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**ICPD/15** International Conference on  
Population and Development

## Arab States Regional Report

Fifteen-Year Review of the Implementation of the  
ICPD/PoA in the Arab World

Prepared by the Arab States Regional Office



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## List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ALDCs	Arab Least Developed Countries
ART	Antiretroviral Therapy
ARH	Adolescent Reproductive Health
ASRO	Arab States Regional Office
CBO	Community Based Organization
CDAs	Community Development Associations
CEDAW	Convention on Elimination of All Forms of Discrimination Against Women
CPR	Contraceptive Prevalence Rate
CSO	Civil Society Organization
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment Short Course
ESCWA	Economic and Social Commission for Western Asia
FBO	Faith Based Organization
FGM	Female Genital Mutilation
FGM/C	Female Genital Mutilation/Cutting
GBV	Gender Based Violence
GDP	Gross Domestic Product
GCC	Gulf Cooperation Council
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
ICPD/PoA	International Conference on Population and Development / Programme of Action
IDPs	Internally Displaced Persons
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
IOM	International Organization for Migration
MCH	Maternal and Child Health
LLIN	Long Lasting Impregnated Nets
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
NGO	Non-governmental Organization
OPT	Occupied Palestinian Territories
ODA	Official Development Assistance
PAPFAM	PAN Arab Project for Family Health
PoA	Programme of Action
STD	Sexually Transmitted Disease
STIs	Sexually Transmitted Infections
TB	Tuberculosis
TFR	Total Fertility Rate
UN	United Nations
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UNHCR	United Nations High Commission for Refugees
VAW	Violence Against Women
WHO	World Health Organization



United Nations

# International Conference on Population and Development

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# FOREWORD

Since its inauguration in April 2009, the UNFPA Arab States Regional Office (ASRO) has considered the review of the implementation of the Programme of Action (PoA) of the International Conference on Population and Development (ICPD) a top priority activity in 2009. The same year commemorates the 15th anniversary of the ICPD held in 1994 in Cairo. As a timely activity for advancing ASRO's strategic niche and relative position in the Arab World, the review process involved 13 out of 14 countries where UNFPA has country offices. This high response rate reflects the commitment of the countries in the region to own and review the ICPD/PoA, which is one of the objectives of UNFPA regionalization and strategic planning for 2008-2013. Besides ascertaining ownership, the involvement of countries in the review facilitated the organization of ICPD events at country and regional levels. These included the launching of the country reports and holding of "The Arab Conference on Population and Development: Facts and Perspectives" in Doha, 18-20 May 2009, where all participants adopted the Doha Declaration and priorities for action during the next 5 years.

Analyses and findings of this review are indispensable for understanding and appreciating the efforts undertaken by governments, national and international development partners. These efforts culminated in impressive achievements in fertility, mortality and reproductive health, maternal health, women's education and empowerment, girls' education and environmental sustainability. However, these achievements are not yet complete and universal. Some countries, particularly, the Arab Least Developed Countries (ALDCs), are still far behind in many of the MDG indicators. Most countries face significant disparities by place of residence (rural/urban) and socioeconomic status (income, education, etc.) in access to reproductive and maternal health services, education, women empowerment, poverty, etc. These disparities leave a daunting picture in the implementation of the ICPD/PoA and the achievement of the MDGs. This report aims at directing the attention of policy makers to the



importance of taking the necessary actions to address disparities and inequalities in development, particularly during this period when people are very much affected by the financial and economic crises.

The review identifies priorities that require attention and actions. At the current rate of progress many countries in the region are not expected to achieve universal access to reproductive health by 2015. Therefore, there is need to act and to scale up sexual and reproductive health services, including family planning. This should be in the context of generating momentum to improve maternal health and reduce maternal mortality. Equally important is the need to eliminate gender based violence, and to empower women through education and increased participation in the labor force, and in policy and decision-making. Countries must also realize the opportunities that exist in the youth bulge and the threats of high unemployment rates among young people. They must integrate population and development dynamics in development strategies and plans, particularly, plans for reproductive health, gender and empowerment of women. Also, it is important to document experiences lessons learned and best practices, build capacities for research and training, and improve the collection and analyses of data for policy and programme development.

It is hoped that policy and decision makers, development partners, international organizations, research institutions and academia will make use of the findings of this report for their work and activities to achieve inclusive and sustainable development in the Arab World.

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# OVERVIEW OF THE REPORT

**T**he Arab Region hosted, in 1994, the International Conference on Population and Development (ICPD). The world leaders and experts who met in Cairo fifteen years ago agreed on a 20-year Programme of Action (PoA) to be implemented by the governments in partnership with the international community including NGOs, the private sector and international development partners. The ICPD/PoA envisions a world where all people enjoy equal rights and opportunities and live up to their full productive and intellectual potential, where violence and discrimination by sex, race, religion, and place of residence are not tolerated; where men and women share equally the responsibilities and decisions at home and in public and private spheres, where the rich and poor people have equal access to resources and opportunities and where the natural resources are protected and well managed for the current and future generations. Indeed, the ICPD envisions a development process that is inclusive, sustainable and respectful of human rights.

This review shows that the vision and actions of the ICPD are relevant today and in the future, particularly at this time when the financial, food and energy crises engulfed the world are affecting the lives of people in the Arab World. Increasing vulnerability and marginalization of poor people should be addressed through the implementation of cost effective social development policies and actions that can yield tangible results in a short time. The PoA is particularly relevant for the achievement of the Millennium Development Goals (MDGs) in the Arab countries where poverty is high and can be reduced through extending reproductive health services and rights to poor women, to vulnerable population groups and to people in humanitarian situations.

Beyond achievement of the MDGs, the relevance of the ICPD/PoA is further justified by its call for addressing the impacts of emerging issues such as climate change and humanitarian crisis. The region's contribution to carbon dioxide emissions is estimated at 4.7%, the second lowest in the world<sup>1</sup>. Also its contribution to the global methane and nitrogen oxide emissions is the lowest in the world because of its relatively low level of industrial development. Yet the Arab countries are among the developing regions that are most affected by climate change. The Arab countries are facing a wide range of impacts related to climate change, water shortage<sup>2</sup>, reduction in agricultural production and food, and increase in environmental refugees. Mitigation and adaptation measures are needed to address the negative impacts of climate change. These measures must integrate population dynamics into development and environment interactions in the region. They must incorporate the climatic and environmental implications of changes in age structure, family composition and structure, and changes in life styles and in consumption and production. Also, they must promote reproductive health to curb

1) UNDP 2009 Arab Human development Report 2009: Challenges to Human Security in the Arab Countries

2) Yemen, for example, is facing a water shortage of about 1 billion cubic meters annually

pressures on natural resources, and to attend to the unmet need for family planning.

This review shows how the implementation of the ICPD/PoA in the Arab countries is linked to their progress in the achievement of the MDGs, to the factors that facilitated the progress and the constraints and challenges encountered in the process. Indeed the report demonstrates the continued interest of the Arab countries and their commitments to implement the ICPD/PoA. Testimony to this commitment is the involvement of these countries in the review process and their emphasis of the need to implement the PoA to accelerate progress towards achievement of the MDGs by 2015.

This commitment will continue to support governments towards achieving universal access to sexual and reproductive health services, particularly among youth (aged 15-24) whose number has rapidly increased by about 1.3 million annually since 1990. Improving youth sexual and reproductive health will reduce the spread of HIV/AIDS, maximize youth production potentials and economic gains and enable countries in the region to make maximum use of the “*demographic window of opportunity*” whenever it takes place. Actions to improve youth sexual and reproductive health must also be accompanied with addressing relevant priorities including housing, sports, jobs, training and skills development and policies targeting youth to harness their potentials for sustainable development.

Continued investment in reproductive health in the region is needed to address poverty and improve maternal health. Strategies and actions in the region should focus on the provision of reproductive health services and information, including family planning, especially to poor households. These actions should include measures to protect the poor from the negative impacts of the financial and economic crisis on food, shelter, and health, and their impacts on reproductive health services and information. Collectively these actions will reduce poverty and hunger, particularly in the Arab Least Developed Countries.



There is need to improve maternal health and reduce maternal mortality through further improvements in antenatal care, delivery under the supervision of skilled health personnel and access to emergency obstetric care and increasing use of contraceptive methods. Countries must devote more resources to reproductive health and HIV/AIDS prevention, and must invest more in maternal services, including family planning, spacing between births and breastfeeding. These interventions are needed, particularly in rural areas and for disadvantaged population groups, so as to uplift them from the vicious cycle of poor reproductive health and poverty. When such investments and interventions are made they will contribute to justice and social equity, and to achieve inclusive social development.

Countries in the region have successfully progressed in women's empowerment through impressive spread in girls' education and in improving their participation in the legislative and executive branches of the government. However, the added value of progress in women's education rests primarily within its power to increase production and transform the economic, social and political relations in societies. Progress in women's education in the region needs to be matched with provision of employment opportunities to increase their participation in the labor force. There is need to increase women's access to productive resources, such as land and finance, and to reproductive health services and information. Gender equity is a major challenge in the region, and focusing on it for achieving population policy objectives will be more beneficial than ignoring it. Besides the elimination of gender based violence and harmful traditional practices, such as Female Genital Mutilation/ Cutting, the laws and rules must be made gender sensitive.

The region has experienced profound social transformations, including changes in family composition and structure, marriage and changes in the age structure of the population and intergenerational relationships. The report analyzes the policy implications of these changes

for the implementation of the ICPD/PoA and the MDGs. Changes in the age structure, for example, which happened as a result of declining fertility and increasing life expectancy at birth, have led to an increase in the relative and absolute numbers of older persons. Ageing is particularly rapid in Tunisia and Lebanon which have experienced demographic transition, as well as in Egypt which is the most populated country in the region. Undoubtedly ageing is a reflection of the success in human development. People in the region live longer and healthier than ever before. However ageing creates major changes in the labor force with consequences on pensions and social security systems that are needed to provide services and an adequate standard of living for older persons. Ageing is a process not an event. Therefore it is important to direct the attention of planners and policy-makers to the importance of early planning for ageing, and to mainstream ageing into development plans and strategies, such as the MDGs and poverty reduction strategies.

The Arab World is rapidly urbanizing, which presents a wide range of opportunities and challenges for the countries in the region. In addition to improving population access to services and reducing social development costs, urbanization presents opportunities for developing human resources, internal trade and markets. However, rapid urbanization can turn into an environmental and economic challenge if policies are not in place to address the growth of slums, to manage municipal waste, and to alleviate urban population pressures on health and sanitary services. In view of rapid urbanization, which is unavoidable and irreversible, countries will have to rethink their strategies for urban management and rural development. Such strategies must promote urban rural linkages through the development of internal markets, financial transfers, and infrastructure. Also the strategies must promote agricultural development, which is highly dependent on labor, in order to meet the high food demand of the urban dwellers and to improve the nutritional status of the people in rural and urban areas.







# I. INTRODUCTION

**T**his Regional Review had been prepared by the UNFPA Arab States Regional Office (ASRO) in commemoration of the 15<sup>th</sup> anniversary of the International Conference on Population and Development (ICPD). It emphasizes the implementation of the ICPD/PoA for accelerating progress towards achievement of the MDGs in the Arab World. The review started with guidelines that were sent to all countries in the region for the preparation of reports on the ICPD+15 and the MDGs. The main purpose of the guidelines was to standardize country reports, and to ensure ownership and contribution by the countries to the regional review process. Moreover, the reporting of the guidelines was intended to help countries to demonstrate synergies and mutual enforcement between ICPD and MDGs.

Reports were received from 13 countries<sup>1</sup>. The reports were prepared by the governments with support of UNFPA Country Offices. Each country report provides an overall background chapter on the population situation, highlighting population size and growth, population distribution, fertility, mortality, and the demographic patterns and differentials within the country. The chapter also documents the challenges and opportunities relating to population and development, and to the demographic transition, including paucity of data and research. This is followed by analyses of the achievements and progress in the MDGs from the context of ICPD. The reports captured qualitative and quantitative data and information on each of the MDGs. For each MDG the national report includes analyses of the status and trends (for major priority issues), actions taken (institutional arrangements, policies, strategies, and programs implemented), and synopses of the main achievements. The country reports document the lessons of experience and best practices.

In addition to the country reports as a source of primary data, this regional review is supported by

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4) Algeria, Tunisia, Egypt, Morocco, Lebanon, Syria, Iraq, Jordan, Yemen, Sudan, Oman, Djibouti, and Occupied Palestinian Territory (OPT). Sudan submitted two similar national reports one to the Arab States regional review process organized by ASRO, and one to the Africa Regional Review organized by the Economic Commission for Africa, the UNFPA, and the African Union. Morocco submitted a national ICPD report to the African Regional Review. All reports have been used as primary sources of information for the preparation of this regional review.

analyses of data obtained from the United Nations Population Division, *World Population Prospects: The 2008 Revision* (estimates and medium variant projections). The analyses are supported by relevant best practices obtained from UNFPA Country Offices. Documentation of best practices in this report are basically for providing compelling evidence of how policy actions could lead to the achievement of tangible results.

Following this introduction, the regional review provides brief analyses of the linkages between the ICPD/PoA and the MDGs (section II), and analyses of the political, socio-economic, and the demographic context (section III). Subsequently the report analyses the progress of countries towards achievement of the MDGs during the period 1990-2008 (Section IV), guided by the linkages between the ICPD/ PoA and the MDGs framework on eradicating extreme poverty and hunger (MDG1), achieving universal primary education (MDG2), promoting gender equality and women's empowerment (MDG3), reducing child mortality (MDG4), improving maternal health (MDG5), combating HIV/AIDS, malaria and other diseases (MDG6), ensuring environmental sustainability (MDG7) and developing a global partnership for development (MDG8). Finally, the review succinctly analyzes the achievements made and the challenges faced during this period (Section V) and concludes (Section VI) with summary of the main findings, and analyses of the priorities for the future.





## II. LINKAGES BETWEEN THE ICPD AND MDGs

**T**he MDGs and the ICPD/PoA are closely interrelated. They mutually reinforce each other. Selected ICPD actions aligned to each of the MDGs are briefly summarized in Table 1. Unanimously adopted in 2000 at the Millennium Summit in New York, the MDGs provide a framework of goals, targets and indicators for monitoring the progress of countries in the achievement of development agenda by 2015. The goals are based on the outcomes of the conferences and summits organized by the international community since 1990, including the ICPD held in 1994 in Cairo, Egypt. The 2005 world summit called for the introduction of a new target on universal access to reproductive health by 2015 to reduce maternal mortality and morbidity.

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The ICPD provides a 20-year PoA to be implemented by governments to improve the quality of life of all people in consistence with their national laws and development priorities, and with the assistance of development partners and the international community. The ICPD/PoA has led to a paradigm shift from perceiving population growth as a threat to development to a right-based approach in which the well-being of men, women and all individuals is paramount. This paradigm shift has been accompanied by a shift from project to program approach in population and development, reproductive health and rights, and gender.

The MDGs and ICPD/PoA share several common principles. Both of them emphasize development in the context of human rights and call upon all nations to cherish fundamental values and principles, including, freedom; equality; solidarity; tolerance; respect for nature; and shared responsibility. Also, both of them urge countries to practice good corporate and political governance, improve the pace of democracy and uphold the right of all people to development. These common principles indicate that development processes and outcomes must be inclusive and sustainable. Inclusivity means that development is for all

people without prejudice to race, culture, ethnic background or sex. Sustainability means green development for current and future generations. The ICPD/PoA highlights the importance of processes for achieving results and intended outcomes. Population programs and activities on reproductive health and rights, women's empowerment, and population and development implemented under the auspices of the ICPD/PoA are indispensable for the achievement of the MDGs. For example, a reduction in infant and child mortality by two thirds (MDG4 Target 1) and a reduction in the maternal mortality ratio by three quarters (MDG5 Target 1) require significant decline in fertility. Fertility decline is a process which is determined by women's education, empowerment to access reproductive health services and to freely decide on when to get married, when to become pregnant and have children, how to space between births and what kind of family planning methods to use. This configuration of processes and outcomes helps in understanding the linkages between implementation of the ICPD/PoA and monitoring the progress of countries in the achievement of the MDGs. This report contributes to furthering this understanding in the Arab countries.

**Table 1 ICPD Actions Related to the MDGs**

MDGs and TARGETS	RELATED ICPD ACTIONS (extracted from the ICPD/PoA)
<b>MDG 1: Eradication of Extreme Poverty</b>	
<p>Target 1.1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day</p> <p>Target 1.2: Achieve full and productive employment and decent work for all, including women and young people</p> <p>Target 1.3: Halve, between 1990 and 2015, the proportion of people who suffer from hunger</p>	<ul style="list-style-type: none"> <li>• Invest in education, training and skills for the development of human capital</li> <li>• Strengthen food, nutrition and agricultural policies and programmes</li> <li>• Facilitate job creation in the industrial, agricultural and service sectors</li> <li>• Provide equal employment opportunities and wages, and facilitate access to credit and microfinance</li> <li>• Promote a supportive economic environment to eradicate poverty and achieve sustained economic growth</li> <li>• Strengthen political commitment to integrated population and development strategies</li> <li>• Eliminate existing barriers to women's participation in the workforce</li> </ul>
<b>MDG 2: Achieve Universal Primary Education</b>	
<p>Target 2: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling</p>	<ul style="list-style-type: none"> <li>• Ensure complete access to primary school or to an equivalent level of education by both girls and boys</li> <li>• Extend education and training to secondary schools and higher levels of education</li> <li>• Eradicate illiteracy</li> <li>• Improve the quality and type of education, including recognition of traditional values</li> <li>• Give high priority to investment in education and job training</li> </ul>
<b>MDG 3: Promote Gender Equality and Empower of Women</b>	
<p>Target 3: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015</p>	<ul style="list-style-type: none"> <li>• Empower women and eliminate inequalities between men and women</li> <li>• Support women's equal participation and equitable representation at all levels of the political process and public life</li> <li>• Promote the fulfilment of women's potential through education, skill development and employment.</li> <li>• Assist women to establish and realize their rights, including those that relate to reproductive and sexual health.</li> <li>• Ensure women's equal access to the labour market and social security systems</li> <li>• Eliminate violence and all discriminatory practices against women</li> <li>• Make it possible, through laws, regulations and other appropriate measures, for women to combine the roles of child-bearing, breast-feeding and child-rearing with participation in the workforce</li> <li>• Promote equal participation of women and men in all areas of family and household responsibilities, including family planning, child-rearing and housework</li> <li>• Promote men's shared responsibility, active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning, and prenatal, maternal and child health</li> </ul>

MDGs and TARGETS	RELATED ICPD ACTIONS (extracted from the ICPD/PoA)
<b>MDG 4: Reduce Child Mortality</b>	
<p>Target 4: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate</p>	<ul style="list-style-type: none"> <li>• Reduce infant and under-5 mortality rates and eliminate disparities between regions, ethnic or cultural groups, and socio-economic groups.</li> <li>• Assess the underlying causes of high child mortality, and extend child health services to all populations</li> <li>• Reduce high risk pregnancies and promote maternal nutrition and health</li> <li>• Reduce the incidence of low birth weight and other nutritional deficiencies, such as anaemia, and promote long intervals between births.</li> <li>• Reduce major childhood diseases, particularly infectious and parasitic diseases, and prevent malnutrition among children, especially the girl child</li> <li>• Promote, protect and support breastfeeding. By means of legal, economic, practical and emotional support, mothers should be enabled to breast-feed their infants exclusively for four to six months without food or drink supplementation and to continue breast-feeding infants with appropriate and adequate complementary food up to the age of two years or beyond.</li> </ul>
<b>MDG 5: Improve Maternal Health</b>	
<p>Target 5.1: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio</p> <p>Target 5.2: Achieve, by 2015, universal access to reproductive health</p>	<ul style="list-style-type: none"> <li>• Reduce maternal morbidity and mortality, and narrow disparities in maternal mortality within countries and between socio-economic and ethnic groups.</li> <li>• Expand the provision of maternal health services in the context of primary health care</li> <li>• Identify the underlying causes of maternal morbidity and mortality, and give attention to the development of strategies to overcome them</li> <li>• Detect, manage and prevent high-risk pregnancies and births, particularly those to adolescents and late-parity women.</li> <li>• Implement programmes to address the special nutritional needs of pregnant and breastfeeding women</li> <li>• Prevent unwanted pregnancies through provision of family planning and reproductive health services and information.</li> <li>• Make accessible through the primary health-care system, reproductive health to all individuals of appropriate ages</li> <li>• discourage harmful practices, such as female genital mutilation</li> <li>• Promote much greater community participation in reproductive health-care services by decentralizing the management of public health programmes and by forming partnerships in cooperation with local non-governmental organizations and private health-care providers.</li> <li>• Assess the extent of national unmet need for good-quality family-planning services and its integration in the reproductive health context</li> <li>• Meet family-planning needs and provide universal access to a full range of safe and reliable family-planning methods and to related reproductive health services which are not against the law. Assist couples and individuals to achieve their reproductive goals and to exercise the right to have children by choice.</li> <li>• Involve the private sector, NGOs in the provision of reproductive health information and services.</li> </ul>



## II. LINKAGES BETWEEN THE ICPD AND MDGs

MDGs and TARGETS	RELATED ICPD ACTIONS (extracted from the ICPD/PoA)
<b>MDG 6 : Combat HIV/AIDS, Malaria and Other Diseases</b>	
<p>Target 6.1: Have halted by 2015 and begun to reverse the spread of HIV/AIDS</p> <p>Target 6.2: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases</p>	<ul style="list-style-type: none"> <li>• Control HIV/AIDS through a multisectoral approach and mobilization of all segments of society</li> <li>• Support the treatment and care of HIV-infected persons and AIDS patients</li> <li>• Promote the use of condom and control the quality of blood products</li> <li>• Raise awareness and emphasize behavioural change</li> <li>• Assess the demographic and development impact of HIV infection and AIDS, and pay attention to its socio-economic ramifications, including the heavy burden on health infrastructure and household income, its negative impact on the labour force and productivity, and the increasing number of orphaned children.</li> <li>• Develop programs to address problems faced by orphans</li> <li>• Provide sex education and information to all</li> <li>• Develop guidelines and provide counselling to services on AIDS and STIs</li> <li>• Develop policies and guidelines to protect the individual rights and to eliminate discrimination against persons infected with HIV</li> </ul>
<b>MDG 7: Ensure Environmental Sustainability</b>	
<p>Target 7.1. Integrate the principle of sustainable development into country policies and programs and reverse the loss of environmental resources.</p> <p>Target 7.2. Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation</p> <p>Target 7.3. By 2020 to have achieved a significant improvement in the lives of at least 100 million slum dwellers.</p>	<ul style="list-style-type: none"> <li>• Integrate demographic factors into environment impact assessments and other planning and decision-making processes</li> <li>• Take measures aimed at the eradication of poverty, with special attention to income-generation and employment strategies directed at the rural poor and those living within or on the edge of fragile ecosystems</li> <li>• Utilize demographic data to promote sustainable resource management, especially of ecologically fragile systems</li> <li>• Invest in clean water, sanitation, and waste management, and promote access to safe drinking water</li> <li>• Respond to pressures caused by rapid urbanization, increase the capacity and competence of city and municipal authorities to manage urban development and safeguard the environment.</li> <li>• Promote the development and implementation of effective environmental management strategies for urban agglomerations, giving special attention to water, waste and air management, as well as to environmentally sound energy and transport systems</li> </ul>
<b>MDG 8: Develop a Global Partnership for Development</b>	
<p>Six targets on trading and financial system (Target 8.1) addressing the special needs of the least developed countries (Target 8.2) addressing the special needs of landlocked developing countries and small island developing States (Target 8.3); dealing comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term (Target 8.4) cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries (Target 8.5) and in cooperation with the private sector, make available the benefits of new technologies, especially information and communications (Target 8.6)</p>	<ul style="list-style-type: none"> <li>• In collaboration with the international community, NGOs and the private sector, governments should mobilize and effectively utilize the financial and human resources needed for implementation of the PoA.</li> <li>• The International community should strive to increase the share of funding for population and development programs commensurate with scope and scale of activities</li> <li>• Governments and parliamentarians, in collaboration with the international community and NGO, in accordance with national concerns and priorities, take the actions required to measure, assess, monitor and evaluate progress towards meeting the goals of the ICPD/PoA</li> <li>• Strengthen national coordination mechanisms for international cooperation in population and development, gender and reproductive health. Ensure that national development plans take note of international funding and cooperation in population and development</li> <li>• Donor agencies should promote and give high priority to south-south cooperation</li> </ul>



### III. POLITICAL, SOCIOECONOMIC, AND DEMOGRAPHIC CONTEXT

**T**he Doha Declaration, which was the main outcome of the *Arab Conference on Population and Development: Facts and Perspectives (Qatar 18-20 May 2009)* reflects concerns with the population and development situation in the region. Acknowledging the diversity of the population and demographic situation and the level of commitment of countries to the ICPD agenda, the Declaration identifies a wide range of challenges faced by Arab countries. These challenges include rapidly changing age structure, increasing number of youth and older persons, gender gaps, weak integration; of population dimensions in sustainable development, wide differentials within countries and between rural and urban areas, high migration trends and shortage of accurate and reliable data.

