**Goal 5: Improve Maternal Health**

**Target 1: Create favourable conditions for childbearing**
Broader opportunities for self-realization of young people have been competing with entering into marriage and having children, and at the same time the social and economic conditions for starting a family have worsened.

**Target 2: Strengthen reproductive health**
The Czech Republic’s maternal mortality rate is very low. Over the last decade, the problem of psychosocial and sexual high-risk behavior among young people has increased, which has undeniably negative consequences for reproductive health, especially as regards the increase in drug use.
**DESCRIPTION**

Goal 5 aims at improving maternal health. It reflects primarily the situation of developing countries that report higher numbers of mothers dying or experiencing serious health problems related to pregnancy and childbirth. The industrialized countries treat these issues in the broader context of prevention, reproductive health and the enforcement of the family planning right as one of the basic human rights. In addition to maternal health, attention is given to ensuring the safety of abortions and lowering their numbers with the help of effective and affordable contraception and sexual education for responsible partnership and parenthood.²⁰

In the Czech Republic, this goal has to be viewed in the context of changes seen in reproductive behaviour in the 1990s, including a striking decrease in fertility rates and an increase in the age of mothers at the birth of the first child. The main target in the coming years should be, therefore, the creation of favourable conditions for childbearing and the increase in total fertility to at least the current EU average rate of 1.5 live births per woman.²¹ The second target should focus on strengthening women’s reproductive health. The formulation of these targets is derived from a broader WHO concept of health as a state of physical, psychological and social well-being.

**STATUS AND TRENDS**

**Situation in general**

**Reproductive health**

The Czech Republic’s maternal mortality rate is very low. The total number of deaths from 1990 to 1993 ranged between 11 and 17, and since 1994, only sporadic cases have occurred. Causes of every death are analyzed very carefully. Assistance from professional personnel in the overwhelming majority of births and the fact that 99 percent of pregnant women receive prenatal care are undoubtedly responsible for the very low figures. During the 1990s, the proportion of pregnancies with complications increased. However, it is not possible to determine the causes for deterioration of these mothers’ health condition since a certain segment of pregnancies are classified as complicated for social reasons.

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²¹ This is a value of the high variant of total fertility for 2015, taken from the population prognosis. It is derived from the assumption of favourable conditions for starting family life and existence of families. Source: Department of Demography and Geo-demography, Faculty of Natural Sciences, ‘Population Development in the Czech Republic 1990—2002,’ Pavlík, Z. and M. Kučera, eds., Department of Demography and Geo-demography, Faculty of Natural Sciences, Charles University, Prague, 2002.
The developments after 1989 have brought a positive reversal in the trends for abortion rates and the availability and use of efficient contraceptive methods. The once high abortion rate has significantly decreased. Per 100 births, the number of abortions dropped particularly in the early 1990s — from 83 abortions in 1990 to 51 in 1994 — and subsequently, down to 36 abortions in 2002. In the early 1990s, there were 1.5 abortions per one woman of reproductive age, but in 2002 it was only 0.4. The drop in the abortion rate accelerated in 1993 because of the introduction of fees for abortion services performed for non-health reasons. From the perspective of reproductive health, the increase in the share of vacuum aspiration abortions, nowadays comprising approximately 80 percent, is also a positive development.

The trend in the abortion rate in the Czech Republic in the 1990s was more favourable than trends in the majority of Central and Eastern European countries — even though they were also on the decline. Compared to the Czech Republic, the average abortion index in Central European countries is still approximately double (64 abortions per 100 births in 2001). The Czech Republic thus ranks among the European countries with low abortion rates. In the EU, abortion rates have not changed very much over the last ten years, averaging 22 abortions per 100 births. It should be noted that the legal obligation to report all types of pregnancy terminations places the Czech Republic, in terms of completeness of records, in a leading position in the world. In terms of comparison with other states, however, this approach becomes a disadvantage since the abortion statistics in most countries remain underestimated.

The most important factor in reducing the number of induced abortions has been the propagation of modern contraception. While in 1990 only 17 percent of women used hormonal or intrauterine contraception prescribed by doctors, in 2000 it was 39 percent of women and by 2002, nearly 45 percent.

From 1990 to 2001, a significant decrease in the induced abortion rate occurred in all age groups. The smallest decrease occurred in the group of women over 30. These women do not use contraception very much and tend to opt for abortion as the main method of protection against unintended pregnancy. On the contrary, the sharpest decrease occurred in the group of women between 20 and 25. Unlike older women, the generations of women born after 1975 have grown quickly accustomed to using modern contraception from the very beginning of their sexual lives.

A positive trend was also apparent among the youngest girls aged 15—19, who are more likely to engage in unplanned sexual intercourse. Given their insufficient experience with contraception, they are also more prone to unintended pregnancies than other groups. The number of teenage pregnancies has significantly decreased; the fertility rate has dropped by over 70 percent and the abortion rate has decreased by two thirds.

**Figure 5.1**

**Total fertility rates in the Czech Republic and EU countries**

![Total fertility rates in the Czech Republic and EU countries](image)

Since 1989, the conditions surrounding family life and childbearing have substantially changed. Broadened possibilities for self-realization of young people have been competing with entering into marriage and having children, and at the same time the social and economic conditions for starting a family have worsened. The overall environment for childbearing has become very unfavourable. As a result, young people have started to postpone childbirth (with a potential risk of more deciding to have no children at all) and the fertility rate has dropped to extremely low levels that are deeply below the replacement threshold. In the last several years, the Czech Republic has had one of the lowest total fertility rates in the world with respect to replacement potential. The continuation of this trend could lead to larger population decreases and more rapid population aging with all its social and economic consequences.

The age of highest fertility for women in the country continues to increase and expand in duration. Women under 25 have been giving birth to a smaller number of children and, since 1999, the largest number of children have been born to mothers between 25 and 29. The number of children born to women over 30 has also moderately increased. The age structure of mothers has been gradually approaching that of many EU member states. While a substantial decrease in fertility in the youngest age group is positive, the increasing fertility in mothers over 30 can be considered biologically and medically unfavourable. Biologists and doctors consider 24—29 to be the optimal age range for childbearing.

### Specific issues

Over the last decade, the problem of psychosocial and sexual high-risk behaviour among young people has increased. This has undeniably negative consequences for reproductive health, especially as regards the increase drug use. The ratio of young...
women under 20 using addictive substances (drugs and tobacco) is above average among pregnant women.\textsuperscript{23}

With respect to child health, as mentioned in Goal 4, potential problems in maternal health can arise in connection with increasing immigration and provision of adequate care to pregnant immigrant women.

**POLICIES FOR GOAL ACHIEVEMENT**

Future trends in fertility will be determined by the overall social and economic development of the country and by young people’s evaluation of the environment for starting their own families.

The current unfavourable climate reflects the hitherto indifferent attitude of the state towards population trends and towards the position of families with children in society. Only after 2000 did the problems in question rise to prominence. The conception of population and family policy became one of the main goals of the ‘Medium-term Conception of the Ministry of Labour and Social Affairs by 2007’. The advancement of population and family policy was also identified in the Human Development Report, The Czech Republic 2003 as one of the strategic tasks whose implementation (or neglect) can influence the future of development in the Czech Republic. The new concept of family policy should include:

- creation of favourable conditions for reproduction;
- improved living conditions for families with children;
- increased societal prestige of the family;
- compensation for the costs of lost opportunities due to parenthood;
- implementation of European priorities (reconciliation of work and family, balanced gender roles in the family);
- multi-sectoral approach;
- strengthening the role of local communities;
- housing policy.

Any efforts to strengthen reproductive health should promote reproductive and sexual health education programmes primarily targeting the young generation. The development of primary health care systems with integrated programmes focused on the care of mothers and children should be a priority.

