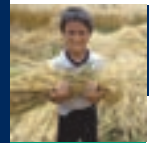


Millennium Development Goals

Progress and Prospects
in Europe and Central Asia



The World Bank

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Acronyms and Abbreviations

AIDS	acquired immune deficiency syndrome
CIS	Commonwealth of Independent States
ECA	Europe and Central Asia
EU	European Union
HIV	human immunodeficiency virus
MDG	Millennium Development Goal
TMD	TransMONEE Database
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WDI	World Development Indicators
WHO	World Health Organization

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The MDGs as a framework for measuring progress

The countries of Europe and Central Asia, even with recent economic growth and institutional strengthening, still face the challenge of meeting many of the MDGs

In 2005, with just a decade left to achieve the Millennium Development Goals (MDGs), the international development community is taking stock of the implementation of the UN's Millennium Declaration and discussing how to accelerate progress toward the MDGs. The MDG agenda emphasizes reducing poverty in all its dimensions, focusing on the poorest. The countries of Europe and Central Asia (ECA), even with recent economic growth and institutional strengthening, still face the challenge of meeting many of the MDGs. And some parts of the region are lagging much farther behind than others.

The MDGs have become widely accepted as a framework for measuring development progress globally, but the ECA region requires special consideration.¹ For example, the use of some indicators might not be appropriate: 1990 as a baseline for measuring progress given the turmoil in the region at that time, when most countries were on the brink of independence; the \$1 a day poverty line given the high spending on heat, winter clothing, and food; maternal/female infection rates even though the majority of reported HIV/AIDS infections are among young people; and child mortality rates given high adult mortality rates.

This publication provides data for key MDG indicators compiled from multiple sources for ECA countries from 1990 onward. It provides a snapshot of the region's progress toward meeting the global MDGs.

(Because the MDG for developing a global partnership for development is hard to measure or predict it is not covered here.)

Unlike the World Bank's *Global Monitoring Report*, which evaluates the progress of the ECA region toward achieving the MDGs, the purpose of this publication is to focus on MDGs country by country. According to the *Global Monitoring Report* for 2005, the ECA region is on target to meet three of the seven goals: for poverty, education, and gender. Looking at the MDGs country by country, eight of the ECA countries are likely to achieve five of the seven MDGs, and Poland and Hungary are expected to meet all seven. Tajikistan is not likely to achieve any.

Perhaps the best outcomes are on the MDG for gender equality in schools—because of the ECA region's tradition of equal access to education. By contrast, the health

MDGs present the largest challenge, with HIV/AIDS and tuberculosis emerging as particular concerns.

This publication assesses the prospects for four regional clusters: European Union 8 (EU8), Southeastern Europe and Turkey, middle-income CIS, and lower income CIS. Within these groups the EU8 countries are most likely to meet the MDGs, while the prospects are mixed, especially in health, for the lower income CIS countries.

The Millennium Development Goals

1. Eradicate extreme poverty and hunger
2. Achieve universal primary education
3. Promote gender equality and empower women
4. Reduce child mortality
5. Improve maternal health
6. Combat HIV/AIDS, malaria, and other diseases
7. Ensure environmental sustainability
8. Develop a global partnership for development

The complete MDG framework—with 8 goals, 18 targets, and 48 indicators—is set out at the end of this publication.

Europe and Central Asia—an overview

2

The ECA region includes the Commonwealth of Independent States (CIS) and the countries of Central and Eastern Europe—28 countries in all.² It occupies a land area of 24 million square kilometers, is home to 473 million people, and has diverse economic, political, and social structures. Estonia is the smallest country, with 1.4 million people, and Russia the largest, with 144.8 million. The Slovak Republic, with 5.4 million people, is at the median. The lowest population densities are in Kazakhstan, with 6 people per square kilometer, and Russia, with 9. Armenia, with 135 people per square kilometer, has the highest density. Tajikistan and the Kyrgyz Republic are the most rural, with almost two-thirds of the people in rural areas. Russia and Turkey are the most urban, with more than

three-fourths of their people in towns and cities. (For a map of the region and list of countries by subgroup, see p. 60.)