These challenges are further complicated by the impacts of conflict and the financial and economic crises and the social changes and transformations that took place during the last two decades. Particularly, the population and development situation is grim in the Arab Least Developed Countries (Comoros, Djibouti, Mauritania, Somalia, Sudan and Yemen). These countries have the highest population growth rates, lowest per capita income and highest prevalence of poverty and infectious diseases in the region.



The GCC countries are the least populated and have highest percentage of expatriate population in the region. The estimated total population of the GCC countries in 2010 is 39.2 million, of which 15.1 million (or 38.5%) are expatriates<sup>2</sup>. The GCC countries are strategically important for the production and supply of energy, for the provision of employment opportunities and remittances (estimated at around US \$25b annually) to millions of workers and their families all over the world, and for their role in funding development programmes and activities, especially in developing countries and in the Islamic world at large. The GCC countries have the highest per capita income and are usually ranked top in the region in the human development index<sup>3</sup>. The real GDP per capita is estimated, in 2010, at around US\$ 18,643.

The Mashreq and Maghreb countries are rich in both human and natural capital. They are endowed with rich natural resources (including oil and gas) and are rapidly urbanizing. These countries are the most populated in the Arab world, and are an important source of international labor and are recipients of migrants' remittances. They have moderate per capita income and are ranked medium on the scale of human development index. Conflict in Palestine and the wars in Lebanon and Iraq have impacted negatively on development and population welfare in the Mashreq countries.

## Impacts of Conflicts and the Financial and Economic Crisis

During the last two decades the Arab region faced serious challenges to development accompanied by profound economic and social changes and transformations. Beside the Arab-Israeli conflict,

2) These numbers are based on estimates and medium variant projections prepared by the UN Population Division, 2009, World Population Prospects: the 2008 Revision

3) See UNDP, 2009. Arab Human and Development Report 2009, Challenges to Human Security in the Arab States.

which continued without reaching lasting peace and solution, the last several years witnessed more intense armed conflicts and wars in several places: Iraq (2003), Darfur (2003), Lebanon (2006), Gaza (2008/09), Somalia and Yemen (2009). Impact of these conflicts extended beyond the boundaries of concerned countries to other neighboring countries and beyond. For long, people of the Arab region have been longing for peace, security and development. However, outbreak of armed conflicts led to displacement of millions of people throughout the region. Consequently, the need for crises management and humanitarian assistance has overshadowed development needs.

The Arab region has been directly affected by the financial and economic crisis. Starting in the mortgage and housing sectors in the USA, the crisis has quickly engulfed the financial sector and negatively impacted the stock markets throughout the Arab World. Consequently, large scale construction projects have halted, tourism has declined, people have lost their jobs, unemployment has increased, remittances have shrunk, foreign direct investment has declined, and countries in the region have experienced budget deficits of variable magnitude. The repercussions of the financial crisis have extended to the social development sector, particularly health and education. Undoubtedly this situation has impacted negatively on the ability and capacity of the countries to implement the ICPD/PoA and to make progress in the achievement of the MDGs.

The responses to the financial crisis have varied considerably in the region. While the GCC countries have introduced a stimulus package, other countries could not adopt a similar rescue policy because of financial and foreign reserve limitations. At the Arab Economic, Developmental and Social Summit, held in Kuwait in January 2009, the Arab countries have called for

coordinated actions and cooperation to confront the financial crisis and promote economic and social development, particularly youth and women empowerment.

## Social Change and Transformations

The region is highly dynamic, and is changing and transforming from within itself. It is rapidly urbanizing and modernizing. Arab populations, especially youth, are increasingly moving to live in urban areas in search for jobs and better life. In fact, most of the wage employment opportunities are created in the public and private sectors in urban areas in addition to the availability of informal activities and social services. Rapid urbanization presents a wide range of challenges and opportunities for population welfare and development in each country. While it intensifies the demand for housing, food, energy, social amenities and services, rapid urbanization presents opportunities for investment in infrastructure and human capital development, and in the creation of employment opportunities to absorb the youth bulge. However, these opportunities, particularly the youth bulge, are yet to be utilized for development through the adoption of youth-focused public policies on health, education and job creation.

Education is spreading throughout the Arab World, leading to improvements in knowledge and information, intensive communication and interaction with the outside world, increasing accessibility to services, and profound behavioral and cultural changes. The traditional values and norms are seriously challenged by newly emerging cultural trends relating to marriage, family formation, and intergenerational relations. Throughout the region, educated youth are

demanding good governance and greater involvement in politics and development in their countries, particularly in the policies, plans and strategies that directly affect their welfare and living conditions. Undoubtedly, social changes and transformations directly impact the implementation of the ICPD/PoA and on the progress of countries in the achievement of the MDGs. These impacts are expounded in the following sections of this review.

## The Family

The ICPD/PoA urged all governments to protect and support the family, and contribute to its stability through the development and implementation of policies and laws. It has called on governments to establish social security measures to address the social, cultural and economic factors behind the increasing cost of child rearing, and promote equality of opportunity for family members. Also, the ICPD/PoA has urged governments to ensure that social and economic development policies are responsive to the needs and rights of families and individual members.

The family in the Arab World is undergoing substantial changes. Traditionally, the family is an important institution in the structure of society and social relations in the region. This is enshrined in the laws and constitutions, which support the role of the family as a unit for reproduction, residence, and for performing economic and social functions, such as providing care for children, older persons, and persons with disabilities, and social protection to family members when they face crisis (unemployment, sickness, poverty, and bereavement). However, these traditional functions have been seriously challenged by changes in the institution of marriage, polygamy, divorce, and increase in the mean age at first

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marriage, changes in marital relationships and living arrangements.

Divorce, for example, is rapidly increasing particularly in the GCC Countries, thereby influencing the marital relationships and stability of the family. Undoubtedly the recent food, energy and financial crises have seriously impacted family welfare in the Arab World. Data and research are needed to study these impacts and to provide relevant policies and actions.

The situation of the family in the ALDCs is seriously impacted by a wide range of factors including conflict and instability, poor governance and deteriorating human rights. The civil wars and internal conflicts have led to the displacement of families and their members, increase in widowhood, teenage pregnancies, homelessness, and street children, particularly in slums around and inside capital cities in the region. Such situations have strained family relations and have led to spreading of violence and crimes among family members.

The centrality of the family and concerns about changes in its traditional functions and roles has triggered a wide range of actions, including establishment of institutions and changes in family laws in the region. In the Maghreb countries, Morocco and Algeria have introduced legal and institutional reforms. In 2004 Morocco adopted a new family law to rise the minimum age at marriage from 15 to 18 and the right for men and women to compose their own marriage contract. In Algeria the government enacted, in 2008 a new civil and administrative code that covers family, particularly marriage, divorce and safeguards the interests of minors. Other recently adopted measures include:

the installation in 2007 of a National Family Council; the finalization in 2008 of an operational plan for the National Strategy on the Family; the National Strategy for the Integration and Advancement of Women (2008-2013); and the National Plan of Action for Children (2008-2015), with the support of the United Nations Children's Fund.

## DEMOGRAPHIC CONTEXT

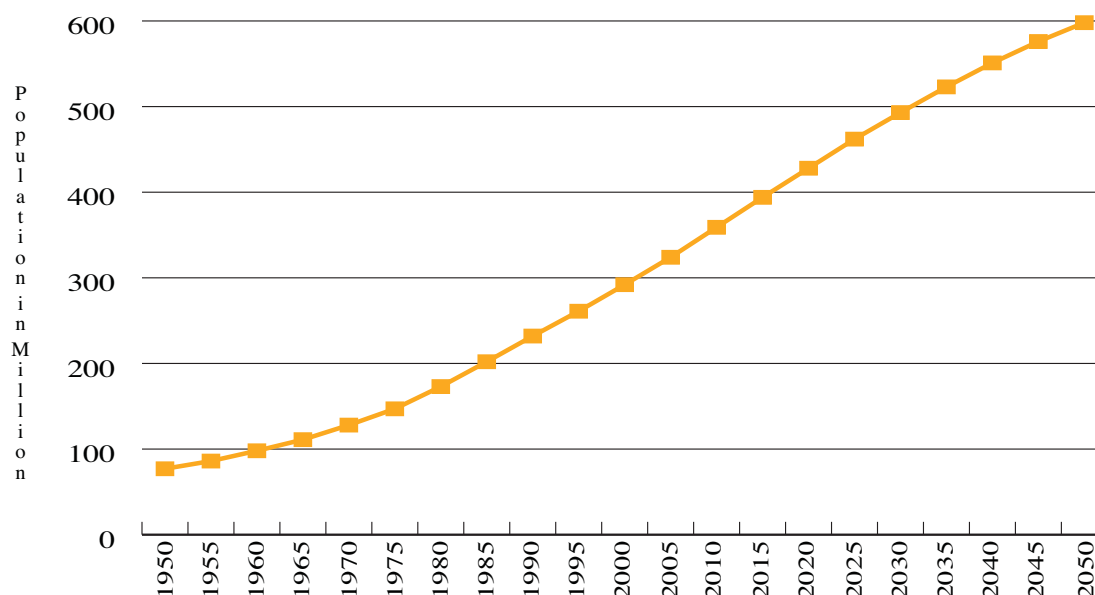
Significant demographic changes took place during the last two decades in the Arab World. Population growth for the region as a whole declined from 2.4% in 1990 to 1.8% in 2010, primarily due to declining fertility. Nonetheless, the number of people increased rapidly from 232 million in 1990 to 359 million in 2010 – an increase of 127 million persons in two decades<sup>1</sup>. It will exceed half a billion by 2035 and will reach about 598 million in 2050 (See Chart 1). most populated countries in the region are Egypt, Sudan, Morocco and Algeria, while the GCC countries are the least populated (See Chart 2). Countries are at different stages of the demographic transition. Some of the countries are demographically advanced (Lebanon, and Tunisia) while others (Yemen, Sudan) are still far behind in fertility and mortality transitions. This diverse situation reflects differences in the levels of modernization and cultural change, and it indicates heterogeneity in the demographic and population situations.

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1) These numbers are based on estimates and medium variant projections prepared by the UN Population Division, 2009, World Population Prospects: the 2008 Revision

Chart 1

### Total Population Arab World (1950-2050)



Source: UN Population Division. 2009. *World Population Prospects, The 2008 Revision (Estimates and medium variant projection)*

## Fertility Transition

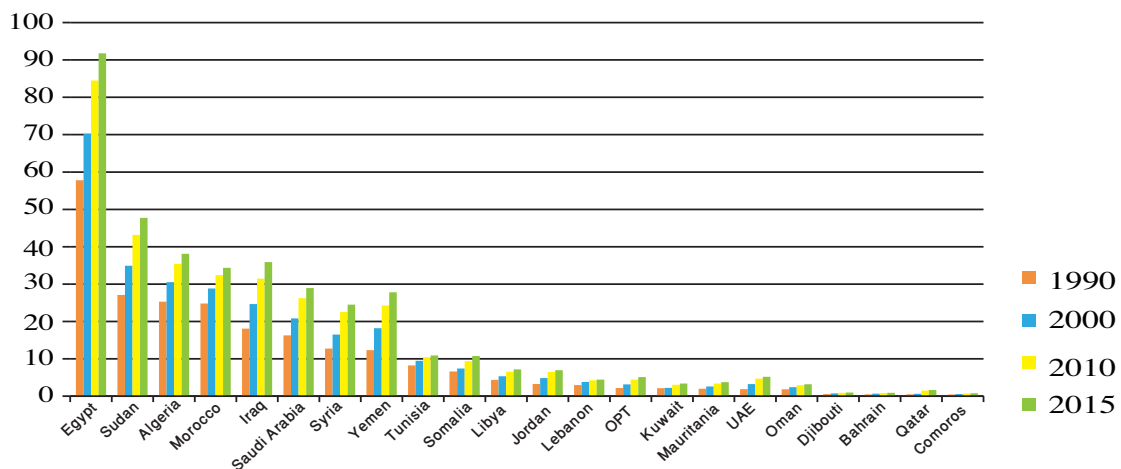
Fertility analyses provide the social and cultural environment for understanding reproduction, and the context for addressing reproductive health issues in societies. This can be revealed through studying closely the cross-cutting fertility map of the region during 1985-2010 (See Table 2). Fertility was universally high, exceeding 7 children per woman during the 1960s and 1970s (not shown in the table). Countries with a total fertility rate (TFR) of 5 or more children per woman were 15 in 1985-1990 declined to 11 in 1990-1995. High fertility is a typical characteristic of traditional societies, where age at first marriage is early, pregnancies are frequent, and women's education and status are low. It is well documented in literature that in traditional societies procreation is the predominant role of women. This was typical to the situation of the Arab countries in the past.

Persistent high fertility continues to reflect a traditional Arab culture that places high value on the reproductive role of women in society. Marriage at an early age, low women status and low level of women's education, and the extended family system provide the social and cultural environment for high fertility. Though highly impacted by the forces of modernization, the traits of this traditional culture still exists especially in the rural areas. Its existence is supporting low use of modern contraceptive methods and high prevalence of harmful traditional practices, such as female genital mutilation/Cutting (FGM/C) particularly in the ALDCs.

The map reflects unprecedented fertility decline in the modern history of the region (See Table 2). In 2005-2010 fertility declined to replacement and below replacement level in 2 countries (Lebanon and Tunisia), to 2.2-2.9 children per woman in 7 countries (Kuwait, Bahrain, Morocco, Algeria,

Chart 2

### Total Population (in millions) by Country in the Arab Region 1990-2015



Source: UN Population Division. 2009. *World Population Prospects, The 2008 Revision (Estimates and medium variant projection)*

Qatar, UAE and Libya. and to 3.0-3.9 in 5 countries (Egypt, Oman, Jordan, Saudi Arabia and Syria) (See Table 2). The fertility decline in these countries has been achieved through increase in the use of modern contraceptive methods, increasing age at first marriage and improvement in women's education. Despite the decline, observed in the remaining countries (Comoros, Iraq, Sudan, Mauritania, Yemen, and Djibouti) fertility is still high. In these countries illiteracy is high, age at first marriage and the mean age of childbearing are low, teenage fertility is high, pregnancies are more frequent, and the contraceptive prevalence rate (CPR) and use of modern contraceptive methods are low. For example, the CPR is 7.6% in Sudan and 23% in Yemen. The use of modern contraceptive methods is 4.3% and 13% in the two countries, respectively (Sudan Country Report,

2009, Yemen Country Report, 2009). In Iraq half of women in the reproductive age use any method, of which 33% use modern contraceptive methods and 7.5% use traditional methods.

Yemen's experience demonstrates the role of high fertility in population growth, and the need to intensify reproductive health activities including the use of modern contraceptive methods to regulate fertility and manage population dynamics. Rapid population growth rate is the ultimate challenge to development and to achieving the MDGs in the country (Yemen Country Report 2009). It remained consistently higher than 3% during 1994- 2007 primarily because of high fertility during the same period. According to the country report, the solution rests primarily with adopting family planning as a strategic option to regulate fertility and to meet

<b>Table 2</b> <b>Fertility Map of the Arab World 1985-2010 - Total Fertility Rate</b>					
<b>TFR</b>	<b>1985-1990</b>	<b>1990-95</b>	<b>1995-2000</b>	<b>2000-2005</b>	<b>2005-2010</b>
<=2.1	0	0	0	<b><u>2 countries</u></b> Tunisia, Lebanon	<b><u>2 countries</u></b> Tunisia, Lebanon,
2.2-2.9	0	0	<b><u>7 Countries</u></b> Tunisia, Kuwait, Lebanon, Bahrain, Algeria, UAE Morocco	<b><u>6 Countries</u></b> Kuwait, UAE, Bahrain, Morocco Algeria, Qatar	<b><u>7 Countries</u></b> Kuwait, Bahrain, Morocco, Algeria, Qatar, Libya, UAE
3-3.9	<b><u>2 Countries</u></b> Lebanon, Kuwait	<b><u>7 Countries</u></b> Lebanon, Tunisia Kuwait, Bahrain, Morocco, UAE, Egypt	<b><u>3 Countries</u></b> Qatar, Libya, Egypt	<b><u>6 Countries</u></b> Libya, Egypt, Jordan, Syria, Oman, Saudi Arabia	<b><u>5 Countries</u></b> Egypt, Oman, Jordan, Saudi Arabia, Syria
4-4.9	<b><u>5 Countries</u></b> Bahrain, Tunisia, Morocco, Qatar, UAE	<b><u>4 Countries</u></b> Libya, Qatar, Algeria, Syria	<b><u>4 Countries</u></b> Syria, Jordan, Comoros, Saudi Arabia	<b><u>5 Countries</u></b> Comoros, Djibouti, Iraq, Sudan, Mauritania	<b><u>5 Countries</u></b> Comoros, Iraq, Sudan, Mauritania, Djibouti.
5+	<b><u>15 Countries</u></b> Egypt, Algeria, Libya, Jordan, Comoros, Saudi Arabia, Mauritania, Iraq, Sudan, Djibouti, Oman, OPT, Somalia, Yemen	<b><u>11 Countries</u></b> Comoros, Jordan, Saudi Arabia, Mauritania, Iraq, Sudan, Djibouti, Oman, OPT Somalia, Yemen	<b><u>8 Countries</u></b> Oman, Djibouti, Mauritania, Iraq, Sudan, OPT, Somalia, Yemen	<b><u>3 Countries</u></b> OPT, Yemen, Somalia	<b><u>3 Countries</u></b> OPT, Yemen, Somalia

Source of Data: UN Population Division. 2009. World Population Prospects: The 2008 Revision (estimates and medium variant projections)

high demand for modern contraceptive methods<sup>1</sup>.

1 ) According to the country report, the unmet need for family planning methods was 36% in 1997 increased to 51% in 2004. In Sudan, 38% of women in the reproductive age are in need for family planning services (Sudan Country Report 2009). In Iraq the unmet need of women in the reproductive age for family planning methods was 11% in 2006 (12% in rural areas and 10% in urban areas) (Iraq Country Report 2009).

However, several constraints would have to be addressed, particularly, lack of resources, shortfall of contraceptives supplies, limited access to services specially in rural areas, shortage of skilled health workers, lack of coordination, and institutional and cultural constraints (Yemen Country Report 2009).



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## Pace and Magnitude of Fertility Decline

The fertility map described above masks significant differences between countries in the pace and magnitude of the fertility decline. In Tunisia and Lebanon, for example, the TFR declined by an average of 0.6 and 0.4 children, respectively, per decade during the same period. In Egypt the pace of decline was high at a rate of 1.7 children per woman during 1980-1995, declined to 0.5 children during 1995-2005. However, this trend has recently seized and has triggered concern on fertility stalemate in the country. Jordan and Syria share the same concern. The decline is significant in some of the countries that had high fertility in the past. For example, the TFR in Yemen, Oman and Saudi Arabia declined by over 3 children during 1985-2005: a decline of 1.5 children per woman each decade. Fertility in Oman declined from 6 children per woman in 1995 to 3.1 children in 2007 (Oman Country Report 2009). Qatar, Kuwait, Bahrain and the United Arab Emirates (UAE) also experienced significant fertility decline. In other past high fertility countries, the pace of the decline is much less. In Sudan, Comoros, and Mauritania fertility declined by an average of 0.5 children respectively, each decade during 1985-2005. These differences in the pace and magnitude of fertility decline reflect diversity in cultural change and modernization in the Arab World.

## Teenage Fertility

The fertility map masks disparities between countries on teenage fertility decline as well. Teenage fertility, defined as the number of live births per 1000 girls in the age group 15-19, declined in Lebanon from 30 in 1996 to 18 in 2004. It declined in Egypt from 78 in 1980 to 48 in 2005. Also, teenage fertility declined in Tunisia

such that the proportion of girls aged 15 to 19 in Tunisia who delivered a baby was 1.5% in 2006, compared to 16% in 1988 (Tunis Country Report 2009). However, teenage fertility in Syria depicts a different trend. The country report documents a decline from 61 in 1993 to 37 in 1999, and an increase to 75 in 2004. High teenage fertility in Syria is due to early marriage and childbearing. According to the country report, 17.7% of women get married before age 18. In Yemen teenage fertility is high due to marriage at very early age and rare use of family planning methods to postpone or delay the first pregnancy (Yemen Country Report 2009). The PAPFAM survey of Yemen 2002/03 documented a significant number of child marriages. Iraq report attributes high fertility to high pregnancy and childbearing at an early age. Currently, pregnant girls aged 12 to 14 and 15 to 19, constitute 21% and 22%, respectively, of all girls in the same age groups in 2006 and About 19% of girls aged 15 to 19 are married.

## Fertility Disparities

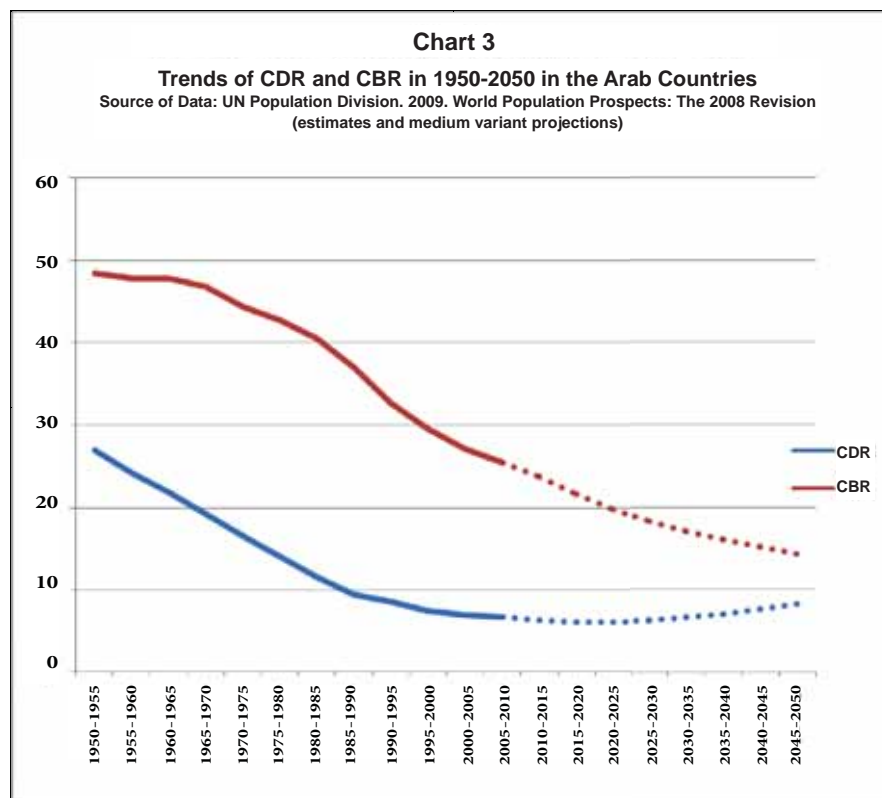
Significant fertility disparities exist by place of residence (rural-urban) and administrative units (districts, governorates, etc.). Generally, fertility is higher in rural than in urban areas within each country and within administrative units. In Egypt, for example, fertility varies considerably between rural and urban areas, and between the upper and lower governorates in the country. The TFR ranged between 3.0 for highly urbanized governorates (Cairo, Alexandria, Port Said) to about 5 children for predominantly rural governorates such as Assuit, Sohag and Minya (Egypt Country Report 2009). In Iraq, the TFR is 5.1 in rural areas and 4.0 in urban areas; a difference of one child per woman. Fertility is highest in Missan and Ninewa (5.4) and lowest in Sulaymaniyah (2.9) and Kirkuk (3.3) governorates (Iraq Country Report 2009).

The sub national disparities are observed in most countries of the region. This is accompanied with disparities in access to reproductive health services including family planning and in exercising reproductive rights by wives and husbands. Such disparities reflect the overall differences and sub national differentials in the environment for implementation of ICPD/PoA.

Higher fertility in rural areas indicates that the fertility decline within each country is not universal. In Lebanon, for example, fertility is highest in the North (TFR=3.4) and lowest in Beirut (1.7) and Mount Lebanon (2.0). In Syria fertility is highest in the governorates of Dier ez-Zour (6.2), Idlib (5.1) and Ar-Raqqah (5.5) and lowest in the governorates of As-Suwayda (1.8), Tartus and, Latakia (2.1) and Dimashq (2.5) (Syria Country Report 2009). Fertility in Sudan is higher in rural

areas where 12% of the girls marry before age 15 and 27% marry before age 18 (Sudan Country Report 2009).

Tunisia experienced fertility decline everywhere in the country, and the difference by place of residence and districts is minimal. In Tunis and East North districts the TFRs in 2006 were 1.6 and 1.9, respectively. The highest TFR is reported in the West Center (2.4). The mean age at first marriage increased from 21.8 in 1966 to 29 in 2001 for women in urban areas, and from 20.2 to 29.5, respectively, for women in rural areas. The delay in marriage is pronounced in both urban and rural areas, and it contributed to fertility decline all over the country, as well as to the decline in rural-urban fertility disparities. In Morocco TFR declined from 4 in 1990 to 2.5 in 2004, with a decline to 2.1 in urban areas compared to 3 in rural areas.