Goal 6

Target 1: Reduce morbidity and premature mortality caused by main chronic diseases
Mortality rates higher than the EU average can now be observed in almost all categories of causes of death. The most striking gap is found in mortality caused by diseases of the circulatory system and malignant tumours.

Target 2: Reduce incidence of injuries and their after-effects
Among causes of death, injuries occupy the third place among the population as a whole and the first place among the population under 40. The 1990s saw an increase especially in the number of deaths and injuries caused by traffic accidents.

Target 3: Maintain incidence of HIV/AIDS and tuberculosis at least at the existing level
As regards the spread of HIV/AIDS, particular attention should be paid to groups characterized by risky behaviour, such as injecting drug users (IDUs), persons with multiple sex partners, commercial sex workers and young people engaging in high-risk sexual behaviour.
DESCRIPTION

Goal 6 focuses primarily on the fight against infectious diseases, which on a global scale represent — from the perspective of morbidity and mortality rates — one of the most serious problems in development. Many parts of the world are now facing pandemics and it is necessary to focus on their prevalence and spread even in countries where the trend is relatively favourable. In the Czech Republic, infectious diseases have been gaining in importance as a health problem because of ongoing social change and emerging discrepancies in health conditions among population groups caused by widening gaps in accessibility to medical services. No social clause on joint payments for medications has been adopted yet in the Czech Republic and their future development, as well as direct payments for medical care, is a subject of very serious discussions. For these reasons, the fight against infectious diseases will include the essential task of maintaining at least the existing incidence levels of HIV/AIDS and tuberculosis (TB) infections.

In industrialized countries, it is primarily non-infectious diseases — chronic diseases and injuries — that threaten the health condition of the population. In terms of the mortality and morbidity rates for this group of diseases, the Czech Republic — despite certain positive trends over the last decade — still lags behind the more industrialized EU countries. The main target within this goal for 2015 should therefore be the reduction of morbidity and premature mortality caused by the major chronic diseases and the reduction of injuries and their after-effects.²⁴

STATUS AND TRENDS

Situation in general

HIV/AIDS and tuberculosis

Even the Czech Republic has not avoided the spread of HIV infection. Newly reported HIV-positive cases have increased annually since 1985. This trend, however, has not been as dramatic as expected in the early stages of the HIV epidemic. In the last few years, the situation has stabilized with the annual increase in newly diagnosed cases steady at about 50 persons per year (i.e. about 5 newly

reported HIV-positive persons per 1 million citizens). The number of people living with HIV/AIDS has grown continually, particularly due to the intense anti-retroviral therapy applied to all the HIV-infected persons in the Czech Republic. As of 31 July 2003, the Czech Republic registered 633 HIV-positive citizens (including foreign nationals in long-term residence in the Czech Republic) and 190 foreigners. Thanks to its overall low prevalence of 61.6 cases per 1 million inhabitants, the Czech Republic ranks among European countries with the lowest HIV/AIDS prevalence rates.²⁵ Laboratory tests continue to detect cases of HIV-positive persons either in the symptomatic or fully-developed stages of the disease. This implies that the number of HIV-infected persons in the population is higher than those reported.

The tuberculosis incidence in the Czech Republic showed a consistently decreasing trend until the mid 1980s, followed by a period of stabilization on the level of approximately 20 cases per 100,000 people. In 1996, the decreasing trend resumed reaching 14 in 2000 and a mere 11.8 cases per 100,000 people in 2002. This last figure is comparable with the EU average (11.5 cases per 100,000 people in 2000) and the lowest number among Central and Eastern European countries. Tuberculosis affects twice as many men as women and its incidence sharply rises with advancing age.

Non-infectious diseases

In the 1990s, the Czech Republic saw a significant rise in life expectancy at birth. Its increase by four years for men and three years for women was one of the sharpest compared to EU countries. However, despite this significant decrease in mortality, life expectancy in the Czech Republic lags behind the EU average by approximately three years and behind the worst EU member countries by one year. In the context of Central and Eastern Europe, the Czech Republic occupies second place behind Slovenia.

An even more substantial difference between the EU and the Czech Republic becomes evident in a comparison with the WHO indicator of health-adjusted life expectancy (HALE) that takes into account both premature mortality and years spent in ill health.²⁶ In 2000, this difference was 4.5 years (65.6 years in the Czech Republic versus 70.1 years in the EU).²⁷ Mortality rates higher than the EU average can now be observed in almost all categories of causes of death.²⁸ The most striking gap is found in mortality caused by diseases of the circulatory system, i.e. the group of diseases representing the main cause of death in industrialized countries. In this category, the mortality rate in the Czech Republic exceeds the EU average for both sexes by more than 40 percent.

At the same time, mortality caused by diseases of the circulatory system has shown a decreasing trend since the 1980s. During the 1990s, the standardised mortality rate²⁹ of men dropped by 31 percent and that of women by 26 percent. In large measure, this trend has contributed to the abovementioned increase in life expectancy. The mortality rate caused by acute forms of cardiovascular diseases, primarily acute myocardial infarction, has also shown a decisive improvement. The decrease of mortality due to acute cardiovascular disease has been accompanied by an increase in the prevalence of chronically ill persons.

The second most frequent cause of mortality is malignant tumours. Approximately one quarter of all deaths annually are attributable to this. Although the mortality rate in this

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²⁶ Health-adjusted life expectancy is a summary measure of the equivalent number of years in full health that a newborn can expect to live based on current rates of ill health and mortality.
²⁸ Department of Demography and Geo-demography, Faculty of Natural Sciences, ‘Population Development in the Czech Republic 1990—2002’, Pavlík, Z. and M. Kučera, eds., Department of Demography and Geo-demography, Faculty of Natural Sciences, Charles University, Prague, 2002.
²⁹ WHO standard — mortality rate devoid of the influence of different age structures.
category of diseases began decreasing in the mid 1990s, its level still remains high. The standardised mortality rate of men exceeds the EU countries’ average by one quarter and in case of women by one fifth. Causes for this gap separating the Czech Republic from western countries can be found especially in the belated detection of tumours and in the poorer quality of services provided. Morbidity has been developing in quite the opposite direction. Compared to 1990, 30 percent more new cases of malignant tumours in men and 40 percent more new cases in women were recorded in 2000. As for the incidence of carcinoma of the large intestine and rectum in men and breast carcinoma in women, the Czech Republic has one of the highest in Europe and the world.

The incidence of diabetes, a common disease accompanied by grave health complications, increases every year in the Czech Republic. The total number of treated diabetics increased by 39 percent over the last 12 years, reaching over 667,000 persons in 2002 (6,538 persons per 100,000 inhabitants). Moreover, the number of complications accompanying diabetes has been on rise, pointing to failures in the system of health services.

Injuries represent a serious problem not only from the medical, but also from social and economic viewpoints. Among causes of death, injuries occupy the third place among the population as a whole and the first place among the population under 40. The 1990s saw an increase especially in the number of deaths and injuries caused by traffic accidents. The overall trend in mortality rates due to external causes has been decreasing, mainly for females. Nevertheless, current mortality levels within this group of causes are considerably higher than the EU average — 60 percent greater for males and 40 percent greater for females.
Specific issues

As regards the spread of HIV/AIDS, particular attention should be paid to groups characterized by risky behaviour, such as injecting drug users (IDUs), persons with multiple sex partners, commercial sex workers and young people engaging in high-risk sexual behaviour. The expected increase in immigration from Eastern Europe also brings a potential risk of further spread of HIV since the number of HIV-infected foreigners has been rising in recent years. At present, foreigners comprise 23 percent of all the infected people in the Czech Republic, while foreign nationals permanently residing in the Czech Republic account for 7 percent. Both groups are composed mostly of persons originating from Eastern Europe, especially Ukraine, which is now witnessing a predominantly drug-driven explosion in its HIV epidemic.

