In the Name of God
the Compassionate, the Merciful

The Second Millennium
Development Goals Report of
the Islamic Republic of Iran
2006

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Foreword by the Vice President of Strategic Planning and Control

During the two years from the publication of the first MDG report of I.R. Iran (2004), extensive measures have been carried out towards the promotion of MDG concepts and advancement of programmes for the achievement of the MDGs in Iran.

Appointment of the Deputy for Social Affairs at the Management and Planning Organisation of Iran (MPO) as the national reference for the Millennium Development Goals (MDGs), establishment of the National MDG Committee, with the participation of stakeholders related to policy-making, tracking and monitoring of the progress of the MDGs, assignment of specific units in government bodies for tracking progress on the MDGs and expansion of activities and measures carried out by the United Nations, the private sector and non-governmental organisations, with regard to the promotion and achievement of the MDGs, could be mentioned as key actions having been carried out in this regard. Publication of various articles and reports in the private and public media, development of promotional videos, tens of educational workshops and many speeches and seminars, are other key activities carried out in this area. It is endeavoured that through the capacity created, we would witness even more extensive activities carried out in this area in the near future.

The Millennium Development Goals are based on the rather critical subject of improving the lives of the poor, which is one of the main concerns of the I.R. Iran and could not be reviewed independently from the extensive programmes implemented in the area of poverty reduction in the country. This fact is evident in indicators having been envisaged within the framework of the 20-Year Development Vision and in tens of sectoral and cross-sectoral development documents related to the Fourth Five-Year Development Plan (FYDP), which surpass even those defined for the MDGs.

Considering the infrastructure established during the past FYDPs, our country is in a favourable condition with regard to various MDG indicators, as can be studied in the present report.

For the first MDG, targets related to the $1 poverty line have effectively been achieved in Iran. However, this indicator could not be considered a realistic measure for determining the minimum standards of living in Iran and therefore more practical indicators, which are included in the documents of the Fourth FYDP, should be used instead.

Considering universal primary education and empowerment of women (MDGs 2 and 3), I.R. Iran is placed in a favourable position with regard to the level of literacy and achievement of gender equality. With reference to education therefore, new indicators would need to be identified and targets defined, establishing relatively higher levels of quality than the indicators defined in the MDGs. The main focus of MDG 3 is on strengthening the role of women in the educational, economic, social and political arenas. In this area, conditions for women have improved significantly in the area of education, with extensive development measures in the economic and political arenas currently under formulation in this regard.

The review of the status of MDGs 4 and 5 shows that the trend of improvement of child and maternal health has been continuous during the recent years and is envisaged to be so in the future years. With regard to MDG 6, expansion of awareness-raising measures and improvement of health measures have resulted in the trend of incidence of tuberculosis and malaria to fall under control, with yearly reduction in incidence observed. Regarding the spread of HIV, despite natural limitations with regard to access to data and statistics, various
efforts are under way in the area of prevention, taking into consideration the experiences of other countries, alongside strengthening of the relevant data collection mechanisms.

For MDG 7, expansion of protected areas, increased access to basic services such as safe water and sanitation, alongside more efficient use of energy are among the most significant achievements attained. Regarding MDG 8, improved economic conditions in the country during the recent years have resulted in the indicator of external debt as a percentage of exports of goods and services to be in a favourable condition. However, considering the demographic changes having taken place during the 1980s in the country improving the status of youth employment would require the implementation of more extensive measures. Indicators related to access to new technologies have witnessed significant improvements, especially during the course of the recent FYDPs.

It should be noted that considering the changes in conditions such as the population structure, society’s health patterns, social conditions, global interactions, etc. maintenance and improvement of the present conditions require formulation of suitable and proportional policies. These policies would not necessarily be restricted to sectoral or specialised areas and would need to stress more on the identification of factors and on inter-sectoral interventions, through a comprehensive outlook, while maintaining and promoting cooperation and participation of all stakeholders. In this regard, the Deputy for Social Affairs at the MPO as the national reference for the MDGs, together with members of the National MDG Committee bear a significant responsibility in identification of suitable policies and strategies for the achievement of the goals and establishment of the MDGs in national and regional programmes.

In conclusion, I would like to take the opportunity to thank the MDGR preparation team, especially the MPO Deputy for Social Affairs as the national coordinator and the MDG research and editorial groups for their most valuable endeavours towards the preparation of this report. I would also like to thank the corresponding offices in the MPO, the Ministry of Foreign Affairs and other related government bodies, together with the United Nations Readers Group in Iran for their suggestions regarding the final text to this report. It is hoped that this report could provide the suitable groundwork for the enhancement of the effectiveness of the policies and programmes devised with regard to the achievement of the MDGs over the course of the coming years.

Amir Mansour Borghei

Vice President of Strategic Planning and Control
Foreword and Technical Note from the United Nations in Iran

Monitoring of progress towards the MDGs at the global level is being reported to the United Nations General Assembly annually, by the Secretary General, with more detailed reporting every five years, while country level MDG reports help to mobilize support from development partners for the achievement of the goals. In this context, Iran published its first MDG Report in 2004, indicating good progress in most of the indicators.

In 2006 the Government established a working group to produce the second report, comprising key experts in relevant institutions and line ministries, along with the participation of the UN’s MDG Theme Group. The qualifying criteria and conditions for both production and assessment of the report were: i) use of available formal statistics ratified by the Statistical Centre for Iran; ii) use of disaggregated data, to the extent available, especially on a provincial basis; iii) full participation by both line ministries and UN; iv) due consideration to constraints in the statistical production process, to the socio-economic complexities and to the institutional structure.

The second MDG Report focuses on the current status of MDG indicators and assesses existing institutional arrangements for the analysis of MDG indicators and data gaps. The report indicates progress in most targets and indicators, and takes a positive perspective indicating that the country will achieve the MDG targets by 2015. The report’s policy and programme sections also indicate pro-active Government willingness to engage with MDG related challenges, and indicate the weaknesses and requirements for meeting these challenges. At the national level, the data on some MDG indicators is not available and many indicators remain outdated. The report does not provide specific analytical reasons as to the degree or extent of the indicators being on track or not, although due consideration is given to weaknesses in the statistical production process, to the Iranian socio-economic structure and institutional functioning. However, the report indicates the need for improving MDG indicators, especially at sub-national levels, and the political commitment to achieve these objectives.

The current quality of available statistics constrains the production of a high quality MDG Report. Therefore, it is recommended that the UN’s main area of support should be to help develop Iranian statistical production and analysis to ensure the quality of the third report. Further, the UN will support the MPO to adopt a methodological approach for the preparation of the 3rd MDG report. This methodology would require capacity for integrated analysis of MDG indicators and their inter-active dynamics.

In conclusion, we would like to thank the Management and Planning Organisation, National MDGs Coordinator, line Ministries and Research Group and United Nation’s Readers Group for their valuable contribution in the preparation of this report.

Mr Knut Ostby
United Nations Resident Coordinator in Iran

Dr. Mubashir Sheikh
WHO Country Representative, I.R. Iran
Chair of UN MDG Theme Group in Iran
Foreword by the Editorial Committee


The Second MDG Report of I.R. Iran elaborates on the achievements of the country towards the realisation of the MDG targets and indicators, while providing details on challenges ahead and policies envisaged. The MDG targets and indicators were decided upon in the UN General Assembly in September 2000 and included within the Millennium Declaration, ratified by a large number of countries.

In the preparation of this report, in addition to utilising experiences gained with regard to the First MDG Report of I.R. Iran, the following resources have been used as the methodological basis the Millennium Declaration, UN manuals regarding definitions, logic and computation methods for the MDG indicators and UNDG guides for the preparation of MDG country reports.

MDG targets and indicators pertinent to I.R. Iran were selected based on the above resources. The research team began the process of data collection for the calculation of the corresponding indicators, in coordination with the MDG groups of international organisations. Inquiries were made for this purpose with corresponding institutional bodies and the Statistical Centre of Iran (SCI). The initial drafts regarding country performance for each MDG were then prepared, with the Editorial Committee having devised the general structure of the report and prepared the final text for each chapter within this structure, based on the initial drafts. The Committee also divided each of the MDG chapters into the following four sections:

- Progress Achieved
- Enabling Policies and Programmes
- Major Challenges and Development Cooperation
- Tracking Progress: Monitoring and Evaluation

The UN Readers Group, related offices within the Management and Planning Organisation of Iran, the MOHME, the SCI and the Ministry of Welfare and Social Security reviewed the complete text of the report and provided feedback and suggestions. Suggestions deemed appropriate were implemented by the Editorial Committee in the final version of the report, resulting in the Second MDG Report of I.R. Iran.

In the preparation of the report, efforts have been made for the latest official data available to be used. Certain values presented are different from those included in the first report, due to modifications in definitions or corrections to estimation methods for the indicators. The process for the formulation and the preparation of this report has been carried out under the direction of the National MDG Coordinator.

A general look at the trend for the achievement of the MDGs in I.R. Iran shows that expansive activities in the areas of policy making, implementation and monitoring have taken place in various social and economic dimensions, resulting in significant achievements with regard to meeting the specified objectives.
However, challenges remain towards the achievement of all the MDGs. Overcoming these challenges and realisation of all the MDGs by 2015 requires systematic effort during the years ahead. This introduction includes a brief overview of key achievements and challenges ahead. In the final section, the level of achievement of the MDGs, status of national support for the MDGs and capacities available for the collection of data, quality of data search, statistical tracking, utilisation of data in policy-making and finally the process of monitoring and evaluation have been presented in the form of two tables.

It should be noted that extensive efforts are under way for the promotion of data generation in relation to the MDGs. It is hoped that during the future years we would be able to witness the production of all data regarding the MDG indicators by the National Statistical System.

Goal 1: Eradicate Extreme Poverty and Hunger

In reviewing the first MDG, it could be seen that the percentage of population below $1 and $2 (PPP) per day has been continuously on the decrease during the recent years, having decreased to 0.2 and 3.1 percent in 2005 respectively, from 0.9 and 7.3 percent in 1999. Also, poverty gap ratio has demonstrated a significant decrease to 0.1 percent based on $1 and 0.6 percent based on $2 in 2005.

Although these indicators demonstrate satisfactory progress in reducing income poverty, official reports indicate that the absolute number of people in need of benefits provided by support organisations has not shown the same decreasing trend. This could point to the fact that the $1 and $2 income poverty indicators are not demonstrative of the real purchasing power required for securing a minimum standard of living in Iran and also that the data collection system would perhaps require quality improvement.

Studying the distribution of income through the indicator for the share of the poorest quintile in national consumption shows that the share of the poorest populations during the recent years has been equal to around 6 percent of that for the rest. The next indicator, prevalence of underweight children, shows that the ratio of underweight children has decreased from 15.8 percent in 1991 to 5 percent in 2004. The status of this indicator points to the achievement and even surpassing of the target set in this regard. Such trend could also be viewed with regard to the share of the population living below the food poverty line, which has decreased during the period 1999-2005 from 13.5 percent to 7 percent.

Implementation and ratification of the Fourth FYDP in continuation of previous FYDPs, has brought increased emphasis on the expansion of social support services coverage and implementation of pro-poor development policies across various economic and social arenas, providing a suitable opportunity for improving the conditions of poverty and hunger in the country. Within the framework of this plan, many cross-sectoral documents considering various aspects of poverty through a comprehensive outlook have been formulated and approved.

Challenges exist with regard to the achievement of MDG 1, such as the conditions of quantitative and qualitative distribution of the population, impact of economic conditions, establishment of a system for identification of low-income households and targeting of
subsidies. Increased consideration of policy makers for precise implementation of policies envisaged during the course of various FYDPs and identification of new mechanisms for addressing existing challenges have paved the way. Use of international capacities for enhancing national capacities in various areas could play a significant role in this regard.

**Goal 2: Achieve Universal Primary Education**

Universal access to primary education has continuously been one of the main priorities of development policies in Iran, with specific emphasis having been placed on this issue in Article 30 of the Constitution of I.R. Iran. Net enrolment ratio has steadily been on the increase during the period 1990-2005, reaching 98 percent in 2005 from 85 percent in 1990.

Likewise, primary survival rate has increased during the abovementioned period. Where in 1990 of every 100 pupils enrolled in grade 1, 13 would have dropped out of education prior to reaching grade 5, in 2005 this number had decreased to less than 6.6.

Demonstrating the same trend, literacy rates of 15-24 year old men and women during the period 1990-2005 increased from 92.2 and 81.1 percent, to 98.1 and 96.7 percent, respectively.

For maintaining and improving the conditions of performance indicators in this sector, various policies have been envisioned in the Fourth FYDP, within the framework of the National Education for All Plan. Creation of equal learning opportunities, universal access to education, improvement of quality of education and promotion of participation of non-government sectors in education have been envisaged as the outlook for this plan.

Major challenges in achieving full public education coverage could be specified as follows:

- High cost of educational opportunities, especially in rural areas
- Provision of essential educational facilities, taking into consideration the vast climatic and geographical dispersal of the population
- Educational assessment methods
- Design and formulation of educational materials and curricula, taking into consideration personal and socio-cultural characteristics
- Improvement of attitudinal and behavioural aspects
- Identification of school age children
- Strengthening the existing statistical system
- Strengthening the awareness-raising system in educational policy-making
- Formulation and implementation of a comprehensive human resources programme

Making use of international experiences in reforming and strengthening formal and non-formal educational structures, together with effective management of resources in the education sector, could prove highly effectual in addressing the above challenges.
Goal 3: Promote Gender Equality and Empower Women

Equal access to education is the only target envisaged within the MDGs for promotion of gender equality and empowerment of women.

The ratio of girls to boys in primary, secondary and tertiary education shows considerable improvement from 79 percent in 1990 to 94.3 percent in 2005. During this period, ratio of literate women to men ages 15-24 also saw an increasing trend, from 87.9 percent to 98.6 percent over the period 1990-2005.

It can thus be observed that in the field of education, indicators for (equal) access to education at the national level demonstrate a favourable status as regards gender equality.

Regarding the labour market and generation of income, the share of women in wage employment in the non-agricultural sector has not shown a significant improvement. However, at present, women constitute around 33 percent of the professional and technical work force.

Higher levels of education and changes in the country's cultural, social and economic conditions have resulted in further opportunities to be created for women for entering the labour market. Due to lack of adequate capacities for absorption of this increasing population into the labour market, the female unemployment rate has been generally much higher than the male unemployment rate, with female and male unemployment rates having been 16.7 and 9.4 percent respectively in 2005.

The number of female parliamentarians has decreased from 14 in 1990 to 12 in 2006. During 2006, share of female parliamentarians had been 4.1 percent.

In continuation of strategies adopted regarding the empowerment of women, various policies have been envisaged within the Fourth FYDP in the following areas:

- Increase of equal learning opportunities
- Employment
- More active participation in policy-making and social activity arenas
- Promotion of civil society organisations
- Protection of women's rights
- Extension of targeted insurance policies to women heads of household
- Provision of legal assistance

Making use of international capacities in the following areas could prove rather beneficial for achieving the above objectives:

- Enhancing women’s employability
- Formulation of measures for alleviating some of the social and cultural barriers facing women for (continued) education, especially in rural areas
- Strengthening gender-disaggregated statistical data collection systems
- Adoption of methods for increasing women's participation in decision-making processes
Goal 4: Reduce Child Mortality

Extensive activities with regard to the continued expansion of the coverage of the primary health care network (PHC) since the 1980s have resulted in I.R. Iran achieving significant progress in reducing child mortality. Under-five deaths per 1,000 live births decreased from 68.1 cases in 1990 to 36 in 2000. However, despite improvement of child health indicators at the national level, differences at the provincial level should be taken into consideration for the improvement of this indicator and effective factors.

With the expansion of access to primary health care services, causes of child mortality are gradually changing and social mechanisms and the methods for the provision of health services are finding a more defining role in this regard.

The next indicator considered for this MDG is vaccination coverage for measles. Practical measures regarding measles vaccination, initiated exactly forty years ago in Iran, have resulted in satisfactory achievements, with coverage at percent being near 100 percent.

Among key programmes under implementation within the framework of the FYDPs, Integrated Management of Healthy Child (IMHC), promotion of mother and baby-friendly hospitals, expansion of Integrated Management of Childhood Illness (IMCI) and improvement of data collection, registration and reporting systems could be pointed out.

Key challenges ahead in achieving this MDG include:

- Data collection status
- Improving the effectiveness of qualitative and quantitative measures in health care networks
- Fighting newly emerging and re-emerging diseases
- The country being host to a continuous influx of foreign migrants
- Reducing child malnutrition
- Inter-sectoral coordination between the private sector, NGOs and governmental bodies in establishing more effective policies and attracting funding in this regard.

International participation could cover various areas in this regard, the most important of which are:

- Provision of scientific and technical assistance regarding the improvement of the Demographic and Health Survey (DHS)
- Estimating the total burden of child death
- Transfer of new technologies for improving the quality of care in hospitals and health centres.

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

The target defined for improving maternal health is reducing by three-quarters, between 1990 and 2015, the maternal mortality ratio. Two main indicators have been defined in this regard, which are maternal mortality ratio and proportion of
births attended by skilled health personnel. Based on the data available, maternal mortality ratio (per 100,000 live births) has demonstrated a significant decrease from 91 cases of death in 1989 to 24.6 cases in 2005. During this same year, the proportion of births attended by skilled health personnel increased from 70 percent to around 97.3 percent.

The results of the Integrated Monitoring and Evaluation System (IMES) survey in 2005 indicates that achievement of many of the indicators specified for this MDG have become feasible. Thus, in 2006, the specified targets were reviewed and new targets were defined above those set for the MDGs.

Maternal death is influenced by the total fertility rate. The reduction in this indicator therefore could have a significant effect in reducing maternal deaths. Implementation of family planning policies during the past years has resulted in the total fertility rate to have decreased to 2 in 2000 (the final year for which information at the national level is available in this regard) from 3.6 in 1993. Studies carried out show that access to family planning services, literacy status, births attended by skilled health personnel and services offered in hospitals and health centres are among key contributing factors to reduction of maternal deaths.

Reducing maternal deaths and improving maternal health in the framework of reproductive health have always been among the main objectives of the FYDPs. Policies and programmes implemented in this regard include:

- Expansion of health care networks and centres
- Improvement of the emergency health care network
- Expansion of health insurances
- Improving food security and safety at national and provincial levels
- Continuation of reproductive health policies
- Strengthening the family planning programme

Reviewing the status of maternal health care within the context of reproductive health in I.R. Iran reveals the following challenges:

- Improvement of insurance benefits and payment system for health services
- Design or improvement of hospital information management systems and the corresponding monitoring and evaluation systems
- Quality improvement for reproductive health services, including family planning and obstetric services
- Ensuring reproductive health commodity security (RHCS)
- Awareness-raising for adolescents with regard to reproductive health issues
- Filling gaps in data in various dimensions of reproductive health, such as abortion and breast and cervical cancers
- Sectoral coordination for expanding health, treatment, rehabilitation and education services

Foreword by the Editorial Committee
• Expansion of re-emerging and newly emerging diseases and increases in incidences of diseases such as tuberculosis, malaria, AIDS, hepatitis, and also the health conditions of neighbouring countries
• Nutritional status of pregnant and lactating women
• Provision of health care for women and mothers in emergencies

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

The global social and economic impacts of HIV/AIDS have been at such extent that it has been defined as the first target in MDG 6. An integrated system is not yet available with regard to the collection of data for indicators related to this target, with expansive measures currently under implementation in this area.

Within the framework of the available data, 13,432 cases of HIV infection had been identified in the country, up to April 2006, with injecting drug use having been the main cause of infection (64.3 percent). Two major external factors affect the spread of HIV in Iran, these being location of the country in the proximity of the largest producers of illicit drugs in the world, which increases the prevalence of drug use and the rapid spread of HIV in some of the countries neighbouring Iran. In addition, existing social and cultural conditions are such that people living with HIV might prefer not to reveal their status.

The most effective solution in prevention and control of the prevalence of HIV, in addition to awareness-raising and control of drug use, is condom use in sexual relations. Based on the available data, condom use rate of the contraceptive prevalence rate does not even reach ten percent in Iran, which intensifies the risk of the spread of sexually transmitted infections (STIs).

Key measures implemented regarding HIV prevention and control include the following:
• Implementation of a strategic five-year plan for raising public awareness regarding HIV/AIDS
• Improving blood safety
• Strengthening the prevention of HIV transmission
• Provision of voluntary counselling and testing (VCT) for at-risk individuals
• Provision of essential care for HIV-positive persons

The Second Strategic Plan for HIV/AIDS Prevention and Control has been formulated for a three-year period and within the framework of the Fourth FYDP.

Key challenges with regard to the target for prevention and reduction of the spread of HIV are as follows:
• Public perceptions regarding HIV/AIDS
• Provision of the required financial resources for the necessary measures
• Reform of the laws related to drug addiction
• Coordination among institutions active in HIV response
• Proximity of Iran to significant centres of production of illicit drugs and the rapid prevalence of HIV across the neighbouring countries

Making use of international experiences and capacities could prove rather effective in addressing these challenges. Main areas of cooperation include:
• Regional cooperation for the prevention of drug trafficking
• Provision of high-quality HIV/AIDS drugs and affordable rapid diagnostic tests (RTDs)
• Facilitation of the provision of financial assistance by international institutions such as the Global Fund for supporting national programmes currently under implementation in the area of HIV/AIDS response
• Introduction of new methods for identification of HIV-positive individuals
• Establishment of a comprehensive database regarding HIV/AIDS

With regard to prevalence of malaria, according to the available data incidence rate per 100,000 people has decreased from 94 cases in 1996 to 30 in 2005, with around 65 percent of cases being in the province of Sistan va Baluchestan. The number of malaria deaths in 2005 has been one case, which is one-third of the level reported for 1996. High prevalence of the disease in neighbouring countries, especially on the Eastern border, is one of the main factors of malaria transmission in the country.

Based on estimates provided by the World Health Organisation (WHO), tuberculosis (TB) incidence, prevalence and death rates in Iran in 2005 have been 23, 30 and 3 respectively, per 100,000 population, which show respective decreases of 36, 40 and 25 percent compared with the values for 1990. At present, 100 percent of detected TB cases in Iran are under directly observed treatment, short-course (DOTS). One of the major issues affecting global TB control programmes is drug-resistance, especially Multidrug-Resistant Tuberculosis (MDR-TB). Prevalence of MDR-TB has been 3, 7 and 5 percent respectively, for Iranian, non-Iranian and total cases of sputum smear-positive pulmonary TB.

Half of the cases of MDR-TB have been non-Iranian (Afghan) patients. Neighbouring high TB prevalence countries, illegal cross-border movements, droughts of the recent years and poverty and malnutrition are among the underlying causes of the spread of this disease.

International organisations could play a significant role in the implementation of expansive measures across neighbouring countries for the harmonisation of disease control programmes, control of cross-border movements, provision of necessary training and facilities and transfer of experiences, towards the achievement of the MDGs.

**Goal 7: Ensure Environmental Sustainability**

Two main targets; i.e. reversing the loss of environmental resources and halving (by 2015) the proportion of people without sustainable access to safe drinking water and basic sanitation, have been defined within the framework of this MDG.

*Foreword by the Editorial Committee*
With regard to the target for reversing the loss of environmental resources through the inclusion of principles of sustainable development in national macro policies, Article 50 of the Constitution of I.R. Iran declares the protection of the environment a universal duty. Correspondingly, five main axes have been stressed upon for policy-making in this area, as listed below:

- Advocacy of environmental culture and ethics
- Promotion of environmentally sound development processes
- Protection, rehabilitation and sustainable exploitation of biodiversity
- Protection, rehabilitation and expansion of natural resources (forest, land, soil and water)
- Enablement of national environmental structures and instruments

An estimated number of 8000 plant species have been identified in Iran, of which around 2500 are endemic to this country. Despite this extensive plant diversity, density of vegetation cover in Iran remains limited, due to the prevailing arid climatic conditions, especially with regard to forests, which stands at a lower ranking in comparison with the global average. In 2004, forest area totalled 14.2 million hectares, which covers around 8.6 percent of the total land area.

