

ECONOMIC AND SOCIAL COMMISSION FOR WESTERN ASIA (ESCWA)

COMPENDIUM OF SOCIAL STATISTICS AND INDICATORS:

**SOCIAL INDICATORS OF THE
COMMISSION OF SUSTAINABLE DEVELOPMENT**

ISSUE NUMBER 8

United Nations

Distr.
GENERAL
E/ESCWA/SCU/2007/9
20 December 2007
ORIGINAL: ENGLISH

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ISSUE NUMBER 8

United Nations
New York, 2007

United Nations publication
E/ESCWA/SCU/2007/9
ISBN. 978-92-1-128318-1
ISSN. 1012-7801
Sales No. E.08.II.L.5
07-0495

Preface

The *Compendium of Social Statistics and Indicators* is a biennial publication, which is published by the Statistics Division of the Economic and Social Commission for Western Asia (ESCWA). It reflects social development in the region through tabulation of time series statistics and indicators covering such areas as population, education, households and family, human settlements, health, work and economic activity, income and expenditure, and others. The *Compendium* was compiled mainly from existing data within national Governments, supplemented by data from international organizations.

This eighth issue of the *Compendium* focuses on social indicators of the United Nations Commission on Sustainable Development (CSD), which constitute a cross-cutting topic within the framework of the Millennium Development Goals (MDGs) and other development indicators. The *Compendium* presents a comparative analysis of selected CSD social indicators for four periods of time, namely, 1990 (as a starting base), 1995, 2000 and 2005 (or the latest available). The analysis includes: (a) within-country analysis by examining the changes to each indicator over time; and (b) cross-country analysis to identify intraregional disparities with regard to those indicators to inform policy decisions and academic research in the area.

The present issue comprises three chapters. Chapter I presents background information on work undertaken at the international level in the formulation and publishing of CSD indicators, including a description of the linkages between social indicators and indicators of sustainable development. It also attempts to explain the selection of indicators that provide the basis for analysis in this *Compendium*. Chapter II reviews comparative cross-country statistics, as well as country-specific time series data on proposed CSD social indicators for the 13 ESCWA member countries. Conclusions are highlighted in Chapter III. Annex I provides relevant tables and annex II includes a glossary of terms.

ABBREVIATIONS AND EXPLANATORY NOTES

CSD	Commission on Sustainable Development
GCC	Gulf Cooperation Council
GDP	gross domestic product
GER	gross enrolment ratio
GPI	gender parity index
ICT	information and communications technology
IMR	infant mortality rate
MDG	Millennium Development Goal
NGO	non-governmental organization
NER	net enrolment ratio
U5MR	under-five mortality rate

Note: References to dollars (\$) are to United States dollars, unless otherwise stated.

Two dots (..) indicate that data are not available or are not separately reported.

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Executive summary

Since 1990, the ESCWA region has witnessed improvements in most social indicators of sustainable development. However, the extent of improvement varies within the region, between urban and rural areas, and among women and men. Progress has largely been affected by conditions of poverty and political instability, which have reflected negatively on access to basic sanitation, health care, education and employment opportunities.

Overall, poverty rates have decreased during the period 1990-2005 in most ESCWA member countries for which time series data are available, with the exception of Palestine. Despite improvements since 1990, substantial disparities in access to sanitation and drinking water persist in some countries, particularly between urban and rural areas. In addition, a decline in access levels in urban areas in some ESCWA member countries has been noted during the period on account of the pressures of rural-urban migration on urban infrastructure.

Nonetheless, improvements in basic sanitation and health services have led to reductions in infant and child mortality rates and increases in life expectancy. The scope of child immunization and access to contraceptives has also broadened. While most ESCWA member countries have achieved considerable progress across all health indicators with minimal gender disparities, Iraq and Yemen consistently show alarming figures, particularly with regard to life expectancy, and child nutrition and mortality.

Alongside improvements in health, the ESCWA region witnessed improvements in adult literary rates and school enrolment during the period 1990-2005. However, insofar as net enrolment ratios are adequate measures of the adequacy of school systems to enrol pupils of official school age, they do not reveal other pertinent information, including, for example, regular school attendance, completion rates and the type or extent of competencies acquired. Moreover, gender parity indices for school enrolment, which in some countries have exceeded equality and are in favour of girls, mask overall low levels of participation.

Demographic indicators in the ESCWA region are largely typical of developing countries with high fertility rates, continued positive growth rates and high dependency ratios, all of which are challenges to economic development. The ratio of young and old people to working-age adults (dependency ratio) remains high in all countries, placing major strains on the economy in those countries in the short run through increased demand for social and health services.

Intraregional discrepancies in economic development are manifested in the rate and type of employment available in each country. The distribution of the type of employment across countries parallels that of gross domestic product (GDP). Moreover, gender disparities in access, type and sector of employment were also pronounced. Equality in access to education at all levels has not translated into equal access to opportunities beyond the educational system and in public life, as demonstrated by the low levels of economic participation among women in the ESCWA region.

I. BACKGROUND

According to the World Commission on Environment and Development, known as the Brundtland Commission, sustainable development can be defined as satisfying “present needs without compromising the ability of future generations to meet their own needs”.¹ A work programme on indicators of sustainable development was approved by the Commission on Sustainable Development (CSD) in its third session in 1995 to promote the use of indicators on the basis that they play an important role in informing decision-making processes at various policy levels. The Commission called upon organizations of the United Nations system, and on intergovernmental and non-governmental organizations (NGOs), in coordination with its secretariat, to implement the key elements of the work programme.² The importance of the work programme was reaffirmed in the nineteenth special session of the General Assembly, which was held in 1997 for the five-year review of the United Nations Conference on Environment and Development. Explicit reference was made to developing “a practical and agreed set of indicators that are suited to country-specific conditions and can be used in monitoring progress towards sustainable development at the national level”.³

In 1995, a framework with a common set of indicators was developed by CSD with the aim of making comparisons across countries more meaningful and facilitating the monitoring and national reporting of countries to the Commission and other intergovernmental bodies. The framework was also intended to motivate further Government and civil society involvement in the use and testing of indicators by making such indicators accessible to decision makers at the national level.⁴ The heterogeneity of contexts and national priorities and the lack of uniformity in the availability of data across countries prompted the adoption of a theme-based indicator approach. The initial set of 134 indicators developed by CSD in 1995 was reduced in the second revision of the framework to 58 indicators, embedded in a thematic framework of the initial 4 major dimensions of sustainable development, namely, social, economic, environmental and institutional, which was further broken down into 15 themes and 38 sub-themes, and was presented to CSD in 2001.⁵ Those indicators covered issues common to all regions and countries of the world and were organized according to the ‘best-fit’ scenario. In other words, the sub-division of the indicators within dimensions and themes did not undermine their linkages to each other.⁶