TB incidence has been affected by the intensified migration after 1989. The share of foreigners in the overall tuberculosis incidence has been increasing annually, and in 2001 already accounted for 14 percent of all newly reported cases. The homeless represent a particularly high risk group in which the TB incidence is higher than in the sheltered population. The homeless tend to be found in large cities, especially in exposed public places, and also tend to migrate. There are no official estimates of their numbers, but unofficial estimates range in tens of thousands, with most being men.

Figure 6.2

Standardised death rates caused by carcinoma in the Czech Republic and selected EU countries


POLICIES FOR GOAL ACHIEVEMENT

HIV/AIDS and tuberculosis
The reduction of the incidence of these contagious diseases requires a coordinated approach combining activities in the sphere of health support (prevention, health education, and public and social policies focused on health) and medical services (efficient and evidence-based health policy in this sphere of public services).

The Czech Republic has adopted the ‘HIV/AIDS Problem-Solving Programme’ and a network of consulting and blood-collecting centres operates in the country. Over 800,000 laboratory tests have been conducted annually in recent years. As part of precautionary measures, the testing of blood donors and pregnant women is compulsory. The HIV/AIDS incidence and spread in risk groups of injecting drug users and commercial sex workers are being monitored. In coming years it will be necessary to carry on this programme and, at the same time, expand health education programmes on sexually transmitted diseases. As regards TB, it is vital to strive for prompt bacteriological diagnostics, detection of complicated cases, implementation of the WHO treatment programme and continued national surveillance.

Chronic diseases and injuries
Despite certain indications in the first half of the 1990s and acceptance of the document Health 21, no comprehensive policy for health protection and promotion that also addresses the regional and community levels has been formulated yet. The overall efficiency of the existing health promotion policy is still very low. There are deficits mainly in the reduction of the most significant risk factors such as smoking, low physical activity, stress and bad eating habits.

Activities focused on the reduction of the morbidity and mortality rates in the category of circulatory system diseases and malignant tumours should be developed as follows:

- Priority must be given to primary prevention activities focused on the reduction of risk factors for these diseases and on the improvement of health promotion policy; this entails the elaboration and implementation of national programmes aimed at motivating the population to lead healthy lifestyles; anti-tobacco policy should play a particularly important role in this respect; and

- Health care activities in the sphere of secondary and tertiary prevention should rely primarily on early diagnostics (efficient implementation and systematic evaluation of the already launched programme ensuring screening of selected malignant tumours in men and women, and a focus on the detection of early stages of diseases) and efficient treatment.

Reduced frequency of traffic accidents, workplace accidents and household injuries will require improvements in the existing precautionary measures and coordination of multi-sectoral and interdisciplinary cooperation in resolving these issues. A higher priority should be given to the social aspects of coexistence, including domestic violence.

The success of all the abovementioned activities in health support and medical services will depend on their clear formulation, management, supervision and the evaluation of results. Public administration reforms have created space and a legal framework for the formulation of public and social policies that take into account the concept of national health, including modern forms of health support, as promoted by the European Union. Strengthening capacity in health promotion and disease prevention with stakeholders on a regional level by including these issues in regional development plans should also be a priority.

³¹ Governmental approval No 1046/2002.
Target 1: Integrate principles of sustainable development into national policies and programmes, and reverse the loss of environmental resources

For most of the monitored parameters, the state of the environment in the Czech Republic does not differ significantly from the EU and OECD averages. The share of forests and protected areas is to be stabilised while the energy use per USD 1 GDP, carbon dioxide emissions and material intensity are to decline.

Target 2: Reduce the proportion of people without access to safe drinking water and improved sanitation

Although the share of population supplied by water from public sources (89.8 percent in 2002) and those having access to public sewage systems, (77.4 percent in 2002) is relatively high, further increase is necessary.
**DESCRIPTION**

For the Czech Republic, an industrialized country, the integration of principles of sustainable development into all major national policies and programmes is a crucial aspect of policy making. Consistent integration will lead to higher efficiency in resource use, less pollution, conservation and enhancement of biodiversity, and in the end, to higher quality of life. Drinking water and sanitation are important components of quality of life, however, due to sufficient performance in achieving Target 2, the main focus in the monitoring of Goal 7 should be on Target 1.

The selected indicators allow for the evaluation of achievements, although in some cases no national targets have been set. When there are no national targets, these indicators can be unambiguously evaluated through trend analysis. It is expected that the ‘Strategy for Sustainable Development of the Czech Republic’ due to be published in 2004 will include measurable targets for those indicators.

**STATUS AND TRENDS**

**Situation in general**

The country's strategy of environmental protection is based on the 'State Environmental Policy of the Czech Republic' (SEP) with the latest version adopted in 2001. The Policy is a cross-sectional document guiding the preparation of detailed programmes for individual components of the environment and for dealing with particular environmental issues. It includes implementation methods and targets for environmental aspects of regional and sectoral policies, such as the energy, raw material, transport, agriculture and other policies. Recently, the Government has been working on the first draft of the 'National Strategy for Sustainable Development', which will provide a framework for all other strategic documents.

Significant progress was also made in EU accession negotiations in the area of the environment and Chapter 22 — Environment was provisionally closed in 2001. The European Commission accepted three requests for...

For most of the monitored parameters, the state of the environment in the Czech Republic does not differ significantly from the EU and OECD averages. The reasons for this situation, which differs greatly from the alarming situation at the end of the 1980s, lie both in the positive impact of national economic restructuring and implementation of active measures, including preparation and enforcement of new legislation in environmental protection (the Czech Parliament approved 16 environmental acts alone in 2002—2003). In addition, the SEP has had a positive effect as well. An effective administrative system was created at all levels, including a system of supporting professional institutions and extensive investments. In the absence of unforeseen events, the basic trend in the period to 2010 should be a very slight gradual improvement in the state of the environment.

**Specific issues**

There are both strengths and weaknesses in seeking a high standard in environmental parameters. The following section shows selected, important environmental issues in the Czech Republic.

Air pollution has improved significantly. Emissions of all the monitored pollutants — particulate matter, sulphur dioxide, nitrogen oxides, carbon monoxide, volatile organic compounds, heavy metals, and persistent organic pollutants — decreased by 41—90 percent during the period 1990—2002 (see Figure 7.1).

The greatest improvement can be seen for particulate matter, sulphur dioxide and lead, where a decrease of almost one order of magnitude has occurred. As a consequence, air quality has improved and stabilized for most indicators. However, specific emissions of sulphur dioxide and nitrogen oxides per capita, per unit area of territory and per GDP unit remain high and constitute a health risk as well as a risk of acidification and eutrophication.
Since 1990, there has been a consistent and significant decrease in the amounts of pollutants discharged into surface waters. Between 1990 and 2001, there was a decrease in discharged organic pollution for these indicators by approximately one order of magnitude (BOD₅ by 89.4 percent, CODCr by 81.6 percent, undissolved substances by 85.5 percent). A decrease of 32.9 percent occurred in the amount of dissolved inorganic salts. In 2002, there was stagnation in these indicators due to catastrophic floods on most of the Czech territory. An important role in water quality was played by an increase in the number of inhabitants connected to the public sewer system. The number of inhabitants living in houses connected to the public sewer system in 2002 equalled 7.99 million, i.e. 77.4 percent of the population of the Czech Republic. However, some parts of the sewer systems are not yet connected to waste water treatment plants and 22 percent of the population still lives in houses that are not connected to public sewers at all.

The Czech Republic has a large number of “environmental burdens from the past”. These include unsafe, closed landfills, contaminated industrial sites and locations used by the Soviet Army. A database of these past burdens contains 3,012 records. Extensive contamination of the geological basement and groundwater by various dangerous substances represent a serious problem for drinking water supplies and for any future use of these sites. Since 1991, studies (including risk analyses) and decontamination work were done at a cost to the state budget of approximately 1.1 billion Czech Crowns (CZK). From 1991 to 2002, the Government approved 267 contract guarantees from the National Property Fund for elimination of environmental burdens from the past in privatized enterprises, with overall guarantees totalling 142.7 billion CZK.