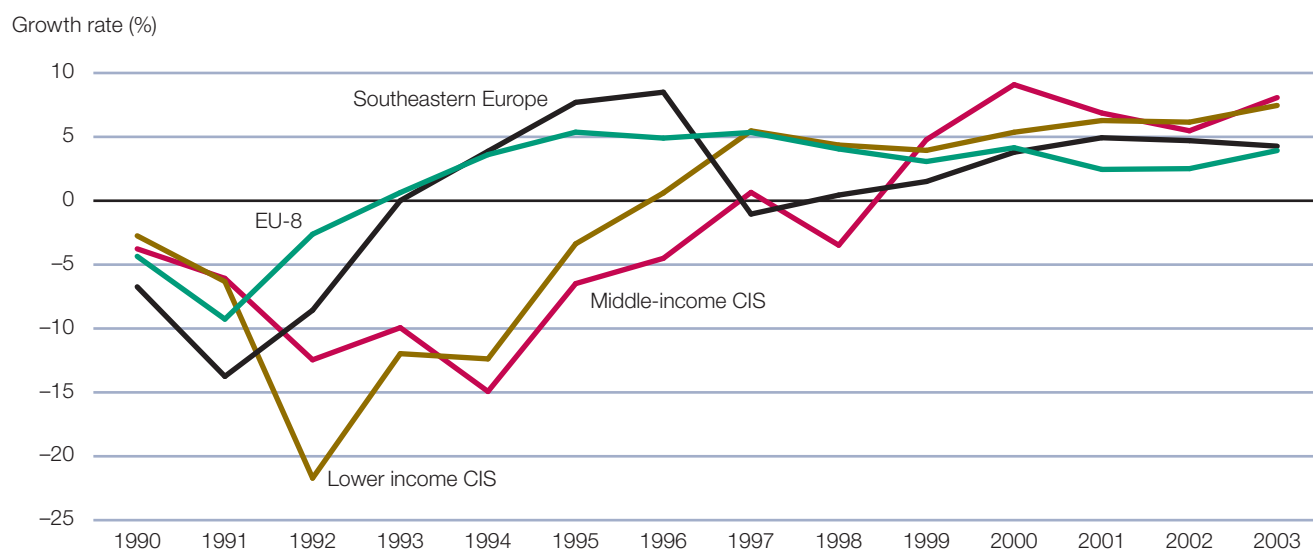
ECA growth, decline, and recovery

The breakup of the former Soviet Union in 1991 led to massive changes in the region's political and economic structures. In many countries the drastic declines in gross domestic product (GDP) and trade, the imposition of tough budget constraints, and the underdeveloped infrastructure all contributed to a reduction in the well-being of their people.³ With marked declines in real wages, reduced access to health services, and declines in other determinants of human development, poverty became more widespread. Regionwide, poverty was rising faster

than anywhere else in the world during most of the 1990s.

Since this upheaval there has been a robust turnaround, with all countries having begun to experience positive economic growth. The EU8 and Southeastern European countries were the first to return to positive growth in the early 1990s, followed by the lower and middle-income CIS countries in the mid 1990s. Despite this strong growth it took until 2004 for the region to return to the GDPs recorded in 1990. And differences within the region have become more pronounced, with incomes ranging from \$11,920 per capita in Slovenia to \$210 per capita in Tajikistan. Growth is likely to continue, but at a slower pace than in recent years.

After an initial sharp decline, the CIS is now the fastest growing ECA subregion



Source: National authorities and World Bank estimates.

There has been a robust turnaround, with all countries having begun to experience positive economic growth

The benefits of EU accession

On May 1, 2004, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, the Slovak Republic, and Slovenia joined the European Union (EU). Bulgaria and Romania are expected to join by 2007.

EU members have set up common institutions, to which they delegate some of their sovereignty so that decisions on specific matters of joint interest can be made democratically at the European level. Membership of the European Union promises many indirect and long-term benefits such as freer movement of goods, capital, and services in the single market, sharing of research and development, and economic and social cohesion. Applicant countries can get financial and technical support for restructuring economies and strengthening democracy. And through its economic and social cohesion funds, the European Union channels financial assistance to members, aimed at reducing inequalities between different regions and social groups. Aspiring members consider that the potential benefits from gaining access to large EU markets and receiving EU transfers are likely to outweigh the costs of opening their markets and adjusting to the institutional framework, laws, and rules of the European Union.

Indeed, the prospect of joining to European Union has helped anchor reforms in the better performing states of Central Europe—and during the late 1990s it was a spur to peace and reconciliation in Southeastern Europe.

MDG Plus

Since the European Union 8 appear likely to achieve most of the MDGs, they have placed the bar much higher by introducing “MDG-plus” targets—a set of ambitious targets for poverty reduction, education, gender equality, health, and environment. Most ECA countries have also developed an MDG-plus agenda, one that goes beyond the global goals to mitigate social and economic risks. Such strategies might include goals to:

- Halt the spread of poverty among Roma and reduce the number of Roma living in settlements.
- Increase GDP spending on education and science to reach the OECD average.
- Reduce the gap between men’s and women’s pay.
- Reduce teen pregnancy.
- Reduce greenhouse gas emissions.

Even so, the MDGs are still relevant because disaggregations of national data by region, ethnic group, or gender may reveal pockets where the targets are less likely to be achieved.

Prospects of meeting the MDGs

Progress toward achieving the global MDGs has been assessed for all ECA countries using simple linear trends of progress since 1990, with estimates providing possible endpoints based on current performance.⁴ (See data issues in assessing progress toward the MDGs on pages 9–10.)

EU8 likely to meet MDGs...except HIV/AIDS in the Baltics

The EU8 have either already achieved or are likely to achieve more than 80 percent of the MDGs at the national level. But the MDG for HIV/AIDS and other diseases appears most at risk of not being achieved. The prevalence of HIV/AIDS is high in the Baltics and increasing in neighboring countries to the East, such as Ukraine, Belarus, and Moldova, where public health conditions are also rapidly deteriorating. Widespread unemployment and economic insecurity make these countries fertile for an HIV epidemic. Unprecedented numbers of young people are not finishing secondary school, and with jobs in short supply many risk joining the vulnerable groups of injecting drug users and regular or occasional sex workers.