The third revision of the framework of sustainable development indicators was initiated in 2005 by the Division for Sustainable Development within the United Nations Department of Economic and Social Affairs, as part of its mandated support to United Nations Member States in their efforts to develop and implement national indicators for sustainable development. It was finalized in 2006 by a group of experts from developing and developed countries and international organizations.⁷ The increased knowledge and experiences of countries and organizations in relation to indicators of sustainable development, and an increasing global emphasis on measuring development progress, as is the case with the Millennium Development Goals (MDGs), motivated the need for a review of the conceptual framework of sustainable

¹ For more information about the Brundtland Commission, see: <http://www.humboldt.edu/%7Eenvecon/ppt/309/unit4/sld002.htm>.

² Commission on Sustainable Development (CSD), “Information for decision-making and participation”, addendum, Report of the Secretary-General; “CSD work programme on indicators of sustainable development”, ninth session of CSD (16-27 April 2001) (E/CN.17/2001/4/Add.1).

³ United Nations, *Indicators of Sustainable Development: Guidelines and Methodologies* (E.01.II.A.6).

⁴ Ibid.

⁵ United Nations Division for Sustainable Development, “Revising indicators of sustainable development – status and options”, a background paper presented at the Expert Group Meeting on Indicators of Sustainable Development (New York, 3-4 October 2006).

⁶ Ibid.

⁷ Ibid.

development indicators.⁸ With that in mind, the review had the following three main aims: (a) to incorporate new thinking on sustainable development and the role of indicators; (b) to reflect country experiences with their indicator sets over the past years; and (c) to exploit synergies with such major indicator initiatives as the MDGs and sectoral indicator programmes.⁹

A. THIRD REVISION OF THE COMMISSION ON SUSTAINABLE DEVELOPMENT FRAMEWORK: THEMES, SUB-THEMES AND INDICATORS

Poverty is one of the main themes in the revised framework, which includes indicators related to income poverty and access to such basic services as sanitation, drinking water and energy. Income inequality is another sub-theme, measured by the ratio of the share in national income of the highest to lowest quintile. The addition of indicators of non-monetary poverty underlines the importance of poverty reduction in fostering sustainable development, which increases the policy relevance of CSD Indicators of Sustainable Development. Living conditions were an added sub-theme under poverty, with a related indicator on the proportion of the population living in slums.

Four sub-themes were included under the theme of health. Mortality has three indicators including under-five mortality, life expectancy and healthy life expectancy, with the latter added on the basis that it better captures the quality of life of people, in addition to the number of years they are expected to live. Health-care delivery is measured by access to primary health care, immunization against childhood diseases and contraceptive prevalence rate, while the nutritional status sub-theme is measured by the percentage of underweight children. Finally, health status and risk was an added sub-theme, measured by smoking prevalence, suicide and the prevalence of major diseases. That addition reiterates the importance of considering the quality of life by addressing morbidity, and not only mortality as determinants of health.

The education theme retained its two sub-themes of education level and literacy. Education level is measured by gross enrolment ratio (GER), net enrolment ratio (NER) and adult schooling attainment level (secondary and tertiary), which was added to capture more adequately development in the key area of sustainable development and lifelong learning. Literacy is measured by adult literacy rates.

The demographics theme, previously called population, was revised to include two sub-themes. The population change sub-theme is measured by the population growth rate, total fertility rate and the dependency ratio. The tourism sub-theme is measured by the ratio of local residents to tourists in major tourist regions and destinations.

The theme of economic development has the largest number of sub-themes and associated indicators. Macroeconomic performance is measured by GDP per capita, investment share in GDP, savings rate, adjusted net savings rate and inflation. Sustainable public finance is measured by the ratio of debt to gross national income. Employment, which was previously under poverty, is measured by labour productivity and unit labour costs, employment-population ratio, employment status and the share of women in wage employment in the non-agricultural sector. Those indicators consider the share of unpaid family workers in total employment, as well as the shares of salaried workers and the self-employed, in order to provide a more complete picture of the employment structure.¹⁰ The information and communications technology (ICT) sub-theme is measured by the proportion of Internet users, fixed telephone users and cellular subscribers. Research and development is measured by the percentage of GDP spent on research and development. Finally, tourism is measured by its contribution to GDP.

Overall and whenever relevant, it was specified that indicators were to be disaggregated by sex, thereby rendering gender a cross-cutting theme throughout the framework of sustainable development.

⁸ United Nations Department of Economic and Social Affairs, Division for Sustainable Development, "Global trends and status of indicators of sustainable development", background paper no. 2, fourteenth session of CSD, (New York, 1-12 May 2006) (DESA/DSD/2006/2).

⁹ Ibid.

¹⁰ Ibid.

B. SELECTION OF INDICATORS

For the purpose of this *Compendium*, a reduced list of indicators is presented that reflect their immediate relevance to the region. For example, health indicators related to suicide and HIV are not of immediate concern to countries in the region based on documented low rates. The infant mortality rate, however, remains an issue of concern in some countries and, therefore, the indicator was added under the health theme. The lack of data available for certain indicators further contributed to the selection of indicators. For instance, data on economic indicators related to macroeconomic performance, public finance, ICT and tourism are hard to find given the limited surveys conducted on those topics at national levels. Table 1 below highlights the latest CSD list of themes, sub-themes and indicators. It also specifies indicators that were selected for analysis in this issue of the *Compendium* for their relevance to countries of the ESCWA region.