During the same period the use of contraceptive methods increased from 42% to 63%; it increased from 55% to 66% in urban areas and from 32% to 60% in rural areas.

## Mortality Transition

The Arab countries have variably experienced mortality transition, reflected in declining death rates and increasing life expectancy at birth. The average crude death rate (CDR) for the whole region, which measures the annual number of deaths per 1000 population, declined rapidly from 24 in 1950-1955 to 6 in 2005-2010 (Chart 3). During the same period the average life expectancy at birth increased from 43 to 69 years. These trends reflect substantial improvements in population health, primarily due to improvements

in medical services, increases in income and nutrition, changes in the style of living, and developments in personal hygiene and sanitation and increased access to public services.

Strategies for improving child health and survival, and for delivering reproductive health services have played a major role in reducing deaths among infant, children and women. This is reflected in declining infant and child mortality rates, and declining maternal mortality rates, which are analyzed in more details in section IV. The outcomes of improvements in maternal and child health are reflected in improvements in life expectancy at birth for females and under five mortality (Table 3). According to the most recent estimates obtained from the UN Population Division, life expectancy at birth for females for

**Table 3**  
**Life Expectancy at Birth and Under 5 Mortality Rates in the Arab Region**

	Life Expectancy at Birth Females		Under 5 Mortality Rate (per 1000 Births)	
	1990-1995	2005-2010	1990-1995	2005-2010
Kuwait	77.30	79.86	15	10
UAE	76.40	78.75	18	11
Bahrain	74.80	77.47	20	13
Qatar	72.99	76.87	20	10
Oman	72.90	77.46	28	14
Saudi Arabia	70.80	75.25	39	22
Tunisia	72.10	76.04	40	22
Libya	71.70	76.87	35	20
Algeria	69.10	73.71	61	33
Morocco	67.50	73.44	77	36
Lebanon	71.60	74.18	38	26
OPT	71.41	74.97	32	20
Syria	71.20	76.07	38	18
Jordan	69.88	74.47	38	22
Egypt	65.60	71.82	79	41
Iraq	73.07	71.69	63	41
Comoros	59.94	67.40	113	63
Mauritania	57.75	58.53	127	120
Yemen	56.46	64.35	131	79
Sudan	55.06	59.53	153	111
Djibouti	53.18	56.66	167	125
Somalia	44.90	51.03	236	180

Source of Data: UN Population Division. 2009. World Population Prospects: The 2008 Revision (estimates and medium variant projections)

2005-2010 has reached a high level of over 75 years in the GCC countries Tunisia Libya and Syria, compared to 51 for Somalia, 56.6 for Djibouti and 59.5 for Sudan. Women in the GCC countries live longer than women in the ALDCs. One major factor for this difference is the availability and accessibility to maternal and reproductive health services. Moreover, communicable diseases, such as malaria and tuberculoses, are major causes of illness and death in the ALDCs.

Mortality transition in the GCC countries, Lebanon Egypt, Jordan, Syria and Tunisia is accompanied with epidemiological transition reduction in infectious diseases and a relative increase in chronic and degenerative diseases as leading causes of death. Non-communicable diseases have become predominant in these countries. Cardiovascular disease, for example, takes a significant toll on the health of the people in Oman – it ranked first among the leading causes of death. A major risk factor for cardiovascular disease, hypertension (i.e. high systolic or diastolic blood pressure), is found in 33% of adults (35.2% for men and 30.9% for women) aged 20 years and older, while elevated cholesterol levels occur in almost 40.6% of the adult population in Oman. Cancer is also reported the second leading cause of death among adults. The burden of non-communicable diseases such as cancer, diabetes and cardiovascular disease, and other lifestyle related health problems will probably continue to increase in the future. In Tunisia the demographic transition has created new health needs and care for the elderly, as their number has increased significantly (Tunisia Country Report, 2009).

## Changing Age Structure

Changing age structure is a dynamic process that has important policy implications for the implementation of the ICPD/PoA and achievement

of the MDGs by 2015 in the region. Population numbers profoundly change as people move upward the age scale. These changes occur as a result of fertility decline, improvements in mortality and to a less extent, age selectivity of migration. Through time population numbers across all age groups will increase, which is usually reflected in expanding age pyramid. Eventually and when the demographic transition is completed, particularly fertility transition, the number of children will shrink and a youth bulge will emerge. Older persons will increase in terms of absolute numbers and in relative terms as a percentage of the total population.

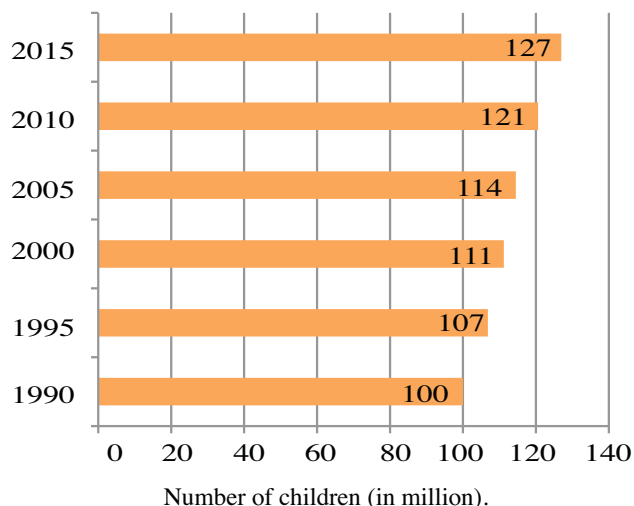
The foregoing analyses on fertility indicate that the Arab States are at different stages of the demographic transition. Consequently, the age structure is currently heterogeneous. Age structure of the population in the region, which was predominantly young for decades, has profoundly changed during the period since 1990 as a result of the demographic developments mentioned before. Particularly the impacts of declining fertility and of persistent high fertility in the past, and of improvements in mortality and health are evident in changes in the functional age groups shown in charts 4 to 7.

## Children and Youth

The region as whole added slightly more than a million children annually between 1990 and 2010. Children aged 0 to 14 increased from about 100 million in 1990 to 121 million in 2010. Had fertility remained high at its 1990 level, the Arab World would have added between 1.5 million to 2 million children annually. Though, it slowed down births, declining fertility did not yet reach replacement level in most of the countries. Therefore, the number of children will continue to increase in the future and will reach about 127 million in 2015 – at the end of the MDGs assessment period.

Chart 4

### Children 0-14 years (Arab World 1990-2015)



Source: UN Population Division. 2009. *World Population Prospects, The 2008 Revision (Estimates and medium variant projection)*

In Tunisia the number of children aged 0 to 14 declined from about 3.1 million in 1990 to 2.37 million in 2010. According to the country report, this decline is alarming and it calls for policy and actions consistent with the fertility transition in the country.

Youth aged 15 to 24 were about 45 million in 1990 increased to 71 million in 2010- an increase of 26 million in two decades (or 1.3 million youth each year). Undoubtedly these rapidly increasing youth numbers are due to past high fertility as most of them were born before 1990. Most of the countries are experiencing rapid increase in youth numbers. In Algeria, Morocco, Kuwait and Tunisia, where fertility declined to below 2.9 children per woman, youth aged 15 to 24 are more numerous than children below age 15. Consequently, a *youth bulge* has emerged. More countries in the region will experience youth bulge at varying time points in the future, as fertility continues to decline towards the replacement level.

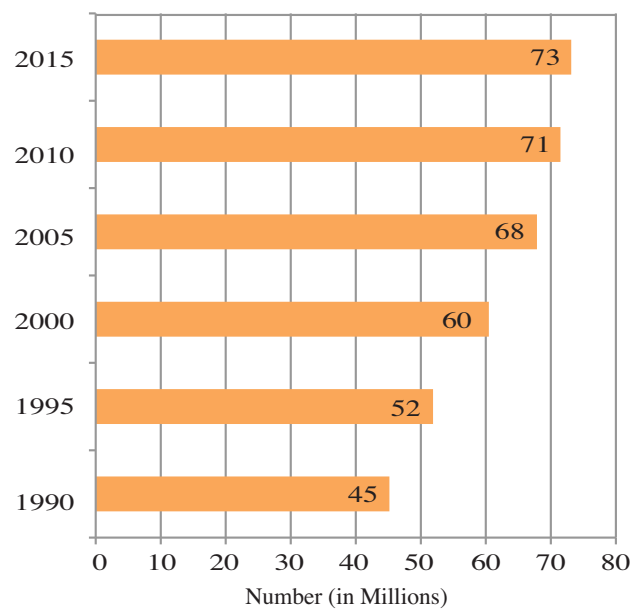
### Working Age Population

The changing age structure is resulting in a rapidly increasing working age population from 124 million in 1990 to 224 million in 2010. This gives an increase of 100 million persons in two decades, an average of 5 million persons annually. Youth constitute a sizeable portion of the working age population (Compare Chart 5 with Chart 6). The developmental impacts of changing age structure are usually reflected in increase in the level of aggregate demand for food, housing, water, etc. These demands escalate when changing age structure is accompanied with rapid urbanization, as is the case in the Arab region.

Rapid increase in the working age population often is associated with expanding productive capacity which can boost the gross domestic product and economic growth, provided that the right social development policies are formulated and implemented. Appropriate policies and investment

Chart 5

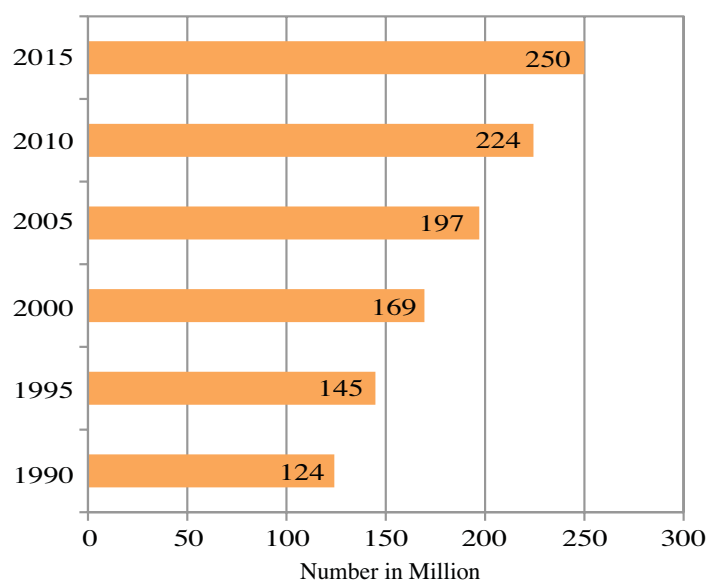
### Youth 15 -24 Arab World 1990-2015



Source: UN Population Division. 2009. *World Population Prospects, The 2008 Revision (Estimates and medium variant projection)*

Chart 6

### Working age population 15-64 Arab World 1990-2015



Source: UN Population Division. 2009. *World Population Prospects, The 2008 Revision (Estimates and medium variant projection)*

in employment and job creation, education, training and skills, and health, are needed to turn the changes in age structure into real development and economic gains. Failures to formulate and implement such policies will, undoubtedly result in loss of human capital and unfavorable conditions, such as high unemployment rates and instability in social and economic conditions.

## Older Persons



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The Arab countries are developing and ageing at the same time. As a result of increasing longevity and improving health conditions, the Arab region is experiencing rapid increase in numbers and shares of the older persons. Those of age 60 years or more reached 22 million in 2010 and are projected to reach 27 million in 2015, up from 12 million in 1990. They will reach 103 million in 2050 (Chart 7). As a percentage of the total population in 2010, the older persons are more significant in Lebanon (10.5%), Tunisia (9.7%), Morocco (8.1%), Egypt (7.5%) and Algeria (6.9%) than other countries of the region.

Also increase in the relative and absolute number of older persons will present special needs for health care and social security that would have to be met in order to improve their welfare.

Development planners are not sufficiently persuaded that older persons can contribute to development and economic growth. This is reflected in the fact that older persons are not adequately covered in national development plans and strategies, such as the PRSPs and the MDGs. This is probably because of the assumption that the family will provide protection and support to older persons. In addition, it is reflected in the fact that older persons are increasingly becoming a vulnerable population group. They are at high risks of abandonment, abuse, sickness and poverty. Also, they are marginalized in living arrangements and housing, particularly in urban areas. Ageing does not mean inability. Older persons can also work, produce and contribute to the GDP. Therefore, it is important not only to ensure the well-being of older persons, but also to make full use of the skills and abilities of older persons have acquired in their lives for the benefit of the entire society.

## Population Distribution and Urbanization

Population distribution is intrinsically linked to social and economic development, and

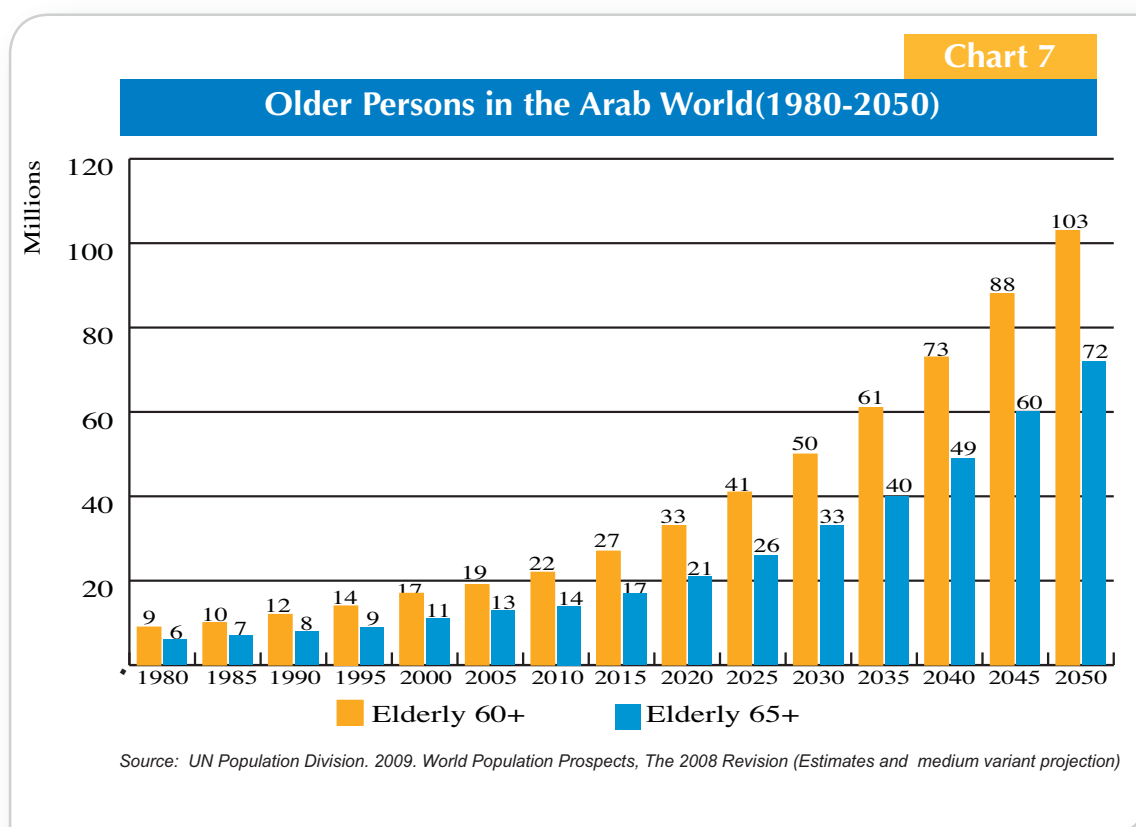


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to the implementation of the ICPD/PoA and achievement of the MDGs. Policies that impact on population distribution, directly and/or indirectly, include distribution of production, investment and employment opportunities, regional development strategies, infrastructure development, distribution of income, goods and services, access to productive resources, governance and administration. When formulating and implementing such policies, the ICPD/PoA called on governments to make sure that they are consistent with development goals and basic human rights, with protecting the environment, as well as with relevant international instruments and rules. It is important for governments and development partners to build local capacities to appropriately respond to population distribution pressures whenever and wherever they arise – in urban areas, in slums, in rural areas and

in displaced persons and refugee settlements. Such capacities include training, competence and capacity of management and administrative systems, and the capacity to assess humanitarian situations and deliver services, security and protection to people. Also it is important for governments to build capacities for national dialogue and development cooperation on bilateral and multilateral bases.

As in other regions, people in the Arab world live in areas where production and economic activities in public and private sectors are concentrated where social and public services particularly health and education, electricity, communication and transportation, water supply and sanitation are available. Therefore, urban inhabitants are gradually outnumbering rural inhabitants. According to the World Urbanization Prospects:



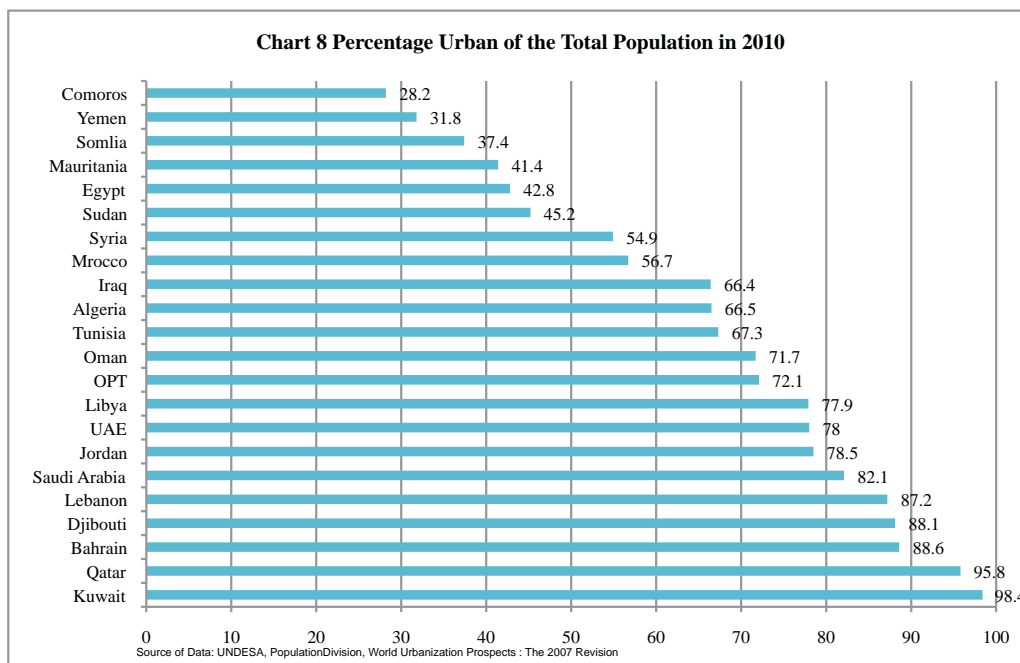


2007 Revision, the percentage urban of the total population increased from 49.4% in 1990 to 55.7% in 2010, and is expected to increase to 57.4 in 2015 and 59.3 in 2020. There were about 114 million urban inhabitants in 1990, increased to 197 million in 2010. By 2015 urban dwellers in the region are expected to reach 222 million. The overall annual growth rate for 1990-2010 is 2.7% for urban areas, compared to 1.5% for rural areas. This difference indicates that urban areas are absorbing most of the population growth rate in the region, primarily through migration (internal and international).

Despite that traditionally documented factors led by ecologically favorable zones (proximity to sources of water and alongside coasts) continue to play an active role in population distribution,

technological advancements in transport and water transfer have occupied more active role than before. Another factor that directly impacts population distribution is conflict, particularly in Palestine, Iraq, Lebanon, Sudan Yemen and Somalia. In these countries people are forced to flee fighting zones to live in temporary camps as refugees and internally displaced persons.

Urban disparities exist within the region as well as within each country. At the regional level 11 countries have a percentage urban of their total population exceeding 70. These are the Gulf States, Lebanon, Jordan, Libya Djibouti and OPT (Chart 8). These are followed by 5 countries (Tunisia, Algeria, Iraq, Morocco, and Syria) with a percentage urban ranging between 54 and 68. Sudan, Egypt, Mauritania, Somalia, Yemen and Comoros are the least urbanized and have



the highest potential in the region for rapid urbanization in the future. Within each country, agglomerations and capital cities dominate the urban systems. This is true throughout the region, particularly in the Gulf countries which are mostly city states. In Kuwait for example, 74% of the urban population live in Kuwait city. In Egypt about half of the urban population lives in Cairo and Alexandria. Approximately 52% of the urban population in Lebanon live in Beirut. Riyadh, Jeddah, Makkah and Medina host about half of the urban population in Saudi Arabia. The same is true for Syria where Aleppo, Damascus and Homs host about 58% of the urban population.

## International Migration

The ICPD/PoA recognizes the importance of international migration for population and development, and calls for actions to maximize its benefits for all - the sending, transit and receiving countries. International migration plays a major role in providing human resources

for development in the GCC countries, and remittances for development in the Maghreb and Mashreq countries. Also, it contributes to addressing poverty in the ALDCs, and to declining fertility transition in the Maghreb Countries.

International migration is a prominent feature of the population and development scene in the Arab World. It is voluminous in terms of both numbers and remittances. The GCC countries have the highest percentage of international migrants in the Arab World. The region as a whole has experienced waves of migrant workers. Before the oil embargo in 1973, when the countries were in the process of state building, migration streams were small in size and most of the international migrants were from within the Arab World. However, since 1973 when the oil embargo was enforced, the international migration streams became larger and attracted labor from other regions and countries, particularly from Asia.

The UN Population Division estimated the total number of international migrants in the GCC countries at about 15.1 million in 2010, which is almost

Table 4 International Migrants in the GCC Countries (Absolute number and % of total population)			
	1990	2000	2010
<b>Bahrain</b>	173200	239366	315403
<b>%</b>	35	37	39
<b>Kuwait</b>	1585280	1500442	2097527
<b>%</b>	74	67	69
<b>Oman</b>	423572	623608	826074
<b>%</b>	23	26	28
<b>Qatar</b>	369816	470731	1305428
<b>%</b>	79	76	87
<b>Saudi Arabia</b>	4742997	5136402	7288900
<b>%</b>	29	25	28
<b>UAE</b>	1330324	2286174	3293264
<b>%</b>	71	71	70
<b>Total International Migrants</b>	8625189	10256723	15126596
Source of Data: UN Population Division. 2009. World Population Prospects: The 2008 Revision (estimates and medium variant projections)			



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double their number (8.6 million) in 1990 (Table 4). The great majority of the migrant labors live in Saudi Arabia (7.3 million), (UAE) (3.3 million) and Kuwait (2.1 million). In relative terms, the migrant laborers are dominant in Qatar where they constitute 87% of the total population, followed by the (UAE) (70%) and Kuwait (69%). These percentages indicate that the Gulf citizens are becoming minority in their own countries.

Undoubtedly the foreign migrants contribute substantially to the GCC economies. But also they contribute significantly to the economies in their countries of origin. A study on foreign labor remittances conducted in 2003 by the GCC show that remittances have increased from an annual average of US\$2 billion in 1975 to US\$ 24 billion in 2003. The annual official remittances of a foreign laborer in the GCC countries range from US\$1755 in Kuwait to US\$4858 in Qatar. In addition to remittances, the GCC countries play a major role in funding development activities, especially in developing countries and in the Islamic World at large.

Arab countries in the Mashreq, Magreb and ALDCs are generally senders of migrant laborers

to the GCC and OECD countries. Most recent estimates show that about 5 million migrants from the Arab World live in the OECD countries. The great majority of them are from Morocco, Algeria, Tunisia, Lebanon, and Egypt. A significant proportion of the Arab migrants to the OECD are youth, with an increasing number of females in the migration streams since 2000. Skilled laborers constitute about 25% of all Arab migrants to OECD. Egypt, Lebanon and Morocco are the largest recipients of migrant remittances in the Arab world, followed by Sudan and Algeria.

Undocumented migration and human trafficking are two important phenomena linked to international migration in the region. Undocumented migrants in the region are mostly in the GCC countries and in North Africa, which have been receiving illegal migrants from Sub-Saharan Africa in transit to Europe. In recent years undocumented migration has been increasing through the North Africa and Yemen. Human trafficking, on the other hand, has been of major concern throughout the region. It poses great challenges to all countries in the region, particularly the GCC countries and Northern Africa.





## IV. PROGRESS IN ACHIEVING ICPD GOALS

**T**he analyses in this chapter expound the implementation of the ICPD/PoA in context of the importance of the actions for making progress in the achievement of the MDGs in the Arab region. It is pertinent at this juncture to make the following three points:

- The population situation has demographically become heterogeneous in terms of fertility and changing age structure, with significant disparities between rural and urban areas.
- The Arab region has experienced social changes and transformations resulting from the spread of education and rapid urbanization, among other factors. These changes impacted the implementation of the ICPD/PoA and on the progress of countries in the achievement of the MDGs
- Wars and armed conflicts sustained in several parts of the Arab region drained great portions of the economic and human resources that could have otherwise been utilized for development and improvement of the living conditions of people. In addition, such conflicts and wars have led to displacement of people and diversion of resources to humanitarian assistance at the cost of development.