Most Southeastern European countries are likely to meet the MDGs... but Albania, Romania, and Turkey are vulnerable

This group has already achieved or is likely to achieve just over half the MDGs. The MDG for HIV/AIDS and other diseases is an issue for several countries, including Bulgaria and Romania, both EU candidates. Romania and Turkey are each unlikely to meet at least one MDG. Given the rising incidence of tuberculosis, Romania will probably fail to meet the MDG for HIV/AIDS and other communicable diseases. Turkey appears unlikely to achieve the MDG for gender equality—even though its gender gap has been closing, girls are significantly underrepresented in primary and secondary schools.

Achieving health MDGs will be a significant problem for the middle-income CIS countries

This group is likely to achieve more than 50 percent of the MDGs, but unlikely to achieve 20 percent of them—all related to health. None of these countries is likely to meet the MDG for HIV/AIDS and other diseases. Indeed, 96 percent of all people infected with HIV/AIDS in the region live in these four countries. Under-five mortality is also an issue for Russia and Kazakhstan, with neither likely to achieve the MDG. Compared with countries at similar incomes in other regions, infant and child mortality in the ECA region are relatively low while adult mortality is high. For middle-income CIS countries, proportionately higher gains in life expectancy could come from reducing adult mortality through the control of noncommunicable diseases than from achieving targets related to child and maternal mortality.

Only the gender equity MDG is on track for lower income CIS countries

This group faces particularly difficult challenges—with the prospects of meeting most MDG targets either unlikely or too hard to call. Moldova is unlikely to meet four MDGs, Georgia five, and Tajikistan six. The health MDGs are of a particular concern, with none of the countries likely to meet the MDG for HIV/AIDS and other diseases and a few unlikely to meet the MDGs for child and maternal mortality. This is the only ECA subregion where, based on current trends, several lower income countries are not likely to achieve the MDG for income poverty.

Prospects of ECA countries achieving the global MDGs

EU8	MDG1 Income Poverty	MDG2 School enrollment	MDG3 Gender equality in school	MDG4 Child mortality	MDG5 Maternal mortality	MDG6 HIV/AIDS, malaria, and other diseases	MDG7 Water access
Slovenia	Likely	Likely	Likely	Likely	Likely	Likely	No data
Czech Republic	Likely	Maybe	Likely	Likely	Likely	Likely	No data
Hungary	Likely	Likely	Likely	Likely	Likely	Likely	No data
Estonia	Likely	Likely	Likely	Likely	Likely	Unlikely	No data
Poland	Likely	Likely	Likely	Likely	Likely	Likely	No data
Slovak Republic	Likely	Maybe	Likely	Likely	Likely	Likely	No data
Lithuania	Likely	Likely	Likely	Likely	Likely	Maybe	No data
Latvia	Likely	Maybe	Likely	Likely	Likely	Maybe	No data

Southeastern Europe

Croatia	Likely	Maybe	Likely	Likely	Likely	Likely	No data
Turkey	Maybe	Maybe	Unlikely	Likely	No data	Likely	Likely
Romania	Likely	Maybe	Likely	Likely	Likely	Unlikely	Maybe
Bulgaria	Maybe	Likely	Likely	Likely	Likely	Maybe	Likely
Macedonia, FYR	Likely	Likely	Maybe	Likely	Likely	Likely	No data
Serbia and Montenegro	No data	Maybe	Likely	Likely	Likely	Likely	Likely
Albania	Maybe	Likely	Likely	Likely	Maybe	Maybe	Maybe
Bosnia and Herzegovina	No data	Likely	Likely	Likely	Likely	Likely	Likely

Middle-income CIS

Russian Federation	Likely	Likely	Likely	Unlikely	Likely	Unlikely	Maybe
Kazakhstan	Maybe	Likely	Likely	Unlikely	Unlikely	Unlikely	Maybe
Belarus	Likely	Likely	Likely	Likely	Maybe	Maybe	Likely
Ukraine	Likely	Likely	Likely	Likely	Likely	Unlikely	Likely

Lower income CIS

Armenia	Maybe	Likely	Likely	Maybe	Maybe	Unlikely	Maybe
Azerbaijan	Likely	Maybe	Likely	Likely	Maybe	Unlikely	Maybe
Georgia	Unlikely	Unlikely	Likely	Unlikely	Unlikely	Unlikely	No data
Moldova	Maybe	Unlikely	Likely	Unlikely	Maybe	Unlikely	Unlikely
Uzbekistan	Unlikely	Likely	Likely	Likely	Maybe	Unlikely	Maybe
Kyrgyz Republic	Maybe	Maybe	Likely	Maybe	Unlikely	Unlikely	Maybe
Tajikistan	Maybe	Unlikely	Unlikely	Unlikely	Unlikely	Unlikely	Unlikely

Likely MDG target likely to be achieved

Maybe Too difficult to tell whether MDG target will be achieved

Unlikely MDG target unlikely to be achieved

No data Inadequate data to tell whether MDG target will be achieved

The ECA region is unique with respect to the MDGs

In assessing progress toward the MDGs, the ECA region has several unique features that influence what targets and indicators are the most appropriate.