TABLE 1. SOCIAL THEMES, SUB-THEMES AND INDICATORS, THIRD REVISION, 2005

Theme	Sub-theme	Indicator
Poverty	Income poverty	Percentage of population living below the national poverty line
		Proportion of Population below the international poverty line (\$1 and/or \$2)
	Income inequality	Ratio of share in national income of highest to lowest quintile
	Sanitation	Proportion of population with access to improved sanitation, urban and rural
	Drinking water	Proportion of population with access to improved water sources, urban and rural
	Access to energy	Share of household with access to electricity or commercial energy
	Living conditions	Percentage of population using solid fuels for cooking Proportion of urban population living in deprived housing conditions
Health	Mortality	Mortality rate for children under age
		Life expectancy at birth
		Healthy life expectancy
	Healthcare delivery	Percentage of population with access to primary health care facilities
		Immunization against infectious childhood diseases
		Contraceptive prevalence rate
	Nutritional status	Nutritional status of children
	Health status and risk	Prevalence of tobacco use
Suicide rate		
Morbidity of such major diseases as HIV/AIDS, malaria and tuberculosis		
Morbidity of such major childhood diseases as diarrhoea, pneumonia and malaria		
Education*	Education level	Gross intake into last year of primary education, by sex
		Net enrolment rate in primary education
		Adult secondary (tertiary) schooling attainment level, by sex
		Lifelong learning
	Literacy	Adult Literacy Rate, by sex
Demographics	Population change	Population growth rate
		Total fertility rate
		Dependency ratio
Tourism	Ratio of local residents to tourists in major tourist regions and destinations	
Economic Development	Macroeconomic performance	GDP per capita
		Investment share in GDP
		Savings rate
		Adjusted net savings rate
		Inflation
	Sustainable public finance	Debt to GNI ratio
	Employment	Labour productivity and unit labour costs
		Employment-population ratio, by sex
		Employment status, by sex
		Share of women in wage employment in the non-agricultural sector
	Information and communications technology	Internet users per 100 population
		Fixed telephone lines per 100 population
		Cellular subscribers per 100 population
Research and development	Research and development expenditure as percentage of GDP	
Tourism	Tourism contribution to GDP	

Source: United Nations Division for Sustainable Development, "Revising indicators of sustainable development – status and options", a background paper presented to the Expert Group Meeting on Indicators of Sustainable Development (New York, 3-4 October 2006).

Note: *NER in secondary and GER tertiary education were used instead of adult schooling attainment level.

selected	not selected
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C. LINKAGES OF SOCIAL INDICATORS TO OTHER DIMENSIONS AND THEMES

Indicators are generally primarily linked to the themes to which they belong, with the exception of indicators under the theme of poverty. Access to improved sanitation and drinking water are primarily linked to health. All poverty indicators are secondarily linked to economic development. The percentage of people below the national poverty line and the proportion of people below the international poverty line are secondarily linked to health, education and demographics. It is acknowledged that poverty influences the health status of people on the basis that they have less access to basic health care, particularly in the developing world, are less likely to be educated and tend to have higher fertility rates.

All health indicators, with the exception of the contraceptive prevalence rate and the prevalence of tobacco use, are secondarily linked to poverty. The contraceptive prevalence rate is secondarily linked to education and demographics on the basis that more educated people tend to have a higher contraceptive prevalence rate, hence a lower fertility rate. Prevalence of tobacco use is secondarily linked to education on the basis that it is inversely related to education level.

All indicators, with the exception of the net enrolment rate, are also secondarily linked to economic development on the basis that education is a measure of human capital, which is an important element for economic development. Gross intake into primary education is secondarily linked to poverty, while net enrolment rate is secondarily linked to poverty and health. The adult literacy rate is also secondarily linked to poverty.

The population growth rate is secondarily linked to poverty, education and economic development. The total fertility rate, a determinant of population growth rate, is secondarily linked to health and education. The dependency ratio is secondarily linked to economic development. The selected indicators of economic development are secondarily linked to poverty. Employment status and the share of women in wage employment in the non-agricultural sector are also secondarily linked to education.

Table 2 highlights linkages of selected indicators to other themes.

TABLE 2. LINKAGES OF SELECTED INDICATORS TO OTHER THEMES

Indicator	Poverty	Health	Education	Demographics	Economic development	Fresh water
Percentage of population living below the national poverty line	Primary					
Proportion of population below international poverty line						
Proportion of population with access to improved sanitation		Primary				
Proportion of population with access to improved water sources		Primary				
Mortality rate under 5 years old		Primary				
Life expectancy at birth						
Percentage of population with access to primary health care facilities		Primary				
Immunization against infectious childhood diseases		Primary				
Contraceptive prevalence rate			Secondary			
nutritional status of children						
prevalence of tobacco use			Secondary			
Gross intake into last year of primary education, by sex	Secondary		Secondary			
Net enrolment rate in primary education			Secondary			
Adult secondary (tertiary) schooling attainment level, by sex					Secondary	
Adult literacy rate, by sex					Secondary	
Population growth rate				Secondary		
Total fertility rate				Secondary		
Dependency ratio					Secondary	
Employment-population ratio, by sex					Secondary	
Employment status, by sex					Secondary	
Share of women in wage employment in the non-agricultural sector					Secondary	

Source: United Nations Division for Sustainable Development, "Revising indicators of sustainable development – status and options," a background paper presented to the Expert Group Meeting on Indicators of Sustainable Development (New York, 3-4 October 2006).

Primary Secondary

II. ANALYSIS

This chapter provides comparative cross-country and country-specific analysis of the compiled data on selected indicators of the CSD framework, in most cases for each of the 13 ESCWA member countries. The analysis focuses on progress made by countries in relation to CSD social indicators for the years 1990, 1995, 2000 and 2005 (or latest available) and examines the limitations and constraints of data on the subject.

A. POVERTY

Poverty was measured according to five indicators that reflect the income poverty of a country, and the access to water, sanitation and energy.

1. *Percentage of population living below the national poverty line*

Iraq and Palestine have alarming poverty rates, with 54 per cent and 36.1 per cent of their populations, respectively, living below the national poverty line in 2003 and 2006. The rate for Iraq coincides with its invasion, and it is expected that the rate has since increased. Overall, poverty rates have decreased over time in most ESCWA member countries for which time series data are available, with the exception of Palestine, where poverty rose from 21 per cent in 2000 to 36.1 per cent in 2006. In Egypt, the proportion of the population living below the national poverty line dropped by 5 percentage points between 1990 and 2000, and in Jordan, it fell by 3 percentage points between 1990 and 1995. The poor in Yemen appear to have made important gains, with poverty levels having fallen from 41.8 per cent in 1996 to 10.2 per cent in 1998. That decline must, however, be treated with caution, particularly given that the time interval is only two years. Unless there has been a major boost to the economy of Yemen affecting all social strata, that change can be attributed to a statistical artifact caused by either a change in the measurement of the poverty line or data quality issues.

