy rate among 15-24 year olds. *Graph 2-2* shows that the literacy rate for the 15-24 age groups for both sexes has progressively increased. The rate for men has risen from 92.2 percent to 97.6, while that of women soared significantly from 81.1 percent to 94.7 over a twelve-year period (1990-2002).

Expanded unofficial literacy programmes from 1990 to 1998 led to desirable results in the campaign against illiteracy. Likewise, official education services to augment school attendance in different schooling groups have positively affected literacy figures in different age groups. Although these achievements have largely met the target, the remaining gaps (2.4 percent for male and 5.3 for female) in relation to the targeted literacy rate are deep-rooted in cultural and economic impediments.

Graph 2-2: Literacy rate of 15-24 years old.



Source: Statistical Bureau, LMO (2003).

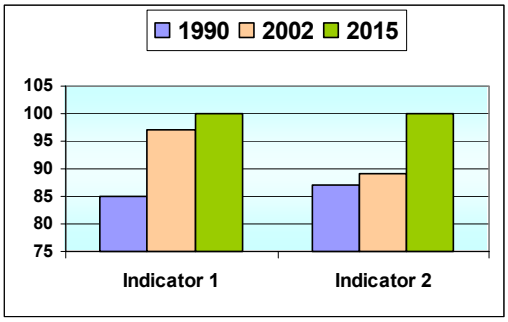
In the mean time, the Third and Fourth FYDPs have tried to deal with such obstacles. Over the past two decades, Literacy Movement Organization (LMO) has been effectively cooperating with the Ministry of Education in shouldering the responsibility of combating illiteracy countrywide and their efforts have played a key role in achieving the progress made.

Box 2-1 and Graph 2-3 show the targeted indicators for universal primary education in 1990 and 2002. They also reveal where the Indicators should stand in 2015 according to the MDG target. They prove the target has been largely accomplished so far and that the recommended target can be reached by 2015.

Box 2-1: Achieving universal primary education, 1990-2015(%).

Indicators	1990	2002	2015
1) Net enrolment ratio in primary education	85	97	100
2)Proportion of pupils starting grade 1 who reach grade 5	87	89	100

Graph 2-3: Achieving universal primary education, 1990- 2015(%).



2- Enabling Policies and Programmes

Achieving universal primary education has always been a priority of the FYDPs in I. R. Iran. The major policies and programmes highlighted in the Third FYDP in order to attain universal primary schooling consist of the following. (a) Provision of nation-wide coverage of primary school-aged population. (b) Financial support to feed boarding-school students in rural areas. (c) Expansion of literacy programmes. (d) Arrangement of preparatory language classes for those primary pupils whose main language is not Farsi.

In the Fourth FYDP, specific policies have been set out with the aim of achieving universal primary education. These include as follows. (1) Providing the necessary grounds for the National Action Plan on Education for All (EFA). (2) Making primary and secondary education compulsory. (3) Promoting training skills of teachers especially through setting professional teaching standards. (4) Formulating and implementing a strategic national literacy programme, taking into account the geographical, social and cultural conditions of various regions of the country. (5) Utilizing Information Technology (IT) to design and implement educational programmes. (6) Providing necessary facilities for abolishing educational deprivation, especially through the expansion of boarding schools and distance learning. (7) Improving the health and nutrition of the pupils. (8) Promoting scientific cooperation with out-standing international education and research institutions.

Concentrating on the "knowledge-based economy", the Fourth FYDP is designed to

complete the above policies by removing the obstacles in access to educational services, particularly for the poor and in the remote areas.

3-Major Challenges and Development Cooperation

Major Challenges

Achieving universal primary education concerning the above three indicators cannot be termed as a major concern in I. R. Iran. Nonetheless, fully realizing the MDG target necessitates prevailing over the following challenges by the country. (1) Producing precise statistics related to primary school-aged children. (2) Improving the weak economic conditions of the children's families in certain rural areas. (3) Making educational programmes more flexible, especially in order to meet regional needs. (4) Overcoming geographical difficulties in accessing some rural and tribal regions. (5) Making use of international experiences effectively to improve quality educational methods and evaluation. (6) Identifying and attracting the illiterate to training classes. (7) Modifying the governmental approach to the literacy campaign in order to involve the private sector more than before.

National priorities for development cooperation

International development organizations can support the Government and the NGOs concerned to overcome the aforesaid challenges through the following initiatives. (1) Transferring and localizing successful international experiences on literacy campaign methods. (2) Setting up an Educational Management Information System for I. R. Iran. (3) Building capacity among senior educational managers for planning the creation of equal educational opportunities. (4) Holding expert workshops designed to convey global experiences gained on teaching methods.

4- Tracking Progress in Primary Education: Monitoring and Evaluation.

Supervisory Mechanisms	Evaluation			
	Strong	Fair	Weak but improving	Weak
Access to goal				
Capacity for data/information collection and assessment				
Follow-up, supervision and analysis				
Capacity for application of data analysis in policy-making and planning				
Presentation of necessary mechanisms in financial resource allocation				

GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

Target -Eliminate gender disparity in primary and secondary education, preferably by 2005, and at all levels of education not later than 2015.

Indicators: (9) Ratio of girls to boys in primary, secondary and tertiary education.
(10) Ratio of literate females to males among 15–24 year olds.
(11) Share of women in waged employment in the non-agricultural sector.
(12) Proportion of seats held by women in the national Parliament.

1- Progress Achieved

Gender equality is another major concern in the MDGs. To achieve this goal, the elimination of gender disparity in primary, secondary and tertiary education has targeted. Four indicators have been introduced to measure progress towards gender equality and women's empowerment. These are as follows. The ratio of female to male students at all levels of education and the ratio of literate females to males among 15-24 year olds. The share of women in waged employment in the non-agriculture sectors. The proportion of seats held by women in the national Parliament.

The female to male students in primary, secondary and tertiary education (Indicator 9) is derived from the proportion of the number of female students enrolled at primary, secondary and tertiary levels to that of male students. The Indicator soared up to 93.1 percent in 2002 from 79.2 in 1990; thanks to the Governmental policies related to improving gender equality in education (*see Table 3-1*).

Table 3-1: Ratio of girls to boys in primary, secondary and tertiary education (%).

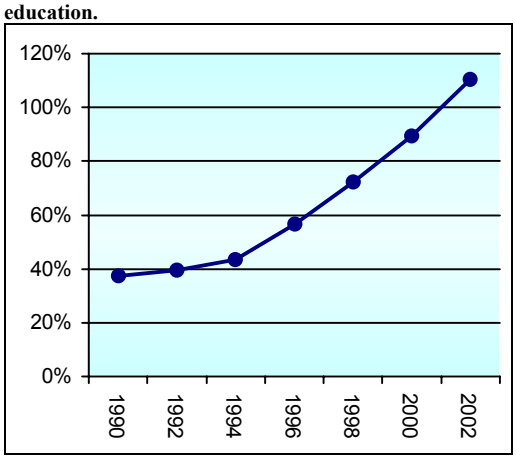
1990	1992	1994	1996	1998	2000	2002
79.2	81.6	83.7	86.5	88.2	91	93.1

Source: Education Affairs Bureau, MPO (2004).

The rapid rise in the above-mentioned ratio resulted mainly from an increase in the survival rate of female students at secondary school and more female entrants to higher education. The drop-out rate of male students, particularly at the secondary and tertiary levels, has partly contributed to the higher ratio of female students.

As *Graph 3-1* indicates, the ratio of female to male students in tertiary education has exploded to 110.5 percent in 2002 from 37.4 in 1990. The gap between male and female enrolments in primary and secondary education continues to be a concern and should be narrowed in the coming years.

Graph 3-1: Ratio of female to male students in tertiary education.



Source: Educational Affairs Bureau, MPO (2004).

Thus, the MDG target of bridging the gender gap in all levels of education by 2015 tends to be attainable. Of course, in order to achieve this target, it is essential that female education be emphasized in the policies of the future FYDPs. This can be accomplished through the application of innovative ways to address capacity building in human resources and educational methods, especially in provinces such as Sistan-Baluchestan, Kurdestan and Khuzestan where the ratio of girls to boys is still lagging behind other regions of the country.

Table 3-2 demonstrates that the ratio of literate women to men in the 15 to 24 age group has increased by 9.1 percent rising from 87.9 in 1990 to 97 in 2002. Success in attaining Indicator 10 has resulted from putting in place efficient government educational policies.

Table 3-2: Ratio of literate women to men 15-24 years old (%).

1990	1992	1994	1996	1998	2000	2002
87.9	90.2	92.6	94.9	95.3	96.1	97

Source: Education Affairs Bureau, MPO (2004).

The share of women in waged employment in the non-agricultural sectors (Indicator 11) is the proportion of the female workers expressed as a percentage of total employment in the sector. *Table 3-3* shows that the share mounted

from 10.5 percent in 1990 to 12 in 2002 (*see technical note*). This rate kept rising from 1990 to 1998 to reach 15.4 percent. It shrank back, however, to stand at 12 percent in 2002. The main reason for this decline stems from an increase in job demands by women as a result of the enhanced number of educated women and the improved socio-cultural bases for women's employment in the past five years.

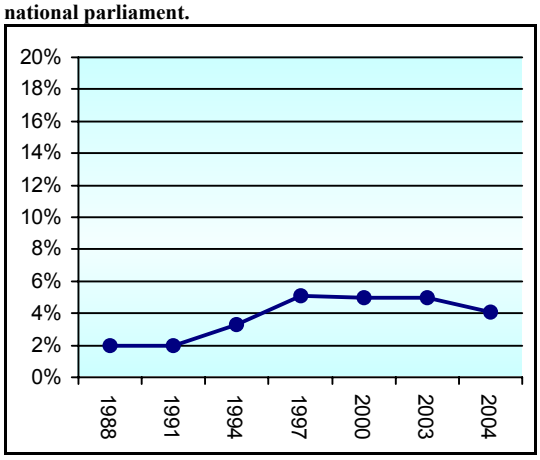
Table 3-3: Share of women in waged employment in the non-agricultural sector (%).

1990	1992	1994	1996	1998	2000	2002
10.5	11.2	12	13.1	15.4	15.3	12

Source: Macroeconomic Bureau, MPO (2004).

Indicator 12 reflects the number of seats held by women expressed as a percentage of all seats occupied in the national Parliament. *Graph 3-2* reveals the percentage of seats held by women during four Parliamentary terms increased from 2 percent in the Third Parliament (1988-1991) to 5 in the Sixth Parliament (2000-2003). However, it declined to 4.1 percent in the first year of the Seventh Parliament (2004).

Graph 3-2: Proportion of seats held by women in national parliament.



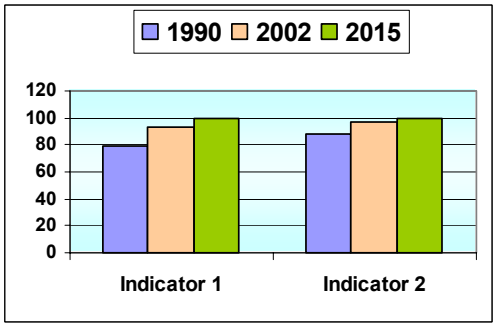
Source: Bureau of Elections, Ministry of the Interior (2004).

Box 3-1 and Graph 3-3 show the targeted gender equality Indicators in 1990 and 2002. They also reveal where the Indicators should be by 2015 based on the MDG target. They demonstrate that the target has been largely achieved so far. The MDG target on gender equality is likely to be attainable by 2015.

Box 3-1: Promoting gender equality, 1990-2015(%).