Poverty

Target: To halve between 1990 and 2015 the proportion of people whose income is less than \$2 a day.

Indicators: Proportion of population living on less than \$1 a day and \$2 a day.

- *Unsuitability of 1990 as a baseline.* In 1990 the social and infrastructure development indicators for transition countries were higher than other countries at comparable incomes. But they were quickly eroded as the transition economies spiraled

into sudden socioeconomic decline. With the resumption of growth, those indicators have started improving again. The 1990 baseline thus hides the improvements since the indicators hit their lowest levels.

- *Inappropriateness of the \$1 a day poverty line in cold climates.* The first MDG calls for halving the proportion of people living on less than \$1 a day by 2015 (in 1993 international prices). The cold climate in many ECA countries means that spending on food, heat, and winter clothing is higher than in other regions. So a poverty line of \$2.15 a day is deemed more appropriate. In addition, the use of 1993 prices provides biased assessments of poverty in the ECA region because the data for

that year reflect the situation amid structural reforms and rapid shifts in relative prices. The pace of these changes varied across countries, so the 1993 prices lead to severe undercounts in some countries and overcounts in others. This publication uses 2000 international prices from a forthcoming major regional study on poverty (World Bank forthcoming c).

Universal primary education

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

Indicators: Net enrollment ratio in primary and secondary education and primary completion rate.

- *Primary or compulsory school completion?* Unlike many “Education for All” countries, all ECA countries require school durations that go well beyond the primary level—usually nine years or more. Since the duration of required schooling reflects a consensus in each country on the minimum acceptable level of schooling, completion of the compulsory cycle is a more appropriate indicator of educational attainment for the MDGs than completion of the primary cycle.

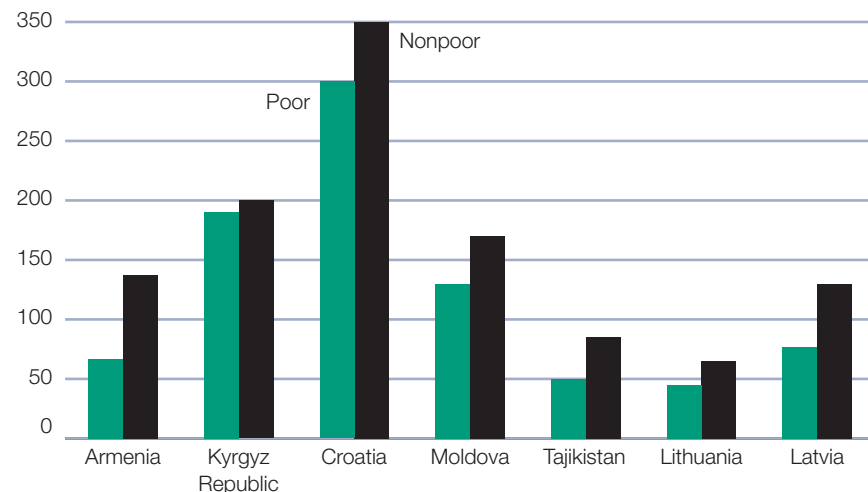
Gender equity

Target: Achieve equality in enrollment ratios by 2005.

Indicators: Ratio of girls to boys enrolled in primary school and proportion of seats held by women in national parliament.

Energy consumption is high in the ECA region because of cold climate

Kilograms of oil equivalent per capita per year



Source: Lampietti and Taft 2002.

The cold climate in many ECA countries means that spending on food, heat, and winter clothing is higher than in other regions. So a poverty line of \$2.15 a day is deemed more appropriate

- *Gender disparities go both ways in the ECA region.* The gender equality goal aims to promote gender equality and to empower women. Internationally, women have borne the brunt of gender inequality, but in the ECA transition countries both men and women have paid a price. There are several instances of gender disadvantages for men, especially in health. Examples are mortality rates and life expectancy, where men in several CIS countries are significantly worse off than women. While women in the ECA region are close to achieving equality in primary and secondary education, much still needs to be done in increasing their role in key decisionmaking positions.

Child and maternal mortality

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

Indicators: Under-five mortality (per 1,000).

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

Indicators: Maternal deaths (per 100,000).

- *High adult mortality rates.* Compared with countries at similar incomes, infant and child mortality in the ECA region are relatively low while adult mortality (ages 15–64) is high. For some countries in the region higher gains in life expectancy could come from reducing adult mortality through

the control of noncommunicable diseases than from achieving the targets for child and maternal mortality. A recent study examined the appropriateness of the health-related MDGs for ECA countries by assessing their impact on life expectancy at birth (Rechel and others 2004). It found that focusing on adult mortality had the greatest impact, resulting in an average gain of 7.8 years, and 10.1 years in Russia. In contrast, reaching the targets for infant, child, and maternal mortality resulted in average gains of only 0.7 years to 1.2, for countries of Central Asia and the Caucasus depending on the data used.