Figures for the percentage of population living below the national poverty line in ESCWA member countries are presented in annex table 1.

2. *Proportion of population living below the international poverty line*

The availability and quality of data is a major problem for this indicator. Only 4 out of 13 countries have reported rates in relation to this, and many of them do not have all the relevant data points, thus constituting an impediment to assessing progress made over time. In Bahrain, the proportion of population living below \$1 per day is zero for the four specified years, and Jordan has shown the same rate of 2 per cent for 1992, 1997 and 2003. Even in Yemen, the only least developed country in the region, the rate was 3.6 per cent in 1992. In general, more estimates are needed to measure the current poverty status in all countries using this indicator. While this indicator makes cross-country comparisons more meaningful, it ignores the diversity of the economic and social circumstances of countries and is generally not suitable for national purposes. That could be the reason why data sets were not available for this indicator.

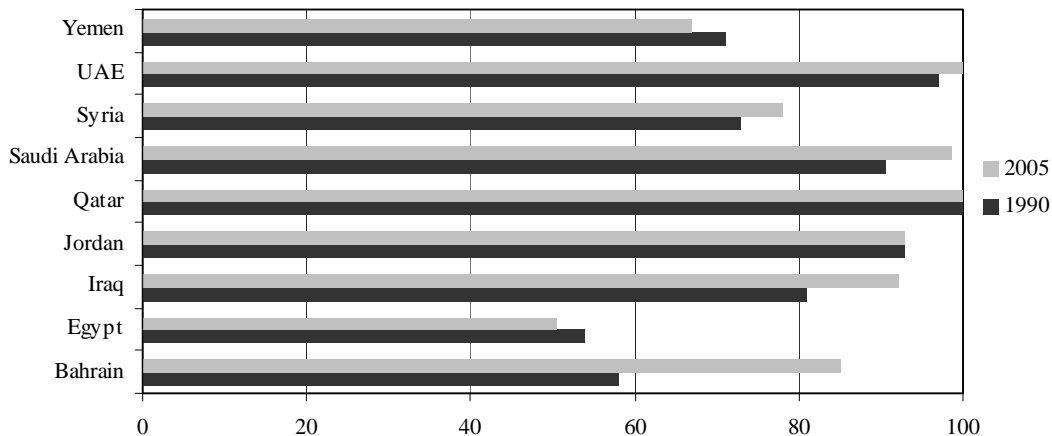
Figures for the proportion of the population living below the national poverty line in ESCWA member countries are presented in annex table 2.

3. *Proportion of population with access to improved sanitation*

In 2005, access to improved sanitation exceeded 90 per cent in 8 of the 13 ESCWA member countries. Universal or near universal coverage was reported in Bahrain, Kuwait, Lebanon, Qatar, Saudi Arabia and the United Arab Emirates. However, in Egypt, Palestine and Yemen, more than a half of the respective populations were deprived of access to improved sanitation. While access levels increased in most countries during the period 1990-2005, in Egypt they dropped from 85 per cent in 1990 to a low of 48.7 per cent in 2005. The greatest percentage point increase was observed in the Syrian Arab Republic, where levels increased from 55 per cent to 97.3 per cent in the same period. As expected, urban areas have better access to sanitation than rural areas. The urban/rural divide in access to sanitation was most notable in Palestine, where only 3.5 per cent of the rural population in 2006 had access compared to 58.4 per cent of urban population. Access to sanitation in urban Egypt was more than three times that of rural areas.

Figures for the proportion of the population with access to improved sanitation in ESCWA member countries are presented in annex table 3. Figure 1 shows access to improved sanitation in selected ESCWA member countries for 1990 and 2005. Figure 2 shows access to improved sanitation in urban and rural areas for selected ESCWA member countries for 2005.

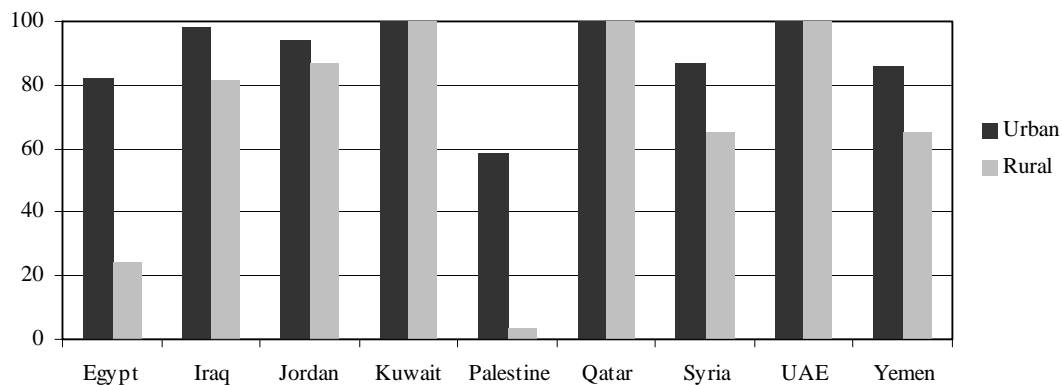
Figure 1. Access to improved sanitation for selected ESCWA member countries, 1990 and 2005



Source: Country Millennium Development Goal (MDG) reports; ESCWA, *Compendium of Environment Statistics in the ESCWA Region* (E/ESCWA/SCU/2007/2), pp. 129-137; and United Nations Statistics Division website for MDG Indicators, available at: <http://mdgs.un.org/unsd/mdg/Data.aspx> (nationally corroborated).

Note: 2005 series data for Egypt and the Syrian Arab Republic pertain to 2006 and for Jordan, Qatar, United Arab Emirates and Yemen to 2004; 1990 series data for Kuwait pertain to 1992.

Figure 2. Access to improved sanitation for selected ESCWA member countries, urban/rural, 2005



Source: Country Millennium Development Goal (MDG) reports; ESCWA, *Compendium of Environment Statistics in the ESCWA Region* (E/ESCWA/SCU/2007/2), pp. 129-137; and United Nations Statistics Division website for MDG Indicators, available at: <http://mdgs.un.org/unsd/mdg/Data.aspx> (nationally corroborated).