Indicators	1990	2002	2015
1) Ratio of girls to boys at all levels of education	79	93	100
2) Ratio of literate women to men 15-24 years old	88	97	100

Graph 3-3: Promoting gender equality, 1990-2015(%).



2- Enabling Policies and Programmes

The Third FYDP has taken seriously into consideration the following policies and programmes designed to promote gender equity. The Centre for Women's Participation (CWP) is required to undertake the necessary measures aiming at preparing the ground for women to play a significant role in the country's development while fostering the institution of the family. The major measures to be taken for preparing the necessary programmes included the following. (1) Recognizing the special educational, cultural and sporting needs of women on the basis Islamic principles and in anticipation of future developments in the society. (2) Expanding employment opportunities. (3) Facilitating women's legal and judicial access. (4) Supporting the formation of NGOs, which give priority to women heading households and those with no legal guardian in the less-developed regions.

The Fourth FYDP (2005-2009) predicts the strategies and policies required for diminishing gender inequity such as the following. (1) Creating equal opportunities for female and males at all educational levels. (2) Promoting women's participation in policy-making and civil society activities. (3) Empowering women through offering technical and vocational training. (4) Creating gender balance in labour market as a response to the increase in the percentage of educated women. (5) Formulating a comprehensive empowerment programme on women's rights. (6) Expanding social institutions to protect women's rights.

3- Major Challenges and Development Cooperation

Major challenges

Despite the remarkable advancement of women in education, their employment and participation in management and policy-making positions need to be further promoted. As a result, in order to promote gender equality

in I. R. Iran major challenges could be identified as follows. (1) Increasing employment for women, especially educated ones. (2) Promoting gender equality in the labour market. (3) Attracting more educated women into the education system as teaching staff. (4) Improving women's technical and vocational training programmes. (5) Reforming laws and regulations to attain higher gender equality. (6) Enhancing women's participation in management and policy-making positions. (7) Expanding NGOs aiming at protecting women's rights.

National priorities for development cooperation

International development agencies can assist the country to overcome the aforementioned challenges in framework of the following initiatives. (1) Identifying the methods for enhancing women's share in employment with respect to I. R. Iran's economic, social and cultural features. (2) Improving women's general job-seeking abilities. (3) Transferring international experience gained in increasing women's participation in decision-making procedures. (4) Identifying means for expanding NGOs to defend women's rights. (5) Reviewing the ways to remove cultural and social barriers that hinder training for rural women.

4- Tracking Progress in Gender Equality: Monitoring and Evaluation.

Supervisory Mechanisms	Evaluation			
	Strong	Fair	Weak but improving	Weak
Access to goal				
Capacity for data/information collection and assessment				
Follow-up, supervision and analysis				
Capacity for application of data analysis in policy-making and planning				
Presentation of necessary mechanisms in financial resource allocation				

GOAL 4: REDUCE CHILD MORTALITY

Target- Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.

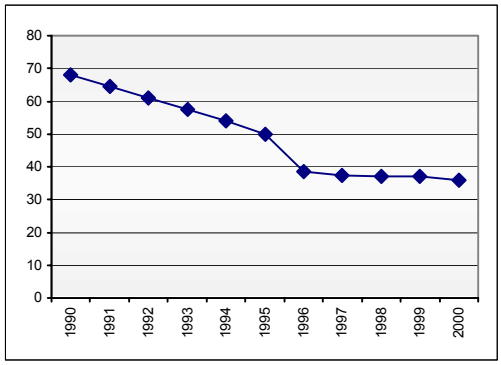
Indicators: (13) Under-five mortality rate.
(14) Infant mortality rate.
(15) Proportion of one year old children immunized against measles.

1- Progress Achieved

Infant and child mortality tells us about the health status of the most vulnerable cohorts in any country. In order to improve the health situation of these groups, the MDGs identify the target of reducing the under-five mortality rate by 2/3 (two-thirds) between 1990 and 2015. Three indicators monitor progress towards this target--the under-five mortality rate, the infant mortality rate, and the proportion of one-year old children immunized against measles.

The under-five mortality rate is the probability of a child born in any given year dying before they reach the age of five (Indicator 13). I. R. Iran has made remarkable progress in decreasing the child mortality rate. The under-five mortality rate has almost been halved, dropping to 36 in1000 live births in 2000 from 68 in 1990. This shows that the above target might well be attainable by 2015. *(See Graph 4-1)*

Graph 4-1: Under-five mortality rate (per 1000 live births).



Source: MOHME (2003), MOHME, DHS (2000) and PBO, NHDR (1999).

The main reasons why mortality rates declined during 1990s include a significant reduction of mortality due to acute respiratory diseases and diarrhea. Other factors contributing to this decline consist of expanded coverage of immunization and country wide free of charge access to safe motherhood and family planning services, malnutrition campaign, breast feeding initiatives and increased quality of care in health services.

The infant mortality rate, Indicator 14, is defined as the number of infants dying before they reach the age of one year old per 1,000 live births in a specified year. It should be noted that I. R. Iran has made a substantial progress, decreasing the rate by over 54 percent, from 52.5 in1000 live births in 1990 to 28.6 in 2000.

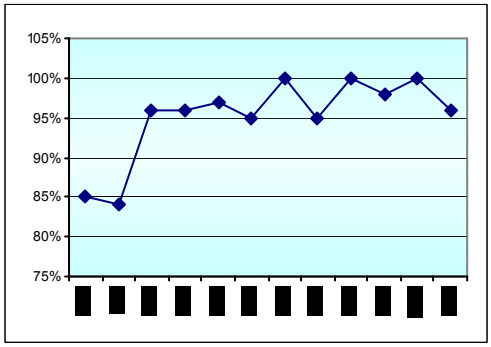
Table 4-1: Infant mortality rate (per 1000 live births).

1990	1992	1994	1996	1998	2000
52.5	48	32.5	31.7	NA*	28.6

Source: MOHME (2003) and PBO, NHDR (1999)
** Not available.*

More than 75 percent of infant mortality is in neonatal period. Premature births and low birth weight, congenital malformations, asphyxia and respiratory infections are major causes of death in infancy. Although infant mortality has declined progressively, neonatal mortality rate seems to be unchanged since 1990. The proportion of one year old children immunized against measles (Indicator 15) is the percentage of children under one year of age who have received at least one dose of measles vaccine. The Indicator has increased from 85 percent in 1990 to 96 in 2001.This trend shows that there is a high probability that all one year old children be immunized against measles in 2015. *(See Graph 4-2)*

Graph 4-2: Proportion of one year olds immunized against measles.



Source: MOHME (2003) and PBO, NHDR (1999).

A key reason for improving the above Indicator has been the expansion in measures taken to vaccinate publicly all children in the country. Implementing the strategy of measles vaccination, for nine month-old (the first dose) and 15 month-old infants, has played a prominent part in increasing the proportion of children under one year old vaccinated against the disease.

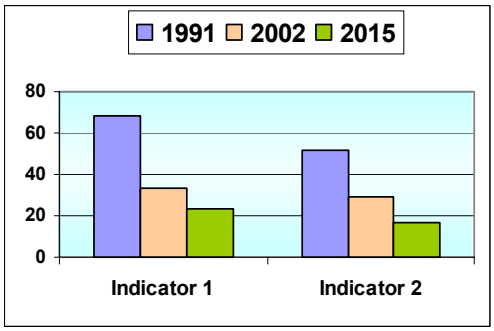
In 1983, MOHME launched a project to expand immunization, and effective steps have been taken so far. This national project sought to deepen active immunization for infants before the age of one, by administering and completing a programme of compulsory vaccinations for infants under one year old. It ensured the sustainability of the immunity level through booster shots for age groups above one-year old. The plan helped greatly reduce mortality rates and disabilities caused by diphtheria, whooping cough, measles, poliomyelitis, Tuberculosis (TB), tetanus and hepatitis B.

Box 4-1 and Graph 4-3 show the targeted child mortality indicators in 1990 and 2001. Additionally, they reveal where the Indicators should stand by 2015 according to the MDG target. They demonstrate that the target has been fairly well fulfilled so far. The MDG target on gender equality is likely to be attainable by 2015.

Box 4-1: Reducing child mortality 1990-2015 (per 1000 live births).

Indicators	1990	2001	2015
1) Under-five mortality rate	68	33	23
2) Infant mortality rate	52	29	17

Graph 4-3: Reducing child mortality 1990-2015 (per 1000 live births).



2- Enabling Policies and Programmes

While the First and Second FYDPs had envisaged "improving public health and reducing child and maternal mortality," the Third FYDP initiated more important policies and programmes to improve health and medical care for children. These are as follows. (1) Reducing the infant mortality rate. (2) Lowering the rate of pregnancy among under eighteen year olds and preventing unwanted pregnancies. (3) Promoting good nutrition among pregnant and breast-feeding mothers and paying more attention to child growth curves. (4) Encouraging breast-feeding. (5) Controlling and later eradicating both infectious and non-infectious diseases. (6) Improving the country's pharmaceutical system. In this light, the Third FYDP has also striven to carry out the following activities. (a) Formulating and implementing the Integrated Management of Childhood Illness (IMCI) Programme in three Iranian cities. (b) Expanding integrated care from sick child to healthy child. (c) Strengthening baby health care while in hospitals. (d) Increasing the number of mother- and child-friendly hospitals. (e) Improving the prenatal care programmes. (f) Formulating and implementing the Integrated Management of Healthy Child (IMHC) Programme.

While placing stress on previous policies, the Fourth FYDP also attaches importance to the reduction of child mortality through the followings. (1) The development of public health education. (2) Continued policies on restricting fertility. (3) Compulsory and public coverage of health insurance. (4) Financial resource allocation for primary health care programmes by the Government with the cooperation of the NGOs concerned and the general public. (5) Further extension of coverage of the IMCI throughout the country. (6) Expansion of the IMHC to children up to eight years old. (7) Improvement of the quality of services for newborn babies in those hospitals equipped with Newborn Intensive Care Units (NICU). (8) Further encouragement of breast-feeding.

In order to achieve the aforementioned policies, the Fourth FYDP intends particularly to undertake the following measures. (a) To prepare identity cards for all preschoolers. (b) To formulate and implement a programme for registering the factors leading to newborn babies' fatality. (c) To incorporate baby care training into the school curriculum. (d) To provide mothers with necessary training in breast-feeding. (e) To promote access to safe, clean deliveries and to improve the malaria and tuberculosis prevention programmes which place emphasis on survival during pregnancy. (f) To provide qualified Family Planning (FP) programmes in order to reduce unwanted pregnancies.

3- Major Challenges and Development Cooperation

Major challenges

In order to improve child health, especially reducing the under-five and infant mortality rate as well as increasing the proportion of one year olds immunized against measles, the following challenges have to be taken into account by the country. (1) Producing comprehensive statistics to evaluate the three mentioned Indicators. (2) Internalizing the measures to be taken for reducing child, infant and neonatal mortality rates in macro health policies. (3) Formulating decentralized (especially provincial) plans to reduce child and infant mortality rates. (4) Mobilizing financial resources to surpass the MDG target concerning the reduction of child and infant mortality. (5) Allocating sufficient budget for implementing newborn baby care programmes. (6) Increasing the number of the cities covered by IMCI/IMHC programmes. (7) Reducing infant mortality rate by addressing causes of neonatal mortality.

National priorities for development cooperation

To reduce child and infant mortality rates, the following cooperation between concerned Iranian bodies and their international development counterparts are to be prioritized. (1) Transferring modern technologies to increase the quality of care in hospitals and health centers. (2) Introducing a new holistic approach for child nutrition including local feeding recommendation. (3) Identifying children's burden of diseases. (4) Improving the country's Demographic and Health Survey (DHS) design.