HIV/AIDS and other diseases

Target: Have halted by 2015 and have begun to reverse the spread of

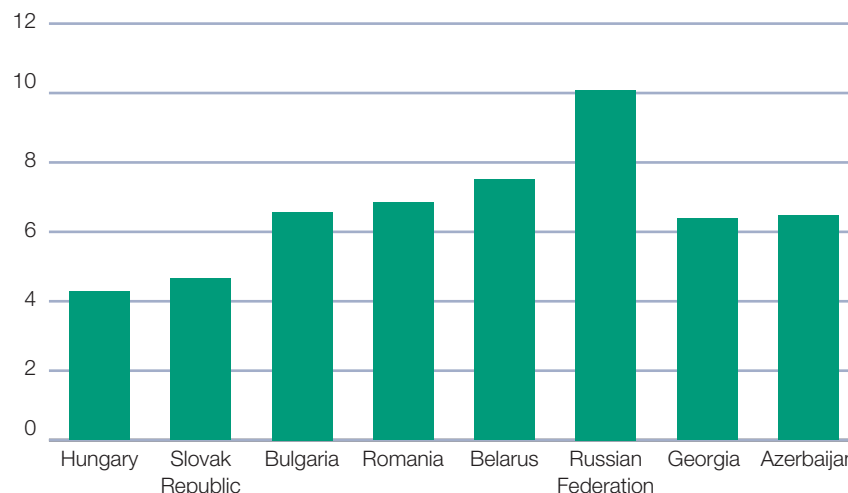
HIV/AIDS and other diseases, such as tuberculosis.

Indicators: HIV infection rates and incidence of tuberculosis (per 100,000 people).

- *Characteristics of the HIV/AIDS epidemic in the ECA region differ from those in other regions.* The ECA region has the world's fastest growing HIV/AIDS epidemic. Unlike in other regions, the epidemic in the ECA region is still in its early stages, so there is a window of opportunity to stop its advance. The vast majority of reported infections in the ECA region are among young people—mainly among injecting drug users (mostly males) and commercial sex workers. Maternal and female infection rates are thus less relevant in the ECA region.

Focusing on adult mortality rather than child mortality can have greater impact on life expectancy

Gain in life expectancy by reducing adult mortality (years)



Source: Rechel and others 2004.

So HIV/AIDS indicators need to be more appropriate for the nature and stage of the epidemic.

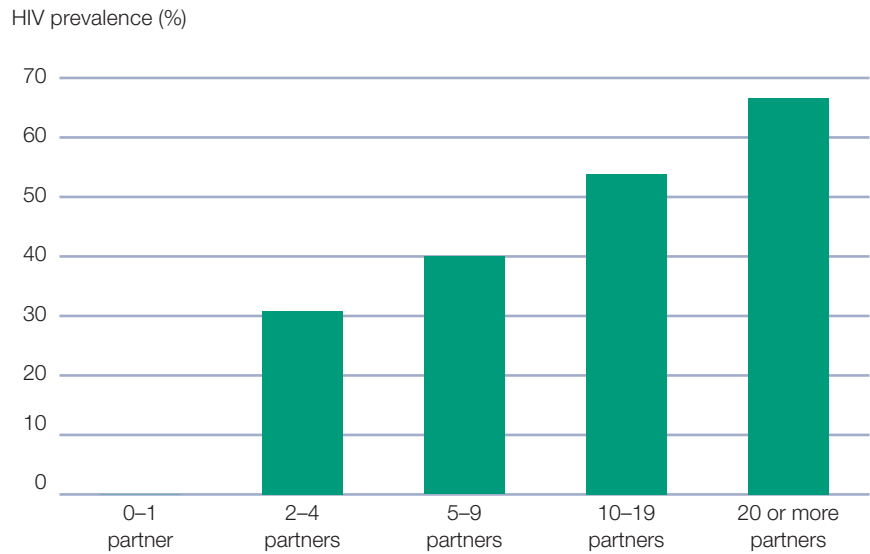
Ensure environmental sustainability

Target: Halve the proportion of people without sustainable access to drinking water by 2015.

Indicator: Proportion of people with access to an improved water source, urban and rural.