In order to protect biodiversity, Iran has become a signatory to the Convention on Biological Diversity. In 2005, around 11.9 million hectares, equal to 7.23 of the total land area was designated as area protected to maintain biological diversity. It is envisaged that during the course of the Fourth FYDP this area would increase to 10 percent of total land area.

In another approach to the protection of the environment, increasing energy efficiency in the context of energy intensity has been extended due consideration. This indicator has reached 0.326 kilogram oil equivalent per $1 GDP in 2005, having demonstrated a gradually decreasing trend during the previous years. Carbon dioxide emissions per capita have reached 5425 kilograms in 2005, showing a continuous increase. Consumption of ozone-depleting chlorofluorocarbons (CFCs) has demonstrated a significant decrease from 4140 tons in 1995 to 2221 tons in 2005. Likewise, proportion of population using solid fuels has been continuously on the decrease.

Regarding access to safe drinking water, in 2002 a reported 95 percent of the population had access to safe water. This level is not uniform across provinces however. Percentage of population with access to improved sanitation (flush toilets) increased from 64.3 percent in 1990 to 82.8 percent in 2000. With regard to proportion of (urban) population with access to secure tenure as the final indicator considered within the framework of MDG 7, accurate information is not available.

Numerous challenges are identified with regard to the achievement of MDG 7, the most significant of which are as follows:

- Iran being located in a semi-arid geographical area
- Shifting to more sustainable patterns of consumption and production (SCP)
- Enforceability of environmental regulations and standards
• Utilisation of capacities ensuing from civil society participation in environmental protection activities
• Unsustainable urban sprawl
• The dispersed nature of rural settlements
• Transboundary environmental problems, such as the country's coastal and marine water pollution

International organisations could provide valuable assistance to the country in addressing the above challenges through the transfer of successful experiences and creation of necessary mechanisms for expansion of dialogue and partnership regarding the protection of the environment at regional and international levels.

Goal 8: Develop a Global Partnership for Development

Implementation of the FYDPs have resulted in the indicator for external debt as a percentage of exports of goods and services to have improved during recent years, through the promotion of exports and repayment of external debts, decreasing from 63.2 percent in 1997 to 33.7 in 2005.

With regard to the next indicator, that is unemployment rate of young people aged 15-24 years, this indicator has been at a minimum of 19.2 percent in 1996 and a maximum of 29.9 percent in 2000, settling on around 21.6 percent in 2005, which is approximately equal to the youth unemployment rate in 1991. Unemployment rate of young women has continuously been significantly higher than unemployment rate of young men. This situation, although being influenced by social conditions, is largely due to the country's economic conditions during the period under study.

Regarding access to new technologies, the indicator for (fixed) telephone lines per 100 population increased from 4 lines in 1990 to 29.6 in 2005. Personal computers in use per 100 urban population increased from 6.28 in 1990 to 10.37 in 2004 and number of Internet users rose from 0.31 percent in 1990 to 9.9 percent in 2004.

For the percentage of population with access to affordable essential drugs on a sustainable basis, based on the latest estimates Iran is in a satisfactory condition, with the indicator having been between 80 to 97 percent in 1999.

During the course of the FYDPs great effort had been made for the improvement of the defined indicators. Among key policies adopted in this regard the following could be mentioned:
• Reform of the employment law towards increased labour market flexibility
• Provision of the foundation for promotion of temporary, part-time and participatory employment opportunities
• Establishment of insurance and tax incentives with regard to employment of new labour force
• Promotion of self-employment opportunities
• Support of ICT-based activities
• Continuation of regulations on restricting obtainment of foreign credit by the Government

Key challenges in meeting the stipulated objectives are as follows:
• Harmonisation of national economic laws, regulations and policies with global developments
• Disproportionate growth of the informal sector due to inefficiencies in the productive and formal sectors
• Labour market disequilibrium in the various dimensions of gender, age, education, urban-rural and provincial
• Extensive government presence in the (national) economy
• Undesirable movement of production factors between Iran and other countries

To conclude, the status of MDGs in I.R. Iran have been summarised in the form of tables 1 and 2.

In Table 1, achievement of the MDGs and the status of national support have been assessed. In Table 2, existing capacities with regard to the monitoring and evaluation of the MDGs have been briefly analysed. As can be seen from Table 1, I.R. Iran is in a satisfactory condition with regard to MDGs 1, 2, 3, 4 and 5. But achievement of MDGs 6 and 7 would require further endeavours.

It should be pointed out that the analyses carried out are based on mean values at the national level. Without doubt, for the realisation of the MDGs efforts should be made for these goals to be evaluated at regional and provincial levels and also according to gender. It is hoped that through the endeavours of the National MDG Committee this objective shall be achieved in the near future.
<table>
<thead>
<tr>
<th>Goal</th>
<th>Achievement of Goal</th>
<th>National Support</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strong</td>
<td>Average</td>
</tr>
<tr>
<td>Eradicate Extreme Poverty and Hunger</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Achieve Universal Primary Education</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Promote Gender Equality and Empower Women</td>
<td></td>
<td>☑</td>
</tr>
<tr>
<td>Reduce Child Mortality</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Improve Maternal Health (in the Context of Reproductive Health)</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Combat HIV/AIDS, Malaria and Other Diseases</td>
<td>☑</td>
<td></td>
</tr>
<tr>
<td>Ensure Environmental Sustainability</td>
<td>☑</td>
<td></td>
</tr>
</tbody>
</table>

### Table 2. Monitoring and Evaluation Capacity

<table>
<thead>
<tr>
<th>Goal</th>
<th>Available Capacity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Data Collection</td>
</tr>
<tr>
<td></td>
<td>Strong</td>
</tr>
<tr>
<td>Eradicate Extreme Poverty and Hunger</td>
<td>☑</td>
</tr>
<tr>
<td>Achieve Universal Primary Education</td>
<td>☑</td>
</tr>
<tr>
<td>Promote Gender Equality and Empower Women</td>
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<tr>
<td>Reduce Child Mortality</td>
<td>☑</td>
</tr>
<tr>
<td>Improve Maternal Health (in the Context of Reproductive Health)</td>
<td>☑</td>
</tr>
<tr>
<td>Combat HIV/AIDS, Malaria and Other Diseases</td>
<td>☑</td>
</tr>
<tr>
<td>Ensure Environmental Sustainability</td>
<td>☑</td>
</tr>
</tbody>
</table>
Goal 1: Eradicate Extreme Poverty and Hunger

Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day
Indicator 1-A) Proportion of population below $1 (PPP) per day
Indicator 1-B) Proportion of population below $2 (PPP) per day
Indicator 2-A) Poverty gap ratio based on $1 (PPP) per day
Indicator 2-B) Poverty gap ratio based on $2 (PPP) per day
Indicator 3) Share of poorest quintile in national consumption

Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger
Indicator 4) Prevalence of underweight children under five years of age
Indicator 5) Proportion of population below minimum level of dietary energy consumption
Indicator 5-A) Poverty gap ratio based on minimum level of dietary energy consumption

1. Progress Achieved

Income poverty is one of the most tangible dimensions of poverty. In an approach based on income poverty, the poor are defined and identified based on their level of income, which in effect represents their purchasing power.

Hunger, as the harshest and most extreme aspect of poverty, is the first area considered in poverty eradication topics. The first MDG therefore is defined based on income poverty and hunger. For assessing the status of this goal certain targets have been specified, including a total of five quantitative indicators.

Prior to discussing the status of these indicators, it should be mentioned that MDG indicators have been defined in the framework of international comparative analysis and therefore might not be completely adaptable with local definitions in certain cases; e.g. the income poverty line. This issue is more pertinent with regard to indicators 1 and 2 and should be taken into consideration when analysing the status of these indicators (for further details, refer to attachments at the end of this report).

Reviewing the indicator proportion of population below $1 (PPP) per day, we can see that this indicator has demonstrated a decrease from 0.9 percent of the total population in 1999 to 0.2 percent in 2005. Likewise, according to the latest data available (Table 1.1), during the period 1999 to 2005, proportion of population below $2 (PPP) per day has seen a significant decrease from 7.3 percent to 3.1 percent.
Table 1-1. Proportion of Population below $1 and $2 (PPP) per Day (1999-2005) (%)

<table>
<thead>
<tr>
<th>Year</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exchange Rate(^1) (Rial)</td>
<td>1237.5</td>
<td>1531.4</td>
<td>1669.4</td>
<td>2105.8</td>
<td>2312.3</td>
<td>2712</td>
<td>3134.9</td>
</tr>
<tr>
<td>Based on $1</td>
<td>0.9</td>
<td>0.9</td>
<td>0.6</td>
<td>0.6</td>
<td>0.5</td>
<td>0.3</td>
<td>0.2</td>
</tr>
<tr>
<td>Based on $2</td>
<td>7.3</td>
<td>7.7</td>
<td>6.3</td>
<td>5.5</td>
<td>4.1</td>
<td>3.2</td>
<td>3.1</td>
</tr>
</tbody>
</table>

Source: Statistical Centre of Iran, Deputy for Statistical Projects, 2006.

- For further details, refer to Technical Notes at the end of this report.

Changes in these indicators are illustrated in Figure 1.1. As can be observed from the figure, during the years of the Third FYPD (2000-2004), the indicators have demonstrated continuous improvement. Continuation of this trend during the future years could ensure the achievement of MDG 1.

It should be taken into consideration that the $1 and $2 income-based poverty indicators are nominal indicators, used mostly for carrying out international comparisons and the minimum standards of living in Iran are actually higher than those defined for these indicators. Therefore, despite the fact that the proportions of population below the $1 or and $2 poverty lines have demonstrated significant decreases, support organisations have as usual a larger portion of the population under coverage.

**Figure 1-1. Proportion of Population below $1 and $2 (PPP) per Day (1999-2005) (%)**

![Figure 1-1. Proportion of Population below $1 and $2 (PPP) per Day (1999-2005) (%)](image)

Source: Statistical Centre of Iran, Deputy for Statistical Projects, 2006.

Indicators *poverty gap ratio based on $1 and $2 (PPP) per day* (indicators 2A and 2B), represent the distance of the income of the poor from the poverty line as a percentage of the poverty line, thus describing the conditions of poverty for people living below the poverty line.

---

1. International Monetary Fund (IMF), World Economic Outlook Database, April 2006.
As can be seen from Table 1.2, there has been considerable improvement in the poverty gap ratio based on $1 and $2 (PPP) per day, from 0.2 and 1.4 percent respectively in 1999 to 0.1 and 0.6 percent in 2005. In other words, average income for people with income below $1 and $2 per day has been on the increase, approaching the standard defined for $1 and $2.

<table>
<thead>
<tr>
<th>Year</th>
<th>1999</th>
<th>2001</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Based on $1</td>
<td>0.2</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
</tr>
<tr>
<td>Based on $2</td>
<td>1.4</td>
<td>1.3</td>
<td>0.8</td>
<td>0.6</td>
<td>0.6</td>
</tr>
</tbody>
</table>

Source: Statistical Centre of Iran, Deputy for Statistical Projects, 2006.

For offering a more suitable analysis of the status of poverty, the indicator *share of poorest quintile in national consumption* (Indicator 3) is used.

As could be seen in Table 1.3, this indicator has gradually progressed from 5.5 percent in 1999 to 5.9 percent in 2005. This trend could reiterate the fact that MDG indicators 1 and 2 cover a small percentage of the poor, as improvement in the status of their poverty has not been sufficient to bear significance on the overall share of low-income groups in national consumption. The two indicators would therefore not be sufficient for properly assessing the status of poverty in the country.

<table>
<thead>
<tr>
<th>1999</th>
<th>2001</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.5</td>
<td>5.7</td>
<td>6</td>
<td>5.9</td>
<td>5.9</td>
</tr>
</tbody>
</table>

Source: Statistical Centre of Iran, Deputy for Statistical Projects, 2006.

Indicator 4 is *prevalence of underweight children under five years of age*. Based on the available data, this indicator has demonstrated a considerable decrease from 15.8 percent in 1991 to 5 percent in 2004 (Figure 1.2). As can be from the figure, this indicator has decreased to one-third during this period, which is a far greater improvement than the defined target of half the original value by 2015.

**Figure 1-2. Prevalence of Underweight Children Under 5 Years of Age (1991-2004) (%)**

![Graph showing prevalence of underweight children](image)

Source: Ministry of Health and Medical Education and Office for Health Affairs, Management and Planning Organisation of Iran.
Table 1-4. Prevalence of Underweight Children Under 5 Years of Age (1991-2004) (%)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>15.8</td>
<td>15.7</td>
<td>10.9</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

Source: Planning and Budget Organisation, National Human Development Report (1999) and the Ministry of Health and Medical Education.

Indicator 5 represents the percentage of the population whose food intake falls below the minimum level of dietary energy requirements (2100 kilocalories). According to the latest data available, proportion of population below minimum level of dietary energy consumption has enjoyed a considerable improvement of around 50 percent, having decreased from 13.5 percent in 1999 to 7 percent in 2005. Poverty gap ratio has also been continuously on the decrease during this period, which is representative of improvements in the poverty status of the population living below the poverty line (Table 1.5).

Considering the conditions of the aforementioned indicators, it could be observed that MDG 1 has nearly been met in the country. This success which has been registered during the course of the FYDPs has been due to various factors, such as sustained economic growth, which has naturally led to increases in national income and reductions in the rate of unemployment, together with the expansion of social security coverage, particularly in the areas of public education, reproductive health and family planning.

Table 1-5. Share of Households below the Food Poverty Line & Food Poverty Gap Ratio (1999-2005) (%)

<table>
<thead>
<tr>
<th>Year</th>
<th>1999</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Share of Households below the Food Poverty Line</td>
<td>13.5</td>
<td>11.9</td>
<td>11.6</td>
<td>11.5</td>
<td>8.8</td>
<td>7</td>
</tr>
<tr>
<td>Food Poverty Gap Ratio</td>
<td>3.9</td>
<td>3.5</td>
<td>3.2</td>
<td>3</td>
<td>2.2</td>
<td>1.9</td>
</tr>
</tbody>
</table>

Source: Statistical Centre of Iran, Deputy for Statistical Projects, 2006.

Despite the improvements achieved, in light of the reality that nearly 7 percent of the population is deprived of the minimum level of dietary energy requirements, more effectual measures are called for in this area.

This indicator also demonstrates the fact that the proportion of the population lacking access to a minimum food basket is twice that of the population whose income falls below $2 per day (Figure 1.3). This issue illustrates the fact that the $2 per day income level could not even guarantee access to minimum food requirements and should therefore be used with care in assessing the degree of deprivation.

1. For further details, refer to the attachments at the end of this report.
At the end of this section, it should be noted that although studying the indicators at the national level could result in useful information regarding conditions of deprivation, the distribution of available indicators at the provincial and regional levels and according to population group is also very important and should be taken into consideration for building the appropriate capacities for the production of statistics and preparation of analytical reports.

2. Enabling Policies and Programmes

Fighting poverty has continuously enjoyed a special mention in the FYDPs. Poverty reduction programmes have been stressed upon in poverty eradication strategies included in the 20-Year Development Plan, general public policies and the Fourth FYDP Bill (2005-2009) and the corresponding sectoral and cross-sectoral documents.

Key focal issues in the 20-Year Development Plan, in line with reduction of poverty and hunger, include:

- Creation of equal opportunities and improvement of the status of indicators such as education, health, access to adequate food and shelter and increased per capita income
- Expansion of the comprehensive social security system
- Increase of social justice and regional equalities
- Alleviation of deprivation, particularly in rural areas
- Continuation of policies regarding reproductive health services
- Curbing inflation
- Increasing the purchasing power of the low-income and poor groups
- Reducing the gap between the richest and poorest income deciles
- Implementation of suitable compensatory policies

For meeting these goals, sectoral and cross-sectoral documents were formulated and ratified for the first time as strategy documents for the Fourth FYDP. Among the many
comprehensive sectoral and cross-sectoral documents and programmes, all or part of whose objectives are related to poverty eradication, the cross-sectoral Poverty Reduction and Targeted Subsidies Charter directly involves poverty alleviation policies and strategies (for further details, refer to the attachments at the end of this report).

Furthermore, specific poverty reduction policies have been envisaged in the Fourth FYDP Bill, key focal areas of which are summarised below:

- Determination of the poverty line and continuous tracking of the impact of socio-economic programmes on the status of the poverty line and the population living below the poverty line
- Improving the social support system for completing the coverage of the population below the poverty line
- Increasing the purchasing power of low-income populations, especially in deprived and underdeveloped areas, through establishment and expansion of appropriate infrastructures and granting of tax exemptions
- Establishment of an employment fund for the rural poor
- Expansion of the comprehensive social security system
- Ensuring access to sufficient and safe food, in line with provision of a suitable food basket
- Ensuring access to free health, medical and rehabilitative care
- Access to reproductive health services
- Provision of affordable housing through effective reallocation of subsidy resources
- Promoting the participation of charity organisations in poverty eradication programmes
- Carrying out detailed studies and creating the necessary databases for the identification of vulnerable populations

It has been envisaged that with the implementation of poverty reduction policies, the associated indicators shall see improvements as stated below:

- Decrease in the ratio of household expenditures for the richest and poorest deciles from 19.4 in 2001 to 14 in 2009
- Decrease in the ratio of household expenditures for the richest and poorest quintiles from 10 in 2001 to 5.5 in 2009
- Reduction in the Gini coefficient from 0.43 in 2001 to 0.38 in 2009

Measures implemented in line with reduction of poverty during recent years include various programmes related to the comprehensive social security system and the expansion of the social insurance system and also provision of non-insurance benefits. An overview is included below:
• Provision of support services to vulnerable populations

In 2005 more than 1.7 million households were covered by direct or indirect government support. Within this framework, 101,000 jobs were created in 2005 for poor people and around 640,000 of the rural elderly received allowances under the Shahid Rajaei Scheme. Other actions carried out in support of the poor included:

o Provision of health insurance for care-seekers

o Support for poor students

o Supplementary feeding for children under six

o Support for the purchase or construction of housing for the poor

• Continued provision of free reproductive health and family planning services through the primary health care system.

This issue has proven effective in reducing the rate of fertility, leading to the reduction of the population growth rate. As this would lead to a reduced rate of support with fewer offspring to care for, it could effectively lead to increased household income and thus a reduction in the level of poverty.

• Expansion of social insurance coverage, such that the indicator of the ratio of population covered by social insurance schemes to the total population has seen an increase from 56.5 percent in 2000 to 67.1 percent in 2004.

In this area, a rural insurance scheme was implemented as pilot, with nearly 6 percent coverage for rural households in the beginning of 2006. Also, the Government has been required to provide social insurance coverage for individuals covered by the employment and self-reliance section of the Imam Khomeini Relief Committee.

• Expansion of health insurance coverage, providing coverage for 94.6 percent of the population and requiring the Government to provide free insurance for people in need of inpatient care, who are not covered by other health insurance schemes.

• Increased allowance for households covered by support institutions, based on a percentage of minimum government wages and improving the purchasing power of pensioners, contributors and people receiving benefits, through increasing minimum wages and allocating essential loans.

• Continued payment of subsidies for ensuring access to minimum basic needs for all.

Within this framework, in 2006 around 30 percent of total subsidies for basic commodities, equalling 3,680 billion Rials, had been allocated to reducing the food poverty of vulnerable households.

• Implementation of the policy for expansion of shelters for the poor in the non-government sector, with the aim of providing the necessary resources for offering residential care for people in need of support and the means for rehabilitation and self-reliance of these people.

• Continuation of the bill for the support of women and children without guardians and also empowerment and reduction in the poverty of poor people.
• Allocation of justice shares, aimed at distribution of wealth among low-income and deprived populations and generation of regular income for poor households.

• Permitting executive bodies to fund the necessary residential and rehabilitative care for the disabled, the elderly and the chronically mentally ill, cared for by own personnel in rehabilitation and residential centres.

• Allocation of the necessary financial resources for providing protection for the prevention and mitigation of social hazards and caring for the socially vulnerable, especially for street children and those without guardians and runaway girls and women.

3. Major Challenges and Development Cooperation

Despite the poverty-related MDG targets and indicators having been met, a percentage of the population still remains below the poverty line and would need to receive government benefits. Major challenges regarding the implementation of poverty reduction policies include:

• Establishment of a system for the identification of low-income households and expansion of benefits coverage for vulnerable populations against economic fluctuations

• Addressing problems arising from the disproportionate growth and distribution of the population, increased migration and urbanisation, changing population structure and increased share of the youth population (for further details, refer to the attachments at the end of this report)

• Identification and alleviation of the undesirable impacts of the implementation of macro policies on the level of poverty and the distribution of income

• Alleviation of the impact of globalisation on the labour market and implementation of risk management mechanisms (both insurances and benefits)

• Disaster (risk) management, in view of the country's location in a region exposed to large-scale natural hazards

National Priorities for Development Cooperation

National priorities for international development cooperation for overcoming existing challenges with regard to poverty reduction could be summarised as follows:

• Strengthening the statistical system, through the introduction of complementary indicators and methods for the measurement of poverty

• Transfer of successful international experiences with regard to micro-finance and micro-credit schemes, strengthening of cooperatives and community-based organisations (CBOs), local and regional employment schemes and the empowerment of women

• Establishment and strengthening of regional development programmes

• Utilisation of international cooperation for strengthening the natural disaster early warning system, making use of ICTs
4. Tracking Progress: Monitoring & Evaluation

Taking into consideration the published data and statistics it seems that the indicators for this goal are in a satisfactory state. However, the existing statistical capacities would need to be enhanced for providing more accurate analyses with regard to these indicators. Also, despite the fact that extensive resources have been utilised in the health sector for carrying out statistical surveys, access to data collected has been limited and publication of data is carried out with delay, calling for appropriate measures for addressing existing shortcomings.

With regard to income-based indicators, it seems that the standards set for these indicators are considerably lower than the purchasing power necessary for affording minimum living standards in Iran, requiring the deployment of complementary indicators. It is hoped that with the establishment of the Ministry for Welfare and Social Security and the High Council of Welfare and Social Security, policy-making and monitoring procedures in the area of reduction of poverty and hunger would be strengthened. Correspondingly, specific mechanisms regarding the allocation of resources in this area have been envisaged in the cross-sectoral Poverty Reduction and Targeted Subsidies Charter, currently under implementation.

<table>
<thead>
<tr>
<th>Monitoring Mechanism</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strong</td>
</tr>
<tr>
<td>Achievement of Goal</td>
<td></td>
</tr>
<tr>
<td>Capacity for Collection and Assessment of Data</td>
<td></td>
</tr>
<tr>
<td>Tracking, Monitoring and Analysis</td>
<td></td>
</tr>
<tr>
<td>Capacity for Application of Statistical Data in Policy-Making and Planning</td>
<td></td>
</tr>
<tr>
<td>Availability of Necessary Mechanisms for Allocation of Resources</td>
<td></td>
</tr>
</tbody>
</table>
Goal 2: Achieve Universal Primary Education

Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

Indicator 6) Net enrolment ratio in primary education

Indicator 7) Proportion of pupils starting grade 1 who reach grade 5

Indicator 8) Literacy rate of 15–24 year-olds

1. Progress Achieved

The second MDG has been defined in the context of one target and three main indicators which are explained in this chapter, for the purpose of providing an appropriate framework for ensuring universal access to primary education.

Net enrolment ratio in primary education (Indicator 6), is the first indicator studied for assessing the status of the third MDG. This indicator represents the ratio of the number of children of official school age (6-10 year-olds) who are enrolled in primary school to the total population of children of official school age. The indicator is influenced mostly by cultural and economic factors and ultimately the level of access to educational opportunities.

Progression of the abovementioned indicator during the recent five years has been slow but steady, as can be seen in Figure 2.1. Subsequent to the implementation of extensive policies for the expansion of public education during the course of the FYDPs, net enrolment ratio has been on the increase in the past years, surpassing 98% in 2005.

Figure 2-1. Net Enrolment Ratio in Primary Education (%)

![Net Enrolment Ratio in Primary Education](image)

Source: Statistical Centre of Iran, 2006.

The second indicator for this goal, proportion of pupils starting grade 1 who reach grade 5 (Indicator 7), demonstrates the primary education survival rate. It should be noted that in the computation of this indicator new entrants, grade skipping, migration or transfers during the school year have not been taken into account.