4- Tracking Progress in Child Mortality Reduction: Monitoring and Evaluation.

Supervisory Mechanisms	Evaluation			
	Strong	Fair	Weak but improving	Weak
Access to goal				
Capacity for data/information collection and assessment				
Follow-up, supervision and analysis				
Capacity for application of data analysis in policy-making and planning				
Presentation of necessary mechanisms in financial resource allocation				

GOAL 5: IMPROVE MATERNAL HEALTH IN THE CONTEXT OF REPRODUCTIVE HEALTH

Target- Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.

Indicators: (16) Maternal mortality ratio.
(17) Proportion of births attended by skilled health personnel.
(17A) Reproductive Health (RH) indicators (adolescent fertility rate, Contraceptive prevalence rate, STIs etc).

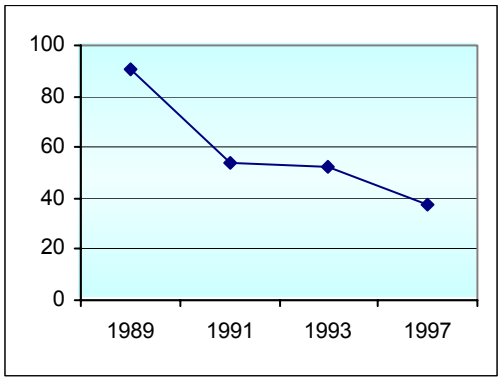
1- Progress Achieved

Millennium Development Goal Five targets the improvement of maternal health and has the sole aim of reducing the maternal mortality ratio by ¾ (three-quarters) between 1990 and 2015. Its Indicators assist in evaluating the extent to which the target has been reached, using the maternal mortality ratio, and the proportion of births attended by skilled health personnel. It should be noted that 'improve maternal health' is addressed in the broader concept of reproductive health, which covers the life cycle of women and men and address physical, psychological and social dimensions of reproductive health care. Moreover, the highest proportion of women's ill health burden is related to their reproductive role. Thus, reproductive health indicators should be evaluated in the context of Goal 5.

Maternal Health and Safe Motherhood

The maternal mortality ratio (Indicator 16) represents the number of women who die from any cause related to pregnancy and childbirth per 100,000 live births. *Graph 5-1* illustrates that the maternal mortality ratio per 100,000 live births has sharply declined to 37.4 deaths in 1997 from 91 in 1989.

Graph 5-1: Maternal mortality ratio (per 100,000 live births).



Source: MOHME (2003) and PBO, NHDR (1999).

The decrease in the maternal mortality ratio is directly related to five factors. (1) A decreased fertility rate. (2) An increase in late marriages and, hence, late childbirths. (3) Improved literacy rates among rural women. (4) Better access to emergency health services especially Emergency Obstetric Care (EOC). (5) Increased access to maternal and childbirth care due to the expansion of health networks and centers.

Fertility rate decrease. The average number of children born per woman was reduced to 2 in 2000 from 5.2 in 1990. As a result of this, the number of live births per 1000 (crude birth rate) has shrunk from 35 live births in 1990 to 16.3 in 2000. Hence, the decrease in the fertility rate is regarded as a factor for reducing maternal mortalities resulting from pregnancy and childbirth.

Increased late marriages and childbirths. The average age for first marriages has gone up to 24 from 19 during 1990s. It should be noted that childbirth for women under 19 years old doubles the danger of maternal death, compared to childbirth for women between 20 to 24 years old.

Enhanced rural women's literacy. The literacy among over 6 year old rural females has increased from 35 percent to over 75 in recent years.

Facilitated access to emergency health services. Only 10 percent of the rural population had no access to emergency health care in 2002. Furthermore, almost all public hospitals in urban areas enjoy emergency health care, particularly the Emergency Obstetric Care (EOC).

Improved maternal and childbirth care. Improved maternal care has reduced substantially the number of maternal deaths. The proportion of births attended by skilled health personnel (Indicator 17) represents the percentage of deliveries attended by the medically trained staff. *Table 5-1* shows the percentage of medically assisted births has increased remarkably from 70 percent in 1989 to 89.6 in 2000, which has reached to the recommended MDG target of 90 percent so soon before 2015.

Table 5-1:Percentage of deliveries attended by skilled personnel (%).

1989	1993	1997	2000
70	NA	86.1	89.6

Source: MOHME (2003) and PBO, NHDR (1999).
NA: Not available

Box5-1 (below) shows also the share of various causes influencing maternal mortality resulting from pregnancy and child delivery in 1996.

Box5-1: Causes of maternal mortality due to pregnancy and delivery (1996) (%).

Pre- and post-natal bleeding	29.3
Heart and coronary diseases	13
Eclampsia	14.4
Ill-defined diseases	9.4
Post delivery infections	8.9
Bleeding during pregnancy	6.3

Source: Health and Social Security Affairs Bureau, MPO (2004).

Reproductive Health

As noted earlier, improving maternal health is closely related to reproductive health situation; hence, it is necessary to look at the country's reproductive health Indicators. As *Table 5-2* (below) shows most, though not all, of the reproductive health Indicators reveal a remarkable improvement in I. R. Iran.

The progress cited above mainly refers to the establishment of a network of health facilities throughout the country. In rural areas each village, or group of villages, has a health house, staffed by trained personnel (or *behvarz)*, to provide primary health care and family planning services. Over 15,000 health houses serve the rural areas (approximately one for every 1,400 people). In addition, rural health centres (which include a physician as well as health technicians and administrators) deal with more complex health problems.

Table 5-2: Indicators of reproductive health.

Indicators	First Date	Value	Second Date	Value	Middle Income Countries(latest)
Life expectancy (year)	1989	62.9	1997	69.5	70
Infant mortality rate (per 1000 live births)	1989	57.9	2000	28.6	31
Under-five mortality rate (per 1000 live births)	1989	76.6	2000	36.0	39
Births attended by trained personnel (%)	1989	70.0	2000	89.6	
Maternal mortality rate (per 100,000 live births)	1989	91.0	1997	37.4	
Contraceptive prevalence rate (%)	1989	49.9	2000	73.8	
Adolescent (15-19) fertility rate (per 1000 women)	1996	54.0	2000	26.8	

Sources: PBO, NHDR (1999), MOHME (DHS) (2000) and World Development Indicators (2002).
Note: The final column shows the average figures for the World Bank category of middle-income countries in which I. R. Iran is included..

On average, there is one health center for every 7,500 people. Similarly, there are health posts and centers in urban areas. The whole network is managed and administered through district health centers, reporting to MOHME.

Family Planning

Family planning as one of the most important components of the reproductive health programme and it is accorded a great importance by I.R. Iran. The country's family planning programme is one of the most successful throughout the world. The contraceptive prevalence rate has increased from 49.9 percent in 1989 to 73.8 in 2000 (*Table 5-2*). Family planning services provide a wide range of contraceptive choices (pills, IUD, condom, injections, tubal ligation, no-scalpel vasectomy) free of charge throughout the Public Health Centres (PHCs) Network set up by the Government. In remote areas, MOHME provides these services through mobile clinics. The progress in this key Indicator (the contraceptive prevalence rate) is attributable to policies introduced in the framework of reproductive health care.

Up until 1990, I.R. Iran's family planning programme pursued three goals: preventing very early pregnancies and staggering pregnancies by three-year intervals, and encouraging women not to have more than three children. Subsequently, the programmes concentrated on maternal and child health services.

Since 1990, the PHCs have been engaged very effectively in counseling services and in making family planning and safe motherhood services widely available to millions of women, who have welcomed this opportunity to improve their own and their children's health. Although the family planning and safe motherhood programmes have been successfully implemented in the past years, there still remain challenges. For instance, the unmet need for family planning is estimated to be 8 percent. After the International Conference on Population and Development

(ICPD), the MOHME has expanded its family planning and safe motherhood programmes to include other aspects of reproductive health. The coverage of the reproductive health programme is over 80 percent in rural areas, nevertheless there are remote areas where there remain gaps in service provision. The issue of quality of care and unwanted pregnancies is now seriously being dealt with in the MOHME.

Adolescent Reproductive Health

Adolescent reproductive health is another concern in the country's reproductive health programme. It should be noted that a large section of the population born after the victory of the Islamic Revolution (1979), in a time of high fertility, is now entering or is already in the reproductive age. Thus, greater efforts are being devoted for increasing awareness among these adolescents about their reproductive issues. Due to the sensitivity of adolescent reproductive health, efforts are being made to address this question through formal and non-formal education channels such as Parent-Teacher Associations. This channel seems to be an appropriate and culturally accepted one, though it should be further strengthened.

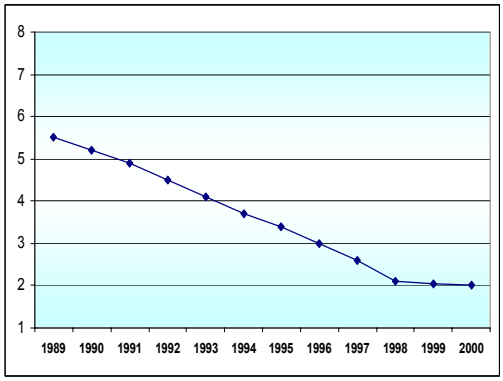
Although the programme for adolescent health in the country is in its early stages, the policymakers and health managers consider it a major issue in relation to reproductive health. For couples about to be married there are about 500 obligatory prenuptial counseling classes all over the country. Couples receive information on reproductive health, family planning, sexually transmitted infections, safe pregnancy and delivery, as well as referral procedures in case of any complications. Over the past few years, a number of steps have been taken to address the particular needs of young people, as well as young couples on the verge of marriage.

Prevention and Management of Unsafe Abortion and Sexually Transmitted Infections

Other aspects of reproductive health such as the prevention and management of unsafe abortion and Sexually Transmitted Infections (STIs) are also among priority areas. However, there is shortage of data with regard to these. Information on illegal abortion is inadequate. The Ministry of Health and Medical Education (MOHME) believes that high-quality counseling together with reliable, effective, modern contraceptive methods will reduce the number of unwanted pregnancies and hence illegal abortions. It should be noted that whilst abortion is illegal, except in special circumstances, post abortion services are available throughout the country in hospitals. There is a shortage of data on the prevalence of the STIs because of a lack of reporting, especially from the private sector clinics. The Government supports free provision of condoms for unmarried clients. Both male and female clients visit Sexual Transmission Disease (STD) clinics, where medicines for treatment of STIs are provided free of charge.

In conclusion, the reproductive health programme, especially the family planning, has had a significant effect on population growth in I.R. Iran. As a result, the annual population growth rate was almost halved from 2.46 percent in 1989 to about 1.20 in 2000. Accordingly, the country's Total Fertility Rate (TFR) decreased remarkably to 2 children from 5.5 over the same period (*Graph 5-2*). Since women's reproductive role directly affects their health, the decrease in population growth and in the TFR has also improved maternal health in the country.

Graph 5-2: Total Fertility Rate (1989-2000) (Person).