Transportation in the Czech Republic has become an important factor with detrimental impact on the quality of the environment. The greatest impact in this area comes from road transportation, manifested primarily as emissions and consequent urban air quality, noise, fragmentation of the landscape and disturbance of ecological systems, use of land, accident rates, etc. Technical progress in the quality of vehicles (lower noise levels, consumption and emissions) is overwhelmed by the increasing number of motor vehicles and increasing traffic density. As a result, the overall trend in environmental impact
from these sources continues to be negative. The development of transport also exhibits negative trends, i.e. from mass transit to individual means of transport and from railways to road-oriented systems.

Waste production remains high and landfilling is still the most common means of waste disposal, accounting for 20 percent of total waste in 2002. All currently operating landfills meet official standards. The recycling and reuse of waste remains low compared to advanced European countries. Primarily metal and metal-containing wastes, waste plastics, glass and collected paper are reused. Of total waste production in 2002, almost 40 percent was recycled and reused as a secondary raw material.

POLICIES FOR GOAL ACHIEVEMENT

In the immediate future, it will be necessary to concentrate on cost-effective measures to deal with environmental problems. The investments should gradually shift from “end-of-the-pipe technology” to the introduction of new “cleaner” production technologies and should utilize flexible and group regulation mechanisms and voluntary activities. It will be necessary to maintain a high level of investment in the environment and be ready to use finances provided from the Cohesion Fund and Structural Funds following accession to the EU.

The greatest emphasis in expenditures in the medium term (until the year 2010) will be shifted to the area of management of municipal waste waters. It will be necessary to construct waste water treatment plants or establish connections to a group of waste water treatment plants and build sewer systems in all municipalities or parts of municipalities with over 2000 inhabitants. Another issue is the need to update many large waste water treatment plants with a process for removal of nitrogen and phosphorus.

Another focus will be on gradual elimination of environmental burdens from the past. Decontamination work must proceed in priority areas. Preference should be given to the elimination of actual or potential sources of contamination of the groundwater. Moreover, the effectiveness of public funds expended for remediation should be monitored.

The government should support more environmentally friendly modes of transport and increase the use of public transport and railways. In land-use and transport planning it is necessary to promote measures to reduce transport demand (e.g. integrated infrastructure, etc.).
Develop a Global Partnership for Development

Goal 8

Target 1: Approach the commitments of EU and OECD in volume of financing ODA

In 2002, official development assistance amounted to approximately 50 million USD (0.065 percent of GNI). At that time, the Czech Government adopted a new concept of developmental cooperation to take it through 2007.
The Czech Republic has always played an active role in international development co-operation. During the cold war, the former Czechoslovakia provided assistance to many developing countries. Despite its ideological subtext, this co-operation brought concrete results. After 1989, during the transformation period, Czechoslovakia benefited from technical and financial assistance of advanced countries and international institutions. This external support boosted the successful transformation process — the Czech Republic stands on the verge of accession to the European Union. But at the same time, this success makes the Czech Republic committed to support development in less fortunate countries and regions throughout the world.

The government policy of development assistance for less developed countries was already renewed in 1995. The volume of received assistance was gradually decreasing and on the other hand the Czech Republic was becoming more and more involved in international development co-operation as a donor. As an emerging donor, the Czech Republic gradually increased the volume and effectiveness of development assistance in accordance with commitments of the United Nations Millennium Summit and results of related international conferences.

In its policy of development assistance, the Czech Republic adopts a multidimensional approach to the concept of poverty that is accepting that poverty reduction cannot be understood just in terms of economic development. Therefore, poverty is not just a mere lack of income, but rather a consequence of many social and environmental factors.

### STATUS AND TRENDS

#### Situation in general

**Czech Development Co-operation — supporting global partnership for development**

The advanced level of Czech education, health care, industry and other sectors ensures that the Czech Republic has all the preconditions to effectively support the international community in its aim to eliminate poverty and to reach other development goals.

In 2002, the Czech Republic provided a total amount of 1,485 million CZK (about 50 million USD) development assistance, which amounts to 0.065 percent of the

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**BOX 8.1: Official Development Assistance (ODA)**

Grants or Loans to developing countries and territories which are:
(a) undertaken by the official sector; (b) with promotion of economic development and welfare as the main objective; (c) at concessional financial terms (if a loan, having a Grant Element of at least 25 per cent). In addition to financial flows, Technical Co-operation is included in aid. Grants, Loans and credits for military purposes are excluded.
Czech GNI. An important share of funds was devoted to the benefit of the Least Developed Countries (LDCs), i.e. 69 percent — which represents 0.045 percent of the GNI.

Development assistance projects focus on sectors where the Czech Republic enjoys comparative advantages. The sectors include education (provided in the form of scholarships), environmental protection (hydrology, biodiversity), infrastructure (energy production, transport, nuclear safety), agriculture (rural development), geological survey and other priorities. The sectoral priorities of the Czech ODA include also basic social services, such as basic education (primary), health care and nutrition, safe water and sanitation. The Czech Republic is especially well placed to support the strengthening of the partner countries’ institutional capacities based on its own recent experience with the political and economic transition.

A significant part of the Czech ODA (i.e. 380 million CZK) is dedicated to the debt relief for developing countries in the period of 2004—2006 representing up to 15 percent of the overall development budget. Some progress is being made also in reducing tariffs, quotas and agricultural subsidies. The Czech Republic plays also an active role in the implementation of the Heavily Indebted Poor Countries Initiative (HIPC).

**Specific issues**

**Strengths and weaknesses**

One of the main positive aspects is the fact that the Czech Republic was one of the first countries undergoing transformation to introduce, already in 1995, the official Government policy for development assistance and foreign aid programme based on principles comparable with policies of advanced donor countries. In 1995, the process of transformation from a primarily recipient to a donor country started. This transformation process can be particularly illustrated by the graduation process of the Czech Republic within the system of the World Bank.

According to annual assessments of all line ministries involved in the implementation of the Czech development co-operation programme, a number of development projects have been completed with clearly positive results, thus making significant contribution to development goals of the international community. These results at the same time fulfil targets of the Czech foreign policy and strengthen bilateral relations with many developing and transforming countries.

Despite positive aspects of development practices to date, the Czech system of development co-operation has had to deal with several objective shortcomings, especially regarding the volume of funding, institutional capacity, efficiency and transparency. The ‘Assessment of Czech ODA programme’, which was undertaken based on the Government decision already in 2000, demonstrated the fact that the Czech Republic has failed to secure appropriate volume of funding for foreign assistance. The one-year financing cycle was proved to be inappropriate for development assistance projects, since their implementation usually requires several years. The system has not yet formed sufficient conditions for the participation of NGOs, civil society and SMEs.

**BOX 8.2: Examples of development activities financed by the Czech Government**

**Ecuador: Reforestation in the Andes (1999—2003)**

The Czech Republic is passing on its wealth of forestry experience by means of this project aimed at revitalization of deforested upper reaches of the Andes. Czech experts are using the special Czech patented Patrik technology of procoated seedlings to renew the woodland.


Through the transfer of modern poultry breeding technologies, the Czech Republic is helping to improve the nutrition of the local population. The successful implementation of this technology will support Mongolia in becoming self-sufficient in the production of poultry and eggs.


The Czech Republic is contributing to the implementation of the Ethiopian National Programme to develop water resources by training local experts who can then evaluate the supply of groundwater and carry out hydrogeological mapping in the area.
Until now, the Czech Republic is carrying out development assistance projects in more than fifty countries, which limits potential impact of development activities and significantly complicates all the monitoring and co-ordination. The establishment of uniform Project Cycle Management methodology has just started. From the institutional point of view, it seems to be necessary to build up an appropriate system of institutions ensuring the coherent implementation of development assistance, including the Czech Development Agency. Czech diplomatic missions should be more involved in implementation of development co-operation activities as well.