This indicator has also demonstrated an improving trend during recent years. While in 1990 of every 100 pupils who had enrolled in grade 1, around 13 would have left
school prior to reaching grade 5, in 2005 this number had decreased to less than 6.6. Factors having played a significant role in the improvement of the abovementioned indicators are as follows:

- Addition of classrooms in deprived rural areas.
- Employment of female teachers for teaching girls, especially in deprived rural areas.
- Provision of free stationery for children in deprived rural areas.
- Continuation of the free feeding and clothing schemes, specifically formulated for deprived areas and gradual expansion of the programme to all areas.
- Raising the awareness and interest of parents regarding their children’s education.
- Establishing multi-grade classes in lowly populated rural areas.
- Carrying out expansive and effective advertising for raising public awareness regarding education.

Consequent to the implementation of the abovementioned measures, primary education indicators demonstrated considerable improvement during the period 1990-2005.

Meanwhile, reduction of fertility rate following the implementation of population control policies in the late 80s has resulted in a significant reduction in the total number of primary school children, from 9.5 million in 1990 to 6 million in 2005. This condition presents a suitable opportunity for improving the quality education and completing coverage for both gender groups and across various geographical regions in the country.

As a result of the envisaged measures, gross primary enrolment ratio decreased from 107.7 percent in 1999 to 103.3 percent in 2005. The reduction in this value is representative of the fact that an increased number of children of official primary school age have entered formal education in the defined age and could benefit from education services at the required time. This trend is indicative of the presence of necessary capacities within the national education system, with regard to quantitative development and creation of flexibility in absorbing school age children.

The ratio of the number of female students enrolled at primary level to the total population of children enrolled in primary school, which had been around 26.2 percent in 1990, has increased to 48.2 percent in 2005, leading to a major improvement in the gender equality indicator during this period.

Due to increased urbanisation of rural areas and the continuing trend of rural to urban migration during the period under study, share of rural students at the primary level in the total population of primary school children has decreased from 46.2 percent in 1990 to 37.8 percent in 2005. Increases have been reported in specific regions however, given the institutional focus on increasing primary education coverage in rural areas. Examples could be increases in the share of rural students in the provinces of Sistan va Baluchestan, Hormozgan and Tehran, standing at 2.4, 5.1 and 0.6 percent during the period 1990-2005\(^1\), respectively.

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With regard to literacy activities, indicators related to the national literacy rate have seen an increasing trend. The literacy rate of 15–24 year-olds (Indicator 8) has been estimated at 98.1 and 96.7 percent respectively for men and women in 2005.

As can be observed from Figure 2.2, while the male literacy rate has witnessed relatively slow growth, female literacy rate has seen considerable improvement with a rising trend, despite minor fluctuations. The trend for this indicator illustrated in Figure 2.2 shows that the disparity between female and male literacy rates is disappearing.

![Figure 2-2. Literacy Rate of 15–24 Year-Olds, Each Sex (%)](image)


| Table 2-1. Values for Indicators Used for Measuring Progress towards MDG Target 3 |
|---------------------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| Net enrolment ratio in primary education (%) | 85  | 88  | 93.6| 94.7| 96.9| 97.9| 97.8| 98.1| 98.1|
| Proportion of pupils starting grade 1 who reach grade 5 (%) | 87.1| 88.4| 91.4| 89.5| 91.5| 91.3| 92  | 92.7| 93.4|
| Literacy rate of 15–24 year-olds (%) - Men | 92.2| 94.2| 97  | 97.1| 97.3| 97.6| 98.09| 98.1| 98.1|
| Literacy rate of 15–24 year-olds (%) - Women | 81.1| 87  | 93.2| 93.3| 94.1| 94.7| 95.94| 96.2| 96.7|


1. In reviewing this indicator, differences in national and global definitions of literacy should be taken into consideration. Based on the definition provided by the Statistical Centre of Iran (Office for Standard Statistical Definition and Labour Force Plan), “a literate person is one who can, with understanding, both read and write a short, simple statement in Farsi or another language, regardless of whether he or she holds a formal education certificate”, which is different from the global definition of literacy, that is “a literate person being one who can, with understanding, both read and write a short, simple statement on his or her everyday life”. Considering the lack of data more in line with the global definition for this indicator, the abovementioned data has been used in studying the status of education indicators in Iran.
2. Enabling Policies and Programmes

Article 30 of the Constitution of I.R. Iran emphasises the provision of free education for all up to the completion of the secondary level. Accordingly, creating suitable and equitable conditions for growth and nurturing of the potential of all children and adolescents in the country, in both urban and rural areas and even abroad, free from gender discrimination and with appropriate distribution of opportunities, while taking into account differences in cognitive and physical abilities and geographical location, would prove effectual in the realisation of this key article of the Constitution and ensuring educational equity.

In line with this goal, creation of the necessary framework for ensuring access to equal educational opportunities and expansion of public education for all school age children has been included in the Third FYDP, as the key policy as regards universal access to education. Implementation of this policy has resulted in educational coverage at all levels demonstrating a balanced trend during the years of the Third FYDP. This trend is representative of reduction of inequalities in access to educational opportunities, especially in deprived areas.

Key actions carried out during the course of the Third FYDP (2000-2004) in the context of operational mechanisms devised and in relation to universal access to primary education include:

- Implementation of support schemes for providing educational opportunities for poorer students in public or private schools.
- Distribution of educational budgets based on the per capita expenditure model and with application of the corresponding adjustment coefficients, for qualitative and quantitative expansion of educational activities in deprived areas and for deprived populations.
- Expansion of lower secondary boarding schools, village-centre schools and satellite schools and free school feeding schemes, with particular emphasis on the education of girls and part-time, correspondence and distance education.
- Promotion of the education of nomadic populations, with emphasis on the enrolment of out-of-school people in remote and deprived areas, with the aim of increasing primary education coverage.

In the Fourth FYDP Bill (2005-2009), lower secondary education attainment has been included within the context of compulsory education, with the Ministry of Education (MOE) being required to act to establish the appropriate framework for the goal of fulfilment of universal access to primary and lower secondary education. Chief complementary policies and actions envisaged in this regard within the Fourth FYDP are as follows:

- Improving resource productivity and increasing public investment for provision of educational opportunities and increasing educational coverage.
- Formulation of the National Education for All Plan, with the aim of improving and expanding public education (including 50 percent improvements in literacy indicators, completing primary education coverage, alleviating gender disparities in education and with particular emphasis on school age children who are out of school).
- Promotion of pre-school education, particularly in bilingual rural areas.
• Completion of the educational coverage of 6-13 year olds.
• Promotion of literacy programmes and ensuring literacy attainment of under 30 year-olds, with the approach based on functional literacy.
• Introduction of flexibility in educational and training programmes.
• Expansion of central dormitories, particularly for lower secondary school students.
• Creation of a database for collection of necessary information on school age children who are out of school.
• Development of a school counselling system at all levels of education, in order to try to keep students within the education system, through the provision of support and guidance in resolving student issues and problems.
• Life skills education.
• Development of student-based learning methods, moving away from the traditional and obsolete methods of teaching and creation of interactive learning methods for inspiring and motivating students with regard to the process of learning.
• Training multi-disciplinary teachers for deprived areas.
• Adaptation of curricula and creation of variety in literacy and adult education methods, with due consideration to basic life skills, learner interests and regional and local requirements.
• Standardisation and quality improvement of educational assessment.
• Expansion of inclusive education for students with special needs.

In addition to the above, based on forecasts presented in the Fourth Five-Year Education Development Plan (2005-2009) and the Education for All Plan devised within the framework of this five-year plan, the MOE is required to act towards the realisation of the following quantitative goals during the course of the plan, from 2005 through 2009:

• In the literacy sector: Increasing the share of literates in the total population aged 6 and above from 86.5 percent to 89.62 percent.

• In primary education: Increasing the ratio of the number of children of official school age (6 year-olds) enrolled in primary school to the total population of children of official school age (primary intake rate) to 99 percent and increasing net enrolment ratio to 99.5 percent.

• In lower secondary education: Increasing the ratio of children enrolled at this level to the total population of this age group (net enrolment ratio) to 80.6 percent.

3. Major Challenges and Development Cooperation

Based on the available data mentioned at the beginning of this chapter, it could be concluded that a small percentage of the target population misses out on education due to the various contributory factors. In light of the information presented, the following key challenges have been identified regarding the achievement of the education goal:
• Relatively high costs of schooling for families (especially in rural communities), which result in the unwillingness of parents to send their children to school.

• The need for creating an appropriate framework for the promotion of non-public sector investment in education.

• Transforming the educational assessment system from one based on the chalk and talk method to one based on performance (process evaluation) on educational components.

• Programming and providing the necessary resources for the education of children, taking into consideration factors such as geographical dispersion of communities, climatic conditions, rural to urban migration and mobility of the nomadic populations, across various areas of the country.

• Taking into consideration personal, psychological, climatic, social, environmental, racial, regional and cultural differences among learners of formal and non-formal education programmes in the design of curricula.

• Strengthening attitude and behavioural aspects required by the labour market through the introduction of life skills (i.e. teamwork, problem solving, creativity, critical thinking, communication skills, goal setting abilities, responsible behaviour, self-confidence, taking initiative, leadership skills and respect for others), in the national education system.

• Implementation of a comprehensive human resources programme and improvement of the motivational system for attracting and retaining quality human resources and providing specialised human resources for special needs schools.

• Identification and enrolment of school age children who are out of school.

• Utilisation of full capacities of the existing information system and establishment of full access to the required data pertinent to various operational units within the education system, in order to facilitate decision-making processes.

• Formulation of a comprehensive and coordinated strategy for education-related research activities.

• Equipping schools with new educational technologies.

• Appropriate assignment of responsibilities to provincial and regional directors and to school principals.

• Development of the necessary skills and updating the knowledge of school principals, educational policy makers, curricula programmers and instructors of teacher training courses, with regard to the use of new educational technologies.

• Strengthening awareness-raising systems (such as research, monitoring, evaluation and quality control) for public education programming.

**National Priorities for Development Cooperation**

At present, I.R. Iran is benefiting from the cooperation of international organisations in education projects such as the following:

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**Goal 2: Achieve Universal Primary Education**

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• Enrolment of all children of official school age, especially girls.
• Curriculum enrichment and adaptation to the needs and interests of primary and secondary school students for creating further motivation for students to remain within the education system.
• Health and nutrition education.
• Supporting low-income and deprived rural households.

These partnerships could extend to cover other aspects, the most important of which are listed below:

- Capacity-building in the area of educational programming and promotion.
- Reform and strengthening of formal and non-formal education systems.
- Transfer of successful international experiences, with regard to effective management of human, physical and financial resources within the education system.

4. Tracking Progress: Monitoring & Evaluation

In light of measures taken in the education sector and approaches existing in this area, it would seem rather promising for the defined education targets to be met by 2015.

Statistical tools, both software and hardware, deployed within the MOE are of a satisfactory standard and in addition to providing information necessary for programmers, enhance the framework for monitoring and evaluation in this sector.

Also, with the adoption of fiscal decentralisation approaches and application of performance-based budgeting methods, necessary mechanisms have been envisaged and are under implementation for increasing the effectiveness of allocated resources, in particular financial resources, in the education sector.

<table>
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<tr>
<th>Monitoring Mechanism</th>
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<td>Tracking, Monitoring and Analysis</td>
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<td>Capacity for Application of Statistical Data in Policy-Making and Planning</td>
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<tr>
<td>Availability of Necessary Mechanisms for Allocation of Resources</td>
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</table>
Goal 3: Promote Gender Equality and Empower Women

Target 4: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

Indicator 9) Ratio of girls to boys in primary, secondary and tertiary education
Indicator 10) Ratio of literate women to men, 15-24 years old
Indicator 11) Share of women in wage employment in the non-agricultural sector
Indicator 12) Proportion of seats held by women in national parliament

1. Progress Achieved

Promotion of gender equality and empowerment of women is the third MDG. While the only target defined in MDG 3 for assessing progress towards gender equality is education-related, other indicators have been set for monitoring performance in this area, which would be discussed within this chapter.

Ratio of girls to boys in primary, secondary and tertiary education (Indicator 9) has demonstrated considerable progress from 79.2 percent in 1990 to 94.3 percent in 2005 (Table 3.1).

In addition to extensive measures taken by the Government for improving educational equality, the significant increase for this indicator has been mainly due to the increased survival rate of girls in (upper) secondary education and increased advancement of girls to tertiary education. Key factors influencing this changing trend have been increased access to educational opportunities, greater interest in continuing education among girls and evolving cultural and societal norms resulting in increased interest in continuing education for girls. Greater number of boys dropping out of education, especially at secondary and tertiary levels, has also contributed to the growing ratio of female students.

Table 3-1. Ratio of Girls to Boys in Primary, Secondary and Tertiary Education (%)

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<tr>
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</thead>
<tbody>
<tr>
<td>1990</td>
<td>79.2</td>
<td>81.7</td>
<td>88.2</td>
<td>89</td>
<td>90.3</td>
<td>91.5</td>
<td>92.8</td>
<td>93.7</td>
<td>94.3</td>
</tr>
</tbody>
</table>


The indicator ratio of literate women to men, 15-24 years old (Indicator 10), represents the disparity between the literacy rates of women and men, in the 15-24 year age group. According to the latest data available, which is tabulated in Table 3.2, ratio of literate women ages 15-24 to literate men in the same age group has witnessed a considerable increase from 87.9 percent in 1990 to 98.6 percent in 2004.
Table 3-2. Ratio of Literate Women to Men, 15-24 Years Old (%)

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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratio</td>
<td>87.9</td>
<td>92.6</td>
<td>96.1</td>
<td>96.1</td>
<td>96.7</td>
<td>97</td>
<td>97.81</td>
<td>98.1</td>
<td>98.6</td>
</tr>
</tbody>
</table>


Changes in the literacy rate of women ages 15–24, in comparison with that of men in the same age group, over the length of the period under study, have been illustrated in Figure 3.1. This trend is due to a more rapidly increasing rate of literacy among women, in comparison with men, which has also been clearly demonstrated in Figure 2.2.

Figure 3-1. Ratio of Literate Women to Men, 15-24 Years Old (%)


Thus, it seems that provided innovative practices are deployed in capacity-building for human resources and teaching methods, the MDG target for eliminating gender disparity at all levels of education will be met by 2015.

Share of women in wage employment in the non-agricultural sector (Indicator 11), is another indicator monitored for assessing gender equality and the empowerment of women.

Despite the fact that during recent years the ratio of educated women to men has enjoyed considerable growth, based on the available information (Table 3.3) share of women in wage employment in the non-agricultural sector (Indicator 11) has remained rather low.

Table 3-3. Share of Women in Wage Employment in the Non-Agricultural Sector\(^1\) (%)

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Share</td>
<td>10.5</td>
<td>12</td>
<td>14.9</td>
<td>15.3</td>
<td>12</td>
<td>12.14</td>
<td>11.1</td>
<td>16.1</td>
</tr>
</tbody>
</table>


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1. The considerable increase for this indicator in 2005 has been due to changing over from the Employment and Unemployment Survey to the new Labour Force Survey in this year.

Goal 3: Promote Gender Equality and Empower Women
Proportion of seats held by women in national parliament (Indicator 12) in the fifth session of the parliament had been 5.1, with its values for the sixth and seventh sessions having been 4.5 and 4.1 percent, respectively (Table 3.4).

The number of female parliamentarians in the fifth session of the parliament had been 14, in the sixth 13 and in the seventh 12. Although share of female parliamentary candidates had been more than twice the percentage of seats occupied, considering the growth in the number of female parliamentary candidates between 1997 and 2003 reported at 53.8 percent, the share of women, regarding both the percentage of candidates and the proportion of seats occupied, has been significantly lower in comparison with that for men.

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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>2</td>
<td>3.3</td>
<td>5.1</td>
<td>4.5</td>
<td>4.1</td>
</tr>
</tbody>
</table>


2. Enabling Policies and Programmes

Various measures and policies with the aim of promoting gender equality and empowering women have been envisaged in the Third FYDP, from among which the following could be pointed out as key:

- Identification of women's educational, cultural and sporting needs, based on Islamic principles
- Enhancement of women's role in the country's development processes
- Increased employment opportunities for women
- Facilitation of women's access to legal assistance
- Supporting the establishment of NGOs which give priority to female heads of household and women lacking adequate legal support in underdeveloped areas

For meeting the above aims, the Centre for Women's Participation (CWP) has been required to take action to establish the foundation for more effective participation of women in the country's development activities, alongside strengthening of the family institution. Furthermore, during the Third FYDP, a programme titled Promotion of Social and Cultural Participation of Women was formulated, with a budget equalling 0.25 percent of the total provincial expenditure budgets. Actions carried out under this programme were aimed at the alleviation of gender disparities in access to opportunities, allowing the country to prosper from women's capabilities in various arenas, while needing to be adaptable to the sphere of duties and objectives of the corresponding institutional bodies.

Alongside various activities carried out for meeting the goals stipulated in the Third FYDP, the CWP implemented various programmes for creating the basis for the utilisation of
women's capabilities in higher echelons of decision-making and public administration. From among these, a management and leadership skills training workshop for women and a plan for training 300 female directors employed in government bodies could be mentioned. Also, based on findings of a study into the conditions of employment of women and men in public administration positions and elucidation of existence of unsatisfactory disparities between men and women in this area, a six-year plan was proposed and formulated for the promotion of the status of women in the public administration system.

In order to promote the status of the indicator of quality of life of women heads of household and those with an incapacitated head of household, the CWP took measures in cooperation with the Social Welfare Organisation to provide essential economic and psychosocial training to female heads of household in 2004. Furthermore, a national plan for the establishment of a database of women heads of household and affected and vulnerable women was implemented during the period 1996-2003 for creating a framework for identification of the conditions and needs of this group. Shortcomings in mechanisms devised for measuring progress towards the goals of the related programmes during the Third FYDP had been among key issues adversely affecting the task of measuring progress made in the implementation of these programmes.

In continuation of the preceding plan, the necessary procedures and policies for alleviation of gender disparities have been envisaged in the Fourth FYDP (2005-2009) as follows:

- Creation of equal educational opportunities at all levels of education for men and women
- Promotion of women's participation in policy-making and civil society activities
- Enablement of women through the provision of technical and vocational training
- Improving gender equality in the labour market in order to accommodate the increasing labour supply of educated women
- Promotion of community organisations supporting women's rights
- Provision of the required securities and freedoms for the promotion of community organisations supporting women's and children's rights
- Formulation of targeted insurance policies for women heads of household and those with an incapacitated head of household and a programme for the empowerment of these women
- Supporting the families of prisoners

3. Major Challenges and Development Cooperation

Looking back at the last three decades, the third decade of the Revolution could be regarded the Decade for Women’s Social and Political Development. Details presented in this section regarding the conditions of the indicators for this MDG reconfirm this socio-political development. Ratification of various bills in line with support for women's rights, particularly during the course of the Fourth FYDP, could be pointed out as a significant achievement in this regard.
Despite significant progress achieved by women in education, it seems that meeting the corresponding targets of the Fourth FYDP and promotion of women’s status in the labour market and within the country's system of governance and policy-making would require further capacity-building and formulation of additional operational mechanisms. This issue seems even more pertinent at present, as it is envisaged that during the future ten years the country shall be faced with increasing numbers of one-person households headed by educated girls.

In conclusion, major challenges regarding promotion of gender equality in I.R. Iran are categorised as follows:

- Increasing employment opportunities, especially for educated women
- Improving gender equality in the labour market
- Increasing support for women to allow them to create a balance between their functions at home and in the workplace
- Improving technical and vocational training programmes for women
- Reform of laws and regulations with the goal of increasing gender equality
- Promotion of women's participation in administrative, managerial and policy-making positions
- Identification of socio-economic problems and negative perceptions which adversely affect women's rights
- Expanding support for NGOs supporting women's rights
- Production of gender-disaggregated statistics, especially in national censuses

**National Priorities for Development Cooperation**

Drawing upon the capacities of international organisations in this area could assist the country in overcoming the abovementioned challenges, within the framework of the following measures:

- Partnering with the Government in identification of appropriate methods and formulation of an action plan for increasing the share of women in the labour market, while taking into consideration existing socio-economic and cultural conditions
- Enhancing women's capabilities in searching for employment
- Transfer of international experiences in promotion of women's participation in decision-making processes
- Identification of mechanisms for strengthening NGOs supporting women’s rights
- Researching mechanisms for alleviating social and cultural barriers to the education of rural women
- Establishment of an appropriate knowledge base, including statistics, comparative indicators and research results in the area of gender equality, for use in policy-making and monitoring processes

4. Tracking Progress: Monitoring & Evaluation

<table>
<thead>
<tr>
<th>Monitoring Mechanism</th>
<th>Evaluation</th>
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<tbody>
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<td></td>
<td>Strong</td>
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<tr>
<td>Achievement of Goal</td>
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<tr>
<td>Capacity for Collection and Assessment of Data</td>
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<tr>
<td>Tracking, Monitoring and Analysis</td>
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<tr>
<td>Capacity for Application of Statistical Data in Policy-Making and Planning</td>
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<tr>
<td>Availability of Necessary Mechanisms for Allocation of Resources</td>
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</tbody>
</table>
Goal 4: Reduce Child Mortality

Target 5: Reduce by two thirds, between 1990 and 2015, the under-five mortality rate

Indicator 13) Under-five mortality rate (per 1,000 live births)
Indicator 14) Infant mortality rate (per 1,000 live births)
Indicator 15) Proportion of 1 year-old children immunised against measles

1. Progress Achieved

Child mortality is directly affected by existing socio-economic conditions. For this reason, it has been chosen as one of the most important indicators for assessing the level of development in a country and given special emphasis within the MDG framework.

Following the implementation of extensive measures towards improving child health, especially through increased access to reproductive health services and education, I.R. Iran has been able to accomplish considerable achievements in the area of reducing the under-five mortality rate (Indicator 13), with the number of deaths per 1,000 live births falling from 68 in 1990 to 36 in 2000. The rate in 2000 had been 36.4 for girls and 37.6 for boys, respectively.

Although the latest data generated at the national level has been for the year 2000, it is envisaged that with the continuation of this decreasing trend the target set for 2015 will be attainable over the coming years. It should be noted that sustained reduction in child mortality towards reaching satisfactory levels of child health over the future years and thus approaching the defined target requires increased effort and more elaborate risk management.

Significant progress has also been achieved with regard to infant mortality rate (Indicator 14), with the rate having reached 28.6 deaths per 1,000 live births in 2000 from 52.5 in 1999, demonstrating a 54 percent decrease.

Reviewing indicators 13 and 14, it can be deduced that nearly 80 percent of under-five deaths have occurred during the first year of life, which clearly demonstrates the need for increased attention to prevention and reduction of child mortality in this age group.

As was mentioned above, the most recent official data regarding child mortality has been from the year 2000 (based on DHS results). Therefore, in the continuation of this section, data released by the national health network during the recent years has been used for analysing the status of child mortality.

In the national health network, comprehensive data regarding the health indicators are collected at the level of smallest geographical divisions, covering mainly rural areas. Population coverage of the network has been 20 million in 2003. Based on vital statistics, infant mortality rate (IMR) has been 24.2 per 1,000 live births in 2003, which has demonstrated a decrease of 13 from 37.2 deaths per 1,000 live births in 1993 (Table 4.1).
Table 4-1. Newborn, Infant and Under-Five Mortality Rates per 1,000 Live Births (based on Vital Statistics)

<table>
<thead>
<tr>
<th>Year</th>
<th>Newborn</th>
<th>Infant</th>
<th>Under-Five</th>
</tr>
</thead>
<tbody>
<tr>
<td>1993</td>
<td>19</td>
<td>37.2</td>
<td>46.3</td>
</tr>
<tr>
<td>1996</td>
<td>17.9</td>
<td>30.2</td>
<td>38.6</td>
</tr>
<tr>
<td>1999</td>
<td>18.3</td>
<td>28</td>
<td>34.4</td>
</tr>
<tr>
<td>2001</td>
<td>17.4</td>
<td>25.2</td>
<td>30.6</td>
</tr>
<tr>
<td>2003</td>
<td>16.9</td>
<td>24.2</td>
<td>39.7</td>
</tr>
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</table>

Source: Website of the Ministry of Health and Medical Education, Deputy for Health Affairs (www.mohme.gov.ir)

Around 57 percent of deaths in 2003 have taken place in the neonatal period (< 1 month), which points to the increase in the share of this age group in total under-five deaths, compared with 41 percent in 1993. As can be seen in Figure 4-1, this decreasing trend also applies to other indicators regarding infant and under-five mortality.