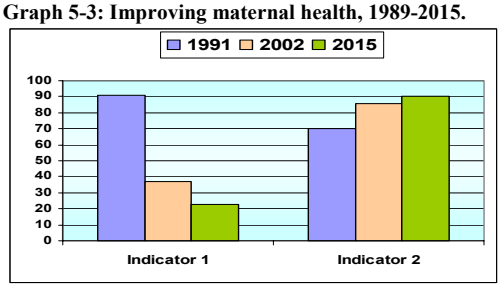
Sources: PBO, NHDR (1999) and MOHME (2002)

Box 5-2 and Graph 5-3 show the targeted maternal health indicators in 1989 and 1997. They also reveal where the Indicators should be by 2015 according to the MDG targets. They imply that the targets have been strongly achieved so far, thus the MDG targets will be attainable by 2015.

Box 5-2: Improving maternal health, 1989-2015.

Indicator	1989	1997	2015
1) Maternal mortality ratio(per 100,000 live births)	91	37	23
2) Percentage of deliveries attended by skilled personnel	70	86	90

Graph 5-3: Improving maternal health, 1989-2015.



2- Enabling Policies and Programmes

The improvement in maternal health in the context of reproductive health has always been one of the goals of the FYDPs. This objective has been pursued through health policies and programmes such as the following. (1) Expanding health network and centres in the country. (2) Organizing the emergency network. (3) Improving pharmaceutical system. (4) Expanding the health insurance system. (5) Promoting food security and safety in national and provincial levels. (6) Strengthening the family planning programme.

The Fourth FYDP has policies on its agenda regarding maternal health, including the empowerment of women to enhance their health.

Other measures include continued fertility control through the family planning programme, fostering a healthy life model, decreasing high-risk behaviours, making efforts to design and make operational a comprehensive health information system, providing the financial resources needed for primary health care by the Government, and promoting health-oriented insurances.

Special measures taken into account in the Fourth FYDP to put the above policies into place include the following: strengthening the standardized protocol for health services during pregnancy, childbirth and the post-natal period and striving to formulate a health system to prevent maternal deaths.

Other measures include taking the necessary actions to train delivery personnel in deprived village areas, making efforts to design a system for monitoring the progress of the maternal death prevention programme, and expanding mother-friendly hospitals.

The final one is undertaking the necessary coordination with insurance organizations as well as High Insurance Council to provide childbirth services cover for poor and low-income groups.

3- Major Challenges and Development Cooperation

Major challenges

A review of maternal health care in the context of reproductive health in I. R. Iran reveals the following challenges. (a) Making operational the standardized protocols for offering pregnancy, delivery and post-delivery services. (b) Producing sufficient information on the side effects resulting from pregnancy and delivery for both mothers and babies. (c) Improving the quality of service provided by midwives. (d) Enhancing the quality of reproductive health including family planning services, and ensuring reproductive health commodity security. (e) Creating a comprehensive national system for the prevention of maternal deaths. (f) Establishing an appropriate monitoring system for maternal care programmes. (g) Increasing awareness among adolescents about the reproductive health issues, including unwanted pregnancies during the early period of their married life. (h) Providing appropriate counselling and user-friendly RH services for youth and adolescents. (i) Bridging data and information gaps on certain notions of reproductive health such as breast and cervical cancer as well as abortion.

National priorities for development cooperation

One priority for improving maternal health may be the transfer of international experience in the following fields. First, in making operational the aforementioned standardized protocols. Second, in reviewing the side effects caused by pregnancy and delivery. Third, in improving the quality of services provided by midwives and the family planning clinics. Fourth, in setting up appropriate systems for operating maternal care programmes. Fifth, in reviewing the situation of unsafe abortion and the STIs, their effects on maternal health and the ways to prevent and control them. Lastly, in improving the adolescent health programme and pre- and post natal care.

4- Tracking Progress in Maternal Health: Monitoring and Evaluation.

Supervisory Mechanisms	Evaluation			
	Strong	Fair	Weak but improving	Weak
Access to goal				
Capacity for data/information collection and assessment				
Follow-up, supervision and analysis				
Capacity for application of data analysis in policy-making and planning				
Presentation of necessary mechanisms in financial resource allocation				

GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

Target- To have halted by 2015 and begun to reverse the spread of HIV/AIDS.

Indicators: (18) HIV prevalence among 15-24 year old pregnant women.
(19) Condom use rate of the contraceptive prevalence rate.
(20) Number of Children Orphaned by HIV/AIDS.

Target- To have halted by 2015 and begun to reverse the incidence of malaria and other major diseases.

Indicators: (21) Prevalence and death rates associated with malaria.
(22) Proportion of population in malaria-risk areas using effective treatment measures
(23) Prevalence and death rates associated with tuberculosis.
(24) Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS).

1- Progress Achieved

A further Millennium Development Goal focuses on combating HIV/AIDS, malaria and other major diseases. Its two targets address halting by 2015 and beginning to reverse the spread of HIV/AIDS, along with the incidence of malaria and other major diseases. Some Indicators are specified to measure in achieving these targets.

Indicator 18 is defined as HIV/AIDS prevalence among 15 to 24 year old pregnant women. This Indicator was zero in 2003 based on data collected from three urban antenatal clinic sentinel sites. Indicator 19, the condom use rate out of the total contraceptive prevalence rate, is the number of women aged 15-49 in marital and consensual unions who are using condoms as their means of contraception. As shown in *Table 6-1*, the *prevalence of* condom use over the contraceptive prevalence rate was 7.99 in 2000. Due to the relative share of urban and rural populations in relation to the total population of the country, some 5.4 percent of the prevalence rate was used in rural areas while 9.3 percent in urban areas in 2000. Since using condoms is the only effective contraceptive method to control HIV/AIDS infection, a special importance is attached to this Indicator.

Table 6-1: Prevalence of condom use rate by married women (15-49) (2000) (%).

	Condom to All Methods*	All Contraception Methods	Condom Use by Married Women (15-49)
Rural	**3.6**	**67.2**	**5.4**
Urban	**7.2**	**77.4**	**9.3**
Total	**5.9**	**73.8**	**7.99**

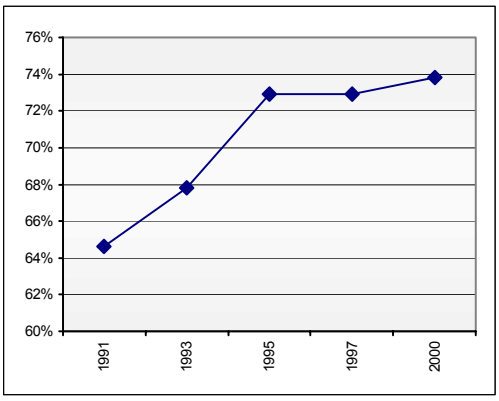
Source: MOHME, DHS (2000).
** **Condom to all methods** indicates rate of users based on a pilot study reported by the DHS taken from a statistical survey containing 114,000 households as a sample for the country.*

Indicator 19.A (condom use at last high-risk sex) is not available. Since I. R. Iran enjoys particular religious values and social norms, the number of condoms purchased by unmarried people is not registered. As a result, the rate for high-risk sex cannot be calculated.

Indicator 19.B, the percentage of the population aged 15-24 with an accurate knowledge of HIV/AIDS has at least more than doubled from 4.09 percent in 2003 to 8.60 in 2004. This figure is estimated on the basis of the only available source, namely the Ministry of Culture and Islamic Guidance.

Indicator 19.C, the contraceptive rate, is the percentage of women who are practising, or whose sexual partners are practising, any form of contraception. *Graph 6-1* shows that this rate has increased by about 10 percent, from 64.6 in 1991 to 73.8 percent in 2000.

Graph 6-1: Rate of marital women using contraception.



Source: PBO, NHDR (1999), MOHME, DHS (2000).

In order to offer further explanation on the share of various contraceptive methods as a proportion of the total contraceptive rate in the country, *Table 6-2* distinguishes the different shares of various methods. As this table shows, the *prevalence of* condom use rate for married women in comparison with all other methods

was 3.6 percent in rural areas compared with 7.2 in urban areas in 2000. Accordingly, the prevalence of condom use rate for married women is 5.4 percent in rural and 9.3 in urban areas in 2000 (Compare Table 6-1with Table 6-2).

Table 6-2: Prevalence rates of various contraceptive methods (married women aged 15-49) (2000) (%).

	Tubectomy	Vasectomy	IUD	Norplant	Injective Ampoule	Tablet	Condom	Total Modern Methods	Total Traditional Methods	Total (Country)
Rural	18.9	1.3	5.3	0.7	5.5	29.9	3.6	57.3	9.9	67.2
Urban	16.1	3.5	10.2	0.3	1.3	16.5	7.2	55.2	22.2	77.4
Total	17.1	2.7	8.5	0.5	2.8	18.4	5.9	55.9	17.8	73.8

Source: MOHME, DHS (2000).

Indicator 20, the number of children orphaned by HIV/AIDS is estimated on the basis of the number of children who have lost their mother, father or both parents to AIDS before age of 15. At present, no reliable estimate is available on this Indicator in the country, but it is going to be added to the new data collection system.

Table 6-3: Registered HIV/AIDS infected cases, based on gender and mode of transmission (2004).

Gender	Injecting Drug Users		Sexually Transmitted		Blood & Blood Products		Mother to Baby		Unknown		Total	
	No	%	No	%	No	%	No	%	No	%	No	%
Male	4,288	99.4	326	63.9	189	93.6	13	43.3	2,329	94.9	7,145	95.1
Female	26	0.6	184	36.1	13	6.4	17	56.7	125	5.1	365	4.9
Total	4,314	100	510	100	202	100	30	100	2,454	100	7,510	100

Source: MOHME, Centre for Disease Control (2004).

Table 6-3 offers further explanations on HIV/AIDS infected cases, especially on the mode of transmission for both sexes. According to the table, the total number of *registered* cases of HIV/AIDS infection was 7,510 up till late September 2004, of which 95.1 percent were men.

The table further discloses that the transmission mode includes 57.4 percent as injecting drug users, 6.8 percent through sexual transmission, 2.7 percent from blood and blood products, and 0.4 percent as mother to baby. In about 32.7 percent, the mode is unknown. When one overlooks cases where the mode of transmission is unknown(32.7 %), injecting drug users (57.4 %) represent the highest mode of transmission responsible for the spread of HIV/AIDS in the country. The next highest mode of transmission (6.8 %) is through sexual contact.

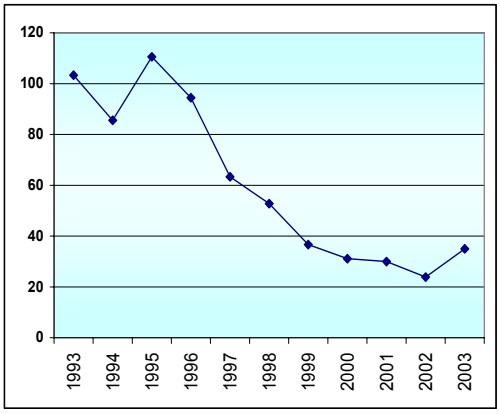
There are two major external reasons affecting the spread of HIV/AIDS in I. R. Iran. (1) Since the country is located on a major narcotics transit route in the Region and also neighbours Afghanistan (the biggest narcotics producer in the world) the drug addiction rate, particularly through injection has been growing in the country. (2) To the north of I. R. Iran, there are also the Newly Independent Countries (NICs) that are suffering from one of the fastest growing HIV/AIDS epidemics in the world. Therefore, the rapid spread of HIV/AIDS in neighbouring countries, especially as a result of narcotics smuggling has, in turn, caused the increase of HIV/AIDS infection amongst domestic injecting drug users.

There is also a domestic factor that adversely affects HIV/AIDS spread, related to the cultural and social consequences brought about by extra-marital sexual activities. As a result of this, those suffering from HIV/AIDS remain hidden and do not present themselves to the relevant medical centres for treatment. In conclusion, the spread of HIV/AIDS infection cannot be easily controlled and prevented.