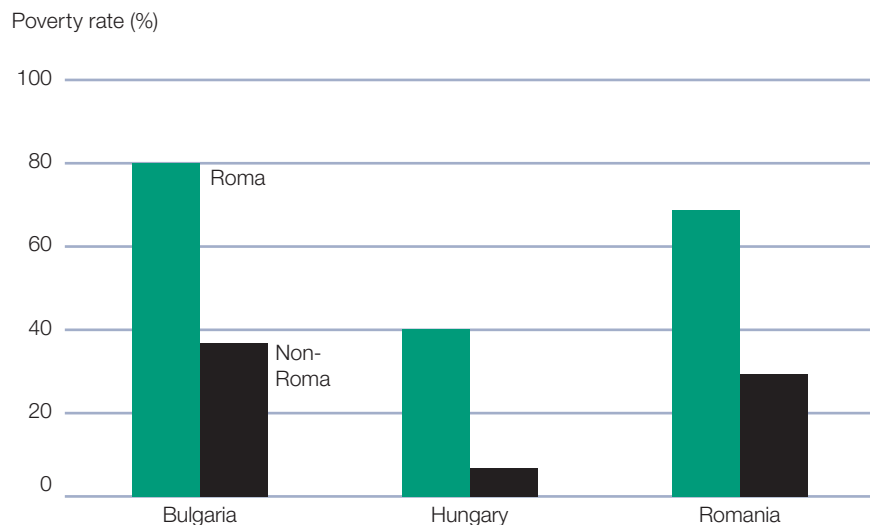
- *Water access data do not present an accurate picture.* The average connection rates to piped water in the ECA region are high by international standards. But because the water infrastructure has been deteriorating since the 1990s, supply is often irregular and of poor quality. Without complementary indicators to measure the regularity of supply and water quality, connection data give a misleading impression of sustainable access to safe drinking water.
- *Marginalized communities.* National data often mask vast disparities in outcomes for such marginalized groups as Roma, the largest and most vulnerable minority in Europe (7–9 million). With poverty rates as much as 10 times those of the total population, Roma constitute pockets of deep poverty in otherwise prosperous countries. In some countries 50–90 percent of Roma children do not complete the compulsory education cycle, and Roma life expectancy is estimated to be 15 years lower than for the majority population.

HIV prevalence among sex workers by number of commercial partners in past seven days, St. Petersburg, Russian Federation, 2003



Source: Smolskaya and others 2004.

Poverty rates are much higher among Roma



Note: Data are for 2000.
Source: Ringold and others 2003.

Data issues in assessing progress toward the MDGs

Several concerns about data need to be kept in mind when assessing the likelihood of reaching MDGs

Monitoring progress toward the MDGs requires good statistics. Several concerns about data need to be kept in mind when assessing the likelihood of reaching MDGs:

- *Data are often inadequate to measure progress and predict trends for some MDG indicators.* Some countries still lack the capacity to produce and use reliable statistical information. A shortage of skills, resources, and technology has often led to incomplete or erroneous data—as has a country's low commitment to data collection. And the upheaval of the transition means that few data series are historically comparable, making it difficult to assess trends. For the prevalence of HIV among females ages 15–24 and for maternal mortality ratios, the World Development Indicators (WDI) provides a single data point for 2001, making it impossible to measure progress and predict trends.
- *Data may not be reliable.* In some instances the data may not represent the true picture. Some ECA countries charge parents for registering newborn children—not affordable for most of the rural poor. In Georgia birth registration fees for single mothers are twice the fees for married mothers. This creates a disincentive for registering newborns, skewing official estimates of under-five mortality. Official estimates are also unlikely to include data from the rural poor, thus further underrepresenting the real situation.

- *Data from different sources often present a different picture.* Data collected from different sources, such as the country official statistics and country surveys, may lead to different conclusions about progress toward the MDGs. Consider the under-five mortality rate data for Kazakhstan. Country data show it to be decreasing, while international estimates have it increasing. The data source thus affects assessments of the likelihood of meeting the MDG target. Survey data, though not always available as a consistent time series, are better than administrative data.
- *Country data may conceal large disparities within countries.* The proportion of people living in urban or rural environments varies greatly. In some countries—Turkey and Russia among them—collecting more disaggregated data is important because national data can mask subnational trends. For example, the rural poor constitute close to 70 percent of all poor in Tajikistan and Romania, and poverty among minority groups, such as Roma, are 10 times those of the general population in Serbia and Montenegro (World Bank forthcoming b). Variations between rural and urban populations might thus have large implications for how countries address the MDGs.

Data sources

The main source of data for all MDG indicators in this publication is the WDI, the World Bank's

annual compilation of data about development, encompassing more than 800 indicators, covering 152 countries, spanning 40 years. The WDI provides a wider picture of poverty trends and social welfare, the use of environmental resources, the performance of the public sector, and the integration of the global economy. While most of the data in the WDI are derived from national statistical agencies, others are estimates reviewed, standardized, and agreed with international statistical agencies, such as the statistical services of the UN specialized agencies. These estimates are considered to better reflect the true situation in a country. More information about the WDI can be found at www.worldbank.org/data/wdi2005/.

Another major source of data across indicators is the *TransMONEE Database* (TMD), produced by the MONEE project of the UNICEF Innocenti Research Centre in Florence, Italy. The TMD contains a wealth of statistical information on social and economic issues relevant to the welfare of children, young people, and women for the 27 transition countries in the ECA region covering 1989 to the present. The TMD data are considered to be a proxy for official country statistics since nearly all the data in the TMD record the data provided by the network of contacts in each of the 27 central statistical offices participating in the MONEE project. More information about the TMD and how to download it can be found at www.unicef-icdc.org/about/IRC/.

Other key sources of data for specific MDG indicators include:

WHO HFA-DB. WHO (World Health Organization). 2005. "European Health for All Database." January 2005 update. WHO Regional Office for Europe, Geneva.

ECEM AIDS. EuroHIV (European Centre for the Epidemiological Monitoring of AIDS). 2004. *HIV/AIDS Surveillance in Europe End-Year Report 2003, No. 70.* Saint-Maurice, France.