## Population and Poverty Reduction

Poverty had shifted to be a central issue in the national and International priorities. Economic growth is necessary but not sufficient to reduce poverty. Strategies to reduce poverty must extend beyond increasing income to include improvement in human capabilities, particularly health and education. In this broad and convincing context, extreme poverty may not be eradicated without achieving universal access to health including reproductive health and rights, and enabling investment in human capital.

Women's reproductive health services and rights to access family planning methods to manage fertility and family size, to space between births, to access maternal health services during pregnancy and childbirth, and to deliver under the supervision of skilled health personnel will greatly help in reducing poverty, especially among poor households. Also, improvements in reproductive health can help to reduce poverty through promoting better management of fertility and reducing population growth rate. At this juncture, it is pertinent to note that inaction and failure to address the reproductive health needs of poor households can undermine national and international efforts to eradicate poverty.

The ICPD/PoA emphasizes the importance of addressing the welfare and reproductive health needs of vulnerable and marginalized population groups, specifically the girl child, persons with disabilities, older persons, indigenous people, and internally displaced persons. Also, it highlights socioeconomic support to the family to meet its reproductive health needs, particularly humanitarian assistance during crises time, taking into account the diversity of family structure and composition, and intergenerational relations. The

ICPD urges governments to eradicate poverty through actions to sustain economic growth, invest in human resources development, particularly in the education and skills development of women, eliminate inequalities and barriers to participation in the labor force and accessibility to productive resources, facilitate the creation of productive jobs in all sectors, and take measures to strengthen food security, improve nutrition, and boost agricultural productivity. These actions are encapsulated in three MDG1 targets to:

- a) Halve , between 1990 and 2015, the proportion of people whose income is less than one dollar a day,
- b) Achieve full and productive employment and decent work for all, including women and young people, and
- c) Halve, between 1990 and 2015, the proportion of people who suffer from hunger.

Poverty is high in the ALDCs and OPT, where almost half of the people live below the national poverty line and half of the children aged less than 5 are malnourished (Table 5). These countries attribute high poverty to low income as well as to poor primary and reproductive health services including family planning and high population growth. Yemen and Sudan, for example, have both expressed concern with poor access of their people to reproductive health services mainly because of low level of investment, large number of women in the reproductive age and high fertility. Wars, conflicts and economic sanctions have also jeopardized country efforts to address poverty and child malnutrition.

The situation is particularly grim in the OPT where the sanctions and war on Gaza have led to an increase in the incidence of poverty and child malnutrition. In addition to the economic and social closure of the territory, the sharp increase

**Table 5**  
**Poverty Indicators in the Arab World 1990-2008**

Country	Poverty incidence Rate in % (Year) Based on national definition of lower poverty line		Underweight children Rate in % (Year)		Proportion of population below the minimum level of dietary energy consumption Rate in % (Year)	
<b>Oman</b>	NA	NA	12.8 (1995)	1.6 (2007)	NA	NA
<b>Lebanon</b>	10.1 (1997) 33.7* (1995)	8.0 (2004) 20.6* (2004)	3.0 (1996)	3.9 (2004)	2.5 (1995)	1.1 (2004)
<b>Syria</b>	14.3 (1997) 33.2* (1997)	11.4 (2004) 30.1* (2004)	12.0 (1993)	9.7 (2006)	NA	NA
<b>Jordan</b>	14.2 (2002)	14.7 (2006)			NA	NA
<b>Urban</b>	12.9 (2002)	13.1 (2006)				
<b>Rural</b>	18.7 (2002)	22.8 (2006)				
<b>Iraq</b>	27.5 (1990)	23.0 (2007)	20.0 (2000)	8.0 (2004)	NA	NA
<b>OPT</b>	25.0 (1996)	35.0 (2007)			NA	NA
<b>Tunisia</b>	8.1 (1995)	3.8 (2005)	3.9 (1994)	3.0 (2006)	NA	NA
<b>Urban</b>		1.9 (2005)	3.7 (1994)	2.1 (2006)		
<b>Rural</b>		7.1 (2005)	4.1 (1994)	4.7 (2006)		
<b>Algeria</b>	14.1 (1995)	12.1 (2000)	10.0 (1995)	3.7 (2006)	5.7 (1995)	2.7 (2005)
<b>Morocco</b>	30.4 (1990)	8.2 (2007)	9.0 (1992)	10.2 (2003)	1.8 (1985)	0.9 (2007)
<b>Urban</b>	13.3 (1990)	3.6 (2007)	3.3 (1992)	6.5 (2003)	0.3 (1985)	0.1 (2007)
<b>Rural</b>	54.5 (1990)	14.3 (2007)	12.0 (1992)	14.0 (2003)	3.7 (1985)	2.0 (2007)
<b>Egypt</b>	16.7 (1999)	19.6 (2005)	6.2 (2005)	7 (2008)		
<b>Yemen</b>	41.8 (1998)	34.8 (2006)	45.6 (1997)	45.6 (2003)	36.0 (1999)	21.7 (2003)
<b>Urban</b>	32.3 (1998)	20.7 (2006)				
<b>Rural</b>	42.5 (1998)	40.1 (2006)				
<b>Djibouti</b>	NA	42.0 (2002) 52.6* (2002)	NA	NA	NA	NA
<b>Sudan</b>	NA	NA	33.0 (1999)	29.6 (2006)	33.0 (1999)	18.0 (2006)

Source of data: ICPD/15 2009 country reports

NA: Data Not Available\* Upper national poverty line

in the prices of major production inputs and basic food supplies has rendered the current national poverty reduction strategies insufficient and less than adequate to face the existing crisis. Lebanon reported an increase in the incidence of child malnutrition to 3.9% in 2004, and in the incidence of poverty to 8.4% following the war in 2006.

The civil wars in Yemen, Somalia and Sudan are associated with high incidence of poverty, high child malnutrition and also high proportion of the population below the minimum level of dietary energy consumption. Undoubtedly, stability is needed to create conducive environment for reducing poverty and hunger in the region.



## Box 1 Community health funds in Djibouti

In October 2008 Djibouti established community health funds in six pilot sites in rural communities remote from health services. The funds consist of a symbolic sum of 35400 FD (US\$ 200) managed by a committee of women in each locality. The fund aims to facilitate and increase women's access to reproductive health information and services in the country. In addition to emergency evacuation, the fund is for the purpose of facilitating antenatal and postnatal visits, and immunization. During the pilot phase the Ministry of Health and UNFPA conducted training and awareness campaigns to encourage people to contribute to the Fund and sustain it in the interest of mother and child. Two teams evaluated the pilot phase and recommended extension of the Fund to other areas. As a result, the Fund has been extended, in August 2009, to 14 additional locations in the country. In addition, the Ministry of Health and UNFPA have jointly decided to contribute 53100 FD (US\$ 300) to each of the mutual health funds. The success of the community health funds is expected to lead to further actions, such as the fight against Female Genital Mutilation, reducing girls drop-out from schools, and reducing the burden of work performed by women. This will empower women and improve their living conditions.

*Source: ICPD/15 Djibouti UNFPA Country Office*

Within country disparities by place of residence are quite significant (Table 5). In all countries the incidences of poverty and child malnutrition are much higher in rural than urban areas. Also, reproductive health disparities between urban and rural areas are quite significant. In Tunisia, where reproductive health and gender equality improved particularly in urban centers, the incidence of poverty is lower in urban (1.9%) than rural (7.1%) areas, and child malnutrition in the former is half that of the latter (Table 3). In Egypt, which is the most populated country in the region, poor persons as a percent of total population, is highest in Assuit (61%) and Beni Suef (45%), and lowest in the urban governorates (5.7%) (Egypt Country Report 2009). In Morocco, which is likely to achieve the target by 2015, the incidence of poverty is about four times higher in rural than urban areas. Child malnutrition in rural areas in Morocco is twice the urban areas. In Yemen, the incidence of poverty in rural areas is twice the urban areas. Poverty is higher among women in poor households, who have the lowest access

to reproductive health services and the highest unmet need for family planning. Children born to poor women are most likely to be malnourished.

The disparities above-mentioned indicate the need for intensification of reproductive health interventions in rural areas and among the urban poor so as to accelerate the progress of countries to achieve MDG1. For example, Djibouti established community health funds to improve women's access to reproductive health services in rural and remote areas in the country (Box 1).

According to the country reports, pensions and social protection schemes play a minor role in supporting the income of poor households, mainly because most of them are not engaged in wage employment. Also, the share of the few working poor in social protection schemes is very low. Therefore, poor households resort to alternative financial support strategies. For example, they

supplement their low earnings with remittances from relatives working abroad<sup>1</sup>.

### Population and Achievement of Universal Primary Education

The ICPD/PoA emphasize the role of education in advancing human rights, including reproductive health and rights, and improving the welfare and the quality of life of all people. It refers to education as a strategic factor linked to several actions on health, rights and equalities, maternal and child health, gender and the empowerment of women, human development and employment opportunities, marriage and the family, and the welfare of vulnerable population groups (Older persons, persons with disabilities, displaced persons, refugees, etc.). It highlights the role of education in promoting equality, especially equal treatment of boys and girls, and promoting access to information and social services. The PoA urges governments to improve the quality of education and eliminate stereotyping in educational materials that reinforce existing inequities between males and females and undermine girls' self-esteem.

Countries must ensure universal access to quality primary education and primary health care, and must invest and give high priority to education, particularly women and girls' education to promote their potential as full participants in development. Also, countries must recognize that, in addition to expanding education for girls, teachers' attitudes and practices, school curricula and facilities must be changed to reflect commitment to eliminate gender bias, and promote parental roles and males' responsibilities in family life. Countries that achieved universal primary education are urged

to facilitate access and completion of education to secondary and higher levels.



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Countries in the region have made variable progress in achieving universal primary education. There is rapid and impressively high net enrollment ratios (more than 90%) in the Maghreb, Mashreq (except OPT and Iraq) and GCC countries (See Chart 9). High enrollment ratios indicate improvement in the implementation of education policies in the region. Also, they reflect the commitment of governments to develop education infrastructure and expand primary and basic education for all children<sup>2</sup>. These countries have also high completion rates (Chart 10) and high literacy rates for youth aged 15-24 (Chart 11).

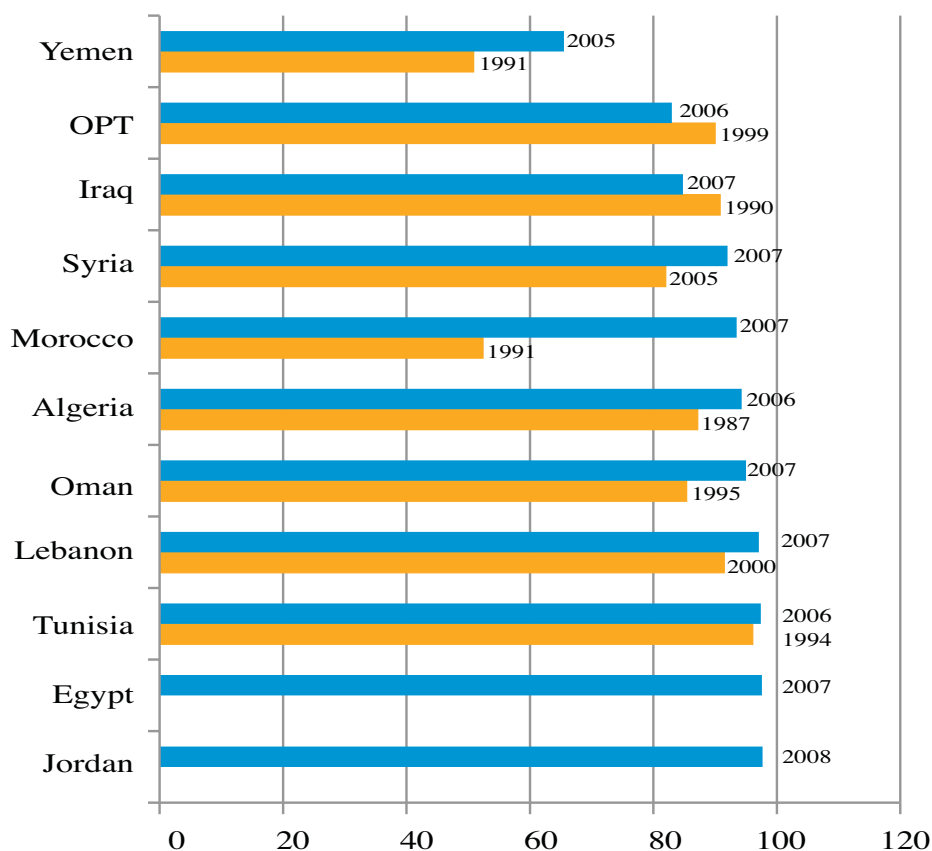
Youth literacy rates have improved in Morocco, but still below optimal level. The high completion rates are due to developments in school infrastructure, particularly in the provision of water, sanitary and health services to children during school time. Other important factors include proximity of school

1) As a percentage of total income of poor households, remittances constitute 39% in Syria. In Jordan remittances constitute 22% of the GDP in Jordan, but are expected to decline with the return of Jordanian workers from the Gulf States (Jordan Country Report 2009).

2) Lebanon, for example, adopted a National Plan for Education for All (2005-2015) and a National Strategy for Education (2006). Syria expanded education services all over the country, and established mobile schools in the badiya (where nomads live) and in the remote areas.

Chart 9

## Net Enrollment Ratio in Primary Education



Source of data: ICPD/15 2009 Country Reports

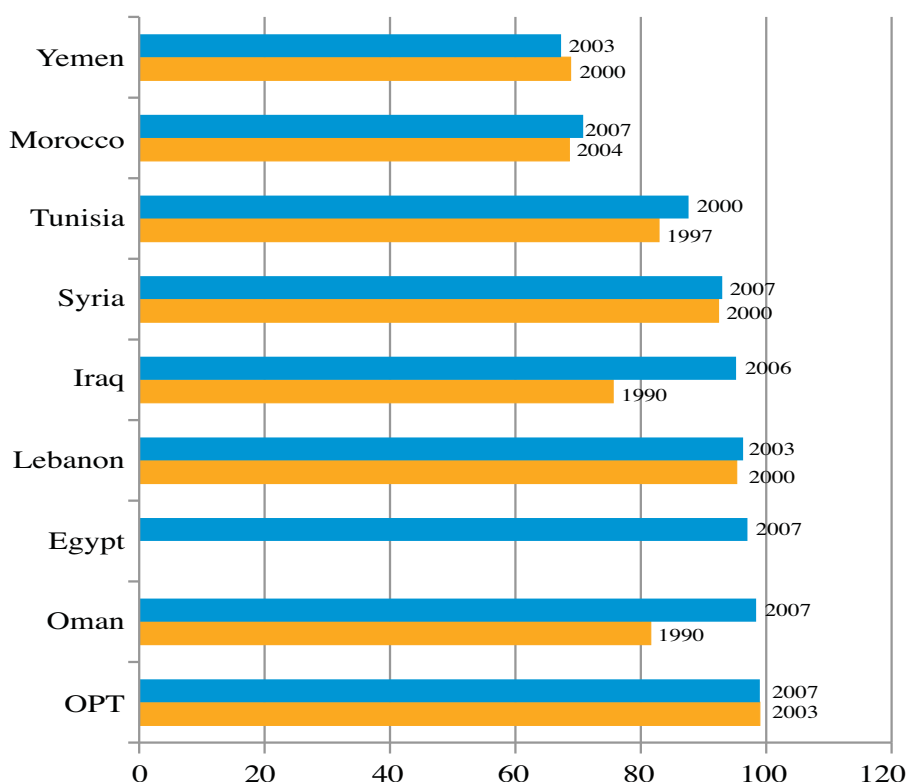
to the place of pupil's residence, and the level of household income. Also, the countries have adopted policies and strategies to expand basic education, and to deliberately reduce drop-out from schools, particularly among girls. However, most of Maghreb and Mashreq countries are worried about coping with rapidly rising demand for primary education emanating from rapid growth of school-age children, particularly in rural areas.

The economic sanctions and wars have led to retrogression in primary enrollment ratios in Iraq and the (OPT) (Chart 9). The net enrollment ratio

in primary education steadily declined to below 85% in 2006 for both boys and girls in Gaza Strip and the West Bank. In Iraq this ratio declined from 90.8% in 1990 to 80.3% in 2000 (not shown in the table). However, this negative trend started to reverse. It increased to 84.8%, due primarily to increase in the number of schools and expansion on the training of trainers and teachers. Since June 2004, 3000 new schools have been built, 860 trainers trained and 31777 teachers trained throughout Iraq. These developments have created an enabling environment that will help Iraq progress more rapidly in achieving universal

Chart 10

## Proportion of Pupils Starting Grade 1 Who Finish Grade 5



Source of data: ICPD/15 2009 Country Reports

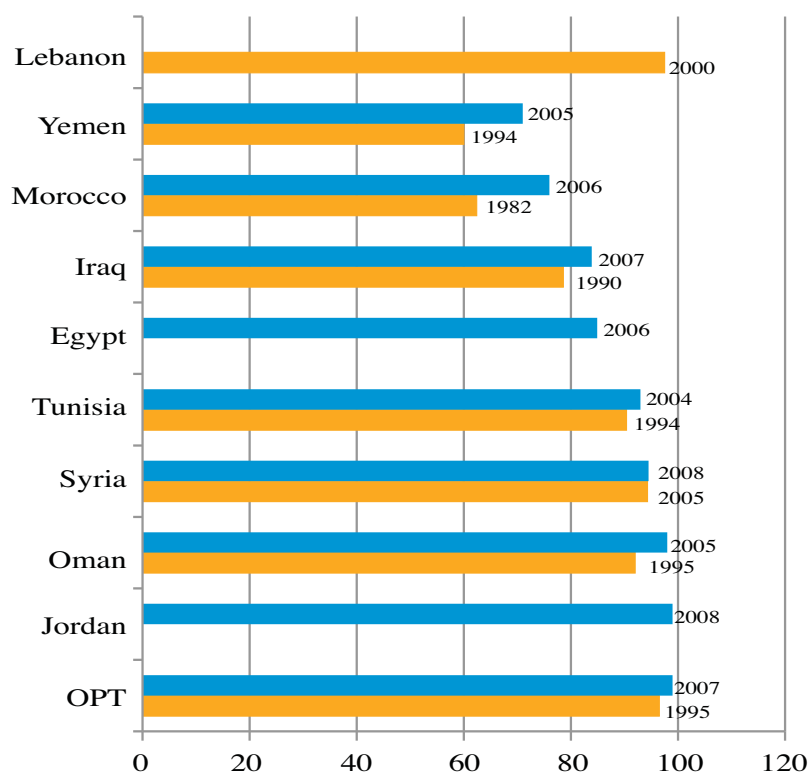
primary education, and in reducing gender and regional disparities in primary education, which are currently high in the country (Iraq Country Report 2009). Completion rates are high in the OPT and improving in Iraq (Chart 10). Youth literacy rates are high in OPT, and are improving in Iraq (Chart 11).

The ALDCs show slow progress and not sufficient to achieve universal coverage by 2015 (Chart 9). In Yemen the net enrollment ratio in primary education slowly improved from 50.9% in 1991 to 65.5% in 2005. With a higher rate for boys (74.7%) than girls (55.3%), the gender gap in primary education is still wide. In Sudan, only 29.5% of

the primary school entry age children enter grade 1 (intake rate). The slow progress in the ALDCs is due to the limited capacity of the educational systems to absorb all school age children whose numbers are increasing at a high rate. Schools lack the necessary basic infrastructure, such as water and sanitary services, to retain students and enable them to complete primary education (Chart 10). Poor school services, long distances and lack of transportation are also factors that discourage children, particularly girls, from continuing their education. High levels of poverty in these countries mean that households cannot afford the high cost of continued education of their children. Therefore, children drop out from

Chart 11

## Literacy Rate of 15-24 Year-olds



Source of data: ICPD/15 2009 Country Reports

schools in order to work and support the family. This is encouraged by the existence of a labor market for children. Youth literacy rates are low in the ALDCs (Chart 11).

Education in the region is linked to reproductive health through the following measures:

1. School enrolment and continuation to high levels of education have increased the mean age at first marriage, mean age of childbearing and mean age at delivery of the first birth in the Maghreb, Mashreq and GCC countries. Also, teenage fertility declined in these countries as a result of increase in girl's education.
2. Educated women are more likely to use modern

contraceptive methods. The higher the level of education the higher the use of modern contraceptive methods. This is true for all countries in the region

3. Women's access to antenatal health care services, follow up and delivery under supervision of skilled health professionals, has increased because of improvement in women's education.

However, the quality of education and stereotyping are still major problems that all countries must address. It is important for countries to improve the quality of education through introducing reproductive health in school curricula. In Oman,



for example, the school health program aims to change the beliefs, attitudes and practices of school children by providing them with adequate knowledge of good healthy habits. This may lead to similar changes in their families and in the community. This could be achieved through a comprehensive health education program directed to all the students. It has been accomplished through the introduction of a book titled "Facts for life" produced in two parts. The first one is distributed to students in grade 9 and it has chapters on adolescence and public health issues. The second part is distributed to children in grade 11 and has chapters on reproductive health and diseases related to lifestyles. About 50000 copies from each part have been distributed (Oman Country Report 2009).

Another issue related to education in the region is the existence of significant disparities between rural and urban areas on the three linkages above mentioned. Because of their low educational level, women in rural areas are still far back on accessing reproductive health services, including the use of modern contraceptive methods and access to antenatal care services.



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### Population, Gender Equality and Women Empowerment

"Every day, women and girls are subject to domestic violence, exploitation, sexual violence, trafficking, honor crimes, harmful traditional practices, such as bride burning and early marriages, and other forms of violence against their bodies, minds and human dignity.

As many as 1 in 3 women has been beaten, coerced into sex, or abused in some other way.... Let us all take a stand and say loud and clear 'No to violence against women.'" From Message of Thoraya Ahmed Obaid, Executive Director, UNFPA, International Day for the Elimination of Violence Against Women 25 November 2009

The ICPD/PoA urges countries to achieve equality and equity based on partnership between men and women; promote women's contribution to development through full involvement in decision-making at all levels; ensure that all women, as well as men, are provided with the education necessary for them to meet their basic human needs and to exercise their human rights; pay special attention to the needs of the girl child; and promote gender equality in all spheres of life, including family and community life. The Beijing Declaration and Platform for Action reiterated these objectives, while the Millennium Summit and the 2005 World Summit affirmed them.

The Millennium Summit emphasized equal rights and opportunities for men and women to development without distinction by race, sex, language or religion. Subsequently, promotion of gender equality and empowerment of women has been considered the third Goal (MDG3) with the target of eliminating gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015. The corresponding indicators for monitoring progress are:

- a) Ratio of girls to boys in primary, secondary and tertiary education;
- b) Ratio of literate women and men, 15-24 years old;
- c) Share of women in wage employment in the nonagricultural sector; and
- d) Proportion of seats held by women in national parliament.

Achievement of gender equality in education is a measure of providing equal opportunities, fairness and efficiency of the education system. Education is important for human development. Therefore eliminating gender disparity at all levels of education will promote human capital development. Secondary and higher levels of education will improve access to reproductive health services, reduce poverty, and increase labor force participation. The share of women in wage employment in the nonagricultural sector is a measure of the degree to which formal labor markets are open to women. Women's access to employment opportunities will improve income distribution and family welfare, will enhance economic efficiency and will promote economic production and growth. Women's representation in parliaments is a measure of political empowerment and participation in the formulation and implementation of public policies.

How did the Arab world progress in gender equality and women's empowerment? And what are the main gender issues and concerns in the region as whole?

Gender relations in the Arab world are largely modulated by culture, religion, politics, ethnicity, among other factors. These relations shape women's access to resources and employment opportunities, frame the role of women in development, at work, in the family and public life. Also, they shape men's attitudes and responsibilities, and define intergenerational relationships. The international policy frameworks (ICPD/PoA, MDGs, Beijing Declaration and Platform for Action, and CEDAW) provide guidance for policy formulation and for assessing progress of the Arab World on addressing gender and development issues.

Advances recently made in promoting women's education and health in the Arab World are well documented<sup>1</sup>. However, these developments have not been equally matched with progress in women's economic and political participation. The gender gaps are reflected in a low share of women in gainful employment in the nonagricultural sector and limited representation of women in national parliaments. In addition women in the Arab world suffer from discriminatory laws and regulations, violence, and inadequate access to productive resources, such as land and finance, and to reproductive health services and information. This is true even though the constitutions in all countries provide for full equality between men and women in rights, duties and opportunities.