The second target of this Goal deals with the incidence of malaria and other major diseases. The Indicators assessed in I. R. Iran include prevalence and death rates associated with malaria and tuberculosis (Indicators 21 and 23). It should be noted that Indicator 22 - the proportion of population in malaria risk areas using effective malaria prevention and treatment measures - was zero according to the latest available data. Control activities in order to eradicate malaria in the country have been integrated in the Primary Health Care since 1988. It is worth reminding that the countries of the Region are categorized into 4 groups according to their epidemiological and operational situation. Group 3 countries with low/moderate endemicity include Iraq, I. R. Iran, Saudi Arabia and Pakistan. Good progress has been achieved in the former three countries in terms of reduction malaria cases.

As demonstrated in *Graph 6-2,* the *prevalence of* this disease (Indicator 21) has fallen sharply to 24.1 cases per 100,000 people in 2002 from 103.5 in 1993 in I. R. Iran; however, it rose to 35.2 in 2003. Malaria is still a health problem in the Southeastern part of the country and its control of transmission in border areas is required. This should be realized through the facilitation of cross border movements of health authorities, an integrated national vector control programme, adoption of a uniform malaria drug policy and strengthening of the Malaria Control Program (MCP) at the national and provincial levels.

Graph 6-2: Prevalence rate of malaria (per 100,000).



Source: MOHME, Centre for Diseases Control, (2004).

The number of deaths associated with malaria in 2002 was estimated to be 2 persons (Indicator 21A). *Table 6-4* (below) shows the *notification rate of* tuberculosis illness slowly declined from 24 cases per 100,000 in 1990 to 16 in 2003. It should be noted the *prevalence rate* of tuberculosis is not available (Indicator 23).The number of deaths associated with tuberculosis per 100,000 people was calculated to be 0.9 person in 2001 (Indicator 23A).

Table 6-4: Notification rate of tuberculosis (per 100,000).

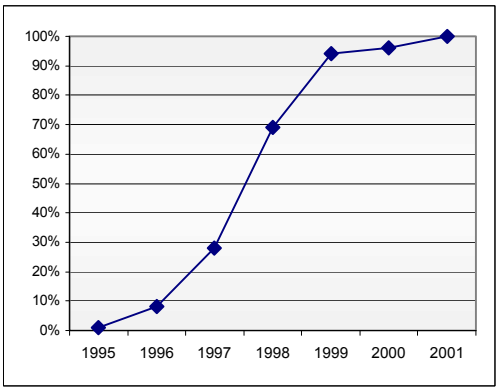
1990	1992	1994	1996	1998	2000	2003
24	42.9	22.6	22.6	19.3	19.9	16.2

Source: MOHME, Centre for Diseases Control (2004).

A challenge concerning tuberculosis control is the prevalence of Multi Drug Resistant (MDR) tuberculosis in the countries surrounding I. R. Iran. Each year, some 120-130 MDR cases are discovered in the country, 50 percent of whom are non-Iranians. Provision of the second line medicines for treatment of the MDR cases is a challenge due to high costs.

The tuberculosis detection rate represents the percentage of estimated new infectious tuberculosis cases detected under the directly observed treatment, short course (DOTS) case detection and treatment strategy (Indicator 24). The indicator has shot up from 1 percent in 1995 to 100 in 2001 (*Graph 6-3*).

Graph 6-3: Proportion of tuberculosis cases detected and cured under DOTS.



Source: MOHME Centre for Diseases Control (2004).

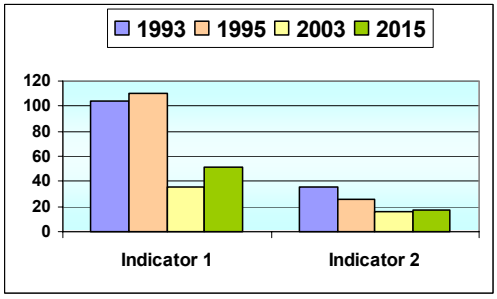
As noted, the DOTS coverage is 100 percent. However, the other two Indicators under DOTS strategy need improvement. The Case Detection Rate at present is 50 percent (WHO standard 70 percent). This is mainly due to the fact that sectors other than the PHC and public sector (i.e. private sector, health insurance schemes; other health care delivery systems) do not report to the MOHME. The other indicator, the Cure Rate, is 81-83 percent for I. R. Iran. The recommended standard is 85 percent.

Box 6-1 and Graph 6-4 show the targeted malaria and tuberculosis indicators in 1990 and 2002. They also reveal where the Indicators should stand by 2015 according to the MDG targets. They demonstrate that the targets have been reasonably well fulfilled so far. In order to meet the MDG targets by 2015, the country must make further efforts in forthcoming years.

Box 6-1: Combating malaria and tuberculosis, 1990-2015.

Indicators	1993	1995	2003	2015
1) Prevalence rate of malaria (per100,000 people)	103.5	110.5	35.2	51.75
2) Notification rate of TB (per 100,000 people	35	26	16	17.5

Graph 6-4: Combating malaria and tuberculosis, 1990-2015.



2- Enabling Policies and Programmes

As explained in relation to Goals 3, 4 and 5, the Third and Fourth FYDPs have adopted policies to promote the level of health in society. The most important of these relate to campaigns against diseases and concern controlling and eradicating preventable infectious diseases and curing non-infectious illnesses. The Fourth FYDP requires the MOHME and other bodies concerned to take the necessary measures for preventing and treating HIV/AIDS.

MOHME is currently running a five-year national strategic plan on confronting HIV/AIDS (2002-2007). The major strategies envisaged in the programme are as follows. Promoting public awareness and Information Education Communication (IEC), improving blood safety and strengthening HIV/AIDS prevention in the health care setting. Providing Voluntary Counselling and Testing (VCT) for people at risk, providing care and treatment for people living with HIV/AIDS, care and treatment for Sexually Transmitted Infections (STIs). Harm reduction among injecting drug users, strengthening research, monitoring and evaluation. Finally, providing social support for people living with HIV/AIDS.

With respect to the number of people infected with HIV/AIDS among injecting drug users, "Triangular Clinics" have been set up in Kermanshah Province in October 2000, on the basis of the above-cited policies. Three main measures have been taken in these Clinics. These are (1) reducing the level of risk among intravenous drug abusers, (2) curing people suffering from the sexually transmitted diseases and (3) protecting and supporting patients infected with HIV/AIDS. In fact, the clinics collect the above three groups together in order to facilitate the organization and provision of integrated services to these patients. Regarding the increased need for the VCT, prevention, care and treatment for injecting drug users, People Living with HIV/AIDS (PLWHA) and STIs, the "Triangular Clinics" are recognized as representing "best practice" in the Middle East and North Africa for controlling and preventing HIV/AIDS infection. These clinics have been so far established in all provinces where integrated services are being provided throughout the country. MOHME's most important priority is to integrate all the aforementioned services into the Primary Health Care System. This programme is being conducted as a Pilot in seven provinces.

In order to campaign against the infectious diseases, four major strategies have been adopted. These are developing and consolidating the health care system, developing human resources nation-wide, providing the resources required for health care services and formulating national programmes for combating infectious diseases and epidemics. Similarly, the BCG (Bacille Calmette-Guerin) immunization coverage along with other relevant medical cares has been successful in reducing the number of infections.

Specific activities accomplished during the past recent years are highlighted in Box 6-2 (below).

Box 6-2: Specific activities to combat HIV/AIDS.

- Forming a Supreme Planning Council for Preventing and Controlling HIV/AIDS disease.
- Integrating HIV/AIDS diagnosis and prevention programmes into the country's national health care system.
- Establishing some 100 consultation centres for HIV/AIDS.
- Holding dozens of retraining courses for the physicians and specialists on HIV/AIDS cure and prevention.
- Publishing some nine books including "Health Fostering" and "Guidance on Preventing HIV/AIDS."
- Including an HIV/AIDS introduction in high school textbooks and curricula reaching over 9 million pupils.
- Conducting observations in 78 "HIV/AIDS sentinel sites" and conducting over 30,000 HIV/AIDS tests for high-risk groups.

Source: Health and Social Security Affairs Bureau, MPO (2004).

3- Major Challenges and Development Cooperation

Major challenges

The major challenges to address in relation to controlling HIV/AIDS infection include the following. (1) Improving public attitudes towards HIV/AIDS infected patients. (2) Paying more attention to solve the issues concerning street women (3) Providing the necessary financial resources to prevent and control HIV/AIDS infection. (4) Amending rules concerning drug addiction. (Since drug addiction is considered a crime, HIV/AIDS infected addicts do not present themselves to medical centres for treatment). (5) Overcoming weaknesses in diagnosis and treatment facilities dealing with the disease, especially shortage of HIV/AIDS specialists, and professional training courses. (7) Reducing the high cost of diagnosing and treating the HIV/AIDS infected patients. (8) Streamlining the existing parallel bodies responsible for

treating and preventing the disease. (9) Increasing the involvement of non-governmental organizations in fighting malaria and TB.

National priorities for development cooperation

International development agencies can assist the country to overcome the aforesaid challenges in framework of the following initiatives. (a) Introducing new methods for locating HIV positive people. (b) Establishing a comprehensive data bank on the HIV/AIDS Surveillance. (c) Implementing effective outreach programmes. (d) Offering educational facilities to domestic specialists particularly to familiarize themselves with modern methods of HIV/AIDS treatment and prevention. (e) Accelerating assistance from international bodies such as the Global Fund to back up the recent national programmes on fighting HIV/AIDS. (f) Modifying cultural and legal approaches that adversely affect HIV/AIDS spread. (g) Cooperating regionally to curb drug trafficking. (h) Providing high quality Anti Retro-Viral medicines (ARVs) and Rapid Diagnostic Kits at low prices to those who need them. (i) Involving the PLWHA in policy making and related programme implementation. (k) Capacity building among care providers and the public. (l) Providing social support to positive people to relieve stigmatization

4- Tracking Progress in Combat HIV/AIDS and Other Diseases: Monitoring and Evaluation.

Supervisory Mechanisms	Evaluation			
	Strong	Fair	Weak but improving	Weak
Access to goal				
Capacity for data/information collection and assessment				
Follow-up, supervision and analysis				
Capacity for application of data analysis in policy-making and planning				
Presentation of necessary mechanisms in financial resource allocation				

GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

Target- Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources.

Indicators: (25) Proportion of land area covered by forest.
(26) Ratio of area protected to maintain biological diversity to surface area.
(27) Energy use (kg oil equivalent) per 1$ GDP (PPP).
(28) Carbon dioxide emissions (per capita0 and consumption of ozone depleting CFCs (ODP tons).
(29) Proportion of the population using solid fuels.

Target- Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation.

Indicators: (30) Proportion of population with sustainable access to an improved water source, urban and rural.
(31) Proportion of urban and rural population with access to improved sanitation.
(32) Proportion of households with access to secure tenure.

1) Progress Achieved

A sustainable environment is the subject of another Millennium Development Goal. Two of the targets of this MDG will be discussed here and evaluated on the basis of the related available Indicators. Since reliable data on the proportion of households with access to secure tenure is not available, the Report overlooks the third target of Goal 7.

The first target deals with integrating the principles of sustainable development into national policies and programmes and with reversing the loss of environmental resources. Indicator 25 represents the proportion of land area covered by forest areas as a share of total land area.