In early 2002, the Czech Government agreed on a new strategy (see below) which deals with all the described weaknesses. Nevertheless, the strategy itself, though a positive step forward, cannot guarantee the success, which is fully in the competence of all the development constituency stakeholders.

Legal and institutional background

The current programme of Development Co-operation is based on Government Decision № 153/1995, which allocated considerable competencies to line ministries, based on the Competency Act. This Act designates the Ministry of Foreign Affairs (MFA) as a supreme body for co-ordinating the implementation of the Czech foreign policy, taking advantage of its network of representative offices abroad. The MFA is to exercise its role as ODA co-ordinator by convening regular inter-ministerial meetings. The Treasury provides the funding for ODA financing directly, instead through the MFA budget. The tasks of MFA include, inter alia, preparing and presenting concepts of the ODA programme, setting out the territorial and sectoral priorities and estimating prospective volumes of funding and structuring of the ODA programme, preparing annual ODA plans and presenting them to the Government, providing information, maintaining ODA statistics and co-ordinating ODA activities with the EU and OECD.

In January 2002, the Government agreed on the ‘Concept of Czech ODA for 2002—2007’. Its purpose was to define new principles and priorities of development co-operation, building the whole strategy on principles of development partnership, recipient responsibility and improved efficiency and transparency.

The concept also introduced a two-phase approach to the modernisation and reform of the Czech ODA programme. While the new strategy underlines that the main responsibility for implementation of ODA projects rests with line ministries, it also deals with the role of the later on established Development Centre. The Centre, as the main supporting expert body for the Ministry of Foreign Affairs, undertakes activities like appraisal of proposals for long term programmes and specific development assistance projects, Monitoring and Evaluation, co-operation with institutions of ODA donor countries, training of experts working in the ODA programme, and co-ordinating research in the area of development assistance.

Based on the concept, the Czech Development Agency should be established, subject of the Government decision. The Agency will build upon the institutional and human capacities of the existing Development Centre.

EU membership

The Czech Republic has pledged to adopt and apply EC primary legislation in the field of development aid policy as of the date of its entry into the EU without exceptions and transitional periods. This means in particular the adoption of the obligation to coordinate its policy in the field of development cooperation and to harmonize its programmes with the EU and the member countries, including a coordinated approach in international organizations and conferences, and the assumption of the obligation to contribute to the realization of Community assistance programmes.

The opportunity of the Czech Republic to provide development and humanitarian assistance on both bilateral and multilateral
basis will not be affected. On the contrary, the Czech Republic intends to maintain and further strengthen its development co-operation programme even after its entry into the EU and to make use of the synergy and complementarity of the Community assistance programmes.

POLICIES FOR GOAL ACHIEVEMENT

As stated in the latest Human Development Report, reaching the Millennium Development Goals would require nearly doubling ODA volumes of advanced donor countries. But increasing the volume of assistance is not enough. To accelerate the progress towards the Goals, assistance should be made more effectively and should focus on stronger governance in partner countries and their increased ownership. Key principles that should govern aid practices are untying of aid, better co-ordination among donors and an increase of the volume. These are the challenges which are currently shaping the new Czech ODA programme.

The Czech Republic shall implement the following measures to support the achievement of international development goals and to become compatible with the EU and other donor countries, which are joined in the OECD:

- Concentrate development activities into selected priority countries (to reach higher impact) and formulate appropriate development programmes;
- Introduce OECD standard Project Cycle Management methodology which would also enable Czech stakeholders to actively participate in the implementation of EU development interventions;
- Introduce a new institutional framework for the Czech development co-operation, including the establishment of the Development Agency and significantly involve Czech diplomatic missions;
- Secure appropriate stability and volume of financing to reach the EU Barcelona commitment of 0.33 percent of ODA as a percentage of GNI.

---

**SOURCES CONSULTED BY GOAL**

**Goal 1**

**Goal 2**
Ministry of Education, Youth and Sport, ‘Main Goals of the Education Policy in the Czech Republic’, Ministry of Education, Youth and Sport, (Government Resolution of the Czech Republic on 7 April 1999).

**Goal 3**

**Goal 4**
Department of Demography and Geo-demography, Faculty of Natural Sciences, ‘Population Development in the Czech Republic 1990—2002’, Pavlík, Z. and M. Kučera, eds., Department of Demography and Geo-demography, Faculty of Natural Sciences, Charles University, Prague, 2002.

**Goal 5**
Department of Demography and Geo-demography, Faculty of Natural Sciences, ‘Population Development in the Czech Republic 1990—2002’, Pavlík, Z. and M. Kučera, eds., Department of Demography and Geo-demography, Faculty of Natural Sciences, Charles University, Prague, 2002.
Sources consulted by goal

**Goal 6**
Department of Demography and Geo-demography, Faculty of Natural Sciences, ‘Population Development in the Czech Republic 1990—2002,’ Pavlík, Z. and M. Kučera, eds., Department of Demography and Geo-demography, Faculty of Natural Sciences, Charles University, Prague, 2002.

**Goal 7**

**Goal 8**


EXPLANATORY NOTES

Goal 1
Absolute poverty
The status of a household and/or its members as defined by the volume of incomes the household requires in order to meet the needs of its members. A household is classified as poor when its income falls below the absolute poverty line (i.e. subsistence minimum or wage minimum).

Deciles (decile group)
A decile group is one tenth of all households arranged by their incomes from minimum to maximum. The first decile group is the first one tenth (the 10% of all household with lowest incomes). The last decile is the one tenth of the households with the highest incomes.

Gini Coefficient
The Gini coefficient measures the degree of inequality of the distribution of earnings. It is equal to zero in the case of total earnings equality and to one in the case of total inequality.

Human Development Index
The Human Development Index was designed to complement the narrow income-based measure of poverty. The index consists of three components (incomes, education and health) that intend to capture a broader field of human development. The three components cover three essential choices, to live a long and healthy life, to acquire knowledge and to have access to resources for a decent standard of living.

Incidence of Poverty
Measures the percentage of the population or of a particular population group (when analysis is disaggregated by groups) living below an established poverty line.

Nomenclature of territorial units for statistics (NUTS)
The NUTS is a single uniform breakdown of territorial units defined for EU Member States and Candidate Countries by EUROSTAT. It provides a classification or harmonization of measurement of sub-national regions and administrative levels for the purposes of regional comparisons. The aim of using NUTS is to ensure that regions of comparable size all appear at the same level, making it possible to compare policies from one country at a certain NUTS level with policies from another country at the same NUTS level.

OECD equivalence scale
Adjustment coefficient used to reflect the economies of scale in households of different size and composition, so that per capita income and expenditures comparisons between them are relevant. This adjustment is based on the assumption that certain household expenditures are independent of the number of household members. OECD equivalence scales assigns the coefficient 1 to the first household member, 0.5 to the second household member, and 0.3 to a child when calculating household incomes per capita. Thus applying equivalence scales to poverty analysis, a three-member household receiving a total of 1200 € from all possible sources would be treated as having per capita household incomes = 1200/(1 + 0.5 + 0.3) = 666.7 € (and not 400 € as it would appear from an unweighted average).

Poverty
Poverty is the status of well-being of the individual and/or household. Because of its multidimensional there are different ways to measure it and various definitions. Depending on the approach to measurement, we distinguish between “absolute” and “relative” poverty. Depending on its definition, we distinguish between “income poverty” (reduced to purely economic dimensions, defining poverty in terms of income or consumption) and “human poverty” (which
takes a sustainable livelihoods approach to poverty and draws on three perspectives of poverty: income, basic needs and capability). Since “human poverty” measurement is difficult and often controversial, poverty analysis uses primarily absolute and relative poverty.