Against this backdrop, the Arab Conference on Population and Development: Facts and Perspectives, held in Doha in May 18-20, 2009 highlighted the "important role of equity, equality, women empowerment, and bridging the gender gap in achieving population targets and the MDGs"<sup>2</sup>. The conference identified as a priority the "achievement of women empowerment goal, confront all types of discrimination and gender-based violence through integrating this goal in population and development policies, formulating legislations based on international resolutions and agreements, advancing specific institutions and mechanisms to achieve this goal with efficiency and effectiveness"

## Gender and Education

Implementation of education policies have led

1 ) ESCWA, The Millennium Development Goals in the Arab Region, 2005, (E/ESCWA/SCU/2006/3/Rev.1). ESCWA, 2008, Gender in the Millennium Development Goals. Information Guide for Arab Millennium Development Goal Reports (E.ESCWA/SCU/2007/ Technical Paper 1 07-0487). UNDP, The Arab Human Development Report 2005. Towards the rise of women in the Arab World

2 ) Doha Declaration, Doha 18-20 May 2009

to considerable increase in enrollment ratios at all levels of education: primary, secondary and tertiary. Consequently, the ratio of girls to boys has improved in all countries during 1990-2007. However, gender gaps in education still exist in the ALDCs and in the rural areas.

Education policies in Tunisia and Lebanon have led to considerable increase in the enrolment rates at all levels of schooling. The net enrolment ratio in primary education increased from 94.5% in 1994 to 97.3% in 2006 for boys, and from 87.4% in 1994 to 97.4% in 2006 for girls. The ratio of girls to boys exceeded parity in secondary (1.13) and tertiary (1.44) levels of education. In Lebanon the government adopted compulsory and free primary education law (Law 686 dated 16/3/1998), which led to tangible achievements in education. Net primary enrolment ratio increased from 91.5% in 2000 to 97.1% in 2007; with a ratio of 99.2% for girls and 95% for boys (Lebanon Country Report 2009). Clearly in both countries girls have achieved much more progress in education than boys.

Socio-economic indicators show impressive improvements in women's conditions in Algeria and Egypt. In Algeria, women's education significantly improved at all levels of education, nationally and in urban and rural areas. At the primary level of education the net enrollment ratio reached 96.3% for girls and 96.9% for boys. Consequently illiteracy rates precipitously declined though still proportionately higher for women than for men. The illiteracy rate for women aged 10 or more years is estimated at 28.9% in 2008, compared to 15.5% for men. In Egypt girls have overtaken boys in some levels of education, but gender gaps exist in literacy and in enrollment in industrial and agricultural concentrations (Egypt Country Report 2009).

Women's education in Syria improved such that the ratio of girls to boys increased at all levels of education. In 2007 it reached 91.8% for primary

and 109% for secondary education, up from 84.7% and 77%, respectively, in 1990. Also, the ratio of literate girls to literate boys aged 15 to 24, increased from 86% in 1990 to 98% in 2007. Women's education in Iraq improved significantly during 1990-2007. During this period the ratio of girls to boys increased from 79.5% to 94.2% for primary education, from 64.1% to 76.9% for secondary education and from 50.9 to 86.6% for tertiary education. The ratio of literate women to men aged 15 to 24 increased from 75.6% in 1990 to 91.6% in 2007. Despite improvements in women's education, illiteracy is still higher among women (26.4%) than men (11.6%).

Significant progress has been made on women's education in the (OPT), but women's economic and political participation remain low. The ratio of girls to boys in basic education increased from 94% in 1994 to 98% in 2007. It increased from 80% to 110% for secondary education, and from 90% to 120% for tertiary education, for the same years respectively. The literacy rates have increased from 96.5% in 1995 to 99% in 2007, with no gender gap. In fact, the Palestinians are amongst the most literate population in the Arab World.

Women's education in the OPT is negatively impacted by the Israeli occupation. Tight closure adversely affected girls' access to education services, particularly in rural areas. Usually parents will not allow their daughters to attend school if they have to travel long distance or cross checkpoints. Therefore school drop-out rate is high. Also, in prisons the Palestinian women are subject to abuse and gross violation of their human rights. Women in prisons are not allowed to take the matriculation exams. For higher education, they are only allowed to enroll in the Open University of Israel that teaches in Hebrew language only, which is an obstacle for those who do not know the language.

Despite progress in education, the gender gaps remain high in the ALDCs. In Yemen the ratio of girls to boys enrolled in primary education improved from 45% in 1990 to 68% in 2006. The same ratio for secondary education improved from 14% in 1990 to 49% in 2006, and for tertiary education improved from 21% in 1999 to 36% in 2005 (Yemen Country Report 2009). The ratio of literate women to men aged 15 to 24 increased from 34% in 1999 to 61% in 2006. These rates indicate that women in Yemen are at disadvantage. In addition Yemeni women are highly illiterate at a rate of 62% nationwide and 72% in rural areas.

Progress has been made on women's education in Sudan supported by evidence on literacy rates which increased from 20% in 1990 to 62% in 2007 for women in Northern Sudan. The ratio of girls to boys in primary schools reached 93% in 2007. However, this indicator ranges from 106% in the Red Sea State to 43% in Northern Bahr Al Ghazal State. Southern Sudan has recently come out of a long protracted civil war. It lacks education infrastructure. Therefore women in southern Sudan are mostly illiterate. These analyses reflect sharp disparity between the states caused by the civil war, shortage of schools and cultural factors that inhibit girls' education (Sudan Country Report 2009).

### **Gender and Employment in Non-agriculture**

Despite improvements in women's education, women's share in wage employment in the nonagricultural sector is low in all countries. Some progress has been made in the Maghreb, Mashreq and GCC countries, but still far below the full productive potential of women. Women's share in wage employment in Tunisia increased from 17.9% in 1984 to 25.3% in 2007 (Tunisia country report

#### **Box 2**

### **Institutional reforms in support of women empowerment in Egypt and Algeria**

In Egypt a National Council for Women was established in 2000. Reporting directly to the president, the Council is governed by a board of 30 distinguished persons. It succeeded in mobilizing both the executive and legislative branches of the state to effect significant legal reforms in favor of women. Through their concerted work, rights and legal mechanisms previously denied became available to women. Article 20 in Personal Status Law No. 1 of 2000 gave women the right to obtain divorce through *khol'* in exchange for forfeiting their rights to the dower and the three month post-divorce spousal maintenance (*idda*). Article 17 of the same law gives women who have contracted an un-registered marriage to file for divorce thus recognizing the rights of women in these illicit unions for the first time in Egypt. In 2004, Personal Status Law No. 10 was passed, which introduced new family courts. Law 11 of the same year established a governmental family fund that allowed women to receive alimony from the fund and made the government responsible for collecting the alimony payments from the men. In 2005, a law extended women's child custody up to age 15 for both male and female children. Women also gained the right to pass on their citizenship to their children by presidential decree in 2004. Prior to that, a number of restrictions on women's mobility were repealed... Egyptian women gained the right to be judges and prosecutors. This was a truly stubborn last frontier for professional women and one which met much resistance due to the prevalent misinterpretation



of religious texts (Quranic and Prophetic). But 30 women judges were appointed in 2007, opening the door for others to follow.

*Source: Egypt Country Report 2009*

Algeria provides distinct experience in strengthening of the institutional mechanisms to ensure gender equality and development. The Council of Ministers adopted a national strategy for combating violence against women in 2007 and a strategy for integration of women in economic and social development in 2008. In addition, a department in charge of the family and women conditions has been established. Institutional developments include amendments of laws and regulations. For example, the family code which legally outline the relations between couples has been amended to ensure gender equality, particularly in relation to marriage and divorce. Also, the nationality code has been amended to allow the children of women married to foreigners to acquire the nationality of their mothers. Other amendments include constitutional changes to promote women's political rights through increasing their representation in elected assemblies.

*Source: ICPD/15 Algeria Country Report 2009*

2009). By contrast men's share declined from 78.6% in 1984 to 68.8% in 2007. Obviously, and despite the progress made in education, Tunisian women are still at disadvantage with regard to wage employment. In Lebanon, women's share in wage employment (as percent of total women's employment) increased from 72.5% in 1997 to 83.3% in 2005. The proportion of business and self employed women reached 11.2% of the total number of women in the labor force. Also the participation of Lebanese women in professional unions increased 57% for pharmacists union, 25% for the lawyers union, and 18.9% for medical doctors union. These indicators imply that women in Lebanon are increasingly becoming engaged in the formal labor market.

In Algeria, women's employment increased in all sectors of the economy. However, the financial crises resulted into decline in household income and increase in women's engagement in the informal sector. In Oman women make about 34.4% of the public sector employees in 2008. Their share in wage employment in the nonagricultural sector increased from 7.8% in 1993 to 17.9% in 2003. Almost 50% of the beneficiaries of the National Sanad for the development of Small and Medium Enterprises are women. In Syria women's participation rate in the labor force declined from 17.3% in 2004 to 16% in 2007, and their participation rate in agriculture declined from 54% in 2000 to 26.3% in 2007. This decline is attributed to women's shift to work in the services sector. Though women's participation in the labor force increased since 1990, Sudanese women are at disadvantage in the labor market. Women have less access to formal employment opportunities.

In the ALDCs, women's participation in the labor force is low. Also, the unemployment rate is higher among women than men. In Sudan for example, the unemployment rate for women (24%) is almost



twice that of men (13%). This gap is evident in both urban and rural areas. Women occupy 44% of the public sector jobs. However, most of them are clerical positions and few (less than 5%) are in top management and decision making positions. With low educational attainment, women's participation in the labor force is low accounting for about 23% in 2006. Their share in wage employment is stable at very low level of 7%. Most women work as unpaid family labor and in self employment business.

### **Political Empowerment and Participation in Public Life**

Women's representation in parliament has improved, but still very low in the region as a whole. It ranges from 1% in Yemen to 27% in Iraq in 2007. In spite of the impressive development in women's education in Tunisia and Lebanon, women in both countries are still at disadvantage with regard to representation in parliament and decision making positions. In Tunisia the representation of women in parliament rose to 22.7% in 2007, up from 7% in 1994. In Lebanon this percentage increased from 2.3 in 2000 to 3.9 in 2005. These low percentages are attributed to the prevailing traditions and cultural norms and values which discriminate against women. In spite of the efforts made in gender mainstream, school curricula is still male-biased. Therefore, there is need for political will and commitment to eliminate gender biases and reduce the gender mismatch, particularly between women's education and their access to wage employment and participation in parliament and decision making positions.

Algeria and Egypt have gone a long way in effecting institutional development reforms for the empowerment of women (Box 2). However, women participation in parliament and public life

is still low. Though it increased from 2.9% in 1997 to 7.8% in 2007, representation of women in the national assembly in Algeria is still low. Algerian women occupy only 13.6% of the senior executive positions in the country in 2009, compared to 4.4% in 1999. In Egypt women have been appointed, not elected, in legislative bodies and in both houses of parliament. Nevertheless, the People's Assembly had endorsed increasing the number of seats occupied by women to 64 as of 2011 elections. In Jordan the temporary election act increased the number of women's seats to 12 in addition to others who win by competition.

### **Gender Based Violence**

Gender based violence is common in the region, primarily because of patriarchal nature of societies. It is particularly high in the ALDCs and conflict countries. In the (OPT), for example, women are victims of various forms of violence including domestic violence, trafficking and sexual abuse (Box 3).

Socio-economic inequities, cultural traditions, conflicts, and the patriarch nature of society render women in Sudan highly vulnerable to violence. Female genital mutilation/Cutting is high at 70% for the country as a whole and 80% in the River Nile State. Some practical measures have been taken to promote women's access to justice and to combat violence against women. These include establishment of "Violence Against Women" unit within the Ministry of Justice and appointment of a gender advisor in each state. Efforts were made in raising awareness on gender based violence, training police and health care workers, and development of guidelines for clinical management of rape.

Female Genital Mutilation/Cutting (FGM/C) is mostly practiced in Sudan, Djibouti, Somalia, Egypt, Yemen, and Oman, and performed by traditional birth attendants. In Oman the FGM/C is prohibited in hospitals. However, 85% of women accept FGM/C. Actual medical examination revealed that 53% of women have endured FGM/C, 45.5% of who were described as “light”. Adolescents Health Survey 2001 indicated that 80% of female and male students in secondary schools believe that FGM/C is essential. However, this percentage goes down among students of educated parents, where 46% of female students of educated mothers expressed their refusal of FGM/C compared to 17% of female students of illiterate mothers.

## Infant and Child Mortality

Children are the most important human resource for the future. Investment in infants and children’s health and welfare is essential for improving maternal and reproductive health, and for achieving sustained economic growth and development. Infants and children are prone to illnesses and are at high risk of death from preventable diseases, such as diarrhea, polio, measles and cough. When children are born closely spaced to each other they are less chances survival compared to well spaced children. Therefore infant and child mortality often are positively correlated to fertility. In countries where fertility is high, infant and child mortality are also very likely to be high. This is

### Box 3 Gender Based Violence in OPT

Settler violence is frequently directed at Palestinians working in their fields. Palestinian women, who represent a substantial percentage of the Palestinian agricultural labor force, are direct victims of settlers violence. To add to their suffering and abuse, female prisoners are not entitled to family visits, including their children, or even call them, which has detrimental effect on their well-being, especially for those with life-long sentences.

Women and girls victims of trafficking for sexual purposes ... are mostly university students in their 20s, but some victims were as young as 12 and 14 years, that were married as “Urffi” and others were in their 30s and 40s that take prostitution as the only available means for living and to escape domestic violence.

The Palestinian society is patriarchal, where the discrimination between men and women is the basic element of men’s violence against women. Violence of occupation against Palestinians makes men take out their anger on women. In 2007, 33% of women in OPT reported physical abuse, 27% sexual abuse by an intimate, and 52% psychological abuse. Based on UNFPA survey in 2007, domestic violence has increased with rising political violence in 2007, with men using women as outlets for their anger, frustrations, and powerlessness. Women with secondary and higher education and working women were less likely to be physically and sexually abused.

*Source: ICPD/15 OPT Country Report 2009*

partly explained by high desired fertility and child replacement behavior: adding another birth each time a child dies. In such situations parents usually raise their fertility level as an insurance policy against future likelihood of death of some of their children. Frequent pregnancies and birth are detrimental to maternal and reproductive health and rights. The cycle of poor infant, child and maternal health is vicious in poor and large families where competition for food and other resources is high and the nutrition status is inadequate. Therefore a reduction in infant and child mortality will lead to multiple social development benefits of improving child and mother's health, reducing fertility and the desire to have more children, improving the level of nutrition in the family, and reducing poverty.

The ICPD/PoA and MDG urged governments to substantially reduce infant and under five mortality between 1990 and 2015. The ICPD advised governments to eliminate within-country disparities between geographical and administrative regions, and among ethnic, cultural and socio-economic groups. It identified a wide range of actions to be undertaken by governments and in collaboration with development partners, such as extension of integrated reproductive health-care and child-health services to all populations and within the framework of primary health care. These services should include adequate delivery assistance, neonatal care, including adequate breast-feeding and weaning practices, promotion of maternal nutrition and child spacing. Governments must give priority to reducing infant and childhood diseases and to preventing malnutrition among infants and children, especially the girl child. Also, they must assess the underlying causes of infant and child deaths, and support research for improving their wellbeing and health.

Overall, Arab countries have made significant

but variable improvements in child health and survival. These improvements are reflected in reductions in infant and child mortality to about 20 or less deaths per 1000 live births between 1990 and 2008 in Oman, Syria, Lebanon, Tunisia and Jordan (Charts 12 and 13). Also Egypt and Algeria have made remarkable progress and can achieve further reductions to below the current levels of 25 to 30 deaths per 1000 live births. In Iraq infant and child mortality increased between 1990 -1999 (not shown in chart 12), then declined in 2006 – reflecting negative impacts of the economic sanctions and subsequent positive effects of improvements in child health care and services, and increase in immunization coverage. Morocco and Yemen have made some progress in infant and child mortality, but not fast enough to achieve the target by 2015. Infant and child mortality have slightly improved in the (OPT) and increased in Sudan (Charts 12 and 13).

The majority of infant deaths in the region occur during the first four weeks after birth. These deaths are due to multiple factors of delivery complications at young age of mothers deformation, and lack of follow up during pregnancy.

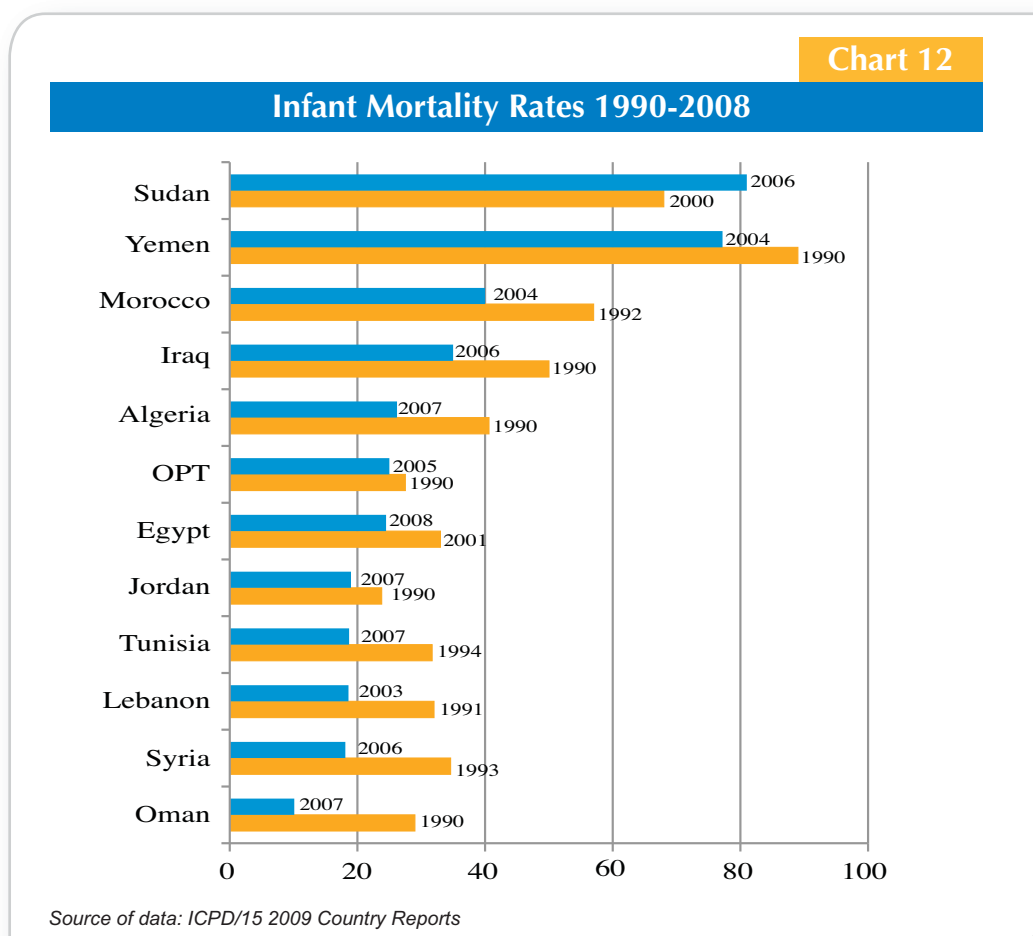


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Supported by declining fertility, the improvements in child health and variable reductions in infant and child deaths above-mentioned are due to expansion in immunization coverage, improvement in food and nutrition, successful facilitated by interventions in addressing childhood diseases such as measles, diarrhea, whooping cough, and polio, facilitated by increase in women's education, decline in teenage pregnancies and increase in the mean age at marriage.

Immunization coverage level of child nutrition have improved significantly in the Tunisia, Lebanon, Algeria, Jordan, Oman, Egypt, and Syria. Syria. For example, Syria has adopted an integrated maternal and child health strategy throughout the country.

Consequently, immunization coverage increased from 87.8% in 1993 to 92.4% in 2006. Results of a national survey conducted in 2007 indicate that 10% increase in immunization coverage will lead to reduction in infant mortality by 8 per thousand. Oman has introduced child spacing services in 1994 as an integral part of the program on maternal and child health care. The main objective of this service is to make contraceptive options available to couples who would choose to space and regulate their fertility, and to raise healthy children and family. Records show that a total of 16371 were registered in birth spacing clinics in 2007, of which 99% were Omanis. Children suffering from protein energy malnutrition in Oman declined from 128 in 1995 to 16 in 2007, per 1000 children below age 5. This



is attributed to increase in women's education and to increasing access to healthy and enriched food. However, official statistics show that about 88% of the infants are exclusively breastfed during the first six weeks. This percentage declines to 38.8 at the age of five-months <sup>12</sup>.

Though immunization reached full coverage, child mortality did not improve much in the (OPT). In fifteen years (1990-2005) under-five mortality slightly declined by 5 percentage points. Also, infant mortality negligibly dropped during the same period (Charts 12 and 13). The most direct causes of infant and child mortality are low birth weight, premature birth, anemia and infectious diseases. This situation is attributed to the occupation, escalation of the military operations, War on Gaza, limited access to health and social services, poverty and high unemployment.

Morocco has increased immunization coverage from 75.7% in 1992 to 89.1% in 2004. Yet improvement in infant and child health has been slow mainly because of insufficient health care services, including accessibility to care and the quality of services. It could also be attributed to decline in the rate of exclusive breast-feeding during the first 6 months from 51% in 1992 to 32% in 2004. In order to improve child health Morocco adopted a National Action Plan for Childhood for the period 2006-2015. This Plan aims at improving child health, particularly in the rural areas where under-five mortality is estimated at 69 and infant mortality at 55 in 2004.

Immunization coverage has improved in Yemen and Sudan, but has not yet reached universal

level. The proportion of one-year old children in Yemen immunized has increased from 52% in 1992 to 66% in 2003. In Sudan only 41% of infants aged 12 -23 months received DPT1-3, OPV1-3, BCG and measles vaccines (Sudan Country Report 2009). In addition to low immunization coverage, high infant and child mortality in both countries is attributed to high fertility and frequent pregnancy, insufficient child health care services, low weight at birth, premature birth, anemia and infectious diseases, limited access to health and social services, poverty and high unemployment, conflict and civil wars.

There is paucity of data and lack of research on infant and child mortality in Sudan. Available information on child health show that high child mortality is due to diarrhea, pneumonia, malaria, dehydration, malnutrition, and anemia. According to Sudan Household Health Survey (2006), 31% of the children under-five were moderately underweight and 9% were severely underweight. Malnutrition among children is due to high illiteracy rates, nutritional illiteracy, health taboos, food insecurity, poverty and lack of health education. In addition, breastfeeding practices are inadequate. One in every three infants is exclusively breastfed for six months. Though introduced in 1996, the Integrated Management of Childhood Illnesses (IMCI) program faced many challenges including inadequate performance of workers, limited skills, inadequate supervision and lack of support from the health system.

### **Disparities in Infant and Child Mortality**

The national picture reflected in table 3 and chart 4 masks within-country disparities in infant and child mortality. Country reports revealed significant disparities between rural and urban areas, administrative geographical divisions, and

5) The ICPD recommended action is to enable women to breast-feed their infants exclusively for four to six months without food or drink supplementation and to continue breast-feeding infants with appropriate and adequate complementary food up to the age of two years or beyond.



socio-economic groups (sex, income, poverty, education, etc.). In all countries the infant and child mortality rates are higher in the rural than urban areas, and higher for the poor than the rich households. In Syria infant mortality is higher for males (21) than females (14), higher for rural (20) than urban (16) areas and higher for the Southern area (22) than the other areas in the country. The same disparities are true for under-five mortality. It is higher for males (26) than females (17), higher for rural (24) than urban (19) areas, and higher in the southern area (27) than the other areas in the country. These disparities are explained by differences in the mean age at first marriage, use of family planning level of income, food availability, and women's education. A one percent reduction in poverty will lead to 1.6 per thousand reduction in infant mortality. Child mortality per 1000 live births is 28.5 for women aged less than 20 years compared to 18.5 for women aged 29 to 29. In Syria, 77% of infant deaths occur to illiterate mothers, and the higher the level of mothers education the lower the infant mortality rate.

Tunisia and Lebanon provide cases to further support the existence of disparities in infant and child mortality in the Arab World. In Tunisia, infant deaths declined in all geographic areas, but are higher in the West Center and the South than in other areas in the country. In Lebanon infant and child mortality are still high in the North and the Beka'a, compared to the low levels in Beirut and Mount Lebanon. In spite of the increase in immunization coverage to 82.9% in 2000, measles are still the most common disease among infants, particularly in the North. These disparities reflect the existence of health inequalities in the country. Most of the health services are concentrated in Beirut and Mount Lebanon.

Within-country disparities indicate that the improvement in infant and child health is not yet spread throughout all areas and socioeconomic

groups within each country. While urban areas and rich households are privileged, rural populations, poor households, and remote districts are at disadvantage in terms of child health services and care. The disparities are explained by differences in income, accessibility to maternal and child health services, level of income, food availability, and women's education.