JMP. WHO (World Health Organization) and UNICEF (United Nations Children's Fund). 2004. "Joint Monitoring Programme for Water Supply & Sanitation Coverage." [www.wssinfo.org]. The JMP data are also the source for the water and sanitation data in the WDI.

Data from these sources are complemented by data from such other sources as demographic health surveys, living standards measurement surveys, multiple indicator cluster surveys, and country-specific surveys—as well as various World Bank publications.

Methodology

For each of the MDG indicators data were compiled for ECA countries from 1990 onward. The primary source of data was the WDI database, supplemented by data from various other sources. On the basis of these data MDG targets were calculated for poverty, under-five mortality rate, and maternal mortality ratio using several assumptions:

- Where no 1990 baseline data exist, the value for the closest year was used to calculate the MDG target on a pro rata basis.
- When both administrative and survey data exist for the baseline, survey data were used in preference to administrative data.
- When more than one value exists for the baseline, the value presenting the largest gap between the data point and the MDG target was used.

The likelihood of achieving the global MDGs—likely, maybe, unlikely, or no data—was then assessed using simple linear trends of progress since 1990, again using several assumptions:

- Where only one data point exists, and the MDG target is expressed as a percentage reduction based on that level, no conclusion is made about progress.
- For under-five mortality, if the MDG target is less than 6 (the European Monetary Union mean in 2003) and is trending downward, a country is judged to have achieved or be likely to achieve the goal.
- For maternal mortality, if the MDG target is less than 9 (the European Monetary Union mean in 2003) and is trending downward, a country is judged to have achieved or be likely to achieve the goal.
- For HIV/AIDS and other communicable diseases, the country was assessed on the basis of trends in the spread of HIV/AIDS and tuberculosis.
- For environment sustainability, the country was assessed on the basis of trends in access to an improved water source and sanitation.

Once the prospects were determined, the assessments were corroborated by the World Bank's relevant country sector specialist.

Notes

1. While many countries in the ECA region have developed country-specific goals and targets, this publication, for comparative purposes, relates only to the global MDGs endorsed by the UN General Assembly in September 2000.

2. The Commonwealth of Independent States (CIS) comprises Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, the Kyrgyz Republic, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan. The countries of Central and Eastern Europe are Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the Czech Republic, Estonia, Hungary, Latvia, Lithuania, FYR Macedonia, Poland, Romania, Serbia and Montenegro, the Slovak Republic, Slovenia, and Turkey. Slovenia is classified as a high-income country (2003 GNI per capita greater than \$9,386). The World Development Indicators does not include high-income countries in its regional aggregates. Therefore, regional totals or averages from the WDI for the ECA region exclude Slovenia.

3. Measurement of GDP in 1990 and earlier is as incorrect and unreliable as measurements of poverty and mortality rates.

4. Except Turkmenistan.

5. Purchasing power parity measures the relative purchasing power of different currencies for the same types of goods and services. Because goods and services may cost more in one country than in another, it allows for more accurate comparisons of living standards across countries. Purchasing power parity estimates price comparisons of similar items, but are not always robust because not all items can be matched across countries and time.

6. The gender gap is defined as a disparity between males and females involving quality or quantity. Median male income higher than median female income in many countries is a gender gap favoring men, while women living longer than men in most countries is a gender gap favoring women.

7. Except for Turkey, where the WHO Health For All data were used.

8. WHO, UNICEF, and UNFPA adopted a similar approach to develop maternal mortality ratio estimates in 1990 and 1995. However, because the margins of uncertainty associated with these estimates are so large, the estimates from different years should not be used to monitor trends.

9. The data presented in MDG table 7 are an updated version of WHO and UNICEF Joint Monitoring Programme (2001).

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Goals, targets, and indicators

Goals and targets from the Millennium Declaration

Indicators for monitoring progress

Goal 1 Eradicate extreme poverty and hunger

Target 1	Halve, between 1990 and 2015, the proportion of people whose income is less than \$1 a day	1	Proportion of population below \$1 (PPP) a day ^a
		1a	Poverty headcount ratio (percentage of population below the national poverty line)
		2	Poverty gap ratio [incidence x depth of poverty]
Target 2	Halve, between 1990 and 2015, the proportion of people who suffer from hunger	3	Share of poorest quintile in national consumption
		4	Prevalence of underweight children under five years of age
		5	Proportion of population below minimum level of dietary energy consumption

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	6	Net enrollment ratio in primary education
		7	Proportion of pupils starting grade 1 who reach grade 5 ^b
		8	Literacy rate of 15- to 24-year-olds

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	9	Ratios of girls to boys in primary, secondary, and tertiary education
		10	Ratio of literate women to men ages 15–24
		11	Share of women in wage employment in the nonagricultural sector
		12	Proportion of seats held by women in national parliaments

Goal 4 Reduce child mortality

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 one-year-old children immunized against measles