Among leading causes of mortality for children aged 1-59 months, respiratory diseases, traffic accidents, cardiovascular disorders and nervous system disorders could be pointed out.\(^1\)

Figure 4-1. Newborn, Infant and Under-Five Mortality Rates per 1,000 Live Births (based on Vital Statistics)


Reviewing proportion of children immunised against measles (Indicator 15), it could be observed that this indicator has increased from 85 percent in 1999 to 99 percent in 2003, which effectively demonstrates the attainment of the defined objective for this indicator in Iran (Figure 4-2).

---

1. Source: Mortality Surveys across 10 provinces in 2000, Ministry of Health and Medical Education.
In view of the epidemiological condition of the disease and the changes observed in the trend of the incidence of the disease during recent years and also the high national vaccination coverage and the successful implementation of control strategies based on international health commitments regarding the global target of eradication of measles, measures regarding programming and implementation of full vaccination with MR (measles and rubella vaccine) have commenced.

2. Enabling Policies and Programmes

The First and Second FYDPs concentrated on improving public health and reducing child and maternal mortality. The Third FYDP saw the implementation of the following measures, which were continued during the Fourth FYDP:

- Formulation and implementation of Integrated Management of Childhood Illness (IMCI)
- Expansion of integrated care for turning sick children into healthy ones
- Formulation and implementation of Integrated Management of Healthy Child (IMHC), increasing the number of mother and baby-friendly hospitals and improving child care services
- Improving antenatal care programmes, promotion of good nutrition among pregnant and lactating women and paying further attention to the child growth curve, together with promotion of breastfeeding
- Prevention of infectious and non-infectious diseases

The Fourth FYDP, while emphasising past policies for reducing child mortality, pays increased attention to this objective through the following measures:

- Public coverage of compulsory health insurances, expansion of public health education and continuation of reproductive health policies
- Allocation of the necessary financial resources by the Government for primary health care programmes with the cooperation of the general public and corresponding NGOs
• Expansion of IMHC coverage nationwide and to children up to eight years of age and improving quality of neonatal care in hospitals equipped with neonatal intensive care units (NICU)
• Expansion of IMCI in the public and non-public sectors
• Establishment of a data collection, registration and reporting system and utilisation of suitable information technology for the realisation of this task and for estimating the total burden of diseases

3. Major Challenges and Development Cooperation

Major challenges regarding the achievement of MDG 4 include:
• Proper access to up-to-date statistics on child mortality
• Quantitative and qualitative equipment of health care networks, for provision of the necessary services for improving child health, taking into consideration changes in the nature of their health risks
• Formulation of decentralised programmes (especially provincial) for reducing infant and child mortality rates
• Expansion of IMCI and IMHC coverage
• Identification of causes of infant mortality and establishment of a suitable mechanism for its prevention and control
• Completion of the outpatient emergency care network
• Management and control of re-emerging and newly-emerging diseases
• Improving child nutrition
• Strengthening inter-sectoral cooperation and harmonisation of policy-making and monitoring bodies
• Facilitating the necessary resources for non-public sector investment in expansion of health and medical activities
• Active community participation in safeguarding child health within the framework of integrated management programmes

National Priorities for Development Cooperation

National priorities for international development cooperation for improving infant and child health include:
• Transfer of new technologies for improving quality of care in hospitals and health centres
• Introduction of a comprehensive approach to improving child nutrition
• Identification of contributory factors and estimation of the burden of childhood diseases
• Provision of technical assistance for the improvement of the DHS
4. Tracking Progress: Monitoring & Evaluation

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<td>Availability of Necessary Mechanisms for Allocation of Resources</td>
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</tbody>
</table>
Goal 5: Improve Maternal Health (in the Context of Reproductive Health)

Target 6: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

Indicator 16) Maternal mortality ratio (per 100,000 live births)

Indicator 17) Proportion of births attended by skilled health personnel

Indicator 17-A) Reproductive health indicators

- Universal access to reproductive health
- Contraceptive prevalence rate
- Unmet need for contraception
- Youth fertility rate
- Access to emergency obstetric care
- STI\(^1\) prevalence rate

1. Progress Achieved

Improving maternal health is analysed within the wider framework of “reproductive health”, which covers the lifecycles of men and women and encompasses the physical, psychological and social dimensions of essential reproductive health care (including safe motherhood, family planning, STI prevention and management, breast and cervical cancers, unsafe abortions, adolescent reproductive health, reproductive health education and services in emergencies, etc.).

The highest burden of disease imposed on women is related to reproductive health. Universal access to reproductive health care - including family planning programmes, antenatal care, prenatal, delivery and postnatal care – would result in the reduction of unwanted pregnancies and unsafe childbirth and therefore saving the lives of mothers and babies through the promotion of maternal health.

Maternal mortality ratio (Indicator 16) is one of the most important development indicators. This indicator presents the annual number of deaths of women from pregnancy-related causes, during pregnancy or within 42 days of termination of pregnancy, per 100,000 live births.

As can be viewed from Table 5.1, maternal mortality in the country has reached 24.6 per 100,000 live births in 2005, following a significant decrease from 91 per 100,000 live births in 1998. According to the target defined for this MDG, this indicator would need to reach 18 to 22 deaths per 100,000 live births by 2015\(^2\).

Figure 5.1 shows clearly the decreasing trend for the abovementioned indicator. Thus, it seems that meeting this target within the time remaining until the year 2015 would be feasible.

1. Sexually Transmitted Infection
2. For further details regarding computation methods used refer to the Technical Notes at the end of this report.
Table 5-1. Maternal Mortality Ratio per 100,000 Live Births (1988-2005)

<table>
<thead>
<tr>
<th>Year</th>
<th>Urban</th>
<th>Rural</th>
<th>Total</th>
<th>Urban</th>
<th>Rural</th>
<th>Total</th>
<th>Urban</th>
<th>Rural</th>
<th>Total</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1988(1)</td>
<td>41.3</td>
<td>137.5</td>
<td>90.6</td>
<td>29</td>
<td>80</td>
<td>54</td>
<td>24.3</td>
<td>54.5</td>
<td>37.4</td>
<td>24.6 ±1*</td>
</tr>
<tr>
<td>1991(2)</td>
<td></td>
<td></td>
<td></td>
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<td>1996(3)</td>
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<td>2005(4)</td>
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</tbody>
</table>

Sources: (1) Health Care Networks in Iran, Dr. Kamel Shadpour, 1973
(2) Maternal and Child Health Survey in I.R. Iran, Dr. Hossein Malek Afzali, 1991
(3) Calculating Maternal Mortality Ratio using Reproductive Age Mortality Surveys (RAMOS), Dr. Mohsen Naghavi, 1996
(4) Data Collected in the National Maternal Mortality Surveillance System, 2005

Figure 5-1. Maternal Mortality Ratio per 100,000 Live Births (1998-2005)

Significant differences could be observed for certain provinces with regard to the provincial dispersion of maternal mortality. For example, data tabulated in Table 5.2 shows that the province of Sistan va Baluchestan, although registering only 6 percent of total births, has 13 percent of maternal deaths in the country. Also, while only 2.94 percent of women ages 15-49 live in Sistan va Baluchestan, 6 percent of total births take place in this province (high fertility rate).

Pregnancy and childbirth therefore carry a higher risk of death in this province, in comparison with other areas in the country. A similar situation, but to a lesser extent, exists for the provinces of Kerman, Kohgiluyeh va Buyer Ahmad, Kermanshah, Hormozgan and Hamadan. The reverse is true for the province of Tehran. Although 15 percent of total births take place in this province, only 6 percent of maternal deaths happen in Tehran. It should be taken into account however that undercounting for maternal deaths is possible in Tehran due to the lack of active participation by the private sector and other service providers (from whom the collection of data is not easily possible).

* Accurate calculation of the maternal death indicator is carried out using data from the national census, together with precise statistics for the number of births. Considering the fact that the last census had taken place in 1996 (population censuses are carried out every ten years in the country), this indicator has been calculated in 2005 by the Ministry of Health and Medical Education using data collected by the National Maternal Mortality Surveillance System in the numerator and an estimation for the number of births in the denominator.
<table>
<thead>
<tr>
<th>Province</th>
<th>Share of the Province in Total Women Ages 15-49</th>
<th>Share of Province in Total Births</th>
<th>Total Maternal Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Azarbaijan</td>
<td>5.30</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>West Azarbaijan</td>
<td>4.09</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Esfahan</td>
<td>1.82</td>
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</tr>
<tr>
<td>Ilam</td>
<td>6.57</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ardebil</td>
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<td>2</td>
</tr>
<tr>
<td>Bushehr</td>
<td>1.21</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Tehran</td>
<td>17.79</td>
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<td>6</td>
</tr>
<tr>
<td>Chahar Mahal va Bakhtiari</td>
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<td>1</td>
</tr>
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<td>Khorasan</td>
<td>9.68</td>
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<td>11</td>
</tr>
<tr>
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<td>6.18</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Zanjan</td>
<td>1.42</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Semnan</td>
<td>0.83</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Sistan va Baluchestan</td>
<td>2.94</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Fars</td>
<td>6.48</td>
<td>6</td>
<td>5</td>
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<tr>
<td>Qazvin</td>
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<td>1</td>
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<td>Qom</td>
<td>1.50</td>
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<td>2</td>
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<td>Kurdistan</td>
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<td>2</td>
</tr>
<tr>
<td>Kerman</td>
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<td>Kohgiluyeh va Buyer Ahmad</td>
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<td>Golestan</td>
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<tr>
<td>Gilan</td>
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<tr>
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<tr>
<td>Markazi</td>
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<tr>
<td>Hormozgan</td>
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<td>3</td>
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<td>Hamadan</td>
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<td>3</td>
</tr>
<tr>
<td>Yazd</td>
<td>1.35</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>


1. For further information on the calculation of the indicators specified in this table, refer to the technical notes at the end of this report.
The following factors play a defining role in increased risk of maternal death due to obstetric complications:

1. Age and fertility level

Around 20 percent of reported deaths during 2000 have taken place for women older than 35. During the same year, 24 percent of maternal deaths have been for women with a history of more than 4 pregnancies. The same issue applies for the period 1997 to 2004, which points to the need for further attention being paid to family planning programmes, especially with regard to high-risk individuals.

2. Literacy status

Nearly 63.3 of maternal deaths in 2004 have been attributed to illiterate women or women with incomplete primary education. This issue is more pertinent with regard to rural women.

3. Deliveries attended by untrained personnel

Despite the fact that during the period 1997 to 2005 the share of births attended by untrained attendants in the total number of deaths has decreased due to improved access to maternal health services (from 44 percent in 1997 to 8 percent in 2005), deliveries carried out by untrained attendants has been one of the key factors in maternal deaths in the last four years.

4. Quality of care provided in hospitals and birth centres

During the period 1997 to 2005, ratio of hospital births has increased from 78.7 percent to 96.3 percent due to increased access to health care centres. During these years share of hospitals in the total number of maternal deaths has also increased, rising from 43 percent of reported deaths in 1997 to 82 percent in 2005. This demonstrates that the trend of development in the country has resulted in increased access to hospital services for pregnant women. Due consideration to the quality of emergency obstetric care (EOC) could play a definitive role in the reduction of hospital deaths.

Also, according to the results published by the National Maternal Mortality Surveillance System from 2001 to 2003 and as illustrated in Figure 5.2, failures in secondary prevention of complications have resulted in 90 percent of the main obstetric complications leading to maternal deaths; with 73 percent of these being related to low quality of care, 25 percent to lack of service availability and 2 percent due to sudden deaths.

Each of these factors is dependent on other factors defined clearly in the figure. Flaws in primary prevention of complications have also resulted in 10 percent of main obstetric complications leading to maternal deaths, which are dependent on factors such as:

- Failure in the identification and management of known risk factors
- Poor management of prenatal, delivery and postnatal care
- Unwillingness to receive preventive services
- Malpractice

In summary, shortcomings in knowledge, attitude and skills of health personnel or with reference to institutions providing maternal care services could all prove contributory causes for maternal mortality.
Figure 5-2. Why do Mothers Die of Obstetric Complications in Iran

A few of the indicators related to reproductive health and the corresponding national objectives have been presented in Table 5.3. As can be seen from this table, percentage of deliveries attended by skilled health personnel (Indicator 17) has significantly increased during the recent years from 89.6 percent of total deliveries in 2000 to 97.3 percent in 2005.

Likewise, prenatal care coverage (at least 6 times) (Indicator 17A) has increased from 80 percent in 2000 to 94.3 percent in 2005. In addition, postnatal care coverage (at least twice) has increased from 31 percent in 2000 to 87 percent in 2005.

Table 5-3. Few Indicators and Targets for the National Maternal Health Programme

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Indicator Status</th>
<th>National Target to 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal care coverage (at least 6 times)</td>
<td>2000 80</td>
<td>2005 94.3</td>
</tr>
<tr>
<td>Safe delivery coverage (in maternity centres and hospitals)</td>
<td>2000 87.6</td>
<td>2005 96.3</td>
</tr>
<tr>
<td>Postnatal care coverage (at least twice)</td>
<td>2000 31</td>
<td>2005 87</td>
</tr>
<tr>
<td>Proportion of births attended by skilled health personnel</td>
<td>2000 89.6</td>
<td>2005 97.3</td>
</tr>
</tbody>
</table>

Source: Demographic and Health Survey (DHS), 2000; Reproductive Age Mortality Survey (RAMOS), 1996; Integrated Monitoring and Evaluation System (IMES) and National Maternal Health Programme, 2005.

In Figure 5.3, trends of change for the national maternal health indicators and the objectives of the national programme are presented. As can be seen in this figure, achievement of these objectives does not seem out of reach, in light of existing conditions.

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1. In 2004, for precise calculation of the programme objectives up to 2015 latest data available from the DHS carried out in 2000 was used, with the values for the indicators being defined according to the MDG targets, with a 75 percent improvement envisaged in comparison with the DHS data. The results of the Integrated Monitoring and Evaluation System (IMES) in 2005 demonstrated that meeting many of the MDG indicators had become feasible. Therefore, in 2006, the targets defined for this MDG were reviewed and new targets were set according to the above table.
Following the implementation of reproductive health policies, the ratio of unwanted pregnancies decreased from 37 percent in 1993 to 18.6 percent in 2005. Also, during the period 1993-2000, the total fertility rate decreased from 3.6 to 2 (Figure 5.5)

Iran's family planning programme has proven one of the most successful in the world, such that contraceptive prevalence rate increased from 68.1 percent in 1993 to 78.8 percent in 2005 and the level of knowledge for women of marrying age regarding emergency contraception increased from 9.1 percent in 2000 (DHS) to 36.4 percent in 2005 (IMES). As can be deduced from Figure 5.6, increase in use of modern methods of contraception from 49.2 percent to 59.6 percent has played a significant role in this regard.
In addition to the data available regarding the maternal health indicators at the national level, extensive amounts of information are also collected and categorised regarding these indicators in smallest detail by the health care personnel in the national health care network for rural areas (with a total population coverage of about 20 million). Following the implementation of extensive programmes in the area of maternal care and safe childbirth, the indicator for deliveries attended by skilled health personnel rose from 72.8 percent in 1993 to 92.5 percent in 2005, with the smallest increase related to the rural areas of Sistan va Baluchestan (56.6 percent).

Furthermore, coverage of modern methods of contraception (all methods registered in the vital statistics, except the natural method) increased in rural areas from 43.5 percent in 1993 to 66.9 percent in 2005, with the highest increases up to April 2006 being reported for the rural areas of Zanjan, Ardebil and Kermanshah, with 80, 76.4 and 75.7 percent, respectively and the lowest increases for the rural areas of Sistan va Baluchestan (38.6 percent) and Hormozgan (43.8 percent).

2. Enabling Policies and Programmes

Identified causes of maternal death in Iran and their statistical representation have been illustrated in Figure 5.7, titled diagnostics tree for causes of maternal deaths in Iran, based on data from the Maternal Mortality Surveillance System during for the period 2001 to 2003. This representation shows that if five strategies are taken into consideration for reducing maternal deaths, the share of the raw effect of each in reducing the number of deaths would be equal to 32, 24.2, 18.6, 15.84 and 9.9 percent, respectively. The five strategies having been identified as follows:

- Improvement of quality of hospital care
- Improvement of quality of outpatient EOC services
- Increased coverage and improvement of family planning services for at-risk mothers
- Increased access EOC services
- Increased public awareness regarding EOC and the need to take advantage of services provided by health centres

Reducing maternal deaths and improving maternal health in the framework of reproductive health have been among the main objectives of the FYDPs, having been followed through various national policies and programmes, including:

- Expansion of health care networks and centres and improving the emergency medical network
- Improvement of the pharmaceutical system
- Expansion of health insurances
- Improvement of food security and safety at national and provincial levels
- Continuation of population control policies
- Strengthening of the family planning programme

Also, in the Fourth FYDP, certain policies have been envisaged in the area of maternal health, including the empowerment of women to improve their own health. Other measures include:
- Continuation of the fertility control policy, through the family planning programme
- Promotion of healthy lifestyles
- Reduction of high-risk behaviours
- Design and implementation of a comprehensive health information system
- Provision of the necessary financial resources for primary health care by the Government
- Expansion of health insurance coverage

Specific measures having been envisaged in the Fourth FYDP for the realisation of the abovementioned policies include:
- Nationwide extension of formulated protocols for Integrated Management of Pregnancy And Childbirth (IMPAC) for prenatal, delivery and postnatal care
- Supporting the implementation of the National Maternal Mortality Surveillance System.
- Taking the necessary actions for training skilled birth attendants in deprived rural areas
- Formulation of a system for monitoring the maternal mortality prevention programme
- Expansion of mother-friendly hospitals
- Carrying out the necessary coordination among insurance organisations and the High Council of Insurance for the provision of obstetric services to poor and low-income households

Priority actions in the National Health Plan in line with improvement of maternal health include:
- Provision of health education before and during marriage
- Provision of health education and services after marriage
- Maternal Mortality Surveillance
- Training skilled birth attendants
- Strengthening mother-friendly hospitals
- Implementation of IMPAC at the outpatient level
- Promotion of breastfeeding
- Integration of community-based rehabilitative and support care for the middle-aged and the elderly at the various levels of the network
- Population control
Figure 5-7. Diagnosis Tree for Causes of Maternal Mortality in Iran
For improving the indicators related to maternal health the MOHME formulated the National Maternal Health Programme, the aim of which is reducing the burden of diseases ensuing during pregnancy, labour and the postpartum period for mothers (up to 42 days after delivery) and newborns (up to 6 hours after delivery), in line with national and international commitments.

The outlook envisaged for this programme is that all mothers, in any condition of health or morbidity and at any time during pregnancy, labour or the postpartum (up to 6 weeks) period, could refer to service provision centres anywhere within the health network, regardless of being in the public or private sector, and receive effective services, such that during this period they do not die or suffer from severe complications, and in the case that any problem arises, they receive correct and effectual treatment and passing through this period leaves them with fond memories.

This programme is divided into four main divisions, which include:

- National Maternal Mortality Surveillance System
- Integrated Management of Pregnancy And Childbirth (outpatient services)
- Mother-friendly hospitals (inpatient or hospital services)
- Training of birth attendants for remote and deprived areas

A) National Maternal Mortality Surveillance System

Investigating and finding the causes of maternal death plays an important role in assessing the level of development in the society and determining the present status of maternal health and formulation of appropriate measures for achievement of maternal health. The Maternal Mortality Surveillance System was initiated in Iran in 2001 with this aim and in line with the realisation of national and international objectives and commitments.

The main aim of this programme is the identification of causes of maternal death during pregnancy, labour and the postpartum period, through the investigation of the path each pregnant woman has followed up to the time of death and identification of preventable complications in each case of death and design of interventions for resolving issues and preventing similar deaths.

In this programme, maternal death is defined as the death of a woman while pregnant or within 42 days after the termination of that pregnancy, regardless of the length and place of the pregnancy, due to any cause related to or aggravated by the pregnancy itself or care received, but not due to accidental or incidental causes. Figure 8.5 show the workflow and the defined activities for the programme.
For monitoring and evaluation of the national Maternal Mortality Surveillance System, certain indicators are defined and corresponding information is collected over a period of 6 months through corresponding questionnaires.

B) Integrated Management of Pregnancy and Childbirth (Outpatient Services)

Standardisation of the protocols for the provision of maternal care during pre-pregnancy, pregnancy, labour and postpartum periods at outpatient levels for physicians and non-physicians, by a team comprising of obstetricians, midwives and other health workers engaged at operational levels, began operation in 1999, leading to the publication of two educational collections and implementation as pilot across various provinces. The programme was monitored and evaluated based on the defined indicators during its implementation. Training at operational levels commenced nationwide in autumn 2006, following the application of the necessary modifications.

At the IMPAC level one, standards of service regarding pregnancy diagnosis, ordinary prenatal care, out-of-hospital delivery and postnatal care are defined and
the corresponding specialised care is specified. Corresponding measures for second level service providers (midwives, physicians) are subsequently specified. Level one personnel take the necessary measures for at-risk mothers in their care based on the opinions and feedback received from physicians or midwives.

General objectives of IMPAC in line with those of the Maternal Health Programme are as follows:

- Increasing IMPAC effectiveness (outpatient services)
- Improving IMPAC quality (outpatient services)
- Increasing the coverage of maternal health care
- Improving the infrastructure for provision of outpatient health services

C) Mother-Friendly Hospitals (Inpatient or Hospital Services)

As around 97 percent of deliveries are carried out in hospitals, for the achievement of the MDGs and in continuation of the standardisation of maternal care at outpatient levels, standardisation of specialised pre-pregnancy, prenatal, delivery and postnatal care at inpatient levels has been stipulated for specialists and other skilled health personnel, in the form of the Mother-Friendly Hospital Movement. The aim of the initiative is improving the quality of inpatient services, especially in obstetric emergencies, setting up childbirth preparedness classes for pregnant women and their birth companions during pregnancy and promotion of labour pain relief (using pharmacological or non-pharmacological techniques) for reducing the number of Caesarean sections and consequently decreasing unnecessary expenditures.

Standardised protocols for the provision of prenatal, delivery and postnatal care in hospitals have been formulated by a team of obstetricians, who are members of the Scientific Committee on Improving Maternal Health. In Figure 5.9 the logical framework to be taken into consideration in mother-friendly hospitals is illustrated.
**D) Improving the Coverage of Safe Childbirth in Remote and Deprived Areas**

For the realisation of safe childbirth and ensuring the presence of skilled attendants during deliveries, training of local people in rural areas where there is no access to birth centres is among the short-term objectives of the Family Health Programme. The programme includes the training of Behvarz midwives or rural midwives, depending on the specific conditions existing in each region.
E) Family Planning Programme

From among other enabling policies in this area the national family planning Programme could be mentioned. Iran's family planning programme has proven one of the most successful of its kind in the world. Through the implementation of the programme, contraceptive prevalence rate has risen from 49 percent in 1989 to 78.9 percent in 2005 in the country.

Within the family planning programme, the Government provides free of charge various types of contraceptives (pills, IUDs, condoms, injectables, tubal ligation, non-surgical vasectomy and emergency contraceptives) through the public health care (PHC) network. In remote areas where access to contraceptives is limited, MOHME provides contraception services through mobile clinics.

Progress for this key indicator is due to policies envisaged within the framework of reproductive health services.

Up to 1990, the national family planning programme followed three main objectives:

- Reduction of the number of early or late pregnancies (women under 18 or over 35 years)
- Three year birth spacing
- Advising a maximum of three births

From 1990 onwards, national public health centres proved rather effective in the provision of family planning and safe motherhood counselling and offered these services to millions of women who welcomed the opportunity to improve their own health and that of their children. Although the family planning and safe motherhood programmes have been carried out satisfactorily during the recent years, certain challenges remain such as unmet need for family planning services, estimated at around 5.9 percent.