**Purchasing Power Parity (PPPs)**
PPPs is a way of expressing the value of GDP or incomes from different countries (usually with different price structures) through the use of a common denominator allowing international comparisons. The need for such common denominator comes from the fact that the price proportions of different goods in a consumer basket are different in different countries hence converting the national currency values to USD using a standard exchange rate is not sufficient to reflect different real costs of living across countries. The GDP value expressed in PPP$ reflects what the real incomes of the population would have been if the price structure in the country was similar to those in the US.

**Relative poverty**
Unlike absolute poverty, which is determined by a fixed value (minimum incomes or expenditures necessary for survival), the relative poverty is poverty vis-à-vis others. The poverty threshold in this case is derived from the incomes or expenditures of other households (most often the value of 60 % of median equivalent income is used).

**Social exclusion**
Social exclusion is a concept reflecting the inequality of individuals or entire groups of a population in their participation in the life of society. Social exclusion can be associated with limited or blocked access to the social system or long-term unemployment based on various factors, such as group characteristics related to ethnic affiliation or sexual orientation, health status (HIV-AIDS), or socially stigmatized categories (e.g., ex-prisoners or drug abusers).

**Goal 2**

**Enrolment Rates (gross and net)**
A gross enrolment rate expresses the total number of children of any age group enrolled in a schooling level for that group as a percentage of the total number of children attending that school level. Net enrolment rate only includes those children who are from the age group supposed to attend this particular educational level. This means that ‘repeaters’ are counted in the gross enrolment rate (ER) but not in the net ER explaining why most often gross ER is higher than net ER.

**International Adult Literacy Survey (IALS)**
The International Adult Literacy Survey database was a seven-country initiative conducted in the fall of 1994. Its goal was to create comparable literacy profiles across national, linguistic and cultural boundaries. The survey also offers the world’s only source of comparative data on participation in adult education and training. A second and a third round of data collection of IALS were conducted in 1996.

**International Standard Classification of Education (ISCED)**
ISCED was designed by UNESCO in the early 1970s to serve as an instrument suitable for assembling, compiling and presenting statistics of education both within individual countries and internationally.
Program for International Student Assessment (PISA)
PISA is a three-yearly survey of the knowledge and skills of 15-year-olds in the principal industrialized countries done by the OECD. The survey consists of 265,000 students from 32 countries. It assesses to what extent students near the end of compulsory education have acquired the knowledge and skills essential for full participation in society. It presents evidence on student performance in reading, mathematical and scientific literacy, reveals factors that influence the development of these skills at home and at school, and examines implications for policy development.

Third International Mathematics and Science Survey (TIMSS)
Offered in 1995, 1999, and 2003, TIMSS provides trend data on students’ mathematics and science achievement from an international perspective. TIMSS 1999 was conducted by the International Study Center at Boston College and included 38 countries. The 1999 assessment measured the mathematics and science achievements of eighth-grade students (ages 13 and 14 years) and collected extensive information from students, teachers, and school principals about mathematics and science curricula, instruction, home contexts, and school characteristics and policies.

Goal 3
Proportion of seats held by women in national parliaments
The number of seats held by women, expressed as a percentage of all occupied seats.

Ratio of girls to boys in primary, secondary and tertiary education
The ratio of the number of female to male students enrolled at primary, secondary and tertiary levels in public and private schools.

Goal 4
Child mortality
The number of deaths of children under the age of five per 1,000 live births.

Infant mortality
The number of deaths of children under the age of one per 1,000 live births.

Goal 5
Maternal mortality rate
The maternal mortality ratio is the number of women who die from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 live births.

<table>
<thead>
<tr>
<th>Name of level</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-primary education</td>
<td>0</td>
</tr>
<tr>
<td>Primary education</td>
<td>1</td>
</tr>
<tr>
<td>First stage of basic education</td>
<td>2</td>
</tr>
<tr>
<td>Lower secondary education</td>
<td>3</td>
</tr>
<tr>
<td>Second stage of basic education</td>
<td>4</td>
</tr>
<tr>
<td>(Upper) secondary education</td>
<td>5</td>
</tr>
<tr>
<td>Post-secondary non tertiary education</td>
<td>6</td>
</tr>
<tr>
<td>First stage of tertiary education (not leading directly to an advanced research qualification)</td>
<td>7</td>
</tr>
<tr>
<td>Second stage of tertiary education (leading to an advanced research qualification)</td>
<td>8</td>
</tr>
</tbody>
</table>
Goal 6
HIV/AIDS prevalence rate
The proportion of individuals in a population who have HIV at a specific point in time. UNAIDS normally reports HIV prevalence among adults, aged 15—49.

Tuberculosis (TB) prevalence rate
Tuberculosis (TB) prevalence is the number of cases of TB per 100,000 people. Death rates associated with TB are deaths caused by TB per 100,000 people.

Goal 7
Carbon dioxide emissions
Carbon dioxide emissions per capita are given by the total amount of carbon dioxide emitted by a country as a consequence of human (production and consumption) activities, divided by the population of the country.

Proportion of the population with sustainable access to an improved water source, urban and rural
Percentage of the population who use any of the following types of water supply for drinking: piped water, public tap; borehole/pump; protected well; protected spring; rainwater.

Proportion of the urban and rural population with access to improved sanitation
Refers to the percentage of the population with access to facilities which hygienically separates human excreta from human, animal, and insect contact.
## NATIONAL MDG TARGETS AND INDICATORS

### Goal 1: Eradicate extreme poverty and hunger

<table>
<thead>
<tr>
<th>Target 1: Reduce poverty among single mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Indicator: Low income rate of single mothers (in %)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target 2: Reduce long-term unemployment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Indicator: Long-term unemployment rate (per labour force, in %)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target 3: Reduce the number of recipients of social benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Indicator: Number of recipients of social benefits (in thousands)</td>
</tr>
</tbody>
</table>

### Goal 2: Achieve universal primary education

<table>
<thead>
<tr>
<th>Target 1: Enable three quarters of young people to pass secondary education at grammar or technical schools</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Indicator: The share of newly-enrolled students at grammar or technical schools per the size of the respective population group of 15 (or 14) year-olds (in %)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target 2: Ensure one half of the related age group the opportunity to enter one of the forms of tertiary education</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Indicator: The share of newly-enrolled students in tertiary education per the size of the population group of 19 (or 18) year-olds (in %)</td>
</tr>
</tbody>
</table>

### Goal 3: Promote gender equality and empower women

<table>
<thead>
<tr>
<th>Target 1: Reduce differences in the earnings of men and women</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Indicator: Ratio of women's earnings to men's earnings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target 2: Improve the position of women in decision-making processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Indicator: Participation of women in the Senate and the Parliament (in %)</td>
</tr>
</tbody>
</table>

### Goal 4: Reduce child mortality

<table>
<thead>
<tr>
<th>Target 1: Maintain the attained low level of infant and perinatal mortality</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Indicator: Infant mortality (per thousand live births)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target 2: Reduce the number of children with congenital malformations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Indicator: Live-born children with congenital malformations per 10,000 live births</td>
</tr>
</tbody>
</table>

### Goal 5: Improve maternal health

<table>
<thead>
<tr>
<th>Target 1: Create favourable conditions for childbearing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Indicator: Total fertility rate (per 1 woman)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target 2: Strengthen reproductive health</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Indicator: Maternal mortality rate (per 100,000 live births)</td>
</tr>
</tbody>
</table>

| 2. Indicator: Share of deliveries assisted by skilled personnel (in %) | 98.5 (2001) | 99 |
### Goal 6: Combat HIV/AIDS, malaria and other diseases