### Reproductive Health

*"Today, on Human Rights Day, let us remember that all human beings are born free and equal in dignity and rights. Today and every day let us work together to end all forms of discrimination. Much progress has been made in the past 15 years to advance the right to sexual and reproductive health. UNFPA is committed to working with partners to advance women's empowerment and gender equality and to ensure universal access to reproductive health." Thoraya Obaid, UNFPA Executive Director, for Human Rights Day 2009.*



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Reproductive health services are essential for improving women's health through better management of pregnancies and fertility, and through reducing maternal mortality. Also, reproductive health promotes the health of infants and children. When women live a healthy reproductive life, their newborn babies will have a better chance to survive,

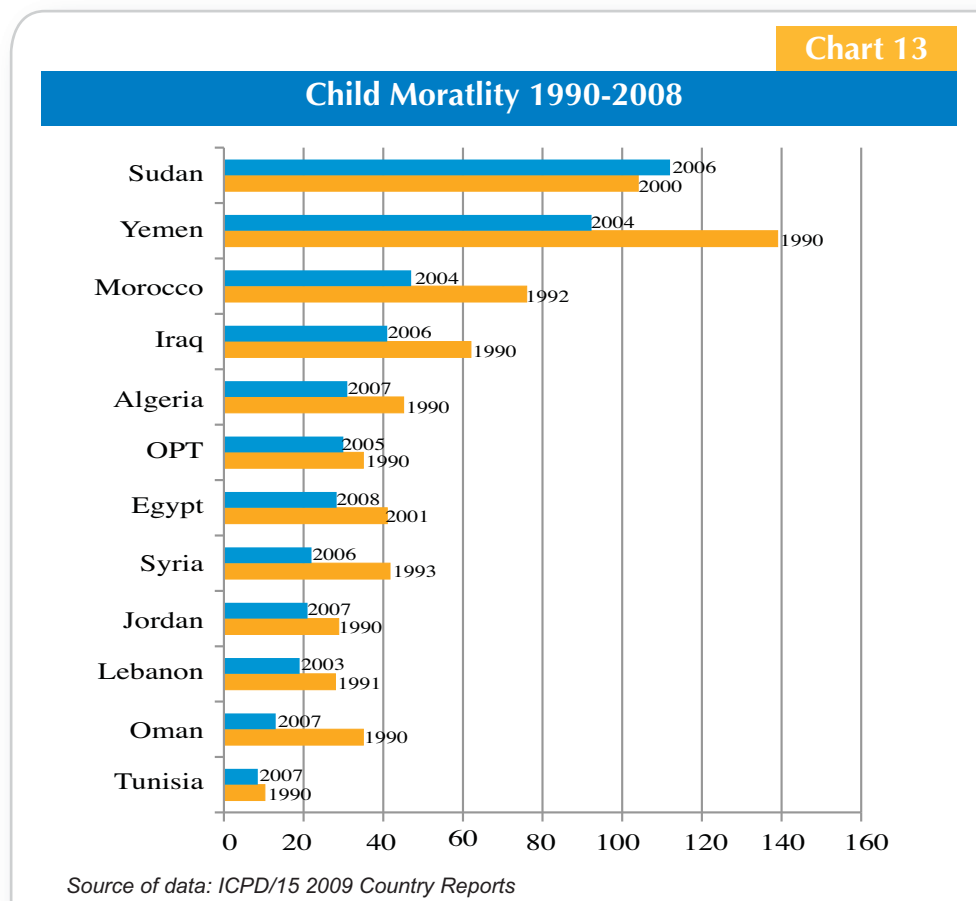
and their families are likely to live a much better life. The benefits of reproductive health extend to reducing health costs, improving productivity, and achieving social justice and stability. These multiple benefits drew the attention of the whole world in 1994 during the International Conference on Population and Development, which urged all governments to invest in reproductive health services and to make them available and accessible through the primary health care systems to all women and population groups.

Reproductive health has recently gained momentum in 2005 when the international community included universal access to reproductive health as an important second target for MDG5 to be achieved by governments in 2015. The first target is to reduce by three-quarters, between 1990 and 2015, the maternal mortality

ratio, which refers to the death of women from causes related to pregnancy and childbirth. These two targets are related and reinforce each other.

## The Demand for Reproductive Health

During the ICPD/PoA implementation and the MDGs assessment period, the Arab region experienced exponential increase in women of reproductive age. In two decades (1990 to 2010) the number of women aged 15-49 increased from about 52 million to 93 million (Chart 14). They will exceed 103 million in 2015. This rapid growth in reproductive age women is due to past high fertility. Undoubtedly, these increasing numbers reflect the level of demand and the pace at which the need for reproductive health services and for education in information and awareness creation

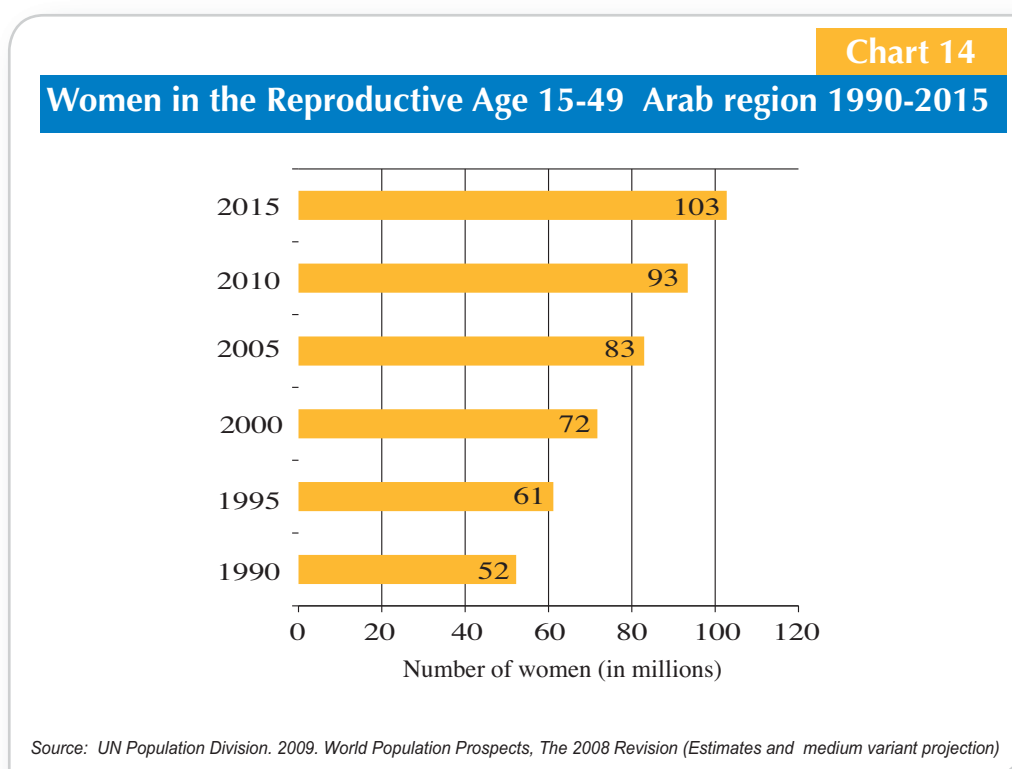


is increasing in the region. This escalating demand is a challenge for the governments. The analyses below show how countries, and indeed all women in the reproductive age, in the region managed this demand through follow up of pregnancies, delivery under supervision of skilled health personnel, provision of modern contraceptive methods and reduction of maternal mortality. The analyses provide information on the health systems, the institutional developments made since 1990, the challenges and constraints countries faced, the progress made, and the prospects for achieving MDG5 by 2015.

All Arab countries are committed to improving maternal and reproductive health, and to addressing maternal health issues. This commitment is reflected in developments in maternal health services made by governments and in partnerships with the NGOs, the private sector and international development partners. Also, it is reflected in declining maternal mortality

ratios, increasing follow-up visits during pregnancy, increasing chances to deliver under the supervision of skilled health personnel, and increasing use of modern contraceptive methods (Charts 15-18). These achievements are modulated by social and cultural changes reflected in indicators such as increasing mean age at first marriage and increasing women's education. Combined with improvements in maternal health, these factors reflect the depth and breadth of social and cultural changes in the region during 1990-2008.

Maternal and reproductive health varies considerably between countries, and within each country between various geographical and administrative divisions, and socio-economic groups (districts, governorates, rural, urban, etc.). Depending on internal political and social circumstances, and on the stage in the demographic transition, each country in the region provides its own unique and rich experience and practices on reproductive health and on improving

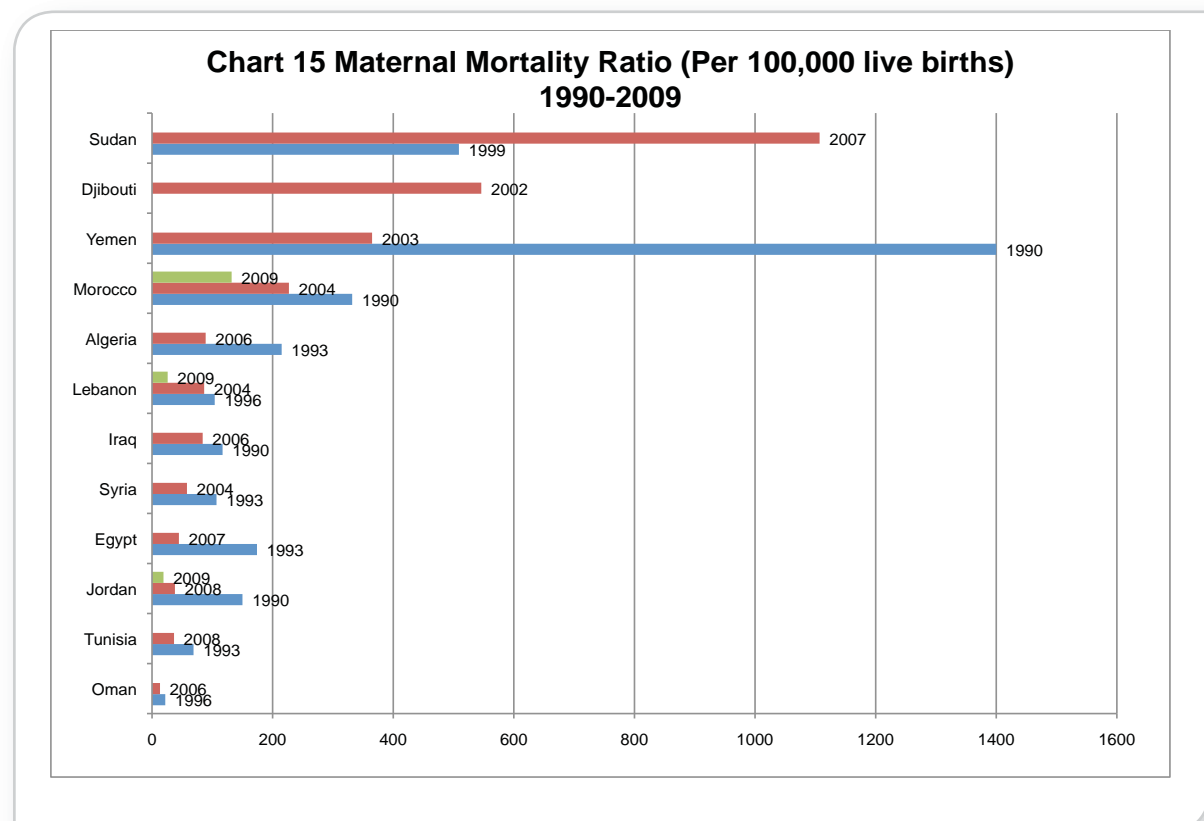


maternal health. The countries vary considerably on their institutional structures in terms of policies, laws, and strategies, on their resources and implementation capacities, and on their progress towards achieving MDG5 by 2015. Also, they vary on their level of investment and resource needs for improving maternal health in the future.

At this juncture it is pertinent to note that improving reproductive and maternal health has been influenced by the financial crisis and conflict and instability in the various parts of the region. With regard to financial crisis, countries in the region are facing budget cuts, phasing out development partners, and decline in public and private allocations to health services and essential drugs, and increasing health costs. On the other hand, conflicts are influencing maternal and reproductive health in Sudan, Somalia, Iraq, Palestine, and Yemen. Women in these countries

face immense difficulties to access reproductive health services. Particularly women displaced by conflicts and wars are in reproductive health crisis including death during pregnancy and delivery, sexual violence, rape, and lack of access to health services.

Chart 15 shows a wide range and variable reduction in the maternal mortality ratio in the Arab countries. The maternal mortality ratio is lowest and has slightly improved in the GCC countries represented here by Oman, where maternal mortality decreased from 22.0 in 1996 to 13.2 in 2006. These countries are rich and have invested heavily in maternal health services and social development during the last two decades. Also, they are highly urbanized, meaning that reproductive and maternal health services are within women's reach and accessibility at low cost. Improvements in maternal and reproductive



health in Oman is associated with the decline in fertility from 6.9 in 1993 to 3.13 in 2007<sup>6</sup> and is supported by the official government position, which encourages women to use family planning techniques and utilize free medical and health resources such as free consultation on reproductive health and free contraceptives. The law does not require a woman to have a signed consent from her husband to avail of health services, including reproductive health.

The Oman government adopted a national population policy that aims to establish empowering and administrative measures to promote reproductive health information and services, particularly those pertaining to family planning. All education and consultation services on family planning and reproductive health are provided free of charge at primary health care facilities. Consequently, antenatal care coverage increased to more than 99% and booking for antenatal care during the first trimester reached almost 65% in 2007. About 86.3% of mothers who delivered in 2007 had 4 or more ANC visits during pregnancy. The average number of ANC visits increased to 7.1 in 2007. Less than 1% of mothers have never visited ANC clinics. Also, postnatal visits of at least once after delivery increased to 100% in 2007, compared to 80% in 1991. Deliveries attended by skilled personnel increased steadily from 95% in 1995 to 99% in 2007.

Though adolescents make 30% of the population in Oman, there are no specialized health care programs directed at their reproductive health and life-styles, except for activities delivered as part of the school health program. Reproductive health is included as a chapter in a book "Facts for Life" for

students in grade 11. Also, there are no specific health care services and programs that address the needs of women at post childbearing age. These women constitute about 8% of all women in the sultanate. Of particular importance in this context is the provision of preventive measures such as regular smear tests, osteoporosis detection and investigation systems for health problems generally associated with this age-group.

Maternal mortality ratio is low and has declined in the Mashreq countries during the period 1990-2008. It declined significantly in Egypt from 174 in 1993 to 45 in 2008 and in Jordan from 61 in 1990 to 19 in 2009. These reductions are similar and are attributed to increase in the percentage of deliveries attended by skilled health personnel, increase in the percentage of pregnant women who had at least 4 visits, and increase in the use of modern contraceptive methods (Charts 16-18). The two countries differ from each other on these three indicators. Antenatal care and delivery under the supervision of skilled health personnel are higher in Jordan than in Egypt. However, the use of modern contraceptive methods is much higher in Egypt than in Jordan. Jordan succeeded to reduce the unmet need for family planning from 22.4% in 1990 to 11.9% in 2007. Egypt could further improve maternal health through increasing antenatal care coverage and deliveries under supervision of trained health personnel<sup>7</sup>. Improvements in maternal and reproductive health in Jordan and Egypt can be partly attributed to declining fertility, particularly among adolescents, in the two countries. Also, the mean age at first marriage increased in both countries. In Jordan there is a fertility stalemate at 3.6 till 2007, due to high increase in the number of married women in the reproductive age and to fertility increase for women aged 25-29.

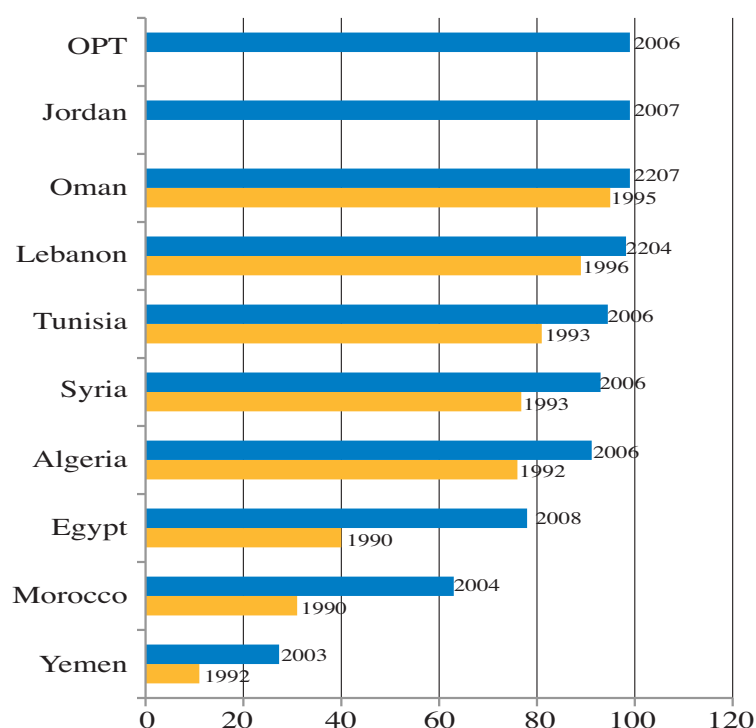
6) The fertility decline in Oman is due to increase in the use of contraceptive methods and increase in the Singulate Mean Age at first Marriage (SMAM) from 20.7 years to 23.3 years for females, and from 24.7 years to 26.2 years for males, during 1993-2003.

7) In the past the great majority of deliveries used to be performed by traditional Birth attendants (Daya). Daya schools in Egypt were abolished in 1954 by a government decree.



Chart 16

### Percentage of Births Attended by Skilled Health Personnel



Source of data: ICPD/15 2009 Country Reports

Lebanon and Syria have made good progress in improving maternal health. In Lebanon, the percentage of pregnant women who received antenatal care increased from 34.2% in 1996 to 70.5% in 2004, and those who delivered under supervision of skilled health personnel increased from 89% to 98.2% for the same years respectively. Syria also achieved high increase from 50.8% in 1993 to 84% in 2006 for antenatal care, and from 76.8% in 1993 to 93% in 2006 for delivery under the supervision of skilled health personnel. Maternal mortality ratio declined from 104 deaths per 100 thousand live births in 1996 to 86.3 deaths in 2004 in Lebanon, and from 107 in 1993 to 58 in 2004 in Syria. Lebanon is planning for a further reduction to 26 while Syria aims to reduce the maternal mortality ratio to 32 in 2015.

These percentages indicate developments and increasing utilization of maternal and reproductive health services during the last two decades in both countries (Box 4). Within-country disparities are quite significant. In Lebanon, the North and deprived areas are still underserved. Extension of reproductive health services particularly to the deprived areas will help in attaining the national target of reducing maternal mortality to 26 deaths per 100 thousand live births by 2015.

In Syria maternal mortality is highest in the eastern areas where fertility is high, education is low, and most of deliveries take place at home and under supervision of a traditional birth attendant. Antenatal care coverage in 2006 in Syria was

**Box 4****Reproductive health services in Syria and Lebanon**

During 1996-2004 Lebanon experienced an increase in the delivery of reproductive health services and information through the primary health care system in the country. Such services are delivered through 430 health and development services centers scattered all over the country. Indeed, while delivery in hospitals is increasing, reliance on traditional birth attendants is declining particularly in the deprived areas. For example, delivery under the supervision of a traditional birth attendant in Akar, the most deprived area in Lebanon, declined from 24% in 1990 to 18% in 1995 to 9% in 2000.

**Source:** Lebanon Country Report 2009.

In Syria reproductive health information and services are delivered as part of the primary health care system through 1750 health centers, hospitals and private health services. Primary health care is part of the overall Ministry of Health Strategy for 2001-2020. The health strategy focuses on integrated primary health care services, on their availability at low cost and on their proximity to the place of residence through providing a health centre for every 10,000 persons in rural areas and every 20,000 persons in urban areas. Reproductive health services and information in the country target all men and women in the reproductive age, as well as adolescents and youth, and women post the childbearing age. These services include antenatal care during pregnancy and delivery, postnatal care, family planning, counseling, consultation and management of sterility, early detection of breast cancer, sexually transmitted diseases including HIV/AIDS. Government commitment to family planning is reflected in the allocation of US\$ 1.6 million for purchasing modern contraceptive methods for the period 2005-2007.

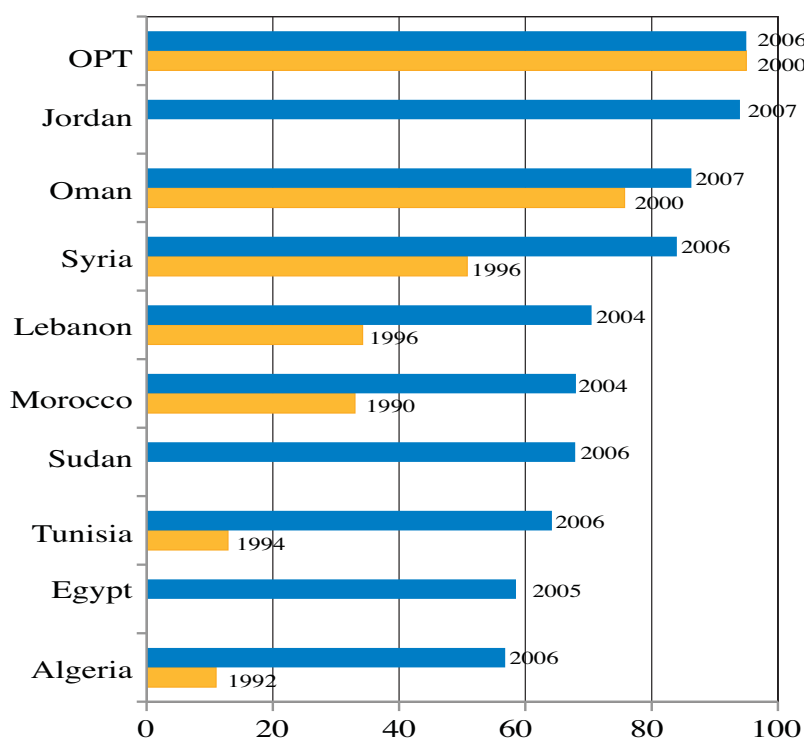
*Source: ICPD/15 Syria Country Report 2009*

90% in urban areas and 77.9% in rural areas. This reflects the difference between urban and rural women in awareness on the importance of antenatal care for their health. The country report document reproductive health disparities between the rich and poor people in 2006, and their implications for addressing poverty in the countries. About 27.4% of women in the poorest 5th of the population did not receive antenatal care during pregnancy, compared to only 5.4% for the richest 5th of the population. The average for the country as whole is 14.7%. In other words, the ratio of rich women to poor women who did not receive antenatal care during pregnancy is

roughly 1 to 5. This indicates that accessibility to reproductive health varies by the level of wealth. Similarly, the unmet need for family planning is highest (14%) among the poorest 5th and lowest (8.3%) among the richest 5th of the population in the country. The average for the country as a whole is 11%. A one percent reduction in poverty will lead to reduction of maternal mortality by 4 women per 100 thousand live births. Also, a 1 child reduction in the total fertility rate will lead to a reduction of maternal mortality by 23 women per 100 thousand live births (Syria Country Report). These disparities indicate the need for intensifying reproductive health interventions among the poor

Chart 17

### Percentage of Pregnant Women who had at Least 4 Antenatal Visits



Source of data: ICPD/15 2009 Country Reports

as a strategy to improve maternal health and address poverty in Syria.

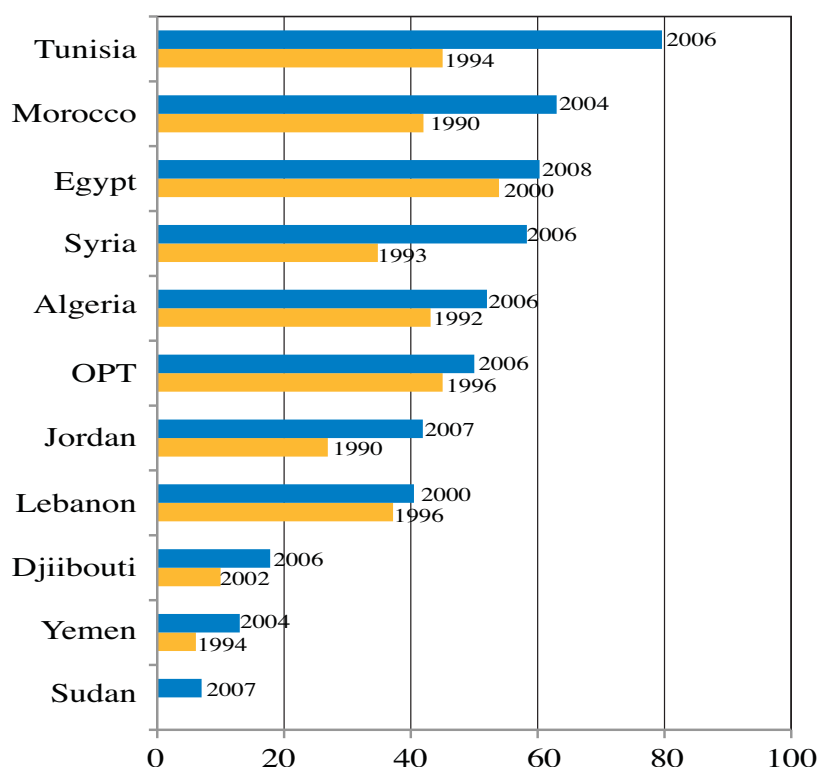
The use of contraceptive methods in Syria varies by place of residence and women's education. It is higher in urban areas (63.5) than rural areas (51.8%), and is highest in Al Suweda province (74.5%) and for women who completed university or higher level of education (70%), and lowest in Al Reiqqa (33.7%) and for illiterate women (45.2%). The unmet need for family planning is 11% for the country as a whole, 13.4% for rural areas and 9.2% for urban areas.