Following the International Conference on Population and Development (ICPD), the MOHME expanded its family planning and safe motherhood programmes to cover other aspects of reproductive health. Today, access to reproductive health services in rural areas exceeds 95 percent. Although it should be noted that there still exist some remote regions to which provision of services is not possible.

Alongside these achievements for strengthening and improving family health programmes, attention would need to be paid to the high percentage of unwanted pregnancies and unmet needs.

Quality of care and unwanted pregnancies are serious issues for the MOHME. In relation to these, the Family Health Office in the MOHME has presented various protocols in regarding reproductive health care, from among which the following are listed here:

- Improvement of guidelines and protocols for mother-friendly hospitals
- Nationwide implementation of IMPAC
- Development of family planning service guidelines
- Review of the reproductive health management information system
- Implementation of the IMES
Other aspects of reproductive health, such as youth reproductive health, HIV and AIDS, STIs and reproductive health in emergencies are among other priorities in this area.

Sufficient data is not available with regard to age-specific percentages of pregnancy-related deaths. However, the general perception is that Iran is transitioning through an epidemiological phase, during which type 1 causes (infectious diseases and congenital anomalies) bear reduced significance on morbidity and mortality. This is while type 2 (noncommunicable diseases, especially cancers and cardiovascular diseases) and type 3 (accidents and crime, particularly traffic accidents) causes are becoming increasingly significant.

This shift is related to reduced infant and maternal mortality rates (which could be observed clearly in Iran during the past 20 years) and increased life expectancy. In turn it leads to a shifting of national health priorities: while the public health mechanisms (preventive programmes, rapid treatment of infections and reproductive health services) are continued and the role of the related causes of morbidity and mortality are controlled at a low level as a result, the need for the diagnosis and treatment of noncommunicable diseases would be on the increase. This process is expected to prove rather costly, as it would include high administrative medicinal and health personnel costs.

In another dimension, with regard to the status of abortions the information available on illegal abortions is insufficient. The MOHME believes that high quality consultation, together with the provision of modern, effective and reliable contraception methods would prove effective in reducing unwanted pregnancies and consequently the number of illegal abortions. It should be noted that although abortion is illegal in Iran (with the exception of specific cases), post-abortion services are offered nationwide in all public hospitals.

Sufficient data is not available with regard to the prevalence of STIs. Based on the data available, it could be stated that the prevalence of syphilis is not very high in the country, such that only one in a thousand donated blood samples has tested positive for syphilis. Regional differences exist with regard to STIs, with metropolises and large towns showing signs of increase of incidence of other STIs.

National reproductive health programmes extend particular attention and support to triangular clinics (voluntary counselling and testing, which would be described in more detail in the chapter on MDG 6). Men and women refer to these clinics to receive free medicinal treatment for STIs.

For meeting the targets set for this MDG, the topic of reproductive health for youth and adolescents bears great significance, with a significant portion of the population born during the period of high fertility rates in the 1980s being now itself of the reproductive age.

Further effort is required regarding youth awareness-raising in the field of reproductive health, including provision of information on unwanted pregnancies during the first years after marriage. Considering the sensitivity attached to youth reproductive health, action is carried out for the provision of the related education through formal and informal channels of education, such as the Teacher Parent Association. Despite this channel seeming well established culture-wise, further support and strengthening is required for its proper utilisation.
Although the National Adolescent Health Programme is still in its formative years, policymakers and directors in the health sector consider it one of the main issues with regard to reproductive health.

Within this framework, around 500 compulsory pre-marriage (reproductive health) education classes have been held for soon-to-be-married couples across the country, during which couples receive information on reproductive health, family planning, STIs, safe pregnancy and childbirth, together with the methods of referral in the event of complications.

Due attention to reproductive health in emergencies is another important topic in this area, requiring the attention of policy-makers. Iran is a country exposed to natural disasters. It should therefore be ensured that a national capacity is constantly in existence and expanding in readiness for and response to natural and man-made disasters. Particularly with regard to reproductive health, a logical capacity is required with effective and coordinated management for limiting loss of life to the extent possible and facilitating rapid return to normal reproductive health and social activity conditions.

Towards this purpose, it should be ensured that all aspects of reproductive health are covered by appropriate guidelines, sufficient supplies of reproductive health commodities for emergencies are stored, support mechanisms for emergency response are strengthened and reproductive health rapid response teams are properly trained and equipped for prompt mobilisation to areas of crisis.

During the recent years, effective steps have been taken towards access to reproductive health information and services in emergencies through the Red Crescent and the MOHME, in coordination with protocols and guidelines for reproductive health in emergencies. Reproductive health services could primarily be provided by the Red Crescent reproductive health rapid response teams and gradually turned over to the MOHME.

Strengthening of national and local mechanisms in humanitarian operations with regard to gender-related issues is essential, in line with strengthening of national legal commitments and for the provision of protection and security for victims of gender-based violence and the utilisation of potential capacities of women in emergencies.

3. Major Challenges and Development Cooperation

Reviewing the status of maternal health care in the framework of reproductive health in I.R. Iran reveals the following challenges:

- Implementation of standardised protocols for provision of prenatal, delivery and postnatal care
- Conversion of existing hospitals into mother-friendly hospitals
- Conducting normal deliveries
- Design and implementation of hospital protocols
- Reform of the insurance support and payment system for health services, particularly with regard to determining real tariffs for normal deliveries and training and consultation services
• Establishment or improvement of hospital information management systems and the corresponding monitoring and evaluation systems
• Improving the quality of reproductive health care, including obstetric and family planning care and ensuring safety of reproductive health commodities and equipment and appropriate level of human resources
• Awareness-raising for adolescents regarding reproductive health issues, including childbirth preparedness and prevention of unwanted pregnancies, while taking into consideration the reproductive health needs of men
• Filling data gaps regarding specific aspects of reproductive health, such as abortion, STIs and breast and cervical cancers
• Sectoral coordination for expansion of health, treatment, rehabilitation and education services
• Improving nutritional status of pregnant and lactating women
• Integration of adolescent reproductive health service packages in the public health network
• Ensuring reproductive health commodity security (RHCS), including upgrading of logistical packages for reproductive health in normal conditions and in emergencies, within the MOHME and the Red Crescent
• Due attention to maternal health in emergencies, through the provision of reproductive health education and services in emergencies, including provision of the necessary support services with regard to gender-based violence during emergencies

**National Priorities for Development Cooperation**

• Operationalisation of standardised protocols in the field of family planning services, and prenatal, delivery and postnatal care at outpatient and inpatient levels
• Establishment of mother-friendly hospitals nationwide
• Implementation of inpatient neonatal care classification
• Establishment of maternal care quality assessment and improvement system at outpatient and inpatient levels
• Promotion of safe childbirth and ensuring access to maternal health services for all poor women
• Continuation of population control policies and reduction of unwanted and at-risk pregnancies
• Reviewing the status of unsafe abortions and STIs and their effect on maternal health and investigating corresponding methods of prevention and control
• Improvement of the adolescent and youth health programme, with the aim of provision of reproductive health education
- Provision of reproductive health information, education and services in emergencies
- Strengthening South-South cooperation in the area of reproductive health
- Launch of a regional centre for non-surgical vasectomy
- Creation of a quality control system for hormonal contraceptives and for condoms manufactured locally
- Establishment of an HIV/AIDS behavioural surveillance system for at-risk groups
- Strengthening of support mechanisms and provision of reproductive health services for normal and crisis conditions

4. Tracking Progress: Monitoring & Evaluation

<table>
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<th>Monitoring Mechanism</th>
<th>Evaluation</th>
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<td>Strong</td>
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<td>Achievement of Goal</td>
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<tr>
<td>Capacity for Collection and Assessment of Data</td>
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<tr>
<td>Tracking, Monitoring and Analysis</td>
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<tr>
<td>Capacity for Application of Statistical Data in Policy-Making and Planning</td>
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<tr>
<td>Availability of Necessary Mechanisms for Allocation of Resources</td>
<td></td>
</tr>
</tbody>
</table>
Goal 6: Combat HIV/AIDS, Malaria and other Diseases

Target 7: Have halved by 2015 and begun to reverse the spread of HIV/AIDS
Indicator 18) HIV prevalence among pregnant women aged 15-24 years
Indicator 19) Condom use rate of the contraceptive prevalence rate
Indicator 20) Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years

Target 8: Have halved by 2015 and begun to reverse the incidence of malaria and other major diseases
Indicator 21) Prevalence and death rates associated with malaria
Indicator 22) Proportion of population in malaria risk areas using effective malaria prevention and treatment measures
Indicator 23) Prevalence and death rates associated with tuberculosis
Indicator 24) Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS)

1. Progress Achieved

The first target studied under MDG 6 is controlling and halving the incidence of HIV/AIDS. Three main and a number of complementary indicators have been defined for measuring progress towards this goal, which are reviewed in the continuation of this section.

Based on data collected from sentinel sites in urban antenatal care clinics, in 2003 *HIV prevalence among pregnant women aged 15-24 years* (Indicator 17) had been equal to zero. Condom use, in addition to being an effective contraceptive method, is one of the most effective methods in preventing sexual HIV transmission. Considering the importance of this issue in topics related to HIV prevention, it has also been taken into account in defining the MDG indicators.

In 2000, *Condom use rate of the contraceptive prevalence rate* (Indicator 19) in urban and rural areas and nationwide stood at 5.4, 9.3 and 7.99 percent, respectively.

*Condom use at last high-risk sex* (Indicator 19A) is another indicator defined within this framework, for which no official data is produced in the country.

In 2004, *percentage of population aged 15–24 years with comprehensive correct knowledge of HIV/AIDS* (Indicator 19B) had increased to 8.6 percent, at least twice the number reported for 2003 (4.09 percent). For awareness-raising in this regard, 6

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1. Human Immunodeficiency Virus / Acquired Immunodeficiency Syndrome
2. As no new data has been produced for indicators 18, 19 and 20, data from the first MDG report has been used here.
hours of learning has been introduced for the first year of upper secondary. Similarly, life-skills based HIV/AIDS education has been initiated in lower secondary on a limited basis.\(^1\)

Indicator 19C, *contraceptive prevalence rate*, is indicative of the percentage of women practicing any form of contraception. This indicator has seen an increase from 64.6 percent in 1991 to 73.8 percent in 2000.

The share of various contraceptive methods as a percentage of all contraceptive methods in use has been tabulated in Table 6.1. As can be seen in this table, in 2000 condom use rate of the contraceptive prevalence rate for married women had been 3.6 percent in urban areas and 7.2 percent in rural areas.

<table>
<thead>
<tr>
<th>Table 6-1. Contraceptive Prevalence Rates for Married Women Ages 15–49 (2000) (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tubectomy</td>
</tr>
<tr>
<td>-----------</td>
</tr>
<tr>
<td>Urban</td>
</tr>
<tr>
<td>Rural</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Source: Ministry of Health and Medical Education, Centre for Disease Management.

Indicator 20, *ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years*, is calculated based on the estimated number of children who have lost their mother, father or both parents to AIDS before age 15. At present, no reliable estimate is available in the country with regard to this indicator.

Currently, HIV testing is carried out on all blood transfused to patients in the health centres.\(^2\)

Table 6.2 provides further details on the number and percentage of people infected with HIV, with regard to mode of transmission and disaggregated by gender. Based on the data provided in this table, by April 2006 the total registered number of people living with HIV (PLHIV) had increased to 13,432, of which 94.5 percent were men.

The numbers in the abovementioned table indicate that from among various modes of HIV transmission, 64.2 percent of the cases registered had been through injecting drug use, 7.4 percent due to unprotected sexual relations, 1.8 percent by infected blood or blood products and 0.5 percent from mother to child, with the mode of transmission for 26.2 percent of the cases having been reported as unknown.

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1. I.R. Iran official report on the monitoring of the declaration of commitment ratified by the United Nations General Assembly regarding HIV/AIDS, Centre for Disease Management, Ministry of Health and Medical Education, January 2006

2. Source: Same as above

Goal 6: Combat HIV/AIDS, Malaria and other Diseases 74
Not taking into consideration unknown cases (26.2 percent), the most significant mode of HIV transmission in the country has been injecting drug use (64.2 percent), followed by unprotected sexual relations (7.4 percent).

Table 6-2. Registered HIV Cases, by Gender and Mode of Transmission

<table>
<thead>
<tr>
<th>Gender</th>
<th>IDU Cases %</th>
<th>Sexual Relations Cases %</th>
<th>Blood and Blood Products Cases %</th>
<th>MTCT Cases %</th>
<th>Unknown Cases %</th>
<th>Total Cases %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>8536 99.1</td>
<td>595 60</td>
<td>223 92.9</td>
<td>34 51.5</td>
<td>3310 94.1</td>
<td>12698 94.5</td>
</tr>
<tr>
<td>Women</td>
<td>81 0.9</td>
<td>396 40</td>
<td>17 7.1</td>
<td>32 48.5</td>
<td>208 5.9</td>
<td>734 5.5</td>
</tr>
<tr>
<td>Total</td>
<td>8617 100</td>
<td>991 100</td>
<td>240 100</td>
<td>66 100</td>
<td>3518 100</td>
<td>13432 100</td>
</tr>
</tbody>
</table>

Source: Ministry of Health and Medical Education, Centre for Disease Management.

Two major external factors contribute to the spread of HIV/AIDS in I.R. Iran. The first one is the location of the country on the main regional drug trafficking route and proximity to major centres of production of illicit drugs, which has resulted in increased drug addiction in the country, especially injecting drug use. The next factor is proximity to countries with some of the highest reported HIV prevalence rates in the world. The existence of these conditions in neighbouring countries is considered a serious threat with regard to HIV/AIDS transmission in the country.

There also exists one internal factor contributing to the spread of HIV/AIDS in the country; that is, the misconception regarding HIV infection and the ensuing negative social consequences, which could lead to PLHIV feeling reluctant to introduce themselves to health centres to seek treatment.

The second target defined for this goal is halving the incidence of malaria and other major diseases, with the focus being on the two diseases malaria and tuberculosis (TB).

The trend for the reported number of malaria cases during the recent years (Indicator 21) has shown that malaria incidence in 1996 had been 94 cases per 100,000 population, reaching 30 cases per 100,000 in 2005, indicating a great decrease (Table 6.3) in the incidence of the disease. As can be seen from Figure 6.1, this downward trend has not been uniform during the period under study, with occasional increases being observed.

According to reports by universities of Medical Sciences and Health Services, in 2005 the number of reported malaria cases had been 19,285, showing a 38 percent increase in comparison with 2004. Of this reported number of cases, 88% have been due to Plasmodium vivax, 11% Plasmodium falciparum and 1% due to mixed infections.

Among the cases reported, 4367 have been non-Iranian, constituting 23% of the total number of malaria cases in the country, which could be indicative of the high prevalence of the disease in the neighbouring countries.
Table 6-3. Malaria Incidence (1996-2005)

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Cases</th>
<th>Incidence Rate (per 100,000 people)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td>56362</td>
<td>94</td>
</tr>
<tr>
<td>1997</td>
<td>38684</td>
<td>63</td>
</tr>
<tr>
<td>1998</td>
<td>32951</td>
<td>53</td>
</tr>
<tr>
<td>1999</td>
<td>23220</td>
<td>37</td>
</tr>
<tr>
<td>2000</td>
<td>19716</td>
<td>31</td>
</tr>
<tr>
<td>2001</td>
<td>19274</td>
<td>30</td>
</tr>
<tr>
<td>2002</td>
<td>15558</td>
<td>24</td>
</tr>
<tr>
<td>2003</td>
<td>25027</td>
<td>35</td>
</tr>
<tr>
<td>2004</td>
<td>13823</td>
<td>20</td>
</tr>
<tr>
<td>2005</td>
<td>19285</td>
<td>30</td>
</tr>
</tbody>
</table>

Source: Ministry of Health and Medical Education, Deputy of Health Affairs, Centre for Disease Management

Figure 6-1. Malaria Incidence Rate per 100,000 People (1996-2005)

Accordingly, despite malaria still proving one of the leading causes of morbidity and mortality in many developing countries, its transmission is not observed in a greater portion of the country at present. Following half a century of successful prevention and control programmes, local malaria transmission is at present restricted to specific areas, mainly located in the South or the South East of the country.

At the end of the abovementioned period, while the incidence of malaria nationwide had been reported as 30 cases per 100,000 population, incidence rate in high-risk areas had been 340 cases per 100,000 population. The main provinces with local malaria transmission are Sistan va Baluchestan, Hormozgan and Kerman, in total including 90% of malaria cases in the country. Of these, Sistan va Baluchestan with 65% of the total number of cases shows the highest incidence of malaria in the country, as can be seen in Table 6-4.
<table>
<thead>
<tr>
<th>Province</th>
<th>Positive Cases</th>
<th>Province</th>
<th>Positive Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sistan va Baluchestan</td>
<td>11319</td>
<td>Markazi</td>
<td>12</td>
</tr>
<tr>
<td>Hormozgan</td>
<td>4958</td>
<td>Yazd</td>
<td>27</td>
</tr>
<tr>
<td>Kerman</td>
<td>1141</td>
<td>Lorestan</td>
<td>8</td>
</tr>
<tr>
<td>Fars</td>
<td>825</td>
<td>Gilan</td>
<td>4</td>
</tr>
<tr>
<td>Esfahan</td>
<td>183</td>
<td>Golestan</td>
<td>6</td>
</tr>
<tr>
<td>Ardebil</td>
<td>2</td>
<td>Shahre Kord</td>
<td>8</td>
</tr>
<tr>
<td>Bushehr</td>
<td>244</td>
<td>Yasuj</td>
<td>7</td>
</tr>
<tr>
<td>Razavi Khorasan</td>
<td>28</td>
<td>East Azarbaijan</td>
<td>6</td>
</tr>
<tr>
<td>Tehran</td>
<td>276</td>
<td>West Azarbaijan</td>
<td>5</td>
</tr>
<tr>
<td>Qom</td>
<td>42</td>
<td>Kurdistan</td>
<td>2</td>
</tr>
<tr>
<td>Mazandaran</td>
<td>41</td>
<td>Hamadan</td>
<td>5</td>
</tr>
<tr>
<td>Qazvin</td>
<td>53</td>
<td>Kermanshah</td>
<td>4</td>
</tr>
<tr>
<td>Khuzestan</td>
<td>38</td>
<td>Ilam</td>
<td>2</td>
</tr>
<tr>
<td>South Khorasan</td>
<td>9</td>
<td>North Khorasan</td>
<td>0</td>
</tr>
<tr>
<td>Semnan</td>
<td>30</td>
<td>Zanjan</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td>19285</td>
</tr>
</tbody>
</table>

Source: Ministry of Health and Medical Education, Deputy of Health Affairs, Centre for Disease Management

**Number of malaria deaths** (Indicator 21A) in Iran had been one reported death in 2005. Also, based on the most recent studies carried out proportion of population in malaria-risk areas using effective malaria prevention and treatment measures (Indicator 22) is at a satisfactory level (95%).

A rather important issue with regard to malaria control is the need for further follow-up and also more attention being paid to the trend of the disease and to malaria-endemic areas. It seems that malaria is still pertinent as a major health problem in areas in the country where local malaria transmission is reported.

Unfavourable health conditions existing in neighbouring countries, especially those to the East, is one of the main factors of malaria transmission in Iran, offering a logical rationale for the high incidence of the disease in Sistan va Baluchestan, which has the longest border with Eastern neighbouring countries.

TB is another disease under study for this MDG. Based on estimates published by the WHO, tuberculosis incidence, prevalence and death rates (Indicator 23) in Iran in 2005 had been 23, 30 and 3 per 100,000 population, respectively, which in comparison with the values for 1990, 36, 50 and 4 per 100,000 population, show decreases of 36, 40 and 25 percent, respectively (Figure 6.2).
Figure 6-2. TB Incidence, Prevalence and Death Rates per 100,000 People (1990-2005)

Source: Ministry of Health and Medical Education.

Achievements of the national TB Control Programme have been significant in comparison with global and regional levels (see Table 6.5).

Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS) (Indicator 24), is an indicator for which the expected level has been defined as 100%, which Iran has been achieving since 2001.

From among the 9422 notified TB cases in the country in 2005, 48% had been female and 52% male, with a total of 15% of cases having been Afghan patients.

Table 6-5. Comparing the Status of TB in Iran and Other Countries

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Year</th>
<th>Global</th>
<th>Eastern Mediterranean Region¹</th>
<th>Iran</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicator 23A.1</td>
<td>1990</td>
<td>297</td>
<td>257</td>
<td>57</td>
</tr>
<tr>
<td>TB Prevalence Rate (per 100,000 People)</td>
<td>2004</td>
<td>229</td>
<td>206</td>
<td>35</td>
</tr>
<tr>
<td>Reduction During the Past 14 Years</td>
<td></td>
<td>22%</td>
<td>20%</td>
<td>39%</td>
</tr>
<tr>
<td>Indicator 23A.2</td>
<td>1990</td>
<td>29</td>
<td>30</td>
<td>4</td>
</tr>
<tr>
<td>TB Death Rate (per 100,000 People)</td>
<td>2004</td>
<td>27</td>
<td>27</td>
<td>3</td>
</tr>
<tr>
<td>Reduction During the Past 14 Years</td>
<td></td>
<td>7%</td>
<td>10%</td>
<td>25%</td>
</tr>
<tr>
<td>TB Incidence Rate (per 100,000 People)</td>
<td>1990</td>
<td>124</td>
<td>124</td>
<td>43</td>
</tr>
<tr>
<td>Reduction During the Past 14 Years</td>
<td>2004</td>
<td>140</td>
<td>122</td>
<td>27</td>
</tr>
<tr>
<td>Reduction During the Past 14 Years</td>
<td></td>
<td>13% Increase</td>
<td>2%</td>
<td>37%</td>
</tr>
</tbody>
</table>


¹ These countries include I.R. Iran, Lebanon, Iraq, Oman, Djibouti, Jordan, Egypt, Syria, Pakistan, Somalia, Sudan, Maghrib, Afghanistan, UAE, Tunisia, Saudi Arabia, Qatar, Palestine, Kuwait, Bahrain and Libya.

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The highest TB Age-Specific Incidence Rate has been for the 65 years and above age group, which is indicative of the success of the TB Control Programme in the country. However, as almost half the crude number of new cases corresponds to the 15 to 45 age group, it should be concluded that TB still remains a priority among national health problems.

As can be seen in Table 6.6, the two provinces of Sistan va Baluchestan and Golestan have reported the highest incidence rates for sputum smear-positive pulmonary TB (with 30 and 19.3 cases per 100,000 population, respectively). Proximity to high TB prevalence countries, illegal cross-border movements, together with droughts, poverty and malnutrition, are a few of the factors contributing to the high burden of TB in Sistan va Baluchestan.

In general, it could be concluded that achievement of the MDGs with regard to TB is not out of reach in I.R. Iran and the defined indicators could be attained through continuation of the current control programme.