<table>
<thead>
<tr>
<th>Target</th>
<th>2002</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Indicator: Life expectancy at birth, Males/Females</td>
<td>72.1/78.5</td>
<td>75/81</td>
</tr>
<tr>
<td>2. Indicator: Standardised mortality rate caused by diseases of the circulatory system, Males/Females (per 100,000 citizens — European standard)</td>
<td>561/379</td>
<td>350/210</td>
</tr>
<tr>
<td>3. Indicator: Standardised mortality rate caused by diseases of malignant tumours, Males/Females (per 100,000 citizens — European standard)</td>
<td>323/175</td>
<td>280—300/160—170</td>
</tr>
</tbody>
</table>

### Target 2: Reduce incidence of injuries and their after-effects

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2002</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardised mortality rate due to external causes, Males/Females (per 100,000 citizens — European standard)</td>
<td>91/33</td>
<td>58/23</td>
</tr>
</tbody>
</table>

### Target 3: Maintain incidence of HIV/AIDS and tuberculosis at least at the existing level

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2002</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS incidence (per 1 million citizens)</td>
<td>4.8</td>
<td>5 and fewer</td>
</tr>
<tr>
<td>Tuberculosis incidence (per 100,000 citizens)</td>
<td>11.8</td>
<td>12 and fewer</td>
</tr>
</tbody>
</table>

### Goal 7: Ensure environmental sustainability

<table>
<thead>
<tr>
<th>Target</th>
<th>2002</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Indicator: Proportion of land area covered by forest (in %)</td>
<td>33.5</td>
<td>steady or increase</td>
</tr>
<tr>
<td>2. Indicator: Ratio of protected area to surface area for maintenance of biological diversity (in %)</td>
<td>15.9</td>
<td>increase</td>
</tr>
<tr>
<td>3. Indicator: Energy use (kg oil equivalent) per USD 1 GDP (PPP)</td>
<td>0.29 (2001)</td>
<td>decrease</td>
</tr>
<tr>
<td>5. Indicator: Material intensity (Total Material Requirements in tonnes per capita)</td>
<td>65.5 (2000)</td>
<td>decrease</td>
</tr>
</tbody>
</table>

### Target 2: Reduce the proportion of people without access to safe drinking water and improved sanitation

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2002</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of population with sustainable access to an improved water source, urban and rural (in %)</td>
<td>89.8</td>
<td>increase</td>
</tr>
<tr>
<td>Proportion of urban population with access to improved sanitation (in %)</td>
<td>77.4</td>
<td>increase</td>
</tr>
</tbody>
</table>

### Goal 8: Develop a global partnership for development

<table>
<thead>
<tr>
<th>Target</th>
<th>2002</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Indicator: Net ODA as a percentage of GNI</td>
<td>0.065</td>
<td>0.13</td>
</tr>
<tr>
<td>2. Indicator: Net ODA to LDCs as a percentage of GNI</td>
<td>0.045</td>
<td>n.a.</td>
</tr>
</tbody>
</table>
### MILLENNIUM DEVELOPMENT GOALS

<table>
<thead>
<tr>
<th>Goal 1: <strong>Eradicate extreme poverty and hunger</strong></th>
<th>Indicators for monitoring progress</th>
</tr>
</thead>
</table>
| **Target 1:** Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day | 1. Proportion of population below $1 (PPP) per day<sup>1</sup>  
2. Poverty gap ratio [incidence x depth of poverty]  
3. Share of poorest quintile in national consumption |
| **Target 2:** Halve, between 1990 and 2015, the proportion of people who suffer from hunger | 4. Prevalence of underweight children under five years of age  
5. Proportion of population below minimum level of dietary energy consumption |

<table>
<thead>
<tr>
<th>Goal 2: <strong>Achieve universal primary education</strong></th>
<th></th>
</tr>
</thead>
</table>
| **Target 3:** Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling | 6. Net enrolment ratio in primary education  
7. Proportion of pupils starting grade 1 who reach grade 5  
8. Literacy rate of 15—24 year-olds |

<table>
<thead>
<tr>
<th>Goal 3: <strong>Promote gender equality and empower women</strong></th>
<th></th>
</tr>
</thead>
</table>
| **Target 4:** Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015 | 9. Ratios of girls to boys in primary, secondary and tertiary education  
10. Ratio of literate females to males of 15—24 year-olds  
11. Share of women in wage employment in the nonagricultural sector  
12. Proportion of seats held by women in national parliament |

<table>
<thead>
<tr>
<th>Goal 4: <strong>Reduce child mortality</strong></th>
<th></th>
</tr>
</thead>
</table>
| **Target 5:** Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate | 13. Under-five mortality rate  
14. Infant mortality rate  
15. Proportion of 1 year-old children immunised against measles |

<table>
<thead>
<tr>
<th>Goal 5: <strong>Improve maternal health</strong></th>
<th></th>
</tr>
</thead>
</table>
| **Target 6:** Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio | 16. Maternal mortality ratio  
17. Proportion of births attended by skilled health personnel |

<table>
<thead>
<tr>
<th>Goal 6: <strong>Combat HIV/AIDS, malaria and other diseases</strong></th>
<th></th>
</tr>
</thead>
</table>
| **Target 7:** Have halted by 2015 and begun to reverse the spread of HIV/AIDS | 18. HIV prevalence among 15—24 year old pregnant women  
19. Condom use rate of the contraceptive prevalence rate<sup>2</sup>  
20. Number of children orphaned by HIV/AIDS<sup>3</sup> |
| **Target 8:** Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases | 21. Prevalence and death rates associated with malaria  
22. Proportion of population in malaria risk areas using effective malaria prevention and treatment measures<sup>4</sup>  
23. Prevalence and death rates associated with tuberculosis  
24. Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS) |

<table>
<thead>
<tr>
<th>Goal 7: <strong>Ensure environmental sustainability</strong></th>
<th></th>
</tr>
</thead>
</table>
| **Target 9:** Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources | 25. Proportion of land area covered by forest  
26. Ratio of area protected to maintain biological diversity to surface area  
27. Energy use (kg oil equivalent) per $1 GDP (PPP)  
28. Carbon dioxide emissions (per capita) and consumption of ozone-depleting CFCs (ODP tons)  
29. Proportion of population using solid fuels |
| **Target 10:** Halve, by 2015, the proportion of people without sustainable access to safe drinking water | 30. Proportion of population with sustainable access to an improved water source, urban and rural |
| **Target 11:** By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers | 31. Proportion of urban population with access to improved sanitation  
32. Proportion of households with access to secure tenure (owned or rented) |
### Goal 8: Develop a global partnership for development

<table>
<thead>
<tr>
<th>Target 12:</th>
<th>Develop further an open, rule-based, predictable, non-discriminatory trading and financial system</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Includes a commitment to good governance, development, and poverty reduction — both nationally and internationally</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target 13:</th>
<th>Address the special needs of the least developed countries</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Includes: tariff and quota free access for least developed countries' exports; enhanced programme of debt relief for HIPC and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target 14:</th>
<th>Address the special needs of landlocked countries and small island developing States</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target 15:</th>
<th>Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Target 16:</th>
<th>In co-operation with developing countries, develop and implement strategies for decent and productive work for youth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>45. Unemployment rate of 15—24 year-olds, each sex and total</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target 17:</th>
<th>In co-operation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>46. Proportion of population with access to affordable essential drugs on a sustainable basis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Target 18:</th>
<th>In co-operation with the private sector, make available the benefits of new technologies, especially information and communications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>47. Telephone lines and cellular subscribers per 100 population</td>
</tr>
<tr>
<td></td>
<td>48. Personal computers in use per 100 population and Internet users per 100 population</td>
</tr>
</tbody>
</table>

The Millennium Development Goals and targets come from the Millennium Declaration signed by 189 countries, including 147 Heads of State, in September 2000 (www.un.org/documents/ga/res/55/a55r002.pdf - A/RES/55/2). The goals and targets are inter-related and should be seen as a whole. They represent a partnership between the developed countries and the developing countries determined, as the Declaration states, “to create an environment — at the national and global levels alike — which is conducive to development and the elimination of poverty.”