It is worth remembering that I. R. Iran is included among arid and semi-arid countries. The average rainfall - lower than the world average and also that of the Asian Continent - is estimated to be 250 mm annually. As a result, I. R. Iran's plant coverage is limited. However, due to existing biodiversity, there is a remarkable biodiversity of flora. Increased population along with unplanned exploitation of the resources over the past decades made forest destruction an environmental problem in I. R. Iran as with many other developing countries.

According to available estimates, the forested area (12.4 million hectares) is about 7.5 percent of the country's total area during the 1990s. Indicator 25 as defined by FAO is forest coverage i.e. land with an existing or expected tree canopy of more than 10 percent and a total area of more than 0.5 hectares where the trees should be able to reach a minimum height of 5 meters. According to these criteria, forest coverage (Indicator 25) in I. R. Iran has been estimated in 2000 at 7.3 million hectares (4.5 percent of the country's total area). The figure has remained unchanged since the 1990s. As shown in *Table 7-1*, the proportion of land areas covered by forests is 4.5 percent according to the above definition.

Table 7-1: Proportion of land areas covered by forests.

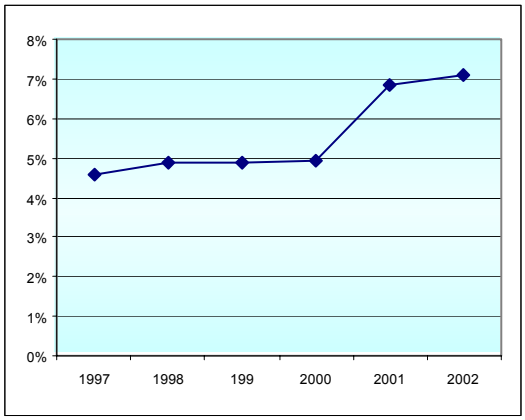
Year	1990	1992	1994	1996	1998	2001
Percent	4.5	4.5	4.5	4.5	4.5	4.5

Source: Agriculture and Natural Resources Bureau and Industries and Mines Affairs Bureau, MPO (2003).

However, if qualitative elements such as forest biomass, removal of superior species through substitution by inferior ones, biodiversity loss etc, are taken into account, the forest destruction trend is also considered a cause for concern. Therefore, the deforestation in I. R. Iran can be regarded also as a "qualitative" issue rather than simply a "quantitative" one.

The ratio of area protected to maintain biological diversity to surface area is defined in terms of nationally protected areas as a percentage of total surface area of a country (Indicator 26). The protected area has, remarkably, increased from 7.6 million hectares in 1997 to 11.7 in 2002. In other words, the ratio of area protected to maintain biological diversity has soared to 7.11 percent in 2002 from 4.58 in 1997 (See *Graph 7-1*).

Graph 7-1: The ratio of area protected to maintain biological diversity.



Source: Department of Environment (2002).

Improving and preserving biodiversity have always been among the environmental objectives of the country. The Department of Environment (DoE) as the national authority responsible for safeguarding the environment has selected some of the country's virgin lands and untouched natural habitat rich in ecological value to further protect and promote ecological diversity. These include national parks, national natural sites, wildlife refuges, and protected areas. In 2002, they included 94 protected areas, 33 wildlife refuges, 13 national natural sites and 16 national parks, covering nearly 7.11 percent of the country's total land surface (Indicator 26). According to international standards, protected zones should cover at least 10 percent of the total surface area of every country. However, this proportion for I. R. Iran was 7.11 percent in 2002, as noted earlier. Of course, it appears that this ratio will match the international standards by 2015, thanks to the environmental policies of the Government.

Indicator 27, as energy use (kilogram oil equivalent) per $1 GDP (PPP), is commercial energy use measured in units of oil equivalent per $1 of GDP. *Table 7-2* demonstrates that the Indicator has increased slightly from 0.309 Kg in 1990 to 0.338 in 2001. (*see technical note*)

Table 7-2: Energy use per $1 GDP (PPP).

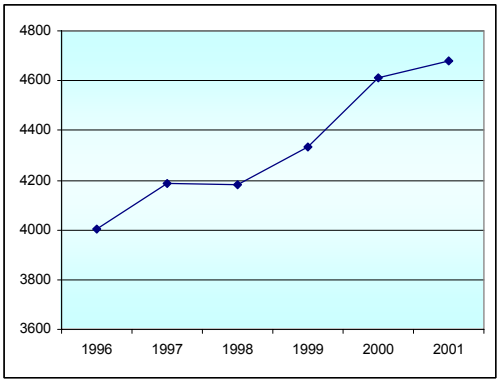
Year	1990	1992	1994	1996	1998	2001
Kg	**0.309**	**0.297**	**0.332**	**0.314**	**0.332**	**0.338**

Source: Energy Affairs Bureau, MPO (2003).

As we can observe from this table, the Indictor has decreased to 0.314 Kg in 1996 from 0.332 in 1994, partly due to the sudden jump in the price of energy carriers.

Per capita carbon dioxide emissions (Indicator 28) are defined as the total amount of carbon dioxide emitted by a country divided by its population. *Graph 7-2* shows that the Indicator has jumped up to 4,681 Kg in 2001 from 4,002 in 1996.

Graph 7-2: Carbon dioxide emissions per capita (Kg).



Source: Balance Sheet of Energy, Ministry of Energy (2001).

Another indicator (28.A), the consumption of ozone-depleting CFCs, is defined as the sum of the consumption of the weighed tons of the individual substances in the group i.e. metric tons of the individual substance multiplied by its ozone-depleting potential. As shown in Box 7-1, the consumption of ozone-depleting CFCs has increased from 4,500 tons in 1995 to about 6,179 tons in 2001. Measures need to be taken, therefore, to slow down the increase.

Box 7-1: Consumption of ozone-depleting CFCs (tons).

Years	Consumption (tons)
1995	4500
1996	4000
1997	7050
1998	6645
1999	4990
2000	5028
2001	6179

Source: Department of Environment (2003).

Indicator 29, the proportion of the population using solid fuels is the ratio of the population that relies on biomass (wood, charcoal, crop residues and dung) and coal as the primary source of domestic energy for cooking and heating. This Indicator is not available for the time being.

The second target deals with the objective of halving, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation. Indicator 30, the proportion of the population with sustainable access to an improved water source is the percentage of the population who use certain types of water supply. *Table 7-3* demonstrates that this Indicator has increased from 89.6 percent in 1990 up to 94 in 1996. It decreased to 93 percent in 2000.

Table 7-3: Proportion of people with sustainable access to safe drinking water.

Year	1990	1992	1994	1996
Percent	**89.6**	**92.6**	**93.3**	**94**

Source: PBO, NHDR (1999).

Indicator 31 is defined as the proportion of the population with access to improved sanitation. The percentage of the population having access to the improved sanitation has significantly increased from 64.3 percent in 1990 to 82.8 in 2000 (MICS 1997 and DHS 2000).

The third target deals with the aim of achieving a significant improvement in the lives of at least 100 million slum dwellers. Indicator 32 is defined as the proportion of households with access to secure tenure (one

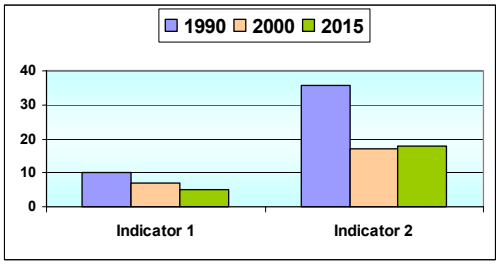
minus the percentage of the urban population that live in slums). The percentage for this Indicator is at present unavailable.

Box 7-2 and Graph 7-3 show the targeted sustainable environment indicators in 1990 and 2000. They also uncover where the Indicators should be by 2015 based on the MDG targets. They demonstrate that the targets have been fulfilled fairly well so far, hence the MDG targets will be attainable by 2015.

Box 7-2: Ensuring environmental sustainability, 1990-2015 (%).

Indicators	1990	2000	2015
1)Proportion of the population without sustainable access to safe drinking water	10	7	5
2)Proportion of the population without access to improved satiation	35.7	17	17.8

Graph 7-3: Ensuring environmental sustainability, 1990-2015 (%).



2- Enabling Policies and Programmes

The following significant environmental policies have been underscored in the Third FYDP. (1) Exploitation of natural resources should be carried out on the basis of their potential. (2) To reduce the environmentally polluting agents, especially those that pollute natural and water resources, manufacturing units are required to take measures to make their technical specifications conform to environmental standards in order to decrease the level of pollution. (3) All large production projects and those providing services must, at the feasibility study stage and before execution, be subject to environment impact assessment (EIA), on the basis of criteria to be drafted by the High Council of the Environment and approved by the Cabinet. (4) Standards and technical specifications relating to energy consumption in equipment and in consumption systems should be prepared and codified. (5) A high-level committee shall draw up regulations and criteria for the observance of energy consumption standards in the design and construction of buildings in the public and private sectors, aiming at avoiding energy wastage.

The Fourth FYDP places stress on "environmental protection to achieve sustainable development." The major policies designed to achieve this are as follows. (a) Reducing and preventing pollutants in the production, infrastructure and service sectors. (b) Environmental monitoring of production, infrastructure and service projects. (c) Reforming production and consumption patterns in line with sustainable development. (d) Managing, refining and controlling environmental pollutants. (e) Reducing air pollution in large and polluted cities. (f) Preserving biodiversity through the establishment of ecological management. (g) Formulating a comprehensive environmental information system. (h) Exploiting natural resources in a sustainable manner and taking into consideration the natural potential of the ecosystem in national and regional development programmes. (i) Developing natural resource management schemes (within the framework of forestry and rangeland programmes). (j) Establishing a monitoring system for the qualitative and quantitative control of water resources. (k) Formulating and implementing structural reform within the Department of Environment as well as the Forest and Range Land and Watershed Organization. (l) Designing and implementing public awareness programmes for the protection of water resources and optimizing their exploitation. (m) Assessing the economic value of environmental resources and the costs of environmental pollution and degradation in the development process, also taking this into consideration in national accounts. (n) Setting realistic energy carrier prices. (o) Continuing to substitute oil products with natural gas, especially in the industry and transportation sectors. (p) Putting into action optimized energy consumption plans and promoting technologies related to factory equipment and energy consumption systems in order to reduce air pollution and energy consumption.

3- Major Challenges and Development Cooperation

Major challenges

Despite real progress, there remain shortcomings to overcome, for instance there is the lack of a comprehensive environmental information system and sufficient equipment to monitor continuously environmental issues. There are some difficulties in confronting the governmental industries that cause pollution and there is a need for constant updating of environmental standards of the country. There is also insufficient attention paid to environmental considerations in macro economic policies, low productivity in energy consumption and low prices of energy carriers.

National priorities for development cooperation

With respect to its commitments to the Montreal Protocol and attaining its ozone protection objectives, I. R. Iran established the Office of Protecting the Ozone Layer in 1993 in cooperation with UNDP and under the auspicious of the DoE. Since 1994, the Office has completed numerous projects to eliminate ODP and UV (Ultra Violet).

International development agencies can support the Government and NGOs concerned to overcome the aforesaid challenges in framework of the following initiatives. (1) Internalizing environmental considerations in the country's development planning system. (2) Assisting the establishment of a comprehensive national and regional environmental information system. (3) Providing technical advice for carrying out programmes on protecting biodiversity and natural resource projects. (4) Providing technical assistance for implementing projects on optimizing energy consumption. (5) Offering assistance on setting energy consumption standards in equipment and consuming systems.

4- Tracking Progress in Ensuring Environmental Sustainability: Monitoring and Evaluation.