### Table 6-6. TB Cases and Incidence in the Country by Province in 2005 (per 100,000 People)

<table>
<thead>
<tr>
<th>Province</th>
<th>Smear-Positive</th>
<th>Smear-Negative</th>
<th>Extrapulmonary</th>
<th>Total</th>
<th>Source Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cases Incidence</td>
<td>Cases Incidence</td>
<td>Cases Incidence</td>
<td>Cases Incidence</td>
<td>Cases Incidence</td>
</tr>
<tr>
<td>Ardebil</td>
<td>60</td>
<td>5</td>
<td>20</td>
<td>2</td>
<td>45</td>
</tr>
<tr>
<td>Mazandaran</td>
<td>127</td>
<td>4</td>
<td>78</td>
<td>3</td>
<td>60</td>
</tr>
<tr>
<td>South Khorasan</td>
<td>68</td>
<td>15.0</td>
<td>22</td>
<td>4.9</td>
<td>28</td>
</tr>
<tr>
<td>Bushehr</td>
<td>29</td>
<td>3.5</td>
<td>17</td>
<td>2.0</td>
<td>24</td>
</tr>
<tr>
<td>Chahar Mahal va Bakhtiari</td>
<td>11</td>
<td>1.3</td>
<td>7</td>
<td>0.8</td>
<td>15</td>
</tr>
<tr>
<td>East Azerbaijan</td>
<td>122</td>
<td>3.3</td>
<td>42</td>
<td>1.1</td>
<td>112</td>
</tr>
<tr>
<td>Esfahan</td>
<td>163</td>
<td>4</td>
<td>97</td>
<td>2</td>
<td>137</td>
</tr>
<tr>
<td>Fars</td>
<td>114</td>
<td>3</td>
<td>45</td>
<td>1</td>
<td>99</td>
</tr>
<tr>
<td>Gilan</td>
<td>168</td>
<td>6.7</td>
<td>63</td>
<td>2.5</td>
<td>110</td>
</tr>
<tr>
<td>Golestan</td>
<td>316</td>
<td>19.3</td>
<td>138</td>
<td>8.4</td>
<td>146</td>
</tr>
<tr>
<td>Razavi Khorasan</td>
<td>720</td>
<td>12</td>
<td>247</td>
<td>4</td>
<td>338</td>
</tr>
<tr>
<td>Hamadan</td>
<td>43</td>
<td>2.3</td>
<td>21</td>
<td>1.1</td>
<td>30</td>
</tr>
<tr>
<td>Hormozgan</td>
<td>140</td>
<td>11.6</td>
<td>70</td>
<td>5.8</td>
<td>79</td>
</tr>
<tr>
<td>Ilam</td>
<td>13</td>
<td>2.4</td>
<td>4</td>
<td>0.7</td>
<td>12</td>
</tr>
<tr>
<td>Tehran</td>
<td>582</td>
<td>5</td>
<td>215</td>
<td>2</td>
<td>288</td>
</tr>
<tr>
<td>Kerman</td>
<td>161</td>
<td>7</td>
<td>106</td>
<td>5</td>
<td>74</td>
</tr>
<tr>
<td>Kerman Shah</td>
<td>127</td>
<td>6.4</td>
<td>50</td>
<td>2.5</td>
<td>82</td>
</tr>
<tr>
<td>Khuzestan</td>
<td>461</td>
<td>11.0</td>
<td>136</td>
<td>3.2</td>
<td>185</td>
</tr>
<tr>
<td>Kohgiluyeh va Buyer Ahmad</td>
<td>12</td>
<td>2.0</td>
<td>10</td>
<td>1.6</td>
<td>17</td>
</tr>
<tr>
<td>Kurdistan</td>
<td>62</td>
<td>4.1</td>
<td>36</td>
<td>2.4</td>
<td>46</td>
</tr>
<tr>
<td>Lorestan</td>
<td>115</td>
<td>6.5</td>
<td>37</td>
<td>2.1</td>
<td>56</td>
</tr>
<tr>
<td>Markazi</td>
<td>69</td>
<td>5.0</td>
<td>56</td>
<td>4.1</td>
<td>45</td>
</tr>
<tr>
<td>North Khorasan</td>
<td>60</td>
<td>11.5</td>
<td>29</td>
<td>5.6</td>
<td>49</td>
</tr>
<tr>
<td>Qazvin</td>
<td>40</td>
<td>4.3</td>
<td>18</td>
<td>1.9</td>
<td>22</td>
</tr>
<tr>
<td>Qom</td>
<td>66</td>
<td>6.9</td>
<td>28</td>
<td>2.9</td>
<td>63</td>
</tr>
<tr>
<td>Semnan</td>
<td>29</td>
<td>5</td>
<td>14</td>
<td>2</td>
<td>19</td>
</tr>
<tr>
<td>Sistan va Baluchestan</td>
<td>572</td>
<td>30</td>
<td>239</td>
<td>12</td>
<td>228</td>
</tr>
<tr>
<td>West Azerbaijan</td>
<td>83</td>
<td>3.0</td>
<td>51</td>
<td>1.8</td>
<td>109</td>
</tr>
<tr>
<td>Yazd</td>
<td>51</td>
<td>6.1</td>
<td>34</td>
<td>4.0</td>
<td>40</td>
</tr>
<tr>
<td>Zanjan</td>
<td>57</td>
<td>4.9</td>
<td>5</td>
<td>0.4</td>
<td>17</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4641</td>
<td>6.8</td>
<td>1935</td>
<td>2.9</td>
<td>2575</td>
</tr>
</tbody>
</table>

Source: Ministry of Health and Medical Education, Centre for Disease Management (2005).
One of the major problems in all national TB control programmes is drug resistance, especially Multidrug-Resistant TB (MDR-TB). Based on a study carried out in Iran in 1997 (biased toward a larger estimate), prevalence of MDR-TB in new cases of sputum smear-positive pulmonary TB has been 3, 7 and 5 percent, respectively, for Iranian, non-Iranian and all cases.

According to surveillance records, increases could be noted in the number of suspected and confirmed cases of MDR-TB detected in the country during recent years (Figure 6.3). Major factors contributing to this increasing trend could be listed as follows:

- Provision of expensive second-line anti-TB drugs
- Establishment and improvement of the referral system for suspected cases (from intermediate level to the National Reference Hospital)
- Improvement of the system for reporting MDR-TB cases from the National Reference Hospital to the Centre for Disease Management

**Figure 6-3. Notified Suspected and Confirmed Cases of MDR-TB**

<table>
<thead>
<tr>
<th></th>
<th>1382</th>
<th>1383</th>
<th>1384</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confirmed MDR-TB</td>
<td>4</td>
<td>29</td>
<td>24</td>
</tr>
<tr>
<td>Suspected MDR-TB</td>
<td>1</td>
<td>5</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: Ministry of Health and Medical Education, Centre for Disease Management (2005).

### 2. Enabling Policies and Programmes

Policies have been ratified in the Third and Fourth FYDPs for improving public health, including fighting diseases, control and eradication of preventable infectious diseases and surveillance of noncommunicable diseases.

Within this framework, the MOHME has formulated and implemented a National Five-Year Strategic Plan for HIV/AIDS Prevention and Control for the years 2002-2006, the main areas of focus of which include:

- Public awareness-raising
- Improvement of information education communication (IEC)
- Provision of voluntary counselling and testing (VCT) for people at risk
• Provision of medical care and treatment for PLHIV
• Provision of care and treatment for people with STIs
• Improving blood safety
• Strengthening HIV prevention through drug use harm reduction services

The following are among other objectives in fighting HIV/AIDS:
• Significant reduction in injecting drug use
• Strengthening research, monitoring and evaluation
• Provision of social support to PLHIV

In 2007, the MOHME acting as the Secretariat of the National Committee, formulated the Second Strategic Plan for HIV/AIDS Prevention and Control for the years 2007-2009. To be in line with the Fourth FYDP, the abovementioned plan is specified as a three-year plan.

Considering the significant number of people infected with HIV through injecting drug use and in light of the abovementioned objectives, triangular clinics were established in October 2000 in the province of Kermanshah. Three main activities carried out in these clinics are:
• Harm reduction among injecting drug users (IDUs)
• Provision of care for people with STIs
• Provision of protection and support for PLHIV

These clinics have effectively been designed to facilitate provision of integrated care to patients from the three groups listed above.

In light of the ever-increasing need for VC’ services and HIV prevention and provision of treatment and care for IDUs and PLHIV, triangular clinics have proven the most successful experience in the Middle East and North Africa regarding HIV prevention and control.

By 2006, triangular clinics had been established across all provinces as part of the public health system. The highest priority for the MOHME has been the integration of all services mentioned above within the primary health care system. This programme expanded rapidly across the country, such that by April 2006 at least one health care clinic had been located in the heart of each province.

With regard to fighting infectious diseases, four key strategies have been approved, namely:
• Improvement and strengthening of the health care system
• Human resource development at the national level
• Securing the necessary resources for the provision of health care services
• Formulation of national programmes for fighting infectious diseases and epidemics
Notably, the annual public vaccination coverage, together with other corresponding medical care, has been effective in reducing infections.

Other specific measures taken for HIV/AIDS response include:

- Establishment of the High Council of Planning for HIV/AIDS Prevention and Control
- Integration of HIV testing and prevention programmes in the national health care system
- Establishment of up to 120 HIV/AIDS counselling centres
- Publication of various books and pamphlets regarding health education and HIV prevention
- Inclusion of an introductory chapter on HIV/AIDS in the secondary education curricula and in the curricula of more than 9 million students
- Formulation of the national HIV/AIDS and high-risk behaviours awareness-raising and education programme for youth
- Formulation of the National Harm Reduction Programme
- Formulation of the protocol for monitoring and evaluation of the National Strategic Plan for HIV/AIDS Prevention and Control
- Setting up universal precautions workshops
- Provision of education for higher risk groups across various levels of society and counselling training nationwide
- Preparation of a four-year plan for the improvement of the health care system

Key policies implemented regarding fighting malaria and TB have been as follows:

- Continuation of the Malaria Control Programme (MCP) for preventing the resurgence of malaria in non-malarious areas
- Strengthening of the integrated malaria vector control programme
- Promotion of free diagnosis and treatment services
- Assessment and evaluation of malaria and TB control activities, based on new indicators
- Implementation of a plan for reviewing the malaria reporting system based on malaria eradication
- Assessment and evaluation of the integrated vector management programme in malarial areas, with the cooperation of the WHO
- Formulation of the National Malaria Eradication Programme, with the cooperation of the WHO
- Development of diagnostics educational materials
- Detecting and fighting malaria epidemics
• Implementation of retraining programmes, for the promotion of the cognitive and behavioural skills of the personnel employed in malaria and TB control programmes
• Provision of materials and supplies, vector control equipment and antimalarial drugs, in line with expansion of free services
• Monitoring insecticides in use and new insecticides
• Monitoring new antimalarial and anti-TB drugs

3. Major Challenges and Development Cooperation

Major challenges regarding HIV/AIDS control are as follows:
• Public perceptions regarding HIV/AIDS
• Encouraging high-risk groups to visit voluntary counselling and testing centres
• Mobilisation and utilisation of financial resources for HIV/AIDS prevention and control
• Reform of laws regarding addiction to drugs (as drug use is considered a crime in Iran, drug users do not present themselves to health centres for treatment)
• Overcoming shortcomings in detection and shortages in medical facilities and resources required for the treatment of patients, especially the shortage of HIV/AIDS specialists and specialised training courses
• High costs of diagnosis and treatment of people infected with HIV
• Lack of a national monitoring and evaluation programme for the coordination, monitoring and evaluation of activities carried out by the corresponding institutional units
• Provision of skilled human resources
• Barriers to reform and expansion of the organisational structure of HIV/AIDS management programmes
• Lack of suitable health care establishments for the provision of HIV/AIDS prevention and care services, such as counselling and testing centres, drop-in centres and triangular clinics
• Problems with accessing certain high-risk groups

Key challenges with regard to the management of communicable diseases such as TB and malaria are as follows:
• Increased participation by NGOs in fighting malaria and TB
• Vector diversity and the lengthy transmission season in malarial areas
• Poor control conditions and high frequency of uncontrolled cross-border movements, especially with regard to Eastern neighbouring countries
• Insufficient participation of the NGOs
• Integrated and coordinated access by patients on both sides of the borders to effective antimalarial drugs
• Strengthening national and regional action for achieving MCP objectives

National Priorities for Development Cooperation

International development agencies could assist the country in addressing the abovementioned challenges in the form of the following measures:
• Introduction of new HIV testing methods for the promotion of VCT
• Cooperation in effective implementation of pilot outreach programmes
• Assisting with the development of a comprehensive HIV/AIDS database
• Capacity-building and cooperation for familiarising local experts with new HIV/AIDS prevention and treatment methods
• Mobilisation of international financial resources such as the Global Fund for supporting current national programmes for fighting HIV/AIDS
• Regional cooperation for prevention of drug trafficking
• Access to high quality HIV/AIDS-related drugs and affordable rapid diagnostic tests (RDTs) for poor people

4. Tracking Progress: Monitoring & Evaluation

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<tr>
<th>Monitoring Mechanism</th>
<th>Evaluation</th>
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<tr>
<td></td>
<td>Average</td>
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<td></td>
<td>Weak but Improving</td>
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<tr>
<td></td>
<td>Weak</td>
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<tr>
<td>Achievement of Goal</td>
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<tr>
<td>Capacity for Collection and Assessment of Data</td>
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<td>Tracking, Monitoring and Analysis</td>
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<tr>
<td>Capacity for Application of Statistical Data in Policy-Making and Planning</td>
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<tr>
<td>Availability of Necessary Mechanisms for Allocation of Resources</td>
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</table>
**Goal 7: Ensure Environmental Sustainability**

**Target 9:** Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources

Indicator 25) Proportion of land area covered by forest

Indicator 26) Ratio of area protected to maintain biological diversity to surface area

Indicator 27) Energy use (kg oil equivalent) per $1 GDP (PPP)

Indicator 28) Carbon dioxide emissions per capita and consumption of ozone-depleting CFCs (ODP tons)

Indicator 29) Proportion of population using solid fuels

**Target 10:** Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

Indicator 30) Proportion of population with sustainable access to an improved water source, urban and rural

Indicator 31) Proportion of population with access to improved sanitation, urban and rural

**Target 11:** By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers

Indicator 32) Proportion of households with access to secure tenure

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1. Progress Achieved

Environmental protection and sustainability are central pillars of sustainable development. Continuance of life on Earth depends on the sustainability of the environment. Considering the significance of this issue, environmental sustainability has been defined as one of the most important Millennium Development Goals, with certain targets and indicators having been devised for monitoring national progress towards the achievement of the defined objectives.

The first target for this MDG is *integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources*, elaborated upon in the context of five indicators.

Indicator 25, *proportion of land area covered by forest*, is the first indicator reviewed for this target. Total forest area in Iran has been estimated at 14.2 million hectares in 2004, equalling around 8.6 percent of total land area\(^1\), classified as Hiranian forests, sub-humid Arasbaran forests, semi-arid Zagros forests, forests of the Irano-Turanian vegetative region and subtropical forests.

Iran’s geographical features, i.e. the mountainous nature of a major portion of the country, together with the location of the country in the arid belt, are key factors contributing to the value of this indicator being relatively low. Forest area per capita has been estimated at 0.2 hectare based on the definition by the Forests, Rangelands and Watershed Management

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\(^1\) 2004 Energy Balance Sheet, Ministry of Power, 2005
Organisation of Iran, while the definition by the Food and Agriculture Organisation (FAO) sets this value at 0.1 hectare, both estimates being considerably lower than the global forest per capita (around 0.6 hectare).

The mountainous conditions existing over the country, together with considerable variations in latitude, have resulted in this vast country being blessed with diverse climatic conditions and highly favourable conditions for the evolution of a diverse range of terrestrial and aquatic ecosystems.

The second indicator for the abovementioned target is ratio of area protected to maintain biological diversity to surface area (Indicator 26).

Distinct climatic and topographic conditions existing over the country have resulted in a diverse range of ecosystems, such as high permanently snow-capped mountains, subtropical lowlands, humid forests to the North and vast deserts in the central and southern regions, leading to a diverse range of plant and animal species to exist in this land.

Based on the latest studies carried out, around 8000 plant species have been identified in Iran, of which an estimated 2500 are endemic to this country.

The Irano-Turanian vegetative region, which covers a large area of the country, contains the largest number of indigenous species and is considered one the most significant in the world regarding richness in varieties.

Similar to the rich plant diversity, a remarkable animal biodiversity has evolved in Iran, such that a wide spectrum of mammals, birds, marine creatures, amphibians and reptiles could be observed.

The number of mammal species in Iran is estimated at around 164, which almost equals the total number of mammal species in Europe. In addition, around 500 bird species, 270 fish species, 180 reptile species and 13 amphibian species are based in this country.\(^1\) Such overwhelming biological diversity has resulted in I.R. Iran being considered one of the key countries with regard to animal biodiversity in international circles.

Protection and preservation of this valuable heritage has constantly been considered one of the most important objectives for the Government of I.R. Iran and within this framework special areas have been designated for the conservation of animal biodiversity, dating back to forty years ago in their modern form. During the recent years, in view of the fact that I.R. Iran is a signatory to the Convention on Biological Diversity, further attention has been devoted to these areas for the protection and sustainability of plant and animal species.

As a result, ratio of area protected to maintain biological diversity to surface area (Indicator 26) has witnessed a significant increase during the recent years, especially in the course of the Second and Third FYDPs.

These areas, classified in four categories as national parks, protected areas, national natural monuments and wildlife refuges, are designated based on ratified international conventions, representing the most remarkable features of this land with regard to topography, natural landscapes and biological diversity.

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1. National Action Plan for Environmental Protection, Department of the Environment, 1999
According to the latest data published, ratio of protected area in total land area has increased from 7.9 million hectares in 1997 to 11.9 million hectares in 2005, registering an annual increase of 5.2 percent. Likewise, during this period nationally protected area as a percentage of total land area has increased from 4.58 percent to 7.3 percent (Figure 7.1). In the cross-sectoral Environment Document formulated in the Fourth FYDP, this ratio has been envisaged to reach the prescribed international standard (10 percent).

**Figure 7.1. Ratio of Area Protected to Maintain Biological Diversity to Surface Area (%)**

![Graph showing the ratio of area protected to maintain biological diversity to surface area from 1997 to 2005.](image)


Increasing use of fossil fuels during the past decade has exerted excessive costs on the environment, resulting in an indicator to be introduced for measuring energy efficiency. *Energy use (kilogram oil equivalent) per $1 gross domestic product (PPP)*, also known as the *energy intensity indicator*, is a criterion for measuring energy efficiency, designated as Indicator 27 for the MDGs.

As can be observed from Figure 7.1, energy intensity in Iran has shown a moderate increase, but with a decreasing trend. Advancements in technology in the energy consuming sectors and implementation of audit and energy conservation plans during the recent years could be stated as a few reasons for this decreasing trend.

**Table 7-1. Energy Use (kilogram oil equivalent) per $1 GDP (PPP)**

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<thead>
<tr>
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<td></td>
<td>0.309</td>
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<td>0.343</td>
<td>0.335</td>
<td>0.327</td>
<td>0.326</td>
<td>0.327</td>
</tr>
</tbody>
</table>

Source: Statistical Centre of Iran.

An indicator monitored for carrying out situational assessment of environmentally damaging substances is *carbon dioxide emissions per capita and consumption of ozone-depleting CFCs (ODP tons)* (Indicator 28). *Carbon dioxide emissions per capita* (Indicator 28A) has seen an increase from 4002 kilograms in 1996 to 5284 kilograms in 2004. Growth and development in
the industrial and transportation sectors, population increase, relatively low price of energy carriers and increased use of natural gas, are among key factors influencing this trend.

<table>
<thead>
<tr>
<th>Year</th>
<th>1996</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
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<th>2004</th>
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<td>4317</td>
<td>4604</td>
<td>4685</td>
<td>5006.1</td>
<td>5016</td>
<td>5284</td>
</tr>
</tbody>
</table>

Source: Statistical Centre of Iran.

The next indicator is consumption of ozone-depleting CFCs (Indicator 28B). In light of the commitments of I.R. Iran, stipulated in the Montreal Protocol regarding reduction of the consumption of ozone-depleting materials, the Department of Environment (DOE) as the national reference for this matter and with technical and financial assistance provided by the UN, in cooperation with corresponding governmental and non-governmental organisations, has implemented extensive measures over recent years for reducing and phasing out the consumption of CFCs, with, achieving the objectives prescribed by the Vienna Convention for the Protection of the Ozone Layer and the Montreal Protocol.

Based on the latest data published by the Ozone Layer Protection Unit at the DOE, level of CFC consumption has decreased from 4140 tons in 1995 to 2221 tons in 2005, as can be seen in Figure 7-2.

**Figure 7-2. Consumption of Chlorofluorocarbons (CFCs) (1995-2005)**

Source: Ozone Layer Protection Unit, Department of Environment, 2006.

Proportion of population using solid fuels (Indicator 29) is the percentage of the population that relies on biomass (wood, charcoal, crop residues and dung) as the
primary source of domestic energy for cooking and heating. As can be seen in Figure 7.3, this indicator is significantly higher for rural areas, in comparison with urban areas.

Use of solid fuels, in addition to posing a significant threat to the environment, could exert irremediable damages on human health. This indicator has demonstrated a downward trend during the years under study. Increased rural access to natural gas and the expanding share of this energy source in the energy basket of rural households are two of the most significant factors influencing this decreasing trend.

**Figure 7-3. Proportion of Population Using Solid Fuels (%)**

![Graph showing the proportion of population using solid fuels from 1997 to 2004.]

Source: Statistical Centre of Iran.

Three indicators have been specified with regard to *halving by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation* (Target 10), which will be reviewed in this section.

Indicator 30, *proportion of population with sustainable access to an improved water source*, is the percentage of the population who use any of the following types of water supply for drinking: piped water, public tap, borehole or pump, protected wells and protected springs. Data available shows that this indicator has seen an increase from 89.6 percent in 1990 to 93 percent in 2000.

Due to lack of availability of up to date information regarding the indicator above, the indicator for access to safe water1 is used instead. Based on the available data, level of access to safe water in 2002 had reached 87.4 percent in rural areas and 98.8 percent in urban areas. Taking into consideration division between urban and rural populations (67 percent urban and 33 percent rural), percentage of the population without access to safe drinking water can be estimated at 5.4 percent.

In 2002, with the exception of the province of Sistan va Baluchestan, urban access to safe drinking water had been nearly 100 percent. The key challenge with regard to

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this indicator has been rural access, with the level of access reported for rural areas of Sistan va Baluchestan standing at lower than 50 percent.

Indicator 31 has been defined as the proportion of population with access to improved sanitation (flush toilets). The percentage of population with access to improved sanitation has demonstrated a rather significant increase from 64.3 percent in 1990 to 82.8 percent in 2000.

The third target defined for this MDG is improving the lives of slum dwellers (Target 11). As, based on the data available in the country, it would not be possible to carry out computations for the indicator corresponding to this target, that is proportion of households with access to secure tenure (Indicator 32), according to the definitions specified by the MDGs, an alternative indicator has been introduced by the SCI. This indicator represents the proportion of households who do not meet the following criteria (for further information, refer to the Technical Notes at the end of the report):

1. Durable housing
2. Access to piped water
3. Access to sufficient living area

As is demonstrated in Figure 7.4, this indicator has not seen a notable difference during the period under study (1998-2005), with the minimum level having been reported at 74 percent and the maximum at 78 percent.

Figure 7-4. Proportion of Households with Access to Secure Tenure (%)


2. Enabling Policies and Programmes

Objectives and strategies of the environment sector in the Fourth FYDP have been formulated in light of experiences of past FYDPs, in particular the Third, based on new theoretical foundations and frameworks. A review of the strategies and objectives of the Fourth FYDP shows that focus has been steered from a passive-reactive approach to a preventive-directive approach, with further emphasis being placed on the need for the sustainability of the country’s development process, upholding environmental balances and enablement.
In the formulation of the Fourth FYDP, five key axes have been approved as listed below with the participation of all corresponding governmental organisations and sectors and representatives of environmental NGOs, with policies and programmes being directed towards the realisation of these objectives.