- For monitoring country poverty trends, indicators based on national poverty lines should be used, where available.
- Amongst contraceptive methods, only condoms are effective in preventing HIV transmission. The contraceptive prevalence rate is also useful in tracking progress in other health, gender and poverty goals. Because the condom use rate is only measured amongst women in union, it will be supplemented by an indicator on condom use in high risk situations. These indicators will be augmented with an indicator of knowledge and misconceptions regarding HIV/AIDS by 15—24 year-olds (UNICEF — WHO).
- To be measured by the ratio of proportion of orphans to non-orphans aged 10-14 who are attending school.
- Prevention to be measured by the % of under 5s sleeping under insecticide treated bednets; treatment to be measured by % of under 5s who are appropriately treated.
- OECD and WTO are collecting data that will be available from 2001 onwards.
- An improved measure of the target is under development by ILO for future years.
## EU INDICATORS OF SOCIAL EXCLUSION

### Primary indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Definition</th>
<th>Data sources + most recent year available</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>Low income rate after transfers with breakdowns by age and gender</td>
<td>Percentage of individuals living in households where the total equivalised household income is below 60% national equivalised median income. Age groups are: 1. 0 — 15, 2. 16 — 24, 3. 25 — 49, 4. 50 — 64, 5. 65+. Gender breakdown for all age groups + total</td>
</tr>
<tr>
<td>1b</td>
<td>Low income rate after transfers with breakdowns by most frequent activity status</td>
<td>Percentage of individuals aged 16+ living in households where the total equivalised household income is below 60% national equivalised median income. Most frequent activity status: 1. employed, 2. self-employed, 3. unemployed, 4. retired, 5. inactives-other. Gender breakdown for all categories + total</td>
</tr>
<tr>
<td>1c</td>
<td>Low income rate after transfers with breakdowns by household type</td>
<td>Percentage of individuals living in households where the total equivalised household income is below 60% national equivalised median income. 1. 1 person household, under 30 years old 2. 1 person household, 30—64 3. 1 person household 65+ 4. 2 adults without dependent child, at least one person 65+ 5. 2 adults without dependent child, both under 65 6. other households without dep. Children 7. single parents, dependent child 1+ 8. 2 adults, 1 dependent child 9. 2 adults, 3+ dependent children 10. 2 adults, 3+ dependent children 11. other households with dependent children 12. total</td>
</tr>
<tr>
<td>1d</td>
<td>Low income rate after transfers with breakdowns by tenure status</td>
<td>Percentage of individuals living in households where the total equivalised household income is below 60% national equivalised median income. 1. Owner or rent free 2. Tenant 3. Total</td>
</tr>
<tr>
<td>1e</td>
<td>Low income threshold (Illustrative values)</td>
<td>The value of the low income threshold (60% median national equivalised income) in PPS, Euro and national currency for: 1. Single person household 2. Household with 2 adults, two children</td>
</tr>
<tr>
<td>2</td>
<td>Distribution of income</td>
<td>S80/S20: Ratio between the national equivalised income of the top 20% of the income distribution to the bottom 20%.</td>
</tr>
<tr>
<td>3</td>
<td>Persistence of low income</td>
<td>Persons living in households where the total equivalised household income was below 60% median national equivalised income in year n and (at least) two years of years n—1, n—2, n—3. Gender breakdown + total</td>
</tr>
<tr>
<td>4</td>
<td>Relative median low income gap</td>
<td>Difference between the median income of persons below the low income threshold and the low income threshold, expressed as a percentage of the low income threshold. Gender breakdown + total</td>
</tr>
<tr>
<td>5</td>
<td>Regional cohesion</td>
<td>Coefficient of variation of employment rates at NUTS 2 level</td>
</tr>
<tr>
<td>6</td>
<td>Long term unemployment rate</td>
<td>Total long-term unemployed population (≥12 months; ILO definition) as proportion of total active population; Gender breakdown + total</td>
</tr>
</tbody>
</table>
## EU indicators of social exclusion

<table>
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<tr>
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</thead>
<tbody>
<tr>
<td>7</td>
<td>Persons living in jobless households</td>
<td>Persons aged 0—65 (0—60) living in households where none is working out of the persons living in eligible households. Eligible households are all except those where everybody falls in one of these categories: • aged less than 18 years old • aged 18—24 in education and inactive • aged 65 (60) and over and not working</td>
<td>Eurostat LFS 2000</td>
</tr>
<tr>
<td>8</td>
<td>Early school leavers not in education or training</td>
<td>Share of total population of 18—24-year olds having achieved ISCED level 2 or less and not attending education or training. Gender breakdown + total</td>
<td>Eurostat LFS 2000</td>
</tr>
<tr>
<td>9</td>
<td>Life expectancy at birth</td>
<td>Number of years a person may be expected to live, starting at age 0, for Males and Females</td>
<td>Eurostat demografická statistika</td>
</tr>
<tr>
<td>10</td>
<td>Self defined health status by income level</td>
<td>Ratio of the proportions in the bottom and top quintile groups (by equivalised income) of the population aged 16 and over who classify themselves as in a bad or very bad state of health on the WHO definition Gender breakdown + total</td>
<td>Eurostat ECHP 1997</td>
</tr>
</tbody>
</table>

### Secondary indicators

<table>
<thead>
<tr>
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<th>Indicator</th>
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</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>Dispersion the low income threshold</td>
<td>Persons living in households where the total equivalised household income was below 40, 50 and 70% median national equivalised income</td>
<td>Eurostat ECHP 1997</td>
</tr>
<tr>
<td>13</td>
<td>Low income rate before transfers</td>
<td>Relative low income rate where income is calculated as follows: 1. Income excluding all social transfers 2. Income including retirement pensions and survivors pensions. 3. Income-after all social transfers (= indicator) Gender breakdown + total</td>
<td>Eurostat ECHP 1997</td>
</tr>
<tr>
<td>14</td>
<td>Gini coefficient</td>
<td>The relationship of shares of the population arranged according to the level of income, to the cumulative share of the total amount received by them</td>
<td>Eurostat ECHP 1997</td>
</tr>
<tr>
<td>15</td>
<td>Persistence of low income (below 50% of median income)</td>
<td>Persons living in households where the total equivalised household income was below 50% median national equivalised income in year n and (at least) two years of years n−2, n−3. Gender breakdown + total</td>
<td>Eurostat ECHP 1997</td>
</tr>
<tr>
<td>16</td>
<td>Long term unemployment share</td>
<td>Total long-term unemployed population (≥12 months; ILO definition) as proportion of total unemployed population; Gender breakdown + total</td>
<td>Eurostat LFS 2000</td>
</tr>
<tr>
<td>17</td>
<td>Very long term unemployment rate</td>
<td>Total very long-term unemployed population (≥24 months; ILO definition) as proportion of total active population; Gender breakdown + total</td>
<td>Eurostat LFS 2000</td>
</tr>
<tr>
<td>18</td>
<td>Persons with low educational attainment</td>
<td>Educational attainment rate of ISCED level 2 or less for adult education by age groups (25—34, 35—44, 45—54, 55—64). Gender breakdown + total</td>
<td>Eurostat LFS 2000</td>
</tr>
</tbody>
</table>

Note: ECHP — European Community Household Panel; LFS — Labour Force Survey

UNDP is the UN’s global development network, advocating for change and connecting countries to knowledge, experience and resources to help people build a better life. We are on the ground in 166 countries, working with them on their own solutions to global and national development challenges. As they develop local capacity, they draw on the people of UNDP and our wide range of partners. World leaders have pledged to achieve the Millennium Development Goals, including the overarching goal of cutting poverty in half by 2015. UNDP’s network links and coordinates global and national efforts to reach these Goals.