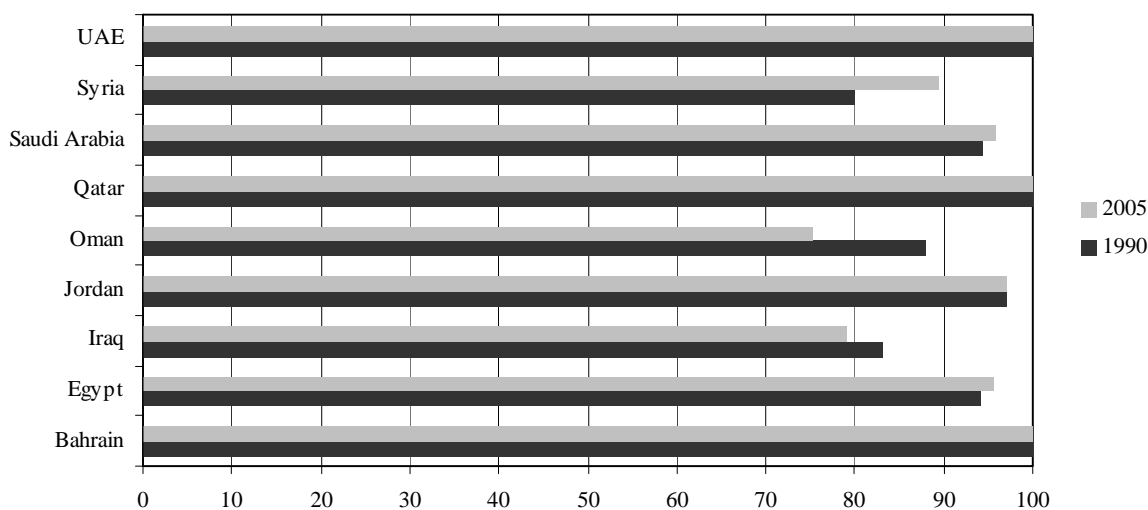
Note: 2005 series data for Egypt, Iraq, Palestine and the Syrian Arab Republic pertain to 2006; and for Jordan, Kuwait, Qatar, the United Arab Emirates and Yemen to 2004.

4. Proportion of population with sustainable access to an improved drinking water source

Access to improved water sources is near commensurate with that of sanitation in ESCWA member countries, with 8 of 13 countries reporting access levels in excess of 90 per cent in 2005. Bahrain, Kuwait, Qatar and the United Arab Emirates reported universal access to improved water sources, while Jordan, Saudi Arabia, Egypt and Palestine recorded levels of 98.1 per cent, 95.8 per cent, 95.3 per cent and 93.8 per cent, respectively. Between 1990 and 2005, access levels increased or remained stable in most countries, with Egypt, the Syrian Arab Republic and Yemen recording double-digit percentage point increases ranging between 15 and 23 points. However, levels dropped in Oman by more than 10 percentage points between 1993 and 2003, to 75.3 per cent. In Iraq, the war, ongoing occupation and internal strife have damaged basic infrastructure, leaving only some 80 per cent of the population with access to an improved drinking water source and more than 40 per cent of the rural population without such access. Despite improvements, access levels remain very low in Yemen, so that half of the population was without drinking water in 2005. The urban-rural divide in access to water was less pronounced than that of sanitation in the ESCWA region. The largest gap was reported in Yemen, where a little over a third of the rural population enjoyed access to a drinking water source in contrast to more than 90 per cent of urban areas.

Figures for the proportion of the population with sustainable access to an improved drinking water source in the ESCWA region are presented in annex table 4. Figure 3 shows access to an improved drinking water source for selected ESCWA member countries for 1990 and 2005. Figure 4 shows sustainable access to a drinking water sources in urban and rural areas in selected ESCWA member countries for 2005.

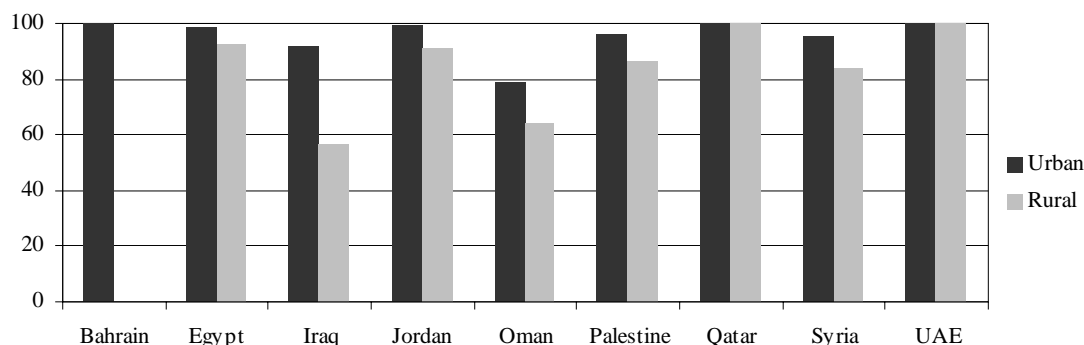
Figure 3. Access to improved drinking water source for selected ESCWA member countries, 1990 and 2005



Sources: Country Millennium Development Goal (MDG) reports; ESCWA, *Compendium of Environment Statistics in the ESCWA Region* (E/ESCWA/SCU/2007/2), pp. 129-137; and United Nations Statistics Division website for MDG Indicators, available at: <http://mdgs.un.org/unsd/mdg/Data.aspx> (nationally corroborated).

Notes: 2005 series data for Egypt and the Syrian Arab Republic pertain to 2006, for Kuwait, Qatar and Yemen to 2004 and for Oman to 2003; 1990 series data for Kuwait pertain to 1992 and for Oman to 1993.

Figure 4. Access to improved drinking water source for selected ESCWA member countries, urban/rural, 2005



Sources: ESCWA, *Compendium of Environment Statistics in the ESCWA Region* (E/ESCWA/SCU/2007/2), pp. 129-137; and United Nations Statistics Division website for Millennium Development Goals Indicators. Available at: <http://mdgs.un.org/unsd/mdg/Data.aspx> (nationally corroborated).

Notes: 2005 series data for Egypt, Iraq, Palestine and the Syrian Arab Republic pertain to 2006; for Kuwait, Qatar and Yemen to 2004; and for Oman to 2003.

5. Proportion of population with access to electricity or commercial energy

Only 6 of the 13 ESCWA countries reported two or more data points on access to electricity, and an even smaller number provided data by urban and rural areas. Access to electricity or commercial energy is almost universal in all countries for which data are available, namely, Bahrain, Egypt, Jordan, Palestine, Saudi Arabia and the Syrian Arab Republic. However, in Yemen, only 67 per cent of the urban population had access to electricity in 2004.