- Advocacy of environmental culture and ethics
- Promotion of environmentally sound development processes
- Protection, rehabilitation and sustainable exploitation of biodiversity
- Protection, rehabilitation and expansion of natural resources (forest, land, soil and water)
- Enablement of national environmental structures and instruments

Among measures and policies implemented during the Third FYDP and continued in the Fourth regarding protection and sustainability of the environment, the following could be pointed out as key:

- Establishment of economic mechanisms regarding renovation and reconditioning of worn-out vehicles
- Formulation, preparation and implementation of an Integrated Master Plan for Air Pollution Control targeted at highly polluted metropolises
- Targeting of energy subsidies and improving fuel quality and efficiency aimed at the protection of the environment
- Extension of applied research regarding the mitigation of environmental impacts of fossil fuel use
- Expansion of the use of cleaner energy technologies, including ones based on wind, solar and geothermal energy
- Estimation of environmental degradation and pollution costs for consolidation into the national accounts
- Formulation of a comprehensive environmental information and monitoring system
- Formulation and implementation of the National Biodiversity Action Plan
- Qualitative protection of national water resources and finalisation and upgrading of the water quality (pollution) standards
- Promotion of the use of treated effluent in agriculture and management of agricultural wastewater
- Formulation of environmental regulations for the sustainable exploitation of urban, industrial and agricultural water resources
- Provision of clean and safe water for drinking, agricultural and industrial purposes
- Qualitative zoning of water resources and prevention of over-exploitation of water resources
• An integrated master plan for the collection, treatment and recycling or disposal of urban, rural and industrial wastewater
• Emphasis on integrated management of natural lands, with the focus being on watersheds
• Implementation of desert reclamation plans
• Reduction and optimisation of the use of agricultural chemicals, particularly (chemical) fertilisers and pesticides, in order to mitigate the pollution of soil and water resources
• Relocation of livestock from natural lands, expanded reforestation of degraded lands and allocation of these areas to the general public for timber and wood production
• Promotion of civil society participation in environmental protection (the number of environmental civil society organisations has increased from 44 in 1997 to 630 in 2005)
• Provision of energy services in rural areas, in order to mitigate the stress on natural resources (rural coverage of the gas network has increased from 0.63 in 1989 to 13.1 in 2004)

Various policies have been devised within the framework of the Fourth FYDP with regard to improving the housing status of the poor, the most important of which are as follows:

• Targeting housing subsidies in the direction of the housing demands of low-income households
• Upgrading slums, with the view of enabling slum dwellers
• Implementing improvements in living area for people living below the poverty line, particularly in under-populated villages and cities

3. Major Challenges and Development Cooperation

Despite favourable progress achieved towards ensuring environmental sustainability during recent years, especially during the course of the Second and Third FYDPs, great challenges remain in light of the country’s accelerated development activities, calling for the formulation of effective policies and strategies for addressing these challenges, from among which the following are key:

• Mitigation of vulnerability to the impact of human activities and natural hazards
• Addressing issues arising from low atmospheric precipitation and the location of the country in the arid belt
• Gaining sufficient knowledge regarding environmental processes and degradation costs
• Establishment of sustainable patterns of consumption and production (SCP), for improving energy efficiency and environmental pollution management
• Soil erosion and desertification
• Dependence of rural livelihoods on natural resources
• Promotion of civil society participation in the protection of the environment

Goal 7: Ensure Environmental Sustainability  92
• Transboundary environmental problems, such as pollution of coastal waters in the Northern and Southern regions of the country

• Implementation of environmental regulations and the monitoring and evaluation system for environmental processes

• Provision of financial and skilled human resources

• The dispersed nature of rural settlements, resulting in problems associated with geographical distances for provision of services to rural communities

National Priorities for Development Cooperation

From among key national priorities for international development cooperation in ensuring environmental sustainability and overcoming corresponding challenges the following could be pointed out:

• Creation of necessary mechanisms for the transfer of international experiences, in particular those of the developed countries, regarding internalisation of environmental expenditures and sustainable exploitation of natural resources

• Carrying out joint projects in areas related to environmental protection, especially in relation to biodiversity conservation, sustainable utilisation of energy and water (supplies) and pollution control of coastal and sea waters

• Assisting with the establishment of a comprehensive environmental information system at national and regional levels

• Enablement of local environmental civil society organisations

• Transfer of the experiences of developed countries regarding internalisation of environmental expenditures in the implementation of plans and projects

• Provision of technical and specialised services for the implementation of environmental mitigation plans

4. Tracking Progress: Monitoring & Evaluation

During the course of the recent years, indicators related to MDG 7, particularly indicators 26, 29 and 30, have demonstrated satisfactory trends. In view of the objectives and policies of the fourth FYDP in the corresponding areas, it is envisaged that meeting the targets defined for this MDG would be feasible within the years specified.

Also, with various statistical surveys having been carried out during the recent years, suitable capacity-building has been achieved for the collection and analysis of data.

With the ratification of Article 198 of the Third FYDP Bill and also Article 157 of the Fourth FYDP Bill regarding monitoring annual progress of the FYDPs, which include the indicators stated for this MDG, tracking, monitoring and analysis of corresponding data will be carried out with increased efficiency.
In addition to the above, following the formulation of supporting sectoral and cross-sectoral development documents based on Article 155 of the Fourth FYDP Bill, suitable groundwork for analytical implementation in policy-making and planning has been established, providing the necessary basis for more effective allocation of resources.

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<tr>
<th>Monitoring Mechanism</th>
<th>Evaluation</th>
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<tr>
<td>Achievement of Goal</td>
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<td>Capacity for Collection and Assessment of Data</td>
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<td>Availability of Necessary Mechanisms for Allocation of Resources</td>
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Goal 8: Develop a Global Partnership for Development

Target 12: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system. Includes a commitment to good governance, development and poverty reduction – both nationally and internationally

Target 13: Address the special needs of the least developed countries. Includes: tariff and quota free access for least developed countries’ exports; enhanced programme of debt relief and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction

Target 14: Address the special needs of landlocked developing countries and small island developing states

Target 15: Deal comprehensively with the debt problems of developing countries through national and international measures

Indicator 44) Debt service as a percentage of exports of goods and services

Target 16: In cooperation with developing countries, develop and implement strategies for decent and productive work for youth

Indicator 45) Unemployment rate of 15-24 year-olds, each sex and total

Target 17: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries

Indicator 46) Proportion of population with access to affordable essential drugs on a sustainable basis

Target 18: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications

Indicator 47) Telephone lines and cellular subscribers per 100 population

Indicator 48-A) Personal computers in use per 100 population

Indicator 48-B) Internet users per 100 population

1. Progress Achieved

The eight MDG aims at the design and implementation of mechanisms which enable developed countries to assist developing countries in meeting their development goals through the use of capacities present in international cooperation.

The cooperation framework stipulated within the Millennium Declaration clarifies that the responsibility for the achievement of MDGs 1 through 7 lies with the developing countries themselves.

The Declaration compels these countries to mobilise internal resources for financing their own development plans and to carry out policy reforms for strengthening financial management, in order to enable the poor to participate in decision-making processes, towards the promotion of democracy, human rights and social justice.
The first three targets for MDG 8 and their corresponding indicators deal mainly with assistance provided by developed countries to least developed countries (LDCs) and heavily indebted poor countries (HIPC) and therefore do not correspond to I.R. Iran.

However, I.R. Iran has taken extensive measures for expanding and strengthening foreign relations with recipient countries through official development assistance (ODA). I.R. Iran initiated a programme, titled I.R. Iran Official Development Assistance to Target Countries, for regulating the allocation of these resources.

The Operational Directive for Development Assistance to Recipient Countries was formulated and ratified in line with these measures, with the corresponding budget nomenclature included in the Annual Budget Acts since 2001.

Countries having received ODA from I.R. Iran to date include: Armenia, Azerbaijan, Burkina Faso, Bangladesh, Cuba, Djibouti, Ethiopia, Gabon, Gambia, Ghana, Guinea Conakry, Ivory Coast, Kosovo, Mali, The Niger, Senegal, Sierra Leone, Sri Lanka, Togo, Uganda and Zimbabwe.

In accordance with commitments agreed upon in the Tokyo Conference on the Reconstruction of Afghanistan, I.R. Iran allocated a total of 250 million USD between 2002 and 2006 for Afghan reconstruction projects, as requested by the Government of Afghanistan. An additional 50 million USD has also been envisaged within the budget for 2007 for the reconstruction of that country.

MDG Target 15, dealing comprehensively with the debt problems of developing countries, is the first target in this goal directly pertinent to I.R. Iran. This target has been assigned a single indicator, debt service as a percentage of exports of goods and services (Indicator 44). In light of the limitations on data available, the value for outstanding external debt is used instead for the analysis of this indicator in this report.

In international comparisons, the maximum value permitted for this indicator is 220 percent, with higher values being regarded as an indication of conditions of crisis for the country.1 Based on the available data, the value for this indicator for I.R. Iran has demonstrated a considerable decrease from 63.2 percent in 1997 to 33.7 percent in 2005. Moving further away from the conditions of crisis of the 80s and repayment of a portion of the loans taken out during that period, together with increased foreign investment and enhanced utilisation of the country’s export capacities during the course of the FYDPs, are among key factors influencing this trend.

The falling trend for this indicator is demonstrative of the fact that a larger portion of resources generated through exports has gradually entered the cycle of national economy as a major resource for boosting capacities for economic growth. Through the strengthening of

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1. IMF, Pamphlet Series – No.51, 1999
this trend, new opportunities could be provided for upgrading the socio-economic infrastructure of the country.

The next target followed within the framework of this goal is cooperation with developing countries for formulation and implementation of strategies for creation of decent and productive work for youth, with the representative indicator being unemployment rate of 15-24 year-olds, each sex and total (Indicator 45).

As can be observed from Table 8.1, the gender-aggregated value for the above indicator had been at a lowest of 19.2 percent in 1996 and a highest of 29.9 percent in 2000; eventually settling on 21.6 in 2005, which is slightly lower than its value in 1991.

During the period under study, the difference between male and female unemployment rates has seen maximum and minimum values of 20.8 percent in 1991 and 6.2 percent in 2000. A review of the variations for this indicator between the years 1991 and 2005 follows.

At the end of the period 1991-1996, youth unemployment rate had decreased to 19.2 percent and the ratio of unemployment rate of young women to that of young men had reached 1.5 with a significant decrease. Decreased youth unemployment rate during these years has been attributed to a reduction in labour force supply due to increased educational coverage at the secondary level and increased higher education coverage. The reduction in youth unemployment rate therefore had not been a result of active labour market policies, especially as during this period youth employment had actually decreased.

During the period 1996-2000, significant numbers of graduates of educational establishments having entered the labour market resulted in increased youth participation rate and youth labour force supply, consequently leading to an increase in the rate of unemployment. Despite a considerable number of employment opportunities having been created for young people during these years, unemployment rate of young people actually increased due to the high pressure of labour force supply.

Table 8-1. Developments in the Youth (15-24 Years) Labour Market

<table>
<thead>
<tr>
<th>Year</th>
<th>Unemployment Rate (%)</th>
<th>Difference between Male &amp; Female Unemployment Rates (%)</th>
<th>Ratio of Female to Male Unemployment Rates (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td>M &amp; F</td>
</tr>
<tr>
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<td>39.3</td>
<td>18.7</td>
<td>21.8</td>
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<td>26.6</td>
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</tr>
<tr>
<td>2000</td>
<td>34.9</td>
<td>28.7</td>
<td>29.9</td>
</tr>
<tr>
<td>2005</td>
<td>34.3</td>
<td>18.4</td>
<td>21.6</td>
</tr>
</tbody>
</table>

- Statistics for 2005 have been normalised based on the definitions of employment and unemployment for the previous years

Source: Estimates by the Office for Macro-Economic Management and Planning, Management and Planning Organisation of Iran, 2006
During the period 2000-2004, following the policies of the Third FYDP and with increases in rates of investment and production growth, employment creation took pace, resulting in the creation of further employment opportunities for young people and subsequent decrease of youth unemployment rate. However, unemployment rate of young women witnessed an increase to 35.3 percent at the end of this period, while unemployment rate of young men decreased to 18.2 percent, with the obvious reason for this disparity being increased number of employment opportunities created for men rather than for women.

It should be noted that the reduction in female labour force supply has prevented further increase of the female unemployment rate. The same applies to some extent for men, resulting in a reduction in (youth) unemployment rate. At the end of the above period, the disparity between the unemployment rates of young men and women reached 15.9 percent and the indicator for ratio of unemployment rate of young women to that of young men increased to 1.9, which points to increased gender disequilibrium in the labour market for youth.

Based on the results of the Labour Force Survey carried out in spring 2005, the unemployment rate of young people aged 15-24 years stood at around 23.8 percent, with disaggregated rates at 33.7 and 20.6 percent, respectively, for women and men. The highest value for youth unemployment rate in spring of 2005 had been reported for the province of Ilam (31.3 percent) and the lowest for East Azarbaijan (10.3 percent). With regard to women, the provinces of Khuzestan with 49.1 percent and East Azarbaijan with 11 percent had seen the highest and lowest rates, whereas for men these had been Ilam with 28.2 percent and East Azarbaijan with 10.1 percent, respectively.

When comparing the indicators for the youth labour market during the beginning and final years of the period 1991-2005, the following could be concluded:

- Although the distance of the youth unemployment rate from the national mean has slightly decreased during this period, youth unemployment rate still remains high, barring minor fluctuations
- The ratio of unemployment rate of young women to that of young men has been considerably high, presenting an alarming reflection of the labour market for young women
- The rate of creation of employment for (young) women has not been proportionate with the increase in their share in labour force supply
- Youth unemployment rate has been alarmingly high in certain provinces, which is indicative of regional disequilibrium in the youth labour market

---

1. It should be noted that the sampling method and the definitions for employment and unemployment changed in 2005. Statistics presented in this section have been normalised using the definitions of unemployment and employment for the previous years, in order for them to have the appropriate degree of compatibility for inter-time comparisons.
2. Statistics presented in this section are based on a new sampling method and updated definitions for employment and unemployment.
Regarding MDG Target 17, which is providing access to affordable essential drugs in cooperation with pharmaceutical companies, in 1999 between 80 to 94 percent of the total population enjoyed access to affordable essential drugs (Indicator 46) according to the latest estimates provided by the WHO. No recent data has been provided by the WHO, which is the responsible body for providing the official estimates for this indicator, however.

The next target for this MDG deals with improving access to new technologies, especially to information and communication technologies (ICTs). During the previous decades, ICTs have played a defining role in the establishment or promotion of many social, economic and cultural developments, towards the achievement of higher echelons of development. In light of the significance of ICTs, access to these technologies has been specifically emphasised in the MDGs. The status of I.R. Iran in this regard is reviewed here in the form of three indicators.

Following expansive policies for the promotion of the country’s telecommunication capacities during the course of the FYDPs, (fixed) telephone lines per 100 population (Indicator 47) increased from 4 in 1990 to 29.6 in 2005 and cellular subscribers per 100 population demonstrated significant increase from 0.1 in 1996 to 12.4 in 2005. The rising trend for this indicator could be viewed in Figure 8.1.

**Figure 8.1. Fixed Telephone Lines per 100 Population**

![Fixed Telephone Lines per 100 Population Graph](image)

Source: Statistical Centre of Iran.

Personal computers in use per 100 (urban) population (Indicator 48A) reached 10.37 in 2004 from 6.28 in 2000. During this same period, the indicator for internet users per 100 population (Indicator 48B) saw a rapid increase from 0.31 in 2000 to 9.87 in 2004.
2. Enabling Policies and Programmes

Making use of existing capacities in international cooperation for improving the country's socio-economic conditions enjoys special standing in the macro programmes of I.R. Iran. For illustrating the significance of MDG 8 in the country's macro policies and programmes, it would be necessary to point out two important measures emphasised in the FYDPs:

- Establishment of international cooperation to attract global participation for the purpose of the realisation of the MDGs
- Importance of knowledge-based international cooperation for meeting the MDGs

I.R. Iran welcomes all foreign investments by foreign individuals and enterprises in all areas of economic activity. In that regard, a set of laws and regulations for management of foreign investment, including the Law for the Promotion and Support of Foreign Investment and the associated operational directive and laws for monitoring the establishment and operation of economic activities in the country were ratified in 2002. Key progress areas resulting from the new law in the area of foreign investment include the following:

- Expansion of the sphere of activity of foreign investors, including the prospect for investment in the country's infrastructure
- Shortening and speeding up of the process for the filing, processing and approval of applications for foreign investment
- Establishment of an independent unit titled Foreign Investment Bureau in the Organisation for Investment, Economic and Technical Assistance, for providing centralised and effective support of foreign investment activities in the country
• Further liberalisation of foreign exchange mechanisms for use by foreign investors
• Introduction of new legal options for monitoring the relation between the Government and foreign investors

In addition, the Government has included a special section in the Fourth FYDP Bill, under the title Proactive Interaction with the Global Economy on this issue.

Based on a special clause in Article 33 of the Fourth FYDP Bill for trade modernisation and facilitation the Government has been required to act upon the following by the end of the first year of that FYDP:
• Increasing the country's share in international trade
• Promotion of exports of non-oil products and services
• Strengthening the competitiveness of the country's exports in the international markets
• Elimination of all non-tariff and non-technical barriers
• Assignment of equivalent duties with fixed schedules and in the form of a pre-announcement

I.R. Iran has included accession to the WTO in its FYDPs and submitted its application for accession to the WTO Secretariat in 1996. Following a lengthy process, the membership application was accepted on May 26 2005 by WTO Members, granting I.R. Iran the rights of an observing member effective from that date.

In light of the commencement of the process of accession of Iran to the WTO and creation of transparency in establishment and collection of duties by the Government, the following, referred to as import duties, are integrated in the Duties Aggregation Law:
• Taxes
• Product order registration fees
• Various types of duties
• Trade profits
• Other receivables from imported goods

It should also be noted that in 2005 general policies of Article 44 of the Constitution of I.R. Iran were formulated with the following aims:
• Accelerated national economic growth
• Increased private ownership for the public towards securing social justice
• Increased efficiency for business enterprises and productivity of financial, human and technological resources
• Enhanced competitiveness in the national economy
• Enablement and increased share of the cooperative and private sectors in the national economy
• Provision of support for increasing competitiveness of export goods in the international markets
• Preparedness of local enterprises for dealing intelligently with global trade rules in a gradual and targeted process
• Extension and promotion of national standards
• Adaptation of quality assessment systems with international standards
• Reductions in the financial and managerial burden of economic activities on the Government
• Increased general employment levels
• Public encouragement to save and invest
• Improved household incomes

The above items have been announced within the general framework of the following policies:
• General policies for the promotion of non-public sectors and prevention of the disproportionate growth of the public sector
• General policies for the cooperative sector
• General policies for the promotion of non-public sectors, through the transfer of government activities and enterprises
• General transfer policies
• General policies for governance and for restricting monopolisation

Among other effective policies and measures implemented during the Third FYDP having positively influenced the achievement of this MDG the following could be listed:
• Assigning a ceiling regarding Government's total external debt, such that during the final year of the Third FYDP (2004) external debt service payments and financial commitments had not exceeded 30 percent of the Government's annual foreign exchange income and net external debt and financial commitments had been less than 25 percent
• Granting discounts on taxes and insurance premiums to entrepreneurs who employed new staff through employment service centres of the Ministry of Labour and Social Affairs (MLSA) during the course of the Third FYDP
• Granting incentives for increased investment in employment creation programmes
• Expansion of ICT infrastructure and networks
The Fourth FYDP, in addition to emphasising on the continuation of the policies of the Third FYDP, introduced new policies, the most significant of which in the two main areas of attracting international cooperation and the labour market have been as follows:

- With regard to the utilisation of foreign financial resources and credit, the debt service payment schedule (table) will be similar to that for the Third FYDP, with priority remaining with long-term credits
- The issue of employment has enjoyed serious attention and in the section on quantitative objectives of the cross-sectoral document titled Expansion of Productive Employment and Reduction of Unemployment it has been specified that youth unemployment rate should have reached 12.6 by the end of the Third FYDP. A set of policies and measures had been envisaged for achieving this target, most significant of which are as follows:
  - Reform of the employment law with the aim of increasing labour market flexibility
  - Quantitative and qualitative development of job centres and vocational and technical training centres for reducing search, selection and training costs for the labour force
  - Expansion of scientific and practical training
  - Payment of educational grants upon hiring
  - Continuation of the Graduate Recruitment Scheme
  - Provision of the basis for development of temporary, part-time and participatory jobs, particularly for young women
  - Establishment of insurance and tax incentives regarding employment of new labour force
  - Promotion of self-employment jobs
  - Allocation of a share of subsidies on loan interests and charges for private and cooperative (sector) investors in the area of knowledge-based activities
  - Support of ICT-based activities
  - Development of a labour market information system for identification of available employment opportunities and for promptly filling these opportunities

A special mention should be made here of the national cross-sectoral document Expansion of Productive Employment and Reduction of Unemployment, issued in 2006 to the MLSA. If the respective policies of this document are implemented, it would seem hopeful that not only would reduction in the unemployment rate of young people be achieved, but its distance from the mean national unemployment rate, together with youth labour market gender and regional imbalances will also be alleviated.
3. Major Challenges and Development Cooperation

Various challenges could be identified in achieving MDG 8, the most significant of which are summarised below:

- Increased attraction of the various industrial service and financial sectors for promotion of further participation
- Expansion of the main development infrastructure and roads and connection networks
- Increased transparency of and access to investment information, for the facilitation of planning required by investors
- Labour market imbalance in various dimensions, such as gender, age, education, urban-rural and provincial
- Disproportionate growth of the informal sector due to the inability of the productive and formal sectors in creation of employment, resulting in an unbalanced national employment structure
- Accession of Iran to the WTO and the ensuing benefits for the country
- Harmonisation of national laws, regulations and policies with global development
- Application of appropriate tariff mechanisms to quantitative and non-tariff restrictions on agricultural and industrial products, for the development of tariff schedules in accordance with international guidelines
- Cultural and political values and viewpoints regarding capital and investment
- Share of the Government in the (national) economy and its unnecessarily monopolistic role in most economic activities and lack of the appropriate framework for competition by the private sector
- Movement of production factors between Iran and other countries

National Priorities for Development Cooperation

Major priorities in addressing existing challenges in the area of international cooperation have been identified as follows:

- Provision of technical and consulting assistance for establishment of an ODA information system
- Searching for innovative methods and solutions for expansion of partnerships towards the realisation of the MDGs in Iran. Towards this end, Participation of NGOs, business enterprises, traders and investors within the framework of government guidance would be necessary.
Attachment One: Technical Notes

Estimation of the Population below $1 and $2 Poverty Line

Population living below the $1 or $2 per day poverty line is a standard for comparing absolute poverty levels of different countries, proposed by the World Bank and included as MDG indicators.

To allow for global comparability, each US dollar is considered in purchasing power parity (PPP) terms in national currency. For calculating the value for this indicator, data from Household Income and Expenditure Surveys (HIES), carried out by the Statistical Centre of Iran, is used; disaggregated by urban/rural.

First, per capita daily expenditure in Rials (expenditure as a representation of income) is calculated and the population living below the $1 or $2 per day in urban and rural areas is determined based on the US dollar equivalent in PPP terms, which is provided by the International Monetary Fund (IMF). Next, population living below $1 or $2 per day is calculated, based on urban/rural.

### USS to Rial Exchange Rate (PPP)

<table>
<thead>
<tr>
<th>Year</th>
<th>1997</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rials</td>
<td>891.10</td>
<td>964.67</td>
<td>1237.53</td>
<td>1531.40</td>
<td>1669.39</td>
<td>2105.81</td>
<td>2312.26</td>
<td>2712.04</td>
<td>3134.93</td>
</tr>
</tbody>
</table>

Source: International Monetary Fund (IMF), World Economic Outlook Database, April 2006.

It should be noted that the indicators reflected in relation with MDG 1 in this report, are different from those presented in the first MDG report. This difference has been resulted from two main factors:

- Changes in $1 and $2 equivalence (exchange) rate
- Changes in minimum level of dietary energy requirements per capita (from 2308 to 2100 kilocalories)

The Statistical Centre of Iran has been designated as the official reference for the production of statistical data and it is hoped that during the future years, data integrity and quality will be improved in this regard.

**Poverty Gap Ratio**

The following equation is used for calculating the value for this indicator:

\[
P_\alpha = \frac{1}{N} \sum_{i=1}^{q} \left( \frac{z - y_i}{z} \right)^\alpha
\]

- \(z\): Poverty line (here $1 or $2 Rial equivalent (PPP))
- \(y_i\): People whose income is below the poverty line ($1 or $2)
- \(q\): Population below $1 or $2 per day
- \(N\): Total population \((\alpha=1)\)
Share of poorest quintile in national consumption

This indicator has been calculated using data from the Household Income and Expenditure Surveys (HIES), as gross per capita expenditure per decile, disaggregated by urban/rural. Next, the share of the 1st and 2nd poorest quintiles in total consumption is computed and estimated for the whole country using the urban/rural ratio.

Percentage of the Population below the Food Poverty Line

Food poverty line is calculated based on daily per capita calorie intake, which has been defined as 2100 kilocalories by FAO (Food and Agriculture Organisation).

For calculating this indicator, household food expenditure per capita is calculated and divided into deciles based on per capita food expenditure. Next, calorie intake per decile is estimated and the population below the 2100 kilocalorie requirements in total population is designated as the population below the food poverty line in urban and rural areas. Then, proportion of population below the food poverty line is calculated, using the urban/rural ratio.