The (OPT) and Iraq are unique with regard to

reproductive and maternal health situations. The proportion of births attended by skilled health personnel, which measures the capacity of the health system to deliver health care services to pregnant women, increased significantly to 99% in both of the West Bank and Gaza Strip. In both OPT regions, the percentage of pregnant women who received antenatal care at least once increased to 99%, and at least four times increased to 95% in 2006. However, maternal mortality is underreported in Palestine. Reported maternal mortality ratio for the West Bank and Gaza Strip is 6.2 per 100,000 live births. A study on 431 women who died between the ages of 15 and 49 years in the West Bank in 2000 and 2001, show maternal

Chart 18

## Percentage of Women 15-49 Using Modern Contraceptive Methods



Source of data: ICPD/15 2009 Country Reports

mortality ratios of 29.2 and 36.5, respectively, per 100,000 live births. Cardiovascular diseases and hemorrhage were the most common causes of maternal death. About 69% of the maternal deaths are classified as avoidable.

Though it dropped in both of the West Bank and Gaza Strip, the adolescents' birth rate is high, at 60 per thousand women in 2005. It is higher in the camps and urban areas than in rural areas. In order to promote adolescents' reproductive health, sexual and reproductive health have been integrated into school curricula of the 11<sup>th</sup>

grade, teacher training and adult education program, the curricula of nursing and midwifery schools as well as in the activities of youth clubs and youth camps. The success of these interventions is due to partnership and close collaboration with ministries, governmental and non-governmental organizations, and development partners and agencies such as UNFPA.

Complex demographic, economic, social and political factors impact on maternal health in the OPT. In addition to high fertility, especially among

teenagers, such factors include low income, poverty, unemployment, and closure, occupation and restriction of movements imposed by the Israeli authorities. Palestinian women in the reproductive age face difficulties in accessing health care facilities. Each year about 2500 pregnant women experience difficulties reaching a delivery facility. Sometimes women deliver at checkpoints, jeopardizing the life of the mother and her child. Since the beginning of uprising in September 2000, at least 70 women gave birth at checkpoints, of these deliveries at least 34 infants and 4 mothers died due to complications. Therefore, pregnant women are discouraged to seek antenatal and postnatal care. Checkpoints obstacles and road closures have increased home deliveries by 8.2% since 2000. Another detrimental effect of movement restriction is the increase in induced labor and cesarean sections by 26% in Jericho.

On the other hand, Iraq has experienced a surge in maternal mortality during the 1990s and a decline in recent years. According to the country report the maternal mortality ratio was 117 per hundred thousand live births in 1990. It increased to 291 in 1999 and declined to 193 in 2004 and further to 84 in 2006. These improvements are due to increase in women's access to antenatal care and increase in the birth delivery under the supervision of a professional health personnel. About 84% of women aged 15 to 49 received antenatal care during pregnancy. Those who did not receive antenatal care during pregnancy expressed no need and difficulties in accessing antenatal care services as the main reasons.

In Iraq antenatal care varies considerably between urban and rural areas, and between the governorates. Access to antenatal care is highest for Alanbar (93%) and Baghdad (91%) and lowest

for Wasit, Gadesia, Nenawe, and Arbeel (ranging from 76% to 78%). The country report highlighted positive correlation between women's education and access to antenatal care; educated women are more likely to access antenatal care services and follow up pregnancies. Also, it documents an increase in the incidences of breast cancer, blood cancer, still births, and other difficult cases from 4259 incidences in 1998 to 6995 in 2004.

Maternal and reproductive health situation in the Maghreb countries is diverse. The maternal mortality ratio declined significantly from 68.9 in 1994 to 36.5 in 2008 in Tunisia, compared to decline from 215 in 1992 to 88.9 in 2007 in Algeria, and from 332 in 1990 to 227 in 2004 and 132 in 2009 in Morocco. The reduction and lower level of maternal mortality in Tunisia compared to Morocco and Algeria is probably due to fertility transition. In addition, birth attended by skilled health personnel in Tunisia is higher than in Morocco and Algeria (Table 6). Most of the improvements in Tunisia occurred in rural areas with 23 percentage points increase compared to only 4 points in urban areas. By contrast, rural areas in Morocco are at disadvantage and maternal mortality is much higher than in urban areas (Table 6).

Antenatal coverage tremendously improved in the three countries (Chart 17). This reflects the success of efforts made by the national safe motherhood programs in promoting antenatal care and in ensuring the quality of services during pregnancy and childbirth. However, these programs are urban biased, as reflected in significantly higher percentage of pregnant women who had at least 4 visits in urban than in rural areas. Extra efforts are needed to close the urban rural gaps in antenatal care. Also, health interventions must focus in the regions and social groups where there is shortage and services are most needed.

The three countries experienced increase in the use of modern contraceptive methods. However, the use of these methods is higher in Tunisia than



**Table 6**  
**Maternal Health Indicators by Place of Residence in Tunisia and Morocco**

Country	Maternal Mortality Ratio		Birth attended by skilled health personnel		Pregnant women who had at least 4 visits		Use of Modern Contraceptive methods	
<b>Tunisia</b>	69 (1993)	37 (2008)	81 (1993)	95 (2006)	13 (1994)	64 (2006)	45 (1994)	60 (2006)
Urban	NA	NA	94 (1993)	98 (2006)	18 (1994)	73 (2006)	67 (1994)*	61 (2006)*
Rural	NA	NA	66 (1993)	89 (2006)	8 (1994)	52 (2006)	33 (1994)*	58 (2006)*
<b>Morocco</b>	332 (1990)	227 (2004)	31 (1990)	63 (2004)	33 (1990)	68 (2004)	42 (1990)	63 (2004)
Urban	284 (1990)	187 (2004)	64 (1990)	85 (2004)	61 (2004)	85 (2004)	55 (1990)	66 (2004)
Rural	362 (1990)	267 (2004)	14 (1990)	40 (2004)	18 (2004)	48 (2004)	32 (1990)	60 (2004)

Source of Data: ICPD/15 2009 Country Reports

NA= Not Available. \* Contraceptive Prevalence Rate

in Morocco and Algeria (Chart 18). In Tunisia the use of pills quadrupled and the use of IUD almost doubled during the period from 1994 to 2006. This reveals women's preference for reliable methods which is linked to their improved level of education. During the same period the contraceptive prevalence rate increased rapidly in rural areas from 32.7% in 1994 to 57.8% in 2006, and declined in urban areas from 67.3% to 61.4%, respectively. The decline in urban areas is more pronounced in metropolitan Tunis than in the other regions, and is attributed to changes in the age distribution, delay in the age at first marriage and increase in the percentage of single women (Tunis Country Report 2009).

High maternal mortality ratios are a major concern for government in the ALDCs. In Yemen the government is concerned with maternal health and is keen to address reproductive health issues. This concern is arising from high fertility and its association with risky childbearing behavior: too early, too many, too close and too late pregnancies.

High fertility in Yemen means that women are exposed to high risk of death from pregnancy complications. Maternal mortality is high, estimated at 351 deaths per 100,000 births according to the 1997 DHS and 365 according to the 2003 PAPFAM Survey. These figures assumed some level of uncertainty imposed by methodologies of data collection and estimation. Still high, maternal mortality is related to low prenatal and postnatal coverage, and low delivery in hospitals under the supervision of skilled health personnel. According to the country report, about 61.7% of pregnant women in rural areas do not receive prenatal care, compared to 30.6% in urban areas. Most of the deliveries take place at home (70%). Only 27% of the deliveries are attended by skilled health personnel and only 16% of births occur in hospitals. Much needs to be done so as to improve maternal health in Yemen.

Though some progress was made since 2000, maternal health remains a major challenge in

Djibouti, mainly because of high fertility and low quality health services in the country. According to the country report, the maternal mortality ratio is estimated at 546 in 2002. The great majority of deaths occur during delivery. Knowing that most of the deliveries occur in medical facilities, much needs to be done to improve the quality of antenatal care. The contraceptive prevalence rate is low; 10% in 2002 increased to 17.8% in 2006. Efforts have been made in collaboration with development partners to improve integrated reproductive and maternal health services in the country, particularly in rural areas not adequately covered by the health system.

Maternal mortality ratio in Sudan was estimated at 509 in 1999 and 1107 according to the 2006 Sudan Household Survey. It is highest in Western Equatorial (2327), South Darfur (1581) and Kassala (1414). High maternal mortality is attributed to insufficient and inadequate maternal and reproductive health services, high illiteracy among women and high prevalence of traditional and harmful practices, such as FGM/C. Village midwives at the community level are the predominant providers of maternal services.



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Yet, village midwives cover only 49.1% of the country in 2006. Antenatal care services are inadequate. For the country as a whole 67.9% of women aged 15-49 had received antenatal care from qualified health personnel. The majority of women in poor states rely on traditional birth attendants who lack basic knowledge and resources. This is further complicated by high prevalence of FGM/C, which was 90% in 1999 declined to 69.4% in 2006. Also, the use of modern contraceptive methods is very low. Clearly, Sudan will not be able to make progress towards achieving the MDG target of reducing by three quarters the maternal mortality ratio. There is need for an assessment of the reproductive health situation in the country, taking into consideration the negative impacts of conflict on reproductive and maternal health.

### **HIV/AIDS, Malaria and other Diseases**

High disease-burden reduces productivity and the quality of life of people, and diverts investment and resources away from development projects and social services. Particularly the spread of HIV/AIDS, increasing prevalence of malaria and tuberculosis, and frequent emergence of health risks such as SARS and H1N1 influenza virus have drained much of the financial and human resources in the world. Therefore, population health received attention at the summits and conferences held during the last two decades, and will continue to attract the international community in the future. The outcomes of these conferences have been consolidated in MDG6 - combat HIV/AIDS, malaria and other diseases.

The ICPD/PoA refers to health as an important determinant of the quality of life and human welfare. People are the most important and valuable resource for any nation, and are entitled

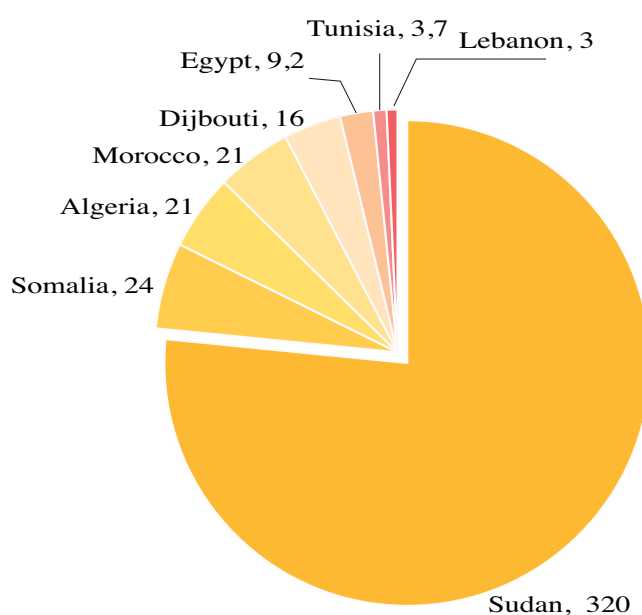
to a healthy and productive life. They have the right to development and the right to enjoy the highest attainable standard of physical and mental health. Therefore, states must take all appropriate measures and actions to ensure universal and equal access to health-care services, including reproductive health care, family planning and sexual health. The ICPD/PoA urges governments to fight HIV/AIDS and to increase their efforts to prevent, detect and treat sexually transmitted infections and other reproductive tract infections, especially at the primary health-care level. Also governments should reform the health sector and health policies, and examine ways to maximize the cost effectiveness of the health programs to reduce morbidity and mortality, and to ensure access to basic health-care services for all people.

## HIV/AIDS

The first HIV/AIDS cases in the region were detected in the 1980s. The Arab region is considered a low prevalence region. However, available information shows that the number of people living with HIV and the HIV prevalence and incidence rates are increasing. Recent UNAIDS estimates on the number of people living with HIV reveal an increasing trend from 107 thousand in 1990 to 419 thousand in 2007; the great majority of them in Sudan, Somalia, Morocco, Algeria and Djibouti (See Chart 19). The highest prevalence rates among adults aged 15 to 49 in the region in 2007 are reported in Djibouti (3.1) and Sudan (1.6). The modes of transmission are mainly heterosexual, multi-partnership without protection and through sharing of syringes.

Chart 19

### Estimated Number of People (000) Living with HIV/AIDS in 2007



Source of Data: 2008 Report on the Global AIDS Epidemic, (UNAIDS/WHO 2008)

Information on mother-to-child transmission, prevalence among pregnant women aged 15 to 49, AIDS deaths and AIDS orphans in the region are scanty. Sentinel surveillance testing conducted in 2004 in Sudan, show prevalence rates of 0.9% among pregnant women, 1.9% among symptomatic STD patients and 2.3% among TB patients. Djibouti reports a prevalence rate of 1.8% in 2007 for youth aged 15-24. In Morocco the incidence of sexually transmitted infections is high and the number of AIDS patients is rapidly increasing among women, professionals and male prisoners (Morocco Country Report 2009). The number of HIV registered cases increased from 6 in 1990 to 2493 in 2008 in Yemen and from 1533 in 2000 to 3747 in 2007 in Algeria. Registration is likely to underestimate the HIV prevalence in these countries.

Increasing HIV incidence and prevalence rates have directed the attention and concern of governments and development partners to the importance of taking actions at the country and regional levels. The ALDCs and Maghreb countries have instituted services to control the spread of HIV/AIDS. Yemen established a national program for HIV/AIDS, appointed focal points in 21 governorates, and formulated a national strategy for prevention and control. Djibouti developed a multi-sectoral strategic framework to guide the coordination of HIV/AIDS actions. Morocco and Algeria made significant progress in treatment of AIDS patients through free provision of antiretroviral drugs, established annual sentinel surveys, and established centers for anonymous and free tracking. Tunisia developed a comprehensive program for service delivery in prevention, counseling, testing and condom distribution. Sudan launched, in 2005, a national project for fighting HIV/AIDS in the country, and the government of South Sudan formed the New Sudan National AIDS Council for mobilization of

resources and coordination of actions against HIV/AIDS.

The GCC and Mashreq countries, where HIV incidence and prevalence rates are low, also instituted actions to fight HIV/AIDS. Oman reports collaboration among the sectors of the economy and society, establishment of a national AIDS technical committee, and national AIDS health education committee. Jordan and Egypt established an anonymous HIV/AIDS hotline service, a national AIDS program, and a national AIDS Coordination Committee. Syria established a community based HIV/AIDS education program for out-of-school youth, and Lebanon prepared a national AIDS plan for 2004-2009.

### **Malaria, TB and other Diseases**

Malaria, TB and other infectious diseases are prevalent in the ALDCs and in Algeria and Morocco. In Yemen, Sudan, and Somalia, malaria is a major public health issue. Through partnership with the Global Fund Yemen took actions to fight the spread of malaria and TB. Consequently, malaria prevalence rate per 100 thousand persons declined from 1263 in 1990 to 263 in 2006. There were 162270 registered cases of malaria in 2006 and 155692 in 2007. TB prevalence rate per 100 thousand persons declined from 188.6 in 1997 to 40 in 2004 and further to 13 in 2006. The proportion of TB cases detected and treated under DOT<sup>8</sup> (short course) was 2% in 1996, 55% in 2000 and 39% in 2004. (Yemen Country Report, 2009)

Almost 80% of the population in Northern Sudan is at risk of malaria transmission. According to Sudan Malaria Indicators Survey conducted in

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8) DOTS is Directly Observed Treatment Short course, which is an internationally recommended TB control strategy.

**Box 5****Activities to Fight Infectious Diseases in Sudan**

The Federal Ministry of Health in partnership with the UNDP and the Global Fund to fight AIDS, Tuberculosis and Malaria made the following achievements:

- TB success rate in 2005 was 81%, which is close to the 85% target set by WHO
- In 2008 5.4 million persons with uncomplicated malaria received correct diagnoses and treatment.
- 480,000 long lasting impregnated nets (LLIN) were distributed in 2008 in northern Sudan (72 000 LLIN in Southern and Western Darfur).
- 1400 service providers trained on malaria case management.
- 2900 service delivery points strengthened to provide diagnoses and treatment

*Source: ICPD/15 Sudan Country Report 2009*

2005, malaria is highly prevalent among children and pregnant women. With regard to tuberculosis, 36,740 new cases were reported in 2005, and the annual risk of infection was about 180 cases per 100 thousand persons, half of them smear-positive. The TB case detection rate was 35%, which is far below the 70% target. In spite of the efforts made to combat infectious diseases (Box 5), TB and malaria remain the major health hazards in Sudan.

TB is a major health problem in Morocco, as 26099 new cases were detected in 2006. Its incidence is high among men aged 15 to 45 in urban areas. The prevalence of TB is high. Deaths attributed to TB increased from 2 per 100 thousand in 2000 to 12.4 in 2006. TB cases detected and treated under DOT reached 90% in 2005 and 86% in 2006.

### **Population, Dynamics Climate Change and Environment**

Population dynamics and climate change are intertwined. Changes in population size and distribution, population movements to work and

live in areas where services and development activities are concentrated, and movements instigated by conflict and war, are all linked to climate change the environment and to the welfare of current and future generations. Consistent with Agenda 21, the ICPD urges governments to take actions to integrate demographic factors into environmental impact assessment, utilize demographic data to promote sustainable resource management, formulate and implement environmentally sensitive population policies and programs, and implement policies to address the ecological and climatic implications of population change and population distribution. The MDG targets related to these actions are:

- a) Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources,
- b) Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation, and
- c) By 2020, to have achieved a significant improvement in the lives of 100 million slum dwellers.



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## Population and Climate Change

Recent research has emphasized the role of population growth and distribution in climatic change, which is caused by emissions of carbon dioxide and gases into the atmosphere. These gases lead to imbalances in the climatic system, which will consequently result into real threats to the environment and the welfare of people. The United Nations Convention on Climate Change (UNCCC) refers to major threats of climate change including water shortage, rising sea levels, droughts, land degradation and soil erosion caused by torrential rains, reduction in agriculture and food production, population displacement from coastal and low land areas, and spread of diseases.

Climate change is produced by human pressures on the ecosystems. These pressures originate from the intensity of human development activities on earth. Therefore people cause climate change and are affected by it. People who contribute most to climate change live in developed countries, where human and industrial activities are intense, population growth is low and the quality of life is high. People most affected by climate change are those who contribute least to it and those who can least afford to address its impacts on people and the environment. The UNFPA agenda on population and climate change is consistent with the ICPD/PoA and the UN Framework on Climate Change. It calls for the promotion of reproductive health and family planning to slow down population growth, which is expected to curb pressures on natural resources, reduction of urban vulnerability. Particularly, cities are highly vulnerable to environmental hazards, such as rising sea levels, earthquakes and mudslides. Also, vulnerable population groups and people living in slums are usually the most affected by global environmental changes. Therefore, it is important to reduce population vulnerability to climatic changes.

The Arab region is characterized by fragile natural resources, and increasing population pressures on the environment. Climatic change, water scarcity, desertification (including shortage of fertile land) and pollution (water pollution, air pollution, pollution of coastal zones) are the environmental challenges that impact on development and human welfare in the region.

The contribution of the Arab region to climate change is minimal. According to the Arab Human Development Report 2009, the Arab World contributes about 4.7% of carbon dioxide emissions, which is the second lowest in the world. Also its contribution to the global methane and nitrogen oxide emissions is the lowest in the world because of its relatively low level of industrial development. However, the Arab countries are among the most affected in the world. Countries in the Arab region are facing a wide range of impacts related to climatic changes, including water shortage, reduction in agricultural production and food, and increase in environmental refugees (Table 7). Therefore the Arab Countries need to introduce mitigation and adaptation measures to address the negative impacts of climate change. These measures must integrate population dynamics into development and environment interactions in the region. They must incorporate the climatic and environmental implications of changes in age structure, family composition and structure, and changes in life styles and in consumption and production. Also, they must promote reproductive health to slow down population growth, which is expected to curb pressures on natural resources, and to attend to the unmet need for family planning.

All countries reported progress in population accessibility to safe drinking water and to sanitation, but the progress is not at the pace of achieving the target by 2015. It is hindered by

water shortage and water management issues, and by lack of financial resources. Also, progress in achieving the targets is slowed down by the rapid increase in slum dwellers. Egypt's slum population is estimated at 9.7 million in 2004 and 12.6 million in 2006. In Syria 23% of the urban population live in slums around the cities (Syria Country Report 2009). Slums create financial pressure on municipalities to provide water, housing and shelter, and to manage waste and combat the spread of diseases. The countries reported direct linkages between rapid growth of slums and the increase in urban poverty, high unemployment rates among urban youth, and increase in the urban informal economic activities. Also countries reported housing congestion. For example, in Iraq 18.6% of the houses in 2007 are occupied by more than one family. This percentage reached 31.6% in Al Basra.

All countries reported significant disparities

between urban and rural areas, and between regions and districts within each country. In Syria, for example, 80.4% of the rural people have access to safe drinking water and only 44.5% have access to sanitary services, compared to 93.5% and 95.5% respectively for the urban people. These disparities reflect urban-bias and inequality in the provision of social services.

Countries are involved in the development of low cost housing as a strategy to provide decent living conditions for poor people and slum dwellers. In Morocco, for example, the government program "cities without slums" aims at improving the conditions of 298 thousand homes. So far 130 thousand people moved from informal to formal housing. In addition to government, the project involves banks and private housing developers. Such partnerships reflect triple wins - for the poor people, the government and the private housing development companies.



**Table 7**  
**A Broad Overview Of Some Potential Effects Of Climate Change In The Arab World**

SECTOR	CURRENT THREATS	POTENTIAL EFFECTS OF CLIMATE CHANGE	SOME ADAPTION OPTIONS
ECOSYSTEMS AND BIO-DIVERSITY	<ol style="list-style-type: none"> <li>1. Increasing population pressure and inappropriate systems of land-use.</li> <li>2. Loss of biodiversity,</li> <li>3. deterioration in land cover</li> <li>4. Depletion of water resources.</li> </ol>	<ol style="list-style-type: none"> <li>1. Arid and semi-arid areas are presently under threat from land degradation and desertification.</li> <li>2. Increasing rates of biodiversity loss</li> <li>3. Tourism industry will be affected.</li> </ol>	<ol style="list-style-type: none"> <li>1. Reduce rates of deforestation.</li> <li>2. Improve land management and reduce rates of land degradation.</li> <li>3. Expand the protected areas</li> <li>4. Encourage the sustainable management of forests.</li> </ol>
WATER RESOURCES	<ol style="list-style-type: none"> <li>1. Most of the ground water resources in the region originate from the neighboring countries</li> <li>2. Water insecurity resulting from scarce water resources and increasing demand for water</li> <li>3. Increasing sea water salinity in the Gulf.</li> <li>4. Increasing levels of pollution and siltation of river basins</li> </ol>	<ol style="list-style-type: none"> <li>1. Reduced precipitation and increased rainfall variability will reduce rates of recharge of underground aquifers and dams.</li> <li>2. The resulting decline in water availability and quality will cause an increase in the cost of supply and will impact on public health, hydropower generation and irrigated food production.</li> </ol>	<ol style="list-style-type: none"> <li>1. Introduce water demand management and other methods that will ensure the more efficient use of water.</li> <li>2. Improve water resource management on a regional basis, particularly regarding shared water resources</li> </ol>
COASTAL SYSTEMS	<ol style="list-style-type: none"> <li>1. Coastal areas are under threat from increasing population pressure, conflicting land use and inshore pollution (from domestic, industrial and agricultural effluent).</li> </ol>	<ol style="list-style-type: none"> <li>1. Sea level rise and increasing rates of erosion and inundation associated with climate change threatens several coastal zones.</li> <li>2. Sea level rise and climatic variation is expected to damage coral beds thus increasing the potential for erosion, inundation and human displacement.</li> </ol>	<ol style="list-style-type: none"> <li>1. Adaptation measures will be costly. It will include relocation of vulnerable human settlements</li> </ol>

**Table 7**  
**A Broad Overview Of Some Potential Effects Of Climate Change In The Arab World**

SECTOR	CURRENT THREATS	POTENTIAL EFFECTS OF CLIMATE CHANGE	SOME ADAPTION OPTIONS
<b>AGRICULTURE AND FOOD SECURITY</b>	<ol style="list-style-type: none"> <li>1. Countries are dependent on agriculture for GDP, employment and food production</li> <li>2. Agricultural output depends strongly on the quality of the rainy season.</li> <li>3. Land degradation reduces the production potential of agricultural land</li> <li>4. High dependence on variable annual rains for crop production</li> </ol>	<ol style="list-style-type: none"> <li>1. Food insecurity, social instability and increased rates of urbanization</li> <li>2. Changes in vegetation cover will increase rates of soil erosion.</li> <li>3. Increased vulnerability to crop failure and reduced productivity from livestock due to increased pests and diseases, rising temperatures and variability in rainfall.</li> </ol>	<ol style="list-style-type: none"> <li>1. Combating land degradation and desertification through sustainable rangeland management practices.</li> <li>2. Offering incentives to farmers to diversify farming.</li> <li>3. Improve monitoring and communication capabilities in order to enhance the responsiveness of farmers to food crises.</li> </ol>
<b>HUMAN HEALTH</b>	<ol style="list-style-type: none"> <li>1. Spread of water born diseases such as bilharzias,</li> <li>2. Malaria</li> <li>3. TB and Hepatitis</li> </ol>	<ol style="list-style-type: none"> <li>1. Threatened food security will impact upon life expectancy and quality of life, especially amongst the poor.</li> <li>2. Deaths from heat waves are expected to rise.</li> <li>3. Altered temperature and rainfall patterns will change the distribution patterns of infectious diseases – particularly those that are insect borne.</li> <li>4. Malaria (and other insect borne diseases) is expected to spread into new areas.</li> </ol>	<ol style="list-style-type: none"> <li>1. Ensure that the quality of life for rural and marginalized urban communities continue to improve.</li> <li>2. Improve disaster preparedness.</li> </ol>

Source

During the period since 1990, the Arab countries prepared environmental action plans and strategies, and issued laws and regulations for better management of their natural resources and to protect the environment. They established ministries, departments, agencies and councils to deal specifically with the environment. Syria, for example, integrated environmental concerns in its tenth national five-year plan, and introduced new policies to improve water use, management and distribution. Such policies included changes in water tariffs to recover operation and maintenance costs.