Figures for the proportion of the population with access to electricity or commercial energy in ESCWA member countries are presented in annex table 5.

B. HEALTH

Nine indicators are used as measures of the health of a country. Four indicators reflect different aspects of child health, for example, infant mortality, under-five mortality, immunization against infectious diseases and the nutritional status of children; two indicators relate to lifestyle behaviours, namely, tobacco use and contraceptive rate. Three other indicators provide an assessment of the health picture of a country, for example, life expectancy, access to health-care facilities and prevalence of infectious diseases.

1. Infant mortality rate

While the infant mortality rate (IMR) declined between 1990 and 2005 in all countries of the ESCWA region as a result of improvement in access to basic health services and better hygienic conditions, it still varies across countries. In 2005, IMR ranged from a high of 77.2 infant deaths per 1,000 live births in Yemen to a low of 7.7 infant deaths per 1,000 live births in the United Arab Emirates. In addition to the United Arab Emirates, most Gulf Cooperation Council (GCC) countries, namely, Bahrain, Kuwait, Oman and Qatar have achieved low rates of approximately 10 or less infant deaths per 1,000 live births. The exception is Saudi Arabia, with 19 infant deaths per 1,000 live births. It can also be noted that IMRs have been steadily decreasing in all countries since 1990, with the exception of Iraq, which witnessed a steep

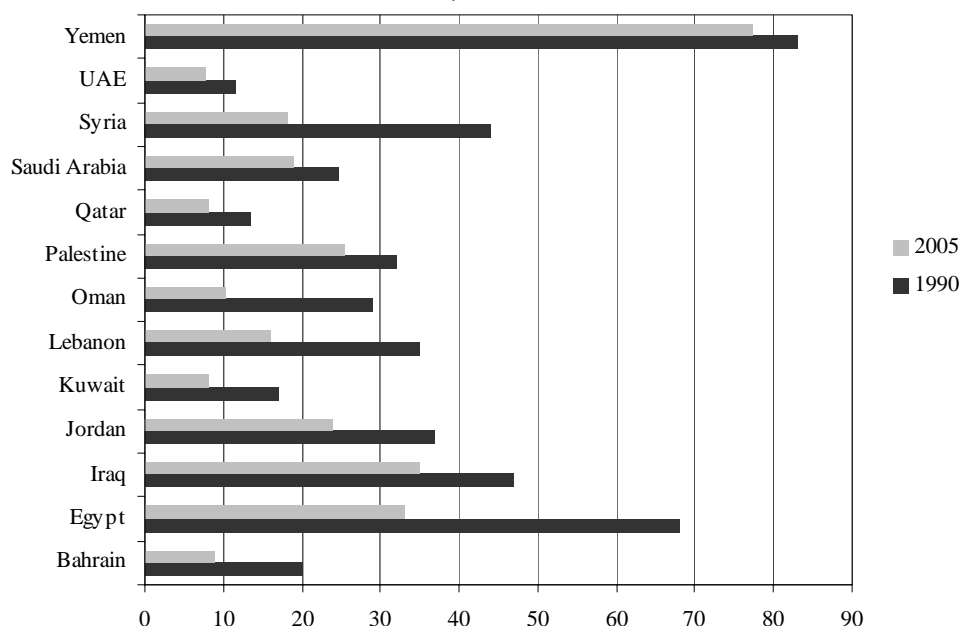
increase in the rate of infant deaths between 1990 and 2000 from 47 to 106, followed by a considerable decrease in 2006 to reach 35 infant deaths per 1,000 live births.

During the same period, namely, from 1990 to 2005, IMRs decreased for males and females. The highest decrease in IMR for males was witnessed in Egypt, where the number of deaths dropped from 73 in 1995 to 43 in 2005; the lowest decrease was reported in Palestine, with the number of male deaths dropping from 30 in 1995 to 27.1 in 2006. With regard to females, the highest decline in IMRs was observed in Egypt, from 73 in 1995 to 37 in 2005; the lowest was recorded in Yemen, which went from 76 in 1994 to 75 in 2004. Moreover, in almost all countries, with the exception of Lebanon where IMR was 19.2 for females and 13.2 for males in 2004, females have a slight advantage over males in terms of this indicator; in other words, IMRs were higher for males than females during the studied period.

With the exception of a few ESCWA member countries, namely, Yemen, which is the least developed country in the ESCWA region, and Iraq and Palestine, which suffer from conflicts, most member countries appear to be on course to reducing their IMRs by 2015, as set out in the Millennium Declaration.

Annex table 6 presents IMRs in the ESCWA region, by sex. Figure 5 highlights IMRs for ESCWA member countries for 1990 and 2005. Figure 6 illustrates IMRs, by sex, in selected ESCWA member countries for 2005.

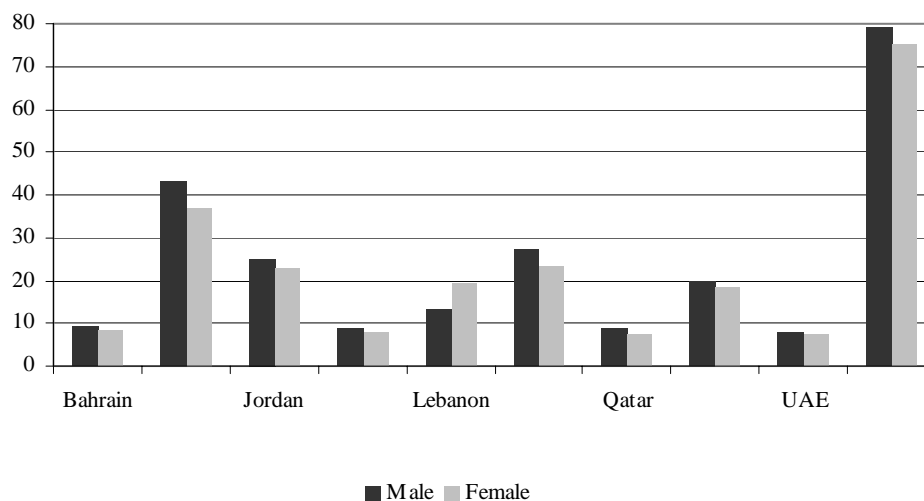
Figure 5. Infant mortality rates for ESCWA member countries, 1990 and 2005



Sources: National data sets, namely, statistical yearbooks and family health surveys; demographic health survey; and national MDG reports.