Estimating the indicator of maternal mortality ratio in 1990 (the baseline for the MDGs)

In the MDGs, the baseline for the calculation of maternal mortality ratio has been designated as 1990. As no studies had been carried out with regard to this indicator during that year, results from two surveys carried out in 1988 and 1991 have been used instead.

In 1988, for computing health and demographic indicators, a study was carried out on 1 percent of total population, in which the maternal mortality ratio indicator has been calculated as 90.6 per 100,000 live births. Another survey with the same method was carried out in 1991 and the value for the indicator was calculated as 54 per 100,000 live births. As the decrease from 91 to 54 within three years does not seem logical, the level for 1990 is estimated at 75 to 90 cases per 100,000 live births. Considering the target defined for this MDG, this indicator would need to decrease to between 18 and 22 deaths per 100,000 live births by 2015.

Analysis method for maternal mortality ratio across provinces (Table 5.2)

As maternal mortality ratio is an indicator for which estimation at the level of national medical universities does not seem logical due to the small values for this indicator. For comparing the status of maternal mortality by university, initially proportion of births is calculated for each university in total births during the past 5 years (2001-2005). Also, share of maternal deaths in the total number of maternal deaths is calculated per university for the same 5 years and finally the proportion of population of women ages 15-49 is calculated for each university in total population of women ages 15-49 during these five years, according to Table 5.2. Thus, the probability of maternal death could be demonstrated numerically for each province.
Calculating the indicator of access to secure tenure in Iran

The proportion of households with access to secure tenure (Indicator 32) is 1 minus the percentage of the urban population that lives in slums. A slum household is as a group of individuals living under the same roof who lack one or more of the following conditions: security of tenure, structural quality and durability of dwellings, access to safe water, access to sanitation facilities and sufficient living area.

For calculating the value for this indicator in the country, as no data is available regarding households without access to secure tenure, the indicator has been redefined by the Statistical Centre of Iran as: households with access to secure tenure being 1 minus the proportion of urban households with at least one of the following conditions:

- Residence in poor-quality housing
- Lack of access to piped water
- Lack of access to sufficient living area
Attachment Two: Concepts and Definitions for Select MDG Indicators

Net enrolment ratio in primary education
Is the ratio of the number of children of official school age (6-10 year-olds) who are enrolled in primary school to the total population of children of official school age.

Proportion of pupils starting grade 1 who reach grade 5
Is the percentage of children starting primary school who eventually attain grade 5. The estimates are based on the reconstructed cohort method, which uses data on enrolment and repeaters.

Primary completion rate
Is the ratio of the number of pupils successfully completing grade 5 in a given year to the total number of children of official graduation age for grade 5 in the population.

Ratio of girls to boys in primary, lower secondary, (upper) secondary and tertiary education
Is the ratio of girls to boys in primary, lower secondary, (upper) secondary and tertiary education in formal and non-formal programmes.

Proportion of seats held by women in national parliament
Is the number of seats held by women expressed as a percentage of all occupied seats.

Telephone lines per 100 population
Is the number of telephone lines connecting subscribers’ terminal equipment to the public switched network and that have a dedicated port in the telephone exchange equipment, per 100 population.

Cellular subscribers per 100 population
Equals the number of users of cellular telephones who subscribe to an automatic public mobile telephone service that provides access to the public switched telephone network using cellular technology, per 100 population.

Personal computers in use per 100 population
As is stated in the title, is the number of personal computers per 100 people.

Internet users per 100 population
The Internet is a linked global network of computers, in which users of computers connected to the network could access other computers connected to the network. Thus, the definition for this indicator could be slightly rephrased as the number of users who use this network per 100 people.

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1. Based on definitions provided with data presented by the Statistical Centre of Iran.
2. This definition has been taken from definitions provided by UNESCO, as the Ministry of Education has not provided any definitions in this regard.
Energy use per $1$ gross domestic product (energy intensity)
Energy use (kilogram oil equivalent) per $1$ GDP (PPP) is commercial energy use measured in units of oil equivalent per $1$ of GDP converted from national currencies using purchasing power parity conversion factors. In summary, this indicator provides a measure of energy intensity, as a representation of total commercial energy consumption for the national gross domestic product. The value for this indicator is in effect a measure for energy intensity.

Proportion of population using solid fuels
Is the proportion 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.

Ratio of area protected to maintain biological diversity to surface area
The ratio of area (terrestrial or marine) protected to maintain biological diversity to surface area.

Consumption of ozone-depleting CFCs
The level of consumption of ozone-depleting chlorofluorocarbons (CFCs).

Carbon dioxide emissions per capita
The total amount of carbon dioxide emissions as a consequence of human (production and consumption) activities, divided by the total population.

Percentage of land area covered by forest
The proportion of land area covered by forest is the forest areas as a share of total land area (the proportion of forest in the total land area).

Literacy rate of 15-24 year-olds
Equals the percentage of the population of literate 15-24 year-olds in total population of 15-24 year-olds.

Ratio of literate women to men, 15-24 years old
Ratio of literate women (number of literate women ages 15-24 divided by the total number of women ages 15-24) to men (number of literate men ages 15-24 divided by the total number of men ages 15-24) in the 15-24 year age group.

Share of women in wage employment in the non-agricultural sector
Is the share of female workers in the non-agricultural sector expressed as a percentage of total employment in the sector.

Unemployment rate of 15-24 year-olds, each sex
Is the number of unemployed people ages 15–24 divided by the labour force of the same age group.
Attachment Three: Introducing the Cross-Sectoral Poverty Reduction and Targeted Subsidies Charter

- **Quantitative Objectives of the Poverty Reduction and Targeted Subsidies Charter**
  1. Improving the status of nutrition
  2. Improved access to essential health, medical and rehabilitative care
  3. Promotion of knowledge-based life skills
  4. Improving the status of housing and shelter
  5. Returning vulnerable groups to the area of social activity
  6. Mitigating the impacts of natural, political and social hazards

- **Assumptions used in the Formulation of the Charter**
  1. Refraining from the culture of dependence
  2. Empowering the poor
  3. Provision of basic human needs
  4. Preventing inefficient overlaps

Qualitative and quantitative objectives and envisaged policies in the Five-Year National Poverty Reduction and Targeted Subsidies Charter in I.R. Iran are according to the following table:

**Objectives, Policies and Indicators of the Poverty Reduction and Targeted Subsidies Charter**

<table>
<thead>
<tr>
<th>Qualitative Objective</th>
<th>Quantitative Objective</th>
<th>Key Policies Implemented</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Food security and eradication of hunger</td>
<td>Access to a suitable food basket</td>
<td>Free provision of a food basket providing minimum level of dietary energy requirements. Implementation of supplementary feeding programme for pregnant and lactating women and children under 6 years. Allocation of subsidies for provision of a suitable food basket and nutrition education for poor groups.</td>
<td>Ratio of the population with access to a suitable food basket to the total population. Ratio of underweight children. Weight for-height. Iron deficiency anaemia prevalence rate. Share of various groups from food subsidies. Share of tax income allocated to social welfare in financing the food security and feeding programme</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Qualitative Objective</th>
<th>Quantitative Objective</th>
<th>Key Policies Implemented</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Provision of essential health care services</td>
<td>Access to essential health care services</td>
<td>Provision of free essential health care services package. Allocation of subsidies toward payments for a portion of health insurance premiums, according to the intensity of poverty. Allocation of financial credit to poor families caring for a disabled family member, in accordance with the degree of disability. Provision of specialised health care services for people with special diseases. Allocation of medical subsidies in proportion with the household paying power for people with special diseases. Extension of the primary health insurance coverage.</td>
<td>Share of out-of-pocket payments in total health expenditures. Indicator for fair financing cooperation (FFC) in financing of health services. Proportion of population with catastrophic health expenditures.</td>
</tr>
<tr>
<td>3. Improvement of housing status</td>
<td>Access to suitable housing</td>
<td>Directing housing subsidies to the housing demand of low-income households Improving urban slums, with the aim of the enablement of slum dwellers Rental housing development for people living below the poverty line in large cities Organisation of living area for people living below the line of poverty, particularly in underpopulated villages and cities</td>
<td>Ratio of housing expenditures to the total non-food expenditures Percentage of houses with access to improved sanitation facilities Percentage of vulnerable households living in durable or non-durable housing Number of homeless persons Number of households per residential unit in urban areas Number of persons per room in rural areas Share of micro-credit loans in total housing credits Per capita living space</td>
</tr>
<tr>
<td>4. Promotion of knowledge-based life skills</td>
<td>Access to free education</td>
<td>Support of governmental and non-governmental organisations and enterprises in the promotion of vocational or technical training in less developed regions Education system reengineering with the approach of meeting the labour market demand</td>
<td>Net enrolment ratio in primary education Proportion of pupils starting grade 1 who reach grade 5 Volume of conditional cash transfers for ensuring school attendance by working children The number of children in receipt of cash</td>
</tr>
<tr>
<td>Qualitative Objective</td>
<td>Quantitative Objective</td>
<td>Key Policies Implemented</td>
<td>Indicator</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>5. Returning low-income groups to the area of social activity through creation of employment opportunities</td>
<td>Creation of employment for vulnerable persons who are able to work</td>
<td>Provision of small business opportunities for women heads of household</td>
<td>Unemployment rate of women heads of household</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Free occupational skills training for the unemployed</td>
<td>Ratio of credits to regular employment to the total employment creation credits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Establishment of mechanisms for creation of general employment for the unemployed</td>
<td>Rate of the population leaving the support coverage of allowance benefits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provision of vocational training and the essential credit for the creation of employment for women heads of household</td>
<td>Level of employment created by the allocated facilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Creation of suitable mechanisms for provision of unemployment loans for the unemployed</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Strengthening and promotion of small business with emphasis on the utilisation of employment creation loans and allocation of tax exemptions</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cancellation of barriers resulting from work permit regulations</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Financial support to SMEs with priority to deprived areas</td>
<td></td>
</tr>
<tr>
<td>6. Mitigating the impacts of natural and social hazards</td>
<td>Providing protection coverage for fighting hazards for vulnerable people</td>
<td>Provision of training for fighting social hazards for all groups in the society</td>
<td>Share of educational expenditures for addressing social risks in total educational expenditures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Accommodation and organisation of street kids and homeless people. Strengthening of NGOs for returning addicts to the arena to social activity</td>
<td>Ratio of insurances paid for damages due to hazards to total damages</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Expansion of natural disaster insurance</td>
<td></td>
</tr>
</tbody>
</table>
Attachment Four: Poverty Criteria in I.R. Iran Poverty Reduction Programmes (Social Safety Net Bylaw)

The criteria for the determination of poverty and hunger based on per capita expenditure could not always prove the most suitable, even if per capita expenditure is measured accurately, as many households do not know what type of food stuffs to purchase, due to poor knowledge and low level of literacy. Also, some families would need to spend a major portion of their income on medical and hospital expenditures, due to unfavourable hygiene conditions or work and life styles.

The food poverty line also suffers from certain shortcomings, due to the following reasons:

- Due to the regional differences in the price of food stuffs, one basket of food could cost differently depending on the area purchased. The definition of a basket of food should vary based on people’s age and life conditions.

- The effect of the household size on non-food expenditures per capita, which should be resolved through the introduction of a household size adjustment coefficient.

Also, the $1 per day poverty line could not be considered the absolute poverty line, as it does not take into account people's capabilities and quality of life and also it is not clear whether this poverty line specifies the threshold necessary for physical survival. Furthermore, international comparisons show that the $1 per day purchasing power is not sufficient for provision of sufficient food and could therefore not be considered the defining factor for the extreme poverty line. In addition, even if the $1 purchasing power is measured with accuracy across various regions, quality of services across different regions in the world hasn’t been taken into account.

Considering the issues points, more accessible criteria are used in poverty reduction target definition in I.R. Iran, which based on the Social Safety Net Bylaw are as follows:

Extreme poverty: a condition where if all the household's income is used for providing food, the head of the household would be unable to afford 2000 kilocalories per household member according to a suitable food basket

Absolute poverty: a condition where a household would be unable to afford both food and non-food needs (housing, clothing, medical care and education)

Based on the above, the target population is divided into three income groups, as follows:

- Group one: people living in extreme poverty
- Group two: population between extreme and absolute poverty lines
- Group three: population living above the absolute poverty line (healthy population)

Households living in extreme poverty are covered fully by the Social Security Net scheme and priority in provision of services would be for households living in absolute poverty, as specified below:
- Children without guardians, child heads of household, orphans, etc.
- Female heads of household and self-supporting women
- The elderly
- The disabled
- Others (the unemployed, chronically physically or mentally ill, etc.)

The support programmes and measures specified under this bylaw include: food security, primary health care, employment, increased public awareness, empowerment, housing and risk management.
Attachment Five: Demographic Challenges in the Area of Poverty and Hunger in I.R. Iran

Disproportionate population distribution
The population density in Iran is less than half the global average and that for Asia. But, the arid and semi-arid conditions of vast regions of the central, south eastern and southern deserts in Iran have resulted in the population to be disproportionately distributed across the country and be more concentrated in regions with more favourable climatic conditions and more efficient economic mechanisms.

Migration flows and increased migration and urbanisation
The urban population is growing more rapidly than the rural population. This trend of growth is due to increased migration and the urbanisation of rural areas or the consolidation of rural areas into sprawling suburbs. Other contributory factors include the selective nature of migrant settlements in peri-urban areas, expansion of suburbanisation and rapidly sprawling of metropolises and satellite cities, the consequences of which are increased social expenditures on fiscal resources.

Population age structure
During the recent years, particular population developments have taken place in Iran, which on the one hand could be considered an opportunity and on the other, a threat. The rate of fertility has decreased, due to factors such as increased literacy and education, rising age at marriage and reduced infant mortality. Reductions in the reproduction allowance in Iran have resulted in major changes in the population age distribution, with youth constituting a large proportion of the population. This means that the ratio of economically active population to the population being supported has increased, which as a population gift could present favourable conditions for the reduction of poverty.

During such times of demographic transition, conditions should be created for maximum utilisation of this population potential in the reduction of poverty. Under the present conditions of high participation rate and low dependency ratio, with provision of employment opportunities for young people it would be possible to strengthen the society’s economic potential for increasing savings and ultimately reducing the population under the poverty line with ensuing improvements in the standard of living.
Attachment Six: Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ANIS</td>
<td>Anthropometry and Nutrition Indicators Survey</td>
</tr>
<tr>
<td>ARVs</td>
<td>Anti Retro-Viral medicines</td>
</tr>
<tr>
<td>BCG</td>
<td>Bacille Calmette-Guerin (Tuberculosis Vaccination)</td>
</tr>
<tr>
<td>CBI</td>
<td>Central Bank of I.R. Iran</td>
</tr>
<tr>
<td>CDC</td>
<td>Centre for Diseases Control</td>
</tr>
<tr>
<td>CFCs</td>
<td>Chlorofluorocarbons</td>
</tr>
<tr>
<td>CWP</td>
<td>Centre for Women’s Participation</td>
</tr>
<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
</tr>
<tr>
<td>DOE</td>
<td>Department of Environment</td>
</tr>
<tr>
<td>DOTS</td>
<td>Directly Observed Treatment Short Course</td>
</tr>
<tr>
<td>EFA</td>
<td>Education for All</td>
</tr>
<tr>
<td>EOC</td>
<td>Emergency Obstetric Care</td>
</tr>
<tr>
<td>FAO</td>
<td>Food and Agriculture Organisation</td>
</tr>
<tr>
<td>FRLWO</td>
<td>Forest and Range Land and Watershed Organisation</td>
</tr>
<tr>
<td>FYDP</td>
<td>Five-Year Development Plan</td>
</tr>
<tr>
<td>HIPC</td>
<td>Heavily Indebted Poor Countries</td>
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<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome</td>
</tr>
<tr>
<td>ICTs</td>
<td>Information and Communication Technologies</td>
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<td>ICPD</td>
<td>International Conference on Population and Development</td>
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<tr>
<td>IEC</td>
<td>Information Education Communication</td>
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<td>IDUs</td>
<td>Injecting Drug Users</td>
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<td>ILO</td>
<td>International Labour Organisation</td>
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<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illness</td>
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<tr>
<td>IMES</td>
<td>Integrated Monitoring and Evaluation System</td>
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<td>IMHC</td>
<td>Integrated Management of Healthy Child</td>
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<td>LCDs</td>
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<td>LMO</td>
<td>Literacy Movement Organisation</td>
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<td>MCP</td>
<td>Malaria Control Programme</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>MDR</td>
<td>Multi Drug Resistant</td>
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<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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<td>MLSA</td>
<td>Ministry of Labour and Social Affairs</td>
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<td>MOE</td>
<td>Ministry of Education</td>
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<tr>
<td>MOHME</td>
<td>Ministry of Health and Medical Education</td>
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<td>MPO</td>
<td>Management and Planning Organisation</td>
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<td>NGOs</td>
<td>Non-Governmental Organisations</td>
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<td>NHDR</td>
<td>(First) National Human Development Report (of I.R. Iran)</td>
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<td>NICs</td>
<td>Newly Independent Countries</td>
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<td>NICU</td>
<td>Newborn Intensive Care Unit</td>
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<td>ODA</td>
<td>Official Development Assistance</td>
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<td>ODP</td>
<td>Ozone-Depleting Potential</td>
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<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<tr>
<td>PBO</td>
<td>Plan and Budget Organisation (now MPO)</td>
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<tr>
<td>PHCs</td>
<td>Public Health Centres</td>
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<tr>
<td>PLHIV</td>
<td>People Living With HIV</td>
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<td>PPP</td>
<td>Purchasing Power Parity</td>
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<td>Acronym</td>
<td>Description</td>
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<td>RHCS</td>
<td>Reproductive Health Commodity Security</td>
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<td>SCI</td>
<td>Statistical Centre of Iran</td>
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<td>STD</td>
<td>Sexually Transmitted Disease</td>
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<tr>
<td>STIs</td>
<td>Sexually Transmitted Infections</td>
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<td>TFR</td>
<td>Total Fertility Rate</td>
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<td>UNAIDS</td>
<td>United Nations AIDS Programme</td>
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<td>UNDCP</td>
<td>United Nations International Drug Control Programme</td>
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<td>UNFPA</td>
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<td>UNICEF</td>
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<td>UV</td>
<td>Ultra Violet</td>
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<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<th>Indicator 8B. Literacy rate of 15-24 year-olds (%) - Women</th>
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<tr>
<td>60.6 60.1 64.3 67.0 67.6 67.1 67.0 66.9 69.6 69.6 69.6 69.6</td>
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<td>Indicator 8A. Literacy rate of 15-24 year-olds (%) - Men</td>
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<td>80.4 80.3 83.4 86.9 87.1 87.0 87.0 86.9 89.6 89.6 89.6 89.6</td>
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<td>Indicator 7. Proportion of pupils reaching grade 5 who reach grade 5</td>
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<td>79.2 79.6 81.3 83.2 83.2 83.2 83.2 83.2 85.3 85.3 85.3 85.3</td>
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<td>Indicator 6. Net enrollment ratio in primary education (%)</td>
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<td>79.2 79.6 81.3 83.2 83.2 83.2 83.2 83.2 85.3 85.3 85.3 85.3</td>
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</tbody>
</table>

**Goal 2. Achieve universal primary education**

- **Indicator 5A. Proportion of population below minimum level of daily energy consumption (%)**
  - 1986: 9%
  - 1987: 10%
  - 1996: 10%
  - 1997: 10%
  - 1998: 10%
  - 1999: 10%
  - 2000: 10%
  - 2001: 10%
  - 2002: 10%
  - 2003: 10%
  - 2004: 10%
  - 2005: 10%

- **Indicator 5B. Proportion of population below minimum level of daily energy consumption (%)**
  - 1986: 9%
  - 1987: 10%
  - 1996: 10%
  - 1997: 10%
  - 1998: 10%
  - 1999: 10%
  - 2000: 10%
  - 2001: 10%
  - 2002: 10%
  - 2003: 10%
  - 2004: 10%
  - 2005: 10%

- **Indicator 5C. Proportion of population below minimum level of daily energy consumption (%)**
  - 1986: 9%
  - 1987: 10%
  - 1996: 10%
  - 1997: 10%
  - 1998: 10%
  - 1999: 10%
  - 2000: 10%
  - 2001: 10%
  - 2002: 10%
  - 2003: 10%
  - 2004: 10%
  - 2005: 10%

**Goal 1. Eradicate extreme poverty and hunger**

- **Indicator 1A. Proportion of population below $1 (PPP) per day (%)**
  - 1997: 12%
  - 1998: 12%
  - 1999: 12%
  - 2000: 12%
  - 2001: 12%
  - 2002: 12%
  - 2003: 12%
  - 2004: 12%
  - 2005: 12%

- **Indicator 1B. Proportion of population below $1 (PPP) per day (%)**
  - 1997: 12%
  - 1998: 12%
  - 1999: 12%
  - 2000: 12%
  - 2001: 12%
  - 2002: 12%
  - 2003: 12%
  - 2004: 12%
  - 2005: 12%

- **Indicator 1C. Proportion of population below $1 (PPP) per day (%)**
  - 1997: 12%
  - 1998: 12%
  - 1999: 12%
  - 2000: 12%
  - 2001: 12%
  - 2002: 12%
  - 2003: 12%
  - 2004: 12%
  - 2005: 12%


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<td>1.13</td>
<td>Percentage of births attended by skilled health personnel</td>
<td>85.1</td>
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<td>96.1</td>
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<td>1.14</td>
<td>Under-five mortality rate (per 1,000 live births)</td>
<td>39.7</td>
<td>33.3</td>
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<td>Proportion of 1-year-olds immunized against measles (%)</td>
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<td>98</td>
<td>96</td>
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<td>Proportion of 1-year-olds alive (per 1,000 live births)</td>
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<td>Proportion of students in primary, secondary and tertiary education (%)</td>
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<td>Proportion of skilled births in primary, secondary and tertiary education</td>
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<td>Proportion of women in wage employment in the non-agricultural sector (%)</td>
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<td>15.4</td>
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<td>Proportion of skilled heads of interstate women 15-44 years old (%)</td>
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<td>95.3</td>
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IR. Iran MDG Indicators (1997-2005) - Continued
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<th>Indicator 2A. Deaths associated with tuberculosis (per 100,000 population)</th>
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<table>
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<th>Indicator 2B. Prevalence and death rates associated with tuberculosis (per 100,000 population)</th>
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<th>Correct knowledge of HIV/AIDS</th>
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<th>Indicator 19A. Contraceptive prevalence among women aged 15-49 years with comprehensive contraceptive use</th>
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<th>Indicator 19B. Contraceptive prevalence among women aged 15-24 years</th>
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<th>Indicator 19C. Contraceptive prevalence among married women aged 15-24 years</th>
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<th>Indicator 19D. Contraceptive prevalence among married women aged 15-24 years</th>
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<th>Indicator 19E. Contraceptive prevalence among married women and other diseases</th>
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IR. Iran MDG Indicators (1997-2005) - Continued
In this study, the indicator, ratio of outstanding external debt to exports of goods and services, provided by the Central Bank of the Islamic Republic of Iran, is used.

Based on the report published by the WHO, the indicator had been at 57 and 55 per 1000 people, respectively, for 1990 and 2004.

Ministry of Health and Medical Education, Office for Population and Family Health, 2006

Around 62% Jews in 2004


Indicators are calculated based on ODPS. Based on ODPS, the indicator has been estimated at 3%.

For the purposes of the report, environmental protection organization has been used.

ODPS: Official Development Assistance and International Assistance.


For the purposes and methods of calculation, 2005: 2004 Energy Balance Sheet, Ministry of Power, 2005. Due to the differences in definitions and information provided by the respective offices of the Statistical Centre of Iran, data for the indicator is based on data from statistical registers and available for rural areas only up to 2003, recorded in the tables provided in the report.

Published in the first MDG report, data regarding the years 1997-2005 have been provided by the Statistical Centre of Iran and due to certain modifications do not necessarily match the information in the tables.

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**CoG 3. Develop a global partnership for development**

**IR. Iran MDG Indicators (1997-2005) - Continued**