Supervisory Mechanisms	Evaluation			
	Strong	Fair	Weak but improving	Weak
Access to goal				
Capacity for data/information collection and assessment				
Follow-up, supervision and analysis				
Capacity for application of data analysis in policy-making and planning				
Presentation of necessary mechanisms in financial resource allocation				

GOAL 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

Target- Deal comprehensively with the debt problems of developing countries.
Indicator: (44) Debt service as a percentage of exports of goods and services.

Target- Develop and implement strategies for decent and productive work for youth.
Indicators: (45) Unemployment rate of 15-24 year olds.
(46) Proportion of population with access to affordable essential drugs on a sustainable basis

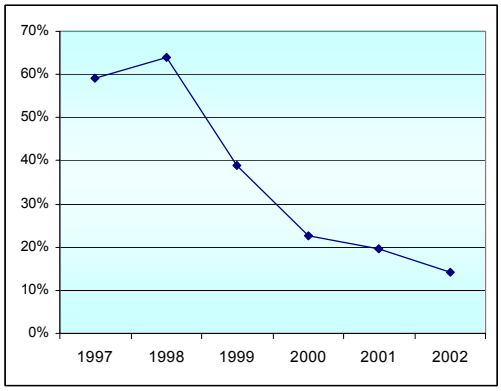
Target- Make available the benefits of new technologies especially ICT.
Indicators: (47) Telephone lines subscribers per 100 population.
(48A) Personal computers in use per 100 population.
(48B) Internet users per 100 population.

1) Progress Achieved

The Eighth Millennium Development Goal aims at exploring ways in which the developed world can assist developing countries to achieve the other seven goals through increased development assistance, improved access to markets and debt relief. The first three targets and related indicators deal mainly with assistance rendered by developed countries to the Least Developed Countries (LDCs) and Heavily Indebted Poor Countries (HIPCs); hence, they do not generally apply in the case of I. R. Iran. Yet, there are some related targets and indicators, which can be addressed.

I. R. Iran attaches importance to the fourth target of Goal 8 that deals comprehensively with the debt problems of developing countries through international cooperation. As demonstrated in *Graph 8-1*, the proportion of debt service as a percentage of exports of goods and services (indicator 44) decreased from 59.2 percent in 1997 to 14.3 in 2002 in the country.

Graph 8-1: Proportion of debt service percentage of exports of goods and services.



Source: Central Bank of I. R. Iran (2002).

One main reason for the sharp decrease in debt services after 1998 is that improvements in foreign exchange revenue after that year have considerably reduced the debt service percentage over the period between 1998 and 2002.

A further target of this Goal places emphasis on developing and implementing strategies for creating decent and productive work for youth. Its sole Indicator is defined as the number of unemployed people aged 15-24 divided by the total labour force of the same age group (Indicator 45). *Table 8-1* shows that the unemployment rate decreased from 23.8 percent in 1990 to 19.2 in 1996, however it increased to 28.2 percent in 2002.

Table 8-1: Unemployment rate of 15-24 year olds (%).

1990	1992	1994	1996	1998	2000	2002
23.8	21.3	21.2	19.2	28.8	30.9	28.2

Source: Macroeconomic Bureau, MPO (2003).

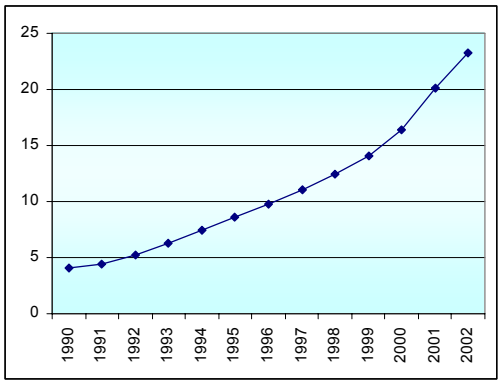
As noted in the above table, the unemployment rate rose rapidly to 28.8 percent in 1998 from 19.2 in 1996. The sudden increase is apparently due to the different statistical sources used to estimate the unemployment rate within the period before and after 1996. However, the rate decrease from 30.9 percent in 2000 to 28.2 in 2002 is the result of the policies that the Government of I. R. Iran adopted in the Third FYDP in order to reduce unemployment.

Another target of Goal 8 relates to providing access to affordable and essential medicines in developing countries. Its only Indicator is defined as the proportion of population with access (*one hour's walk*) to affordable essential medicines on a sustainable basis (Indicator 46). In terms of the definition given for this Indicator, there are no reliable estimates available.

The last target of Goal 8 aims at making available the benefits of new technologies to developing countries especially information and communication technologies. The success of these can be measured by estimating Indicators 47 and 48. Indicator 47 relates to the

number of telephone line subscribers per 100 population. Telephone lines refer to the number of telephone lines connecting subscribers' terminal equipment to the public switched network. *Graph 8-2* shows that the number of telephone lines has soared up from 4.04 per 100 population in 1990 to 23.2 in 2002. This more than five-fold increase proves that the people have enjoyed a better improved telecommunications access during that period.

Graph 8-2: Number of telephone lines subscribers per 100 population.



Source: Selected ICPD & MDG Indicators in Iran Statistical Centre of Iran (2003).

Personal computers (PCs) in use per 100 population (Indicator 48A) is defined in terms of computers designed for operation by a single user at a time. *Table 8-2* shows the number of personal computers per 100 population has more than doubled from 1.96 in 2000 to 4.80 in 2002. Such a remarkable increase indicates that the Government has attached importance to the question of access to telecommunications and Information Technology.

Table 8-2: Number of personal computers in use per 100 urban population.

Year	2000	2001	2002
Urban	1.96	3.07	4.80

Source: Statistical Centre of Iran (2002).

Indicator 48B, Internet users per 100 population is defined as the number of Internet users who are linked to a global network of computers in which users at one computer, if they have permission, get information from another computer in the network. The number of Internet users per 100 population was 8.3 persons in 2003.

2- Enabling Policies and Programmes

Policies have been adopted in the Third FYDP in relation to the Indicators discussed above, of which the most important are as follows. (a) The timetable for foreign debt service and financial commitments must be such that annual payments do not exceed 30 percent of the Government's foreign exchange revenues in the last year of the Plan. (b) The Government is required to operate throughout the Plan in such a manner that the net value of foreign debts and financial commitments do not exceed USD 25 billion in the last year of the Plan. (c) Employers who hire new employees through employment centres of the Ministry of Labour and Social Affairs (MLSA) during the period of the Plan are entitled to discounts on insurance and tax premiums. (d) The Government is allowed to offer facilities and incentives to promote investment in job-creating projects and small-scale industries. (e) Three percent (3%) of the legal deposits held by banks with the Central Bank of I. R. Iran (CBI), based on 1999 rates, shall be entrusted to certain banks in order to grant credits to develop several sectors of the economy and create more jobs. (f) Great importance has been attached to the telecommunications and computer networks in the Plan.

While placing stress on the policies adopted in the Third FYDP, the Fourth Plan has introduced some new policies in this area. These are as follows:

(1) Debt service schedules will be similar to those in the Third Plan.

(2) When accessing foreign financial resources, priority will be given to long-term credits.

(3) The most important policies on job-creation in the Fourth Plan include the following. (a) Removing obstacles in the way of private sector production growth and expanding investments particularly through ensuring investment security. (b) Removing hurdles to production growth. (c) Promoting stable and transparent laws and regulations. (d) Reforming rules and regulations governing the labour market. (e) Curbing monopolies and promoting competitiveness. (f) Reducing nonessential commitments for employers. (g) Supporting job-intensive and modern activities in the construction, social service and cultural sectors. (h) Reducing labour market imbalances. (i) Creating a balance between the education system and labour market demands. (j) Establishing coordination between the various bodies concerned with managing the labour market.

(4) Giving importance to the expansion of the information society, with special emphasis on increased application of Information and Communications Technologies.

3- Major Challenges and Development Cooperation

Major challenges

As noted earlier, Goal 8 is seeking ways of facilitating development cooperation in order to provide better access to the other seven goals. Accordingly, the major challenges faced can be categorized as follows. (1) Institutionalizing international development cooperation in order to meet the Millennium Development Goals. (2) Placing an emphasis on knowledge-based assistance in the international development cooperation mentioned above.

National priorities for development cooperation

In response to these challenges, there are two major national priorities for international development cooperation. These are as follows. (1) Granting assistance to the MDG Focal Point in order to institutionalize the international development assistance for achieving the MDGs, and setting up an information system for Official Development Assistance (ODA). (2) Discovering new methods for transferring knowledge-based development assistance in order to realize the MDGs in I. R. Iran.

Annex I

Technical Note

I- Poverty

Indicator 1: P0
The data sets gathered by the Household Income and Expenditure Survey (HIES) have been used to calculate Indicator 1. The HIES data are annually and officially collected by the Statistical Centre of Iran (SCI) from rural and urban areas. As shown in *Table 1-1* of the *Report*, Indicator 1 is estimated for both scenarios of 1$ (equal to 1.08 international dollars) and 2$ (equal to 2.15 international dollars) according to the PPP exchange rate calculated and published by the World Bank. The PPP conversion factor for 2002 which estimated at 1,963 Rials has been taken from Table 5.7 of the World Development Indicators (WDI) Report (2004) published by the World Bank (*base year 1993*). It should be noted that the second scenario ($2 PPP) is recommended for middle-income countries as a more realistic threshold to measure extreme poverty (The World Bank Group, Millennium Development Goals, 2004).

In order to calculate this Indicator, first the expenditure of every household (for urban and rural population) is amended to the per capita expenditure of its individual members according to household size. Then the per capita expenditure of the individuals was compared to 1.08 and 2.15 international dollars. In this way those below the poverty line have been identified. Second, the proportion of the population under the poverty line to the total population (taking account of household size) has been calculated. Third, the relative shares of rural and urban populations in relation to the total population of the country have been taken into account in calculating the Indicator for whole population of the country. The percentage of this population (P0) is shown in *Table (1-1)*.

Indicator 2: P1
In order to calculate this Indicator (P1), the following equation has been used, utilizing HIES statistics and the PPP exchange rate:

$$P1 = \frac{1}{n}\sum_{i=1}^{q}\frac{z - xi}{z}$$

Where n is the total number of people,
q is the number of poor people,
z is the poverty line based on Rial value of the 1.08 and 2.15 international dollars, and
x*i* is the expenditure of the poor person i.

The ratio is multiplied by 100 for each year and is given in *Table 1-2* as a percentage. Based on the relative shares of rural and urban population in proportion to the total population of the country, P1 is adjusted for each year in an identical manner to the P0 adjustment.

The Food Poverty Line as the National Poverty Line:
The necessary caloric criterion as advised by nutritionists has been used to calculate the Food Poverty Line. The Iranian Institute for Nutritional Research estimated the average caloric level required by a typical person for 2002 on the basis of an adaptation of the age-sex pyramid with the recommended calorie intake standards for each age-sex group. The figure reached (average caloric level) is estimated to be 2,308 Kg calories per person daily.

Then, rural and urban households have been separately categorized in 50 two-percent groups on the basis of their per capita expenditure. The calories consumed by the members of the households in each two-percent group have been calculated, and the point for reaching 2,308 Kg calories has been separately specified for rural and urban samples as the poverty line.

According to the Food Poverty Line (Caloric Approach), P0 is estimated at 9.4 and 8.1 percent for urban and rural areas in 2002, respectively; and the poverty gap (P1) is calculated to be 2.4 percent for urban and 1.9 for rural areas in 2002. As mentioned above, in applying this approach, the relative

shares of rural and urban populations of the whole country have been taken into consideration and the necessary adjustment has also been made. The results are displayed in *Table 1-3*.
According to this approach, the poverty line has been estimated at 109,000 Rials for rural areas and 191,000 Rials for urban areas, on the basis of monthly per capita expenditure.