Note: 2005 series data for Iraq, Oman and Palestine pertain to 2006; for Lebanon and Yemen to 2004.

Figure 6. Infant mortality rates, by sex, for selected ESCWA member countries, 2005



Sources: National data sets, namely statistical yearbooks; family health surveys; demographic health survey; and national MDG reports.

Note: 2005 series data for Jordan pertain to 2002.

2. Under-five mortality rate

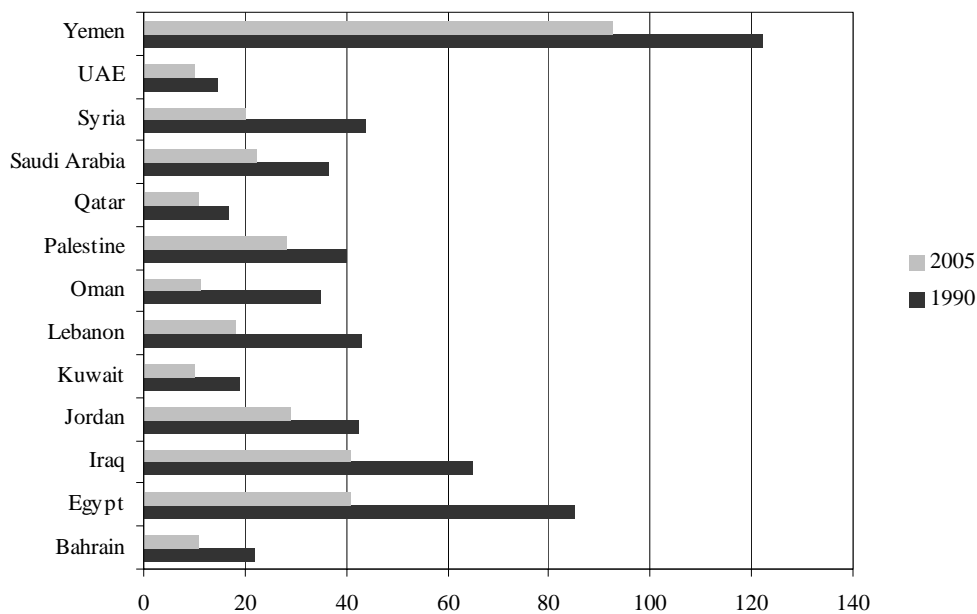
Under-five mortality rates (U5MRs) have decreased in all countries of the ESCWA region during the period 1990-2005. The decline varies from country to country, declining by approximately a quarter in Palestine and Yemen, almost a third in Iraq, Jordan, Qatar, Saudi Arabia and the United Arab Emirates, and more than a half to a third in Bahrain, Egypt, Kuwait, Lebanon and the Syrian Arab Republic. The highest declines were observed in Egypt, where the rate dropped from 85 in 1990 to 41 in 2005; and in Yemen, where the rate dropped from 122 in 1990 to 92.3 in 2004. The lowest drop in U5MR was reported for the United Arab Emirates, with a drop from 14.4 in 1990 to 9.9 in 2005, followed by Qatar from 16.6 in 1990 to 10.6 in 2005.

In 2005, the United Arab Emirates and Kuwait had the lowest U5MRs for both males and females, respectively, with 10.3 and 9.4 for the United Arab Emirates and 10.4 and 9.4 for Kuwait. While Yemen, Iraq and Egypt had the highest U5MR for both males and females, respectively, with 92.9 and 91.7 for Yemen in 2004, 44 and 37 for Iraq in 2006, and 33 and 47 for Egypt in 2005.

Gender disparities are relatively low in almost all countries, with slightly higher under-five mortality among males than females, particularly in Iraq, where the rate was 44 for males compared to 37 for females in 2006. Egypt and Lebanon, however, recorded higher female child mortality, with a rate of 47 for females and 33 for males for Egypt in 2006, and 22 for females and 14.8 males in Lebanon in 2004. Conflicts, extreme poverty, inadequate health services, poor nutrition and mothers' lack of education are the main causes of child mortality.

Figures for U5MR, by sex, for ESCWA member countries are presented in annex table 7. Figure 7 illustrates U5MRs for ESCWA member countries for 1990 and 2005, while figure 8 highlights U5MRs for selected ESCWA member countries, by sex.

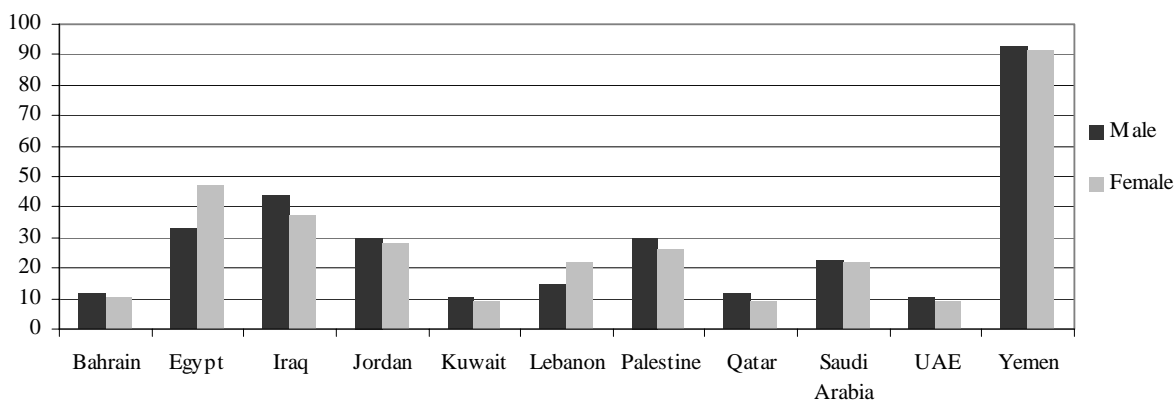
Figure 7. Under-five mortality rates for ESCWA member countries, 1990 and 2005



Sources: National data sets, namely, statistical yearbooks; family health surveys; demographic health survey; national MDG reports.

Note: 2005 series data for Iraq and Palestine pertain to 2006; for Lebanon and Yemen to 2004.

Figure 8. Under five mortality rates, by sex, for selected ESCWA member countries, 2005



Sources: National data sets, namely, statistical yearbooks; family health surveys; demographic health survey; national MDG reports.