Goal 5 Improve maternal health

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

Goal 6 Combat HIV/AIDS, malaria, and other diseases

Target 7	Have halted by 2015 and begun to reverse the spread of HIV/AIDS	18	HIV prevalence among pregnant women ages 15–24
		19	Condom use rate of the contraceptive prevalence rate ^c
		19a	Condom use at last high-risk sex
		19b	Percentage of 15- to 24-year-olds with comprehensive correct knowledge of HIV/AIDS ^d
		19c	Contraceptive prevalence rate
		20	Ratio of school attendance of orphans to school attendance of nonorphans ages 10–14
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 ^e
		23	Prevalence and death rates associated with tuberculosis
		24	Proportion of tuberculosis cases detected and cured under directly observed treatment, short course (DOTS)

Goal 7 Ensure environmental sustainability

Target 9	Integrate the principles of sustainable development into country policies and programs 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 (kilograms of oil equivalent) per \$1 GDP (PPP)
		28	Carbon dioxide emissions per capita and consumption of ozone-depleting chlorofluorocarbons (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 and basic sanitation	30	Proportion of population with sustainable access to an improved water source, urban and rural
		31	Proportion of population with access to improved sanitation, urban and rural

Goals and targets from the Millennium Declaration

Indicators for monitoring progress

Target 11	By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	32	Proportion of households with access to secure tenure
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Goal 8 Develop a global partnership for development

Target 12	Develop further an open, rule-based, predictable, nondiscriminatory trading and financial system Includes a commitment to good governance, development and poverty reduction—both nationally and internationally	Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked countries and small island developing states.	
Target 13	Address the special needs of the least developed countries Includes tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction	Official development assistance (ODA)	
Target 14	Address the special needs of landlocked countries and small island developing states (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the 22nd special session of the General Assembly)	33	Net ODA, total and to the least developed countries, as a percentage of OECD/DAC donors' gross national income
Target 15	Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	34	Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation)
Target 16	In cooperation with developing countries, develop and implement strategies for decent and productive work for youth	35	Proportion of bilateral official development assistance of OECD/DAC donors that is untied
Target 17	In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	36	ODA received in landlocked countries as a proportion of their gross national incomes
Target 18	In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	37	ODA received in small island developing states as proportion of their gross national incomes
		Market access	
		38	Proportion of total developed country imports (by value and excluding arms) from developing countries and from the least developed countries, admitted free of duty
		39	Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries
		40	Agricultural support estimate for OECD countries as a percentage of their gross domestic product
		41	Proportion of ODA provided to help build trade capacity
		Debt sustainability	
		42	Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative)
		43	Debt relief committed under HIPC Debt Initiative
		44	Debt service as a percentage of exports of goods and services
		45	Unemployment rate of 15- to 24-year-olds, male and female and total ^f
		46	Proportion of population with access to affordable essential drugs on a sustainable basis
		47	Telephone lines and cellular subscribers per 100 people
		48a	Personal computers in use per 100 people
		48b	Internet users per 100 people

Note: Goals, targets, and indicators effective September 8, 2003.

a. For monitoring country poverty trends, indicators based on national poverty lines should be used, where available. b. An alternative indicator under development is "primary completion rate." c. Among contraceptive methods, only condoms are effective in preventing HIV transmission. Since the condom use rate is only measured among women in union, it is supplemented by an indicator on condom use in high-risk situations (indicator 19a) and an indicator on HIV/AIDS knowledge (indicator 19b). Indicator 19c (contraceptive prevalence rate) is also useful in tracking progress in other health, gender, and poverty goals. d. This indicator is defined as the percentage of 15- to 24-year-olds who correctly identify the two major ways of preventing the sexual transmission of HIV (using condoms and limiting sex to one faithful, uninfected partner), who reject the two most common local misconceptions about HIV transmission, and who know that a healthy-looking person can transmit HIV. However, since there are currently not a sufficient number of surveys to be able to calculate the indicator as defined above, UNICEF, in collaboration with UNAIDS and WHO, produced two proxy indicators that represent two components of the actual indicator. They are the percentage of women and men ages 15–24 who know that a person can protect herself from HIV infection by "consistent use of condom," and the percentage of women and men ages 15–24 who know a healthy-looking person can transmit HIV. e. Prevention to be measured by the percentage of children under age five sleeping under insecticide-treated bednets; treatment to be measured by percentage of children under age five who are appropriately treated. f. An improved measure of the target for future years is under development by the International Labour Organization.

ECA's four country groups

European Union (EU8)—the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, the Slovak Republic, and Slovenia

Southeastern Europe—Albania, Bosnia and Herzegovina, Bulgaria, Croatia, FYR Macedonia, Romania, Serbia and Montenegro, and Turkey

Middle-income CIS—Belarus, Kazakhstan, the Russian Federation, and Ukraine

Lower income CIS—Armenia, Azerbaijan, Georgia, the Kyrgyz Republic, Moldova, Tajikistan, and Uzbekistan

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In 2005, with just a decade left to achieve the Millennium Development Goals, the international development community is taking stock of the implementation of the UN's Millennium Declaration and discussing how to accelerate progress.

This publication assesses the prospects for four regional clusters: European Union 8, Southeastern Europe and Turkey, middle-income CIS, and lower income CIS. The European Union 8 countries are most likely to meet the Millennium Development Goals, while the prospects are mixed for the other regions.