Indicator 3

The following steps have been taken in order to calculate the share of the poorest quintile in consumption. First, urban and rural households of HIES have been categorized in deciles based on per capita expenditure. Second, the share of the poorest quintile in total consumption has been calculated for the years between 1995 and 2002 (*Table 1-4*). The composition of rural and urban populations in relation to the total population of the country has been taken into account in the calculation of this Indicator for the whole country.

II- Education

Regarding the statistics published in I. R. Iran, the exact calculation of the net enrollment rate in primary education is possible after each census carried out at ten-year intervals, the last of which was in1996. *Graph 2-1* of the Report has estimated the net enrollment rate in primary education on the basis of official statistics released by the Ministry of Education as well as other annual sample-takings. The General and Higher Education Affairs Bureau, the Management and Planning Organization (MPO) have made the estimation.

III- Women's Employment

The Female Share of Waged Employment in the Non-Agricultural Sector (FSWENAS) has been calculated through dividing the female population in waged employment in the non-agricultural sector by the total population in waged employment in the non-agricultural sector multiplied by 100, according to the following equation:

$$FSWENAS = (FPWENAS \div TPWENAS) \times 100$$

Where FPWENAS = the female population in waged employment in the non-agricultural sector.
TPWENAS = total population in waged employment in the non-agricultural sector.

The statistics required for calculating this Indicator have been provided through the Population and Housing Censuses of 1986 and 1996, and Sampling Data on Households Employment and Unemployment from 1997 to 2002.

IV- Energy

The Indicator, "energy use per $1 GDP" also referred to as energy intensity, is calculated by dividing total energy consumption by Gross Domestic Product (based on PPP). This is a criterion used to measure the efficiency of energy consumption. Since the Indicator is influenced by the energy consumers' compositions in different countries as well as the Foreign Exchange Rate, it is necessary to be cautious while comparing the figures in various countries.

Energy consumption includes domestic consumption of different kinds of primary commercial energy such as crude oil, natural gas, coal, hydroelectric energy, solar energy, wind energy etc. In order to calculate total energy consumption, different kinds of energies have been converted to a common unit (kilogram oil equivalent) according to their equivalent thermal values.

Internal energy consumption (in terms of kilograms oil equivalent) is calculated using the following equation:

$$EC = \sum_{i=1}^{n} (Pi + Mi - Xi \pm Si)$$

Where EC is internal energy consumption
P is the production of commercial energy,
M is the import of commercial energy,
X is the export of commercial energy,
S is the change in inventory stock of energy, and
i represents the different kinds of commercial energy being consumed in the country

Annex II
Acronyms and Abbreviations

ANIS	Anthropometry and Nutrition Indicators Survey
ARVs	Anti Retro-Viral medicines
BCG	Bacille Calmette- Guerin (Tuberculosis Vaccination)
CBI	Central Bank of I.R. Iran
CDC	Centre for Diseases Control
CFCs	Chlorofluorocarbons
CWP	Centre for Women's Participation
DHS	Demographic and Health Survey
DoE	Department of Environment
DOTS	Directly Observed Treatment Short Course
EFA	Education for All
EOC	Emergency Obstetric Care
FAO	Food and Agriculture Organization
FRLWO	Forest and Range Land and Watershed Organization
FYDP	Five-Year Development Plan
HIPCs	Heavily Indebted Poor Countries
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IEC	Information Education Communication
ILO	International Labour Organization
IMCI	Integrated Management of Childhood Illness
IMHC	Integrated Management of Healthy Child
IMPS	Institute for Management and Planning Studies
ICT	Information and Communication Technology
ICPD	International Conference on Population and Development
LCDs	Least Developed Countries
LMO	Literacy Movement Organization
MDGs	Millennium Development Goals
MDR	Multi Drug Resistant
MICS	Multiple Indicator Cluster Survey
MLSA	Ministry of Labour and Social Affairs
MOHME	Ministry of Health and Medical Education
MCP	Malaria Control Programme
MPO	Management and Planning Organization
NGOs	Non-Governmental Organizations
NHDR	(First) National Human Development Report (of I.R. Iran)
NICs	Newly Independent Countries
NICU	Newborn Intensive Care Unit
ODA	Official Development Assistance
ODP	Ozone-Depleting Potential
OECD	Organization for Economic Co-operation and Development
PBO	Plan and Budget Organization (now MPO)
PHCs	Public Health Centres
PLWHA	People Living With HIV/AIDS
PPP	Purchasing Power Parity
SCI	Statistical Centre of Iran
STD	Sexually Transmitted Disease
STIs	Sexually Transmitted Infections
TFR	Total Fertility Rate
UNAIDS	United Nations AIDS Programme
UNDCP	United Nations International Drug Control Programme
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UV	Ultra Violet
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Annex III

The Millennium Development Goals Indicators for I.R. Iran (1990-2003)*

Millennium Development Goals and Indicators	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Goal 1: Eradicate poverty and hunger														
1. Proportion of population below $1 (PPP) per day (%)						2.24	1.99	1.25	1.05	0.97	1.30	0.78	0.62	
1. Proportion of population below $2 (PPP) per day (%)						13.46	12.40	9.47	8.29	7.85	9.57	7.33	6.21	
1A. National (Food) Poverty of Line (%)						12.75							8.99	
2. Poverty gap ratio by $1(%)						0.558	0.505	0.279	0.240	0.214	0.246	0.172	0.113	
2. Poverty gap ratio by $2 (%)						3.823	3.488	2.586	2.158	1.993	2.507	1.812	1.536	
2. Poverty gap ratio for Food Poverty Line						4.116							2.238	
3. Share of poorest quintile in national consumption (%)						6.83	6.84	7.03	6.80	7.07	7.18	7.19	7.40	
4. Prevalence of underweight children under five years of age (%)		15.8				15.7			10.9					
5. Proportion of population below minimum level of dietary energy consumption (%) (Food Poverty Line)						12.75							8.99	
Goal 2: Achieve universal primary education														
6. Net enrolment ratio in primary education (%)	85.0	85.7	86.5	87.2	88.0	88.7	90.3	91.4	92.5	93.6	94.7	95.8	97.0	
7. Proportion of pupils starting grade 1 who reach grade 5 (%)	87.1	86.0	87.8	88.2	88.4	88.7	88.8	89.4	89.3	91.4	89.5	89.2	89.1	
8. Literacy rate of 15-24 year olds, men (%)	92.2	92.7	93.2	93.7	94.2	94.7	95.3	96.4	96.6	97.0	97.1	97.3	97.6	
8. Literacy rate of 15-24 year olds, women (%)	81.1	82.5	84.0	85.5	87.0	88.7	90.5	91.8	92.0	93.2	93.3	94.1	94.7	
Goal 3: Promote gender equality and empower women														
9. Ratio of girls to boys in primary, secondary and tertiary education (%)	79.2	80.3	81.6	82.5	83.7	85.1	86.5	87.6	88.2	89.0	91.0	92.3	93.1	
10. Ratio of literate women to men among 15-24 year olds (%)	87.9	89.0	90.2	91.4	92.6	93.8	94.9	95.2	95.3	96.1	96.1	96.7	97.0	
11. Share of women in waged employment in the non-agricultural sector (%)	10.5	10.8	11.2	11.6	12.0	12.5	13.1	14.8	15.4	14.9	15.3	13.6	12.0	
12. Proportion of seats held by women in the national Parliament (%)	2.0	2.0	3.3	3.3	3.3	3.3	5.1	5.1	5.1	5.1	5.0	5.0	5.0	5.0
Goal 4: Reduce child mortality														
13. Under-five mortality rate (per 1000 live births)	68.1	64.5	61.0	57.5	54.1	50.0	38.6	37.3	37.0	37.0	36.0			
14. Infant mortality rate (per 1000 live births)	52.5	50.2	48.0	45.7	32.5	40.7	31.7	30.7			28.6			
15. Proportion of 1 year old children immunized against measles (%)	85	84	96	96	97	95	100	95	100	98	100	96		
Goal 5: Improve maternal health in the HR Context														
16. Maternal mortality ratio (per 100000 live births)	91(1989)	54.0		52.0	52.0			37.4						
17. Proportion of births attended by skilled health personnel (%)	70(1989)							86.1			89.6			
17A. Adolescent (15-19) fertility rate							54.0				29.8			

* The blank boxes represent that the data were not available.

Millennium Development Goals and Indicators	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003
Goal 6: Combat HIV/AIDS, malaria and other diseases														
18. HIV prevalence among pregnant women aged 15-24 years														0.00
19. Condom use rate of the contraceptive prevalence rate (%)											7.99			
19A. Condom use at last high-risk sex														
19B. Percentage of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS														4.09
19C. Contraceptive prevalence rate		64.6	64.6	67.8	70.0	72.9	76.3	72.9			73.8			
20. Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years														
21. Prevalence rate associated with malaria (per 100000 person)				103.5	85.3	110.5	94.2	63.2	53.0	36.8	30.9	30.2	24.1	35.2
21A. Number of deaths associated with malaria (person)													2.0	
22. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures														
23. Notification rate associated with tuberculosis (per 100000 people)	24.0	23.5	42.9	35.1	22.6	25.9	22.6	20.9	19.3	19.5	19.9	18.4	17.6	16.2
23A. Number of deaths associated with tuberculosis (per 100,000 people)											0.9	0.9		
24. Proportion of tuberculosis cases detected and cured under DOTS (%)						1	8	28	69	94	96	100		
Goal 7: Ensure environmental sustainability														
25. Proportion of land area covered by forest (%)	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	
26. Ratio of area protected to maintain biological diversity to surface area (%)								4.58	4.87	4.87	4.91	6.82	7.11	
27. Energy use (kg oil equivalent) per $1 GDP (PPP)	0.309	0.302	0.297	0.314	0.332	0.316	0.314	0.322	0.332	0.329	0.329	0.338		
28. Carbon dioxide emissions per capita (Kg)							4002	4186	4182	4333	4610	4681		
28A. Consumption of ozone-depleting CFCs (ODP tons)						4500	4000	7050	6645	4990	5028	6179		
29. Proportion of population using solid fuels														
30. Proportion of population with sustainable access to an improved water source (%)	89.6	91.5	92.6	92.7	93.3	93.6	94.0	94.5			93.0			
31. Proportion of population with access to improved sanitation (%)	64.3										82.8			
32. Proportion of households with access to secure tenure														
Goal 8: Develop a global partnership for development **														
44. Debt service as a percentage of exports of goods and services (%)								59.2	64.1	38.8	22.5	19.7	14.3	
45. Unemployment rate of young people aged 15-24 years (%)	23.8	21.8	21.3	21.6	21.2	20.6	19.2	30.1	28.8	31.0	30.9	33.6	28.2	
46. Proportion of population with access to affordable essential drugs on a sustainable basis														
47. Telephone lines subscribers per 100 population	4.04	4.40	5.30	6.30	7.40	8.60	9.80	11.10	12.50	14.10	16.40	20.10	23.20	
48A. Personal computers in use per 100 population (Urban)											1.96	3.07	4.80	
48B.Internet users per 100 Population														8.3

** According to the MDG Manual, the Indicators 33-43 are not applicable for the developing countries, including I. R. Iran.

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Annex VI

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3- **Employment Indicators:** Macroeconomic Bureau, MPO, 2004.
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Annex VII
Iran Map