Conflicts in the region, particularly the recent wars in Gaza Strip and in Lebanon, have led to the destruction of the water and sanitation infrastructure. In Sudan, Yemen and Somalia conflict hampered institutional development for protection of the environment and integration of environmental concerns in national development plans and strategies.

## Partnership for Population and Development

Both of the ICPD/PoA and MDGs recognize the crucial role of partnership for development at the global, regional and country levels. Partnership between Governments, national and international NGOs, and the donor organizations is needed for dialogue, consultation, and building consensus on national development priorities, and to facilitate the role and contribution of various stakeholders in the formulation and implementation of development activities. Besides ensuring availability of adequate financial and human resources, partnership helps in sharing responsibilities, and in linking program and project inputs to delivery of the final results. Important conditions for effective partnership include the existence of institutions and governance structures to provide legitimacy and framework for implementation of

the activities, and development of the necessary infrastructure to facilitate communication and sharing of information and knowledge among the development partners.

Partnership for population and development in the Arab region is quite diverse, as the countries are at various levels of income and welfare. The countries vary considerably in their institutional capacities and national development priorities and needs. The GCC states are high income countries endowed with energy resources. They have advanced information and telecommunication systems. They have been building and developing partnerships mostly in relation to the management of energy and wealth, and to their needs for human resources and expertise. These countries cooperate with each other bilaterally and through the GCC on population and development activities, population policies and on laws and regulations relating to migrant labor. Together they undertook the GCC Family Survey 2008, which is expected to provide a base for regional partnership in reproductive health and family planning. Also they have developed partnerships for the consolidation of humanitarian and emergency assistance to the ALDCs and other Arab states.

The Maghreb, Mashreq and ALDCs have established partnership frameworks for cooperation with donors and international NGOs. The main purpose of partnership in these countries is to coordinate stakeholders' contributions to various activities, and to utilize international resources, including technical and financial assistance, to address complex development challenges (Box 6 for development partnership in Egypt). Therefore, the development of partnership in these countries is a complex matrix that covers many stakeholders and partners at all levels involved in complex population and development programs and activities. It has included civil society organizations, national and international NGOs, parliamentarians,



### Box 6 Development Partnership in Egypt

The population Sector went through a series of large USAID-supported population projects. The most recent two projects implemented in the area of RH/FP are TAHSEEN implemented by CATALYST, and TAKAMOL implemented by Pathfinder consortium.

TAHSEEN mission is to improve the quality and availability of sustainable reproductive health and family planning services. TAHSEEN developed partnership with political leaders, physicians, nurses, community outreach workers, religious leaders, literacy educators, agriculture and irrigation workers, media professionals and youth

TAKAMOL started in 2006 for 5 years. The project aims at achieving sustainable reduced fertility and improved health outcomes for mothers, newborns and young children in Egypt. TAKAMOL works with local Community Development Associations (CDAs), train them and the Raeda Rifeya (RR) to implement behaviour change activities targeting women, men and youth.

*Source: ICPD/15 Egypt Country Report (2009)*

trade unions, institutions of excellence and networks of professionals, faith-based groups, and the private sector, among others. The countries have developed strategies and policies, and established institutional structures to coordinate NGOs activities and programs and promote their efforts. For example, the overall health strategy in Egypt calls for encouraging public private partnership and involvement of counties and civil society organizations in addressing different health concerns.

During the period since 1994, development partnerships in the Maghreb, Mashreq and ALDCs have covered a wide range of programs and projects in population and development, HIV/AIDS, tuberculoses, and malaria, reproductive health, gender and empowerment of women, gender based violence, humanitarian assistance, and fighting harmful traditional practices such as FGM/C. Countries have streamlined development partnership in these areas in their national development strategies and plans. Activities

include service delivery, social aid, financial support, local society development, protection and care, and meeting special needs. Partnerships on these activities cover local communities and vulnerable population groups at national and local levels, and difficult-to-reach areas.

The strength of partnership varies across program areas, and often is short term for the duration of the project. Partnership for development in the ALDCs is constrained by limited financial, institutional and human capacities, and high staff turn-over. National NGOs lack resources and are often weak partners with Government. Therefore, population and development programs and activities are largely dependent on funding through the UNFPA. Partnership for development in conflict areas focuses on crises management, emergency and humanitarian assistance. In the areas such as Darfur, the UNFPA gives priority to reproductive health and gender based violence.



## V. ACHIEVEMENTS AND CHALLENGES

**T**he foregoing analyses show that countries in the Arab region are committed to the implementation of the ICPD/PoA and monitoring progress towards achievement of the MDGs. This is reflected in institutional developments including formulation of policies, establishment of national councils and committees, involvement of parliamentarians, faith based organization and NGOs. However, these efforts are greatly challenged by a wide range of factors such as changing family composition and relations, changing age structure, rapid urbanization, and international migration.

Most of the Arab countries are of middle income level, meaning that extra efforts are needed to mobilize domestic resources and harness partnerships and technical assistance to support the implementation of the ICPD /PoA. Particularly, investment in reproductive health including family planning to improve the survival of mothers and their infants require mobilization of resources and adoption of innovative funding strategies. The achievements related to the implementation of the ICPD/PoA and the constraints encountered in the implementation process, are described in the next Section.

## A. Arab region overall

### **Achievements**

1. Continued commitment to the implementation of the ICPD/PoA and to monitor progress towards achievement of the MDGs
2. Institutional developments including formulation of policies, establishment of national councils and commissions, involvement of parliamentarians, faith based organization civil society and NGOs
3. Demographic transition shown in declining fertility and improving mortality. The demographic transitions reflects modernization and cultural change, and overall improvement in population health
4. Decline in population growth from 2.4% in 1990 to 1.8% in 2010
5. Change in age structure leading to rapid increase in the working age population, youth and older persons

### **Challenges**

1. Instability and negative impacts of conflicts and wars on development and human welfare (the 1990 gulf war, wars in Yemen in 1994 and 2009, in Iraq 2003, Lebanon 2006, Gaza Strip 2008, Darfur 2003, and continuing conflict in Somalia and Palestine)
2. Direct impacts of foreign dominance, occupation, geopolitical and strategic position in the world, on development priorities in the region. Diversion of the financial and human resources from development activities to conflict management and humanitarian assistance
3. Impacts of the financial and economic crisis, including budget deficits, decline in revenues and remittances, decline in tourism, and increasing unemployment. Negative impacts of the financial crises on population health and welfare, and on the availability of funds for the implementation of programs and activities
4. Low implementation of the policies and commitments on population and development, reproductive health and rights and gender

5. High population growth momentum due to past high fertility and young age structure
6. Weak coordination of population activities and programs, and integration of population dynamics and issues in national development plans and strategies
7. Low community and civil society participation in the implementation of population programs and activities
8. within country disparities in economic and social development, in the provision of education and health services, and in infrastructure and communication technology

## B. Poverty

### **Achievements**

1. Increased per capita income and food production
2. Moderate increase in employment and labor force participation rates
3. Diversification of the economies and improvements in human capital

### **Challenges**

1. Increasing income inequality and skewed income distribution in favor of the rich people
2. High food insecurity due to water shortage compounded with high population growth.
3. High and rapid increase in unemployment rates, particularly among women and youth
4. Low role of pensions and social protection schemes in supporting poor households
5. Low wages and earnings, and declining remittances

## C. Education

### **Achievements**

1. Rapid progress towards achievement of universal primary education due to improvement in the implementation of education policies



2. Overall rapid increase in girls education, and increase in the progression of girls in primary schools to secondary and tertiary levels of education
3. Decline in drop-out from schools due to expansion of the education system and improvement in education infrastructure

### **Challenges**

1. Slow progress in primary, secondary and tertiary education in the ALDCs. The capacity of the education systems in these countries is still below the rapid growth of school age population
2. Continued investment in education to sustain the achievements made. Low Investment and low quality education, especially in ALDCs
3. Accessibility to schools constrained by long distance from home and lack of school transportation services
4. Improvement of educational infrastructure, particularly class rooms, water, sanitation and health services, is challenge that needs to be addressed so as to improve the retention and progression of children to the higher levels of education, and to reduce drop out from schools especially among girls.
5. High cost of education for children in poor households

### **D. Gender Equality and Empowerment of Women**

#### **Achievements**

1. Institutional developments relating to gender equality and empowerment of women. These include amendment of the laws that discriminate against women, ascendancy of women to high level positions, and establishment of relevant national councils and institutions

2. Significant gains achieved by women in the labor force, voting in elections, in politics, in business and participation in public and private arenas
3. Increased ratio of girls to boys at all levels of education, reflecting progress towards gender parity in education

### **Challenges**

1. Low share of women in wage employment in the nonagricultural sector. Women's involvement in paid employment is still below their productive potentials and not commensurate with their educational attainment
2. Low women's access to productive resources, including land and funds
3. High gender gap in education in ALDCs
4. Gender based violence
5. Show progress in eradication of Female Genital Mutilation/Cutting.

### **E. Child Health**

#### **Achievements**

1. Significant reductions in infant and child mortality
2. Expansion of immunization coverage
3. Successful interventions in addressing childhood diseases, such as measles, diarrhea, and whooping cough
4. Decline in teenage pregnancies
5. Increase in women's education and the mean age at marriage

### **Challenges**

1. High child malnutrition in poor households
2. Low immunization in ALDCs especially in rural areas
3. Declining rate of exclusive childbearing
4. High infant and child mortality in the ALDCs and in rural areas
5. High fertility, particularly in rural areas and in the ALDCs



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## **F. Reproductive Health**

### **Achievements**

1. High commitment to improving maternal and reproductive health and rights
2. Successful interventions to promote safe motherhood and ensure safe pregnancy delivery and new born children.
3. Expansion of primary health care services
4. Decline in maternal mortality ratios
5. Increased delivery under the supervision of skilled health personnel
6. Increase in the use of modern contraceptive methods in the Mashreq, Maghreb and GCC countries

### **Challenges**

1. Alarming high maternal mortality in the ALDCs
2. Below universal access to reproductive health and rights. There is still need for further improvement of maternal health in the region through increasing antenatal care coverage, anti tetanus toxoid vaccination coverage, medically assisted delivery, and the use of modern contraceptive methods
3. High unmet demand for modern contraceptive methods, particularly in rural areas and in the ALDCs

## **G. HIV/AIDS, Malaria, TB and Other Diseases**

### **Achievements**

1. Development of health services for the treatment of communicable and non- communicable diseases
2. Development of institutional structures and implementation of programs to fight HIV/AIDS, TB, and malaria
3. Increasing knowledge and awareness on HIV/AIDS

### **Challenges**

1. Increasing HIV/AIDS prevalence. The currently low HIV prevalence rates might rapidly increase in the future, and the region might face an epidemic unless intervention measures focusing on high risk behaviors are in place
2. Inadequate HIV interventions. Knowledge and awareness on HIV are blemished with misconceptions
3. Low use of condom, which is generally viewed as a family planning method rather than a tool for HIV prevention
4. Stigmatization of people living with HIV/AIDS, due to conservative culture.
5. Tendency to downplay the prevalence of HIV, which resulted into lack of evidence and ineffective and rare surveillance in the region
6. Increasing morbidity associated with the spread of infectious and communicable diseases such as malaria, TB and Hepatitis, particularly in the ALDCs
7. Increasing morbidity associated with changes in lifestyles, obesity, the epidemiological transition, and non-communicable diseases such as diabetes, cancer and cardiovascular diseases, particularly in the GCC
8. Emerging health needs associated with ageing

## **H. Environmental Sustainability**

### **Achievements**

1. Formulation of environmental action plans and strategies, and establishment of institutional structures for better management of the environment
2. Increased population access to safe drinking water
3. Increased population access to sanitary services
4. Improvement in housing development and ownership

### **Challenges**

1. Climate change and its impacts on food and agricultural production, and on population dynamics and distribution
2. Drought and rising sea levels associated with climatic change
3. Rapid urbanization associated with consumerism and increasing waste production, increasing demand for housing and rapid growth of slums
4. Water insecurity due to origination of water resources outside the region, and to increasing demand for fresh water for drinking and agriculture
5. Air pollution and its impacts on population health and the environment in cities

### **I. Partnership for Development**

#### **Achievements**

1. Existence of institutions and governance

structures to provide legitimacy and framework for implementation of the activities,

2. Existence of relevant policies and development frameworks
3. Advanced information and telecommunication systems.

### **Challenges**

1. Dependence on external sources of funding
2. Shortage of financial resources for the NGOs
3. Limited financial, institutional and human capacities, and high staff turnover
4. Lack of data and paucity of research remain as major challenges for policy and decision making. There is lack of baseline surveys and indicators on important thematic areas such as maternal mortality, poverty, urbanization.
5. Shortage of resources, particularly human resources, for data generation and analyses



## VI. MAIN CONCLUSIONS AND PRIORITIES FOR THE FUTURE

**D**uring the period since 1990, the Arab World has experienced significant changes and transformations that have a wide range of policy implications for the implementation of the ICPD/PoA and achievement of the MDGs. Besides the Arab Israeli conflict, which continued for long without reaching lasting peace and solution, the Arab World witnessed wars in Iraq (2003) and the conflict and instability for decades, Lebanon (2006), and Gaza Strip (2008), conflict in Darfur (2003), and civil wars in Somalia since 1990s and Yemen 1994 and 2009. Frequent outbreak of conflicts has led to the displacement of millions of people throughout the region, thereby jeopardizing efforts for peace, security and development. Also, crises management and humanitarian assistance have overshadowed developmental needs in the region. The situation has been further complicated by the financial and economic crisis, which has impacted on the financial resources and on the implementation of development projects in the region.



The Arab region has undergone profound changes and transformations during the last two decades. They include changes in family composition and structure, marriage and family formation, culture, urbanization, age structure and intergenerational relationships. These changes have a wide range of policy implications for the implementation of the ICPD/ PoA and achievement of the MDGs. They provide opportunities and at the same time generate new challenges to be addressed. People in the region live longer than ever before, but this has been accompanied with ageing and epidemiological changes both of which necessitate development of health policies and capacities. The Arab region is highly urban, which is advantageous for accessibility of people to health services and care delivery. Yet, rapid urbanization poses the challenge of increasing high demand for food and freshwater, for housing and for the need to improve the management of huge waste production.

Population growth has declined from 2.4 in 1990 to 1.8 in 2010. This decline is due to unprecedented fertility decline in the region. Nonetheless, the Arab Population increased from 232 million in 1990 to 359 million 2010, and will exceed 500 million in 2035. These increasing numbers are associated with changes in the age structure. Youth (15-24), women in the reproductive age (15-49), working age population (15-64), and older persons (60+) have respectively increased annually by 1.3 million, 2.05 million, 5 million, and 0.5 million, annually during 1990-2010. These numbers translate into high demand for education, jobs, reproductive health services, food, among others. Therefore, countries need to incorporate population dynamics into the development plans and strategies. Also, they need to improve population to through increasing efforts and activities to achieve universal programmes access to reproductive health services and information in the following areas:-

1. Progress towards the elimination of extreme poverty and hunger requires the implementation of strategic and well coordinated policies and interventions to cover the reproductive health needs of poor people, particularly in the rural areas and city slums. Strategies and actions should focus on the provision of reproductive health services and information, including family planning methods, to poor households. These actions should include measures to protect the poor from the negative impacts of the financial and economic crisis on food, shelter, and health, and from their impacts on reproductive health services and information. At the macro level, countries must increase food production, promote job creation, and improve income distribution as well as the distribution of goods and services. These actions must be accompanied by an expansion of the social security and social protection schemes to cover rural areas, the working poor, and vulnerable population groups (older persons, poor women, orphans, persons with disabilities, etc.). In order for these actions to be effective they must be based on accurate information and policy research and analyses on reproductive health and poverty. Such research must integrate population dynamics and population distribution into actions for eliminating extreme poverty and hunger in the Arab region.
2. The Arab region made significant progress in education. Rapid progress in primary education is an impressive achievement for the Maghreb, Mashreq and GCC countries. These countries are faced with the challenge of continued investment in education so as to sustain the achievements made, to improve the quality of education and to remove stereotyping and enrich the education curricula with information on sexual and reproductive health and gender equality. With regard to sustainability, countries



are worried about coping with rapidly rising demand for primary education emanating from rapid growth of school-age children, particularly in rural areas. Therefore, countries need to consider the role of reproductive health and expansion of family planning programmes in alleviating pressures on schools, and to integrate their internal population dynamics into national and local education plans and systems. Also, these countries are faced with the challenge of eliminating disparities between urban and rural areas, and between governorates, districts and geographic zones. The ALDCs must increase public and private expenditure and investment in education beyond the currently low level of less than 1% of the GDP. They must invest in the establishment of new schools, training of teachers, and in the development of school infrastructure so as provide education for all. Also, it is important to consider education as a pillar of reconstruction and peace building activities in the war torn areas.

3. The Arab region made significant progress in women's education. However, the added value of progress in women's education rests primarily with its power to increase production and transform the economic, social and political relations in societies. Therefore, progress in women's education in the region needs to be matched with provision of employment opportunities. Also, there is need to increase women's access to productive resources, such as land and finance, and to reproductive health services and information. Gender equity is a major challenge in the region, and focusing on it for achieving population policy objectives will be more beneficial than ignoring it. In this context fertility and the use of modern contraceptive methods must be viewed as important components of reproductive health and rights. In order to achieve equality and social justice, countries will need to improve

women's access to gainful employment, in high decision-making positions, and in political representation in parliament and government. ALDCs need to increase the investment in girls' education, and to improve girls' progression to secondary and higher levels of education. All countries need to address spatial disparities, particularly between rural and urban areas.

4. Impressive improvements in infant and child health are likely to continue in the future as fertility in the Arab World will continue to decline. However, infant death during the first four weeks after birth is still high. Therefore, there is high potential to further reduce infant and child mortality in the Arab World through extending reproductive health services to rural areas, improving maternal and child health services, eliminating childhood diseases, improving the food and nutrition status of both mothers and their infants, and sustaining full immunization coverage. Extra efforts are needed in the Arab ALDCs, where child mortality is still high. The countries emphasized the importance of promoting breastfeeding, child spacing and reducing high risk pregnancies, particularly among teenagers, and alleviating poverty.
5. Continued investment in maternal and reproductive health services is needed to further reduce maternal mortality in the Arab World. There is need to reduce teenage pregnancies, improve antenatal care services, and promote pregnancy follow-up, and delivery under the supervision of skilled health personnel. Also, countries will need to reduce disparities in maternal and reproductive health through extending services and information to rural areas and poor households. ALDCs need to adopt innovative approaches to extend services to people living in remote areas and to internally displaced persons. Also, governments in the Arab World must focus, prioritize and

intensify maternal and child health interventions in the disadvantaged areas and among the low socioeconomic status and vulnerable population groups. This will lead to the reduction of disparities between geographical and administrative regions, ethnic, cultural and socio-economic groups. Also, it will lead to further reduction in infant and child mortality.

6. Though commendable, actions still fall short of containing the rising spread of HIV/AIDS in the region. Efforts are needed at country and regional levels to maintain low prevalence and control the spread of HIV. Countries need to promote sexual and reproductive health and introduce cost effective interventions, such as promotion of condom use, which is currently very low in the region. Also, there is need to intensify their efforts to detect and register HIV cases, and to monitor and follow up interventions and treatment. Countries need to address the paucity of data and research on the prevalence and incidence of HIV and TB, and to improve people's knowledge on the modes of transmission and means of prevention and protection.

7. Countries need to enforce their environmental laws and regulations, and implement their environmental strategies and plans. Particularly, there is need to link gender and reproductive health to the role of women in promoting sustainability of the environment. This will require human capacity development in the management of natural resources, and in environmental impact assessment, particularly assessment of the impacts of climatic and ecological changes on the welfare and quality of life of people. Also, countries need to develop housing, water and sanitation services in both rural and urban areas, and to promote population access to these services. There is need to address the lack of knowledge and paucity of research on population distribution and growth and climate change, through collection of time series data, national surveys, and policy research.

8. Partnership for development in the Arab world has become broad and diverse. Therefore, maximization of its benefits for development is an urgent strategic question that countries would need to address, particularly in view of the negative impacts of the financial and economic crisis. There is need to improve coordination and streamlining of partnerships with national development priorities, plans and strategies. Also, the countries will need to develop innovative partnership approaches and strategies, including networking, participatory planning and decision-making, cost-sharing improve coordination and joint programmes, activities and service delivery, harmonization and standardization of procedures, rules and regulations, information sharing of lessons of experiences and best practices. Also, the countries will need to develop their institutional and organizational capacities, remove bureaucratic obstacles and duplication of efforts, and to promote capacity development of civil society organizations and NGOs and the private sector. Finally, countries will need to establish information and data banks, and undertake research on profiling and environmental scanning of partnerships for development.

### **Priorities for the Future**

The priorities for the future have been thoroughly discussed and agreed during the Arab Conference on Population and Development: Facts and Perspectives held in Doha in May 2009. The conference endorsed the Doha Declaration, which affirms full commitment to the ICPD programme Action and to the MDGs framework. Based on the above, the participants highlighted the following priorities for action during the next phase:

- Improve and expand the scope of opportunities and choices of citizens in order to increase the standard of living and quality of life, and to alleviate poverty;

## VI. MAIN CONCLUSIONS AND PRIORITIES FOR THE FUTURE

- Employment of the demographic window of opportunity to empower young people, who are considered the main factor for population and development policies. Ensure their rights to quality health, education, work, capacity development, training, and protect them from all risks;
- Expedite the achievement of the maternal health goal and access to comprehensive reproductive health care services for all, to improve maternal health, and factor this goal in population and health policies; enhance the efficiency of health care systems capacities, and secure the financial and human resources;
- Achieve the gender and women empowerment goal, confront all types of discrimination and gender-based violence through integrating this goal in population and development policies, formulating legislations based on international resolutions and agreements, advancing specific institutions and mechanisms to achieve this goal with efficiency and effectiveness;
- Sustain the environment and provide basic infrastructure services such as clean water and sanitation in all regions;
- Establish improved communication channels between migrants and their communities of origin, formulate policies for better management of migration and ensure best use of Arab and migrants and their remittances, especially in the area of scientific research and localization of knowledge with consideration of the enabling environment and incentives for their voluntary return;
- Give special attention to the population and development conditions in the Arab states affected by occupation, war and conflict; especially in the areas of sickness, death, women's and children's issues, forced migration and poverty;
- Develop national institutions, especially the national population councils/commissions and related institutions, and enhance their work modalities and develop the capacities of their employees;
- Enhance networking, coordination and partnership between government institutions, civil society organizations, regional and international organizations, including The League of Arab States, to provide specific mechanisms for population and development at regional and national levels;
- Develop and support legislations, especially those related to the rights of diverse social population groups, and facilitate the role of parliamentary committees on population and development matters;
- Develop information systems, data collection and analysis, and conduct in-depth comparative studies, while developing human capacities;
- Give due attention to the elderly and improve quality services and develop alternative care, conduct scientific research to study their situation and identify their needs; and
- Secure funds for population programs; develop ways and mechanisms to sustain financing through establishing Arab trust fund with participation of the Arab private sector.



UNFPA, the United Nations Population Fund, is an international development agency that promotes the right of every woman, man and child to enjoy a life of health and equal opportunity.

UNFPA supports countries in using population data for policies and programmes to reduce poverty and to ensure that every pregnancy is wanted, every birth is safe, every young person is free of HIV/AIDS, and every girl and woman is treated with dignity and respect.

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