Note: 2005 series data for Iraq and Palestine pertain to 2006; for Lebanon and Yemen to 2004.

3. Life expectancy at birth

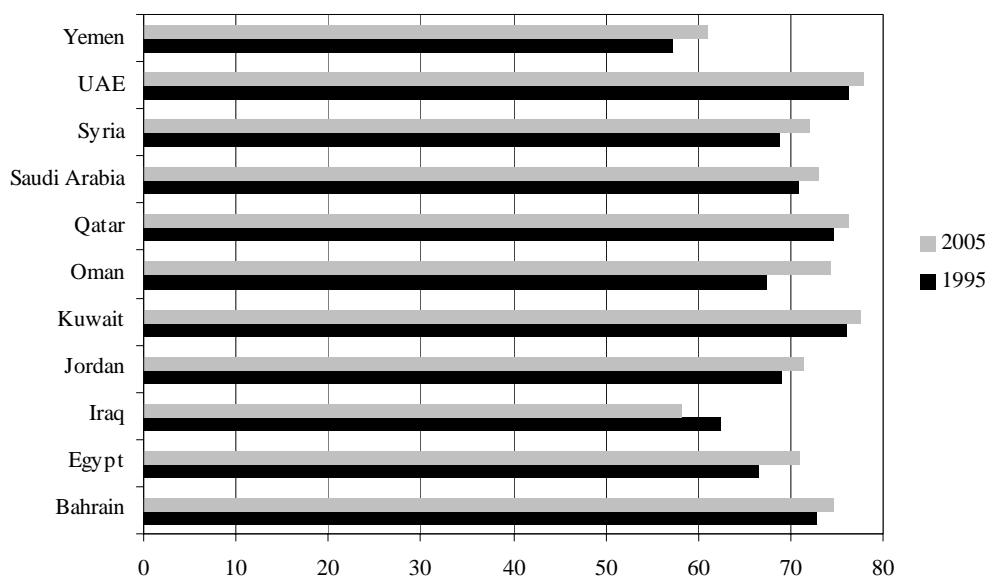
During the period 1990-2005, life expectancy at birth increased in all ESCWA member countries, with the exception of Iraq, where it decreased between 1990 and 2006 from 63 to 54.9 years of age for men and from 62 to 61.6 years of age for women. The highest increase during that period was reported in Oman, where life expectancy increased by 8.4 years, followed by Egypt and the United Arab Emirates, with increases of 6.9 and 6.7 years respectively. Other countries witnessed a more moderate increase ranging from 4.9 years in the Syrian Arab Republic to 2.8 years in Kuwait and Qatar. Iraq was the only country that noted a decrease of 4.3 years between 1990 and 2006.

Moreover, for 2005, all countries reported that females have a higher life expectancy than males. In 2005, the United Arab Emirates, followed by Qatar, reported that life expectancy at birth for females was 79.1 and 76.7 years, respectively. Yemen and Iraq had the lowest life expectancy at birth for females in that year of 62 and 61.6 years, respectively. The same trend was observed for males in 2005, with the United Arab Emirates and Qatar having the highest life expectancy for males, 76.7 and 76.1 years, respectively; while Yemen and Iraq reported the lowest life expectancy at birth for males, 60.2 and 54.9 years, respectively.

Extreme poverty and inadequate social services are among the main reasons for low life expectancy in Yemen, while the ongoing conflict in Iraq had a direct effect on its total life expectancy.

Figures for life expectancy at birth, by sex, for the ESCWA member countries are presented in annex table 8. Figure 9 illustrates life expectancy at birth in selected ESCWA member countries for 1995 and 2005, while Figure 10 shows life expectancy at birth, by sex, in selected ESCWA member countries for 2005.

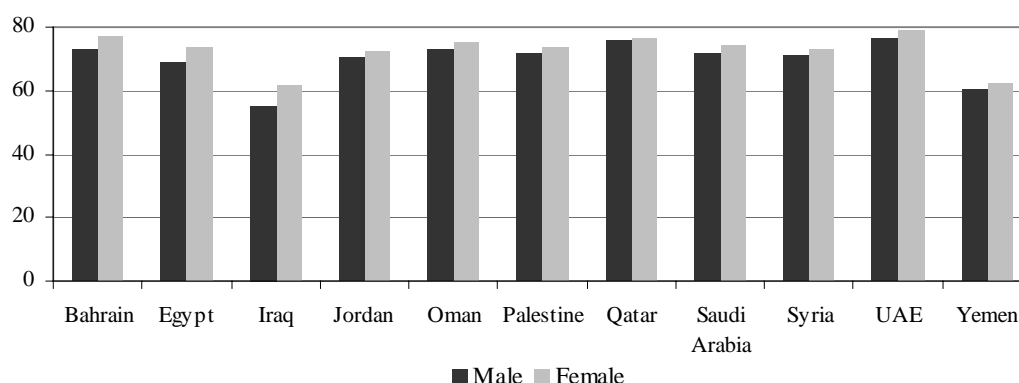
Figure 9. Life expectancy at birth for selected ESCWA member countries, 1995 and 2005



Sources: National data sets, namely, statistical yearbooks; family health surveys; and demographic health survey.

Note: 2005 series data for Iraq, Oman and Palestine pertain to 2006.

Figure 10. Life expectancy at birth, by sex, for selected ESCWA member countries, 2005



Sources: National data sets, namely, statistical yearbooks; family health surveys; and demographic health survey.

Note: 2005 series data for Iraq, Oman and Palestine pertain to 2006.

4. Percentage of population with access to primary health-care facilities

Data on population access to primary health-care facilities were largely missing for the majority of ESCWA member countries, with the exception of some GCC countries, namely, Bahrain, Kuwait, Oman and Qatar. In 2005, Bahrain, Kuwait and Qatar reported that 100 per cent of their populations had access to primary health-care facilities, while results for Oman indicated that 95 per cent of the population had access to primary health-care facilities in 2000. Data on access to essential health care in general, and access to primary health care in particular, are needed to monitor progress on the access of the population to primary health-care facilities that goes beyond physical access to reflect economic, social and cultural accessibility and acceptability. Such data are also crucial for the planning of health issues, distribution of health resources and the setting of priorities in health policies at the national, as well as the regional, level. Countries must be encouraged to make concerted efforts to collect such important information.

Annex table 9 presents figures for the percentage of the population with access to primary health-care facilities in ESCWA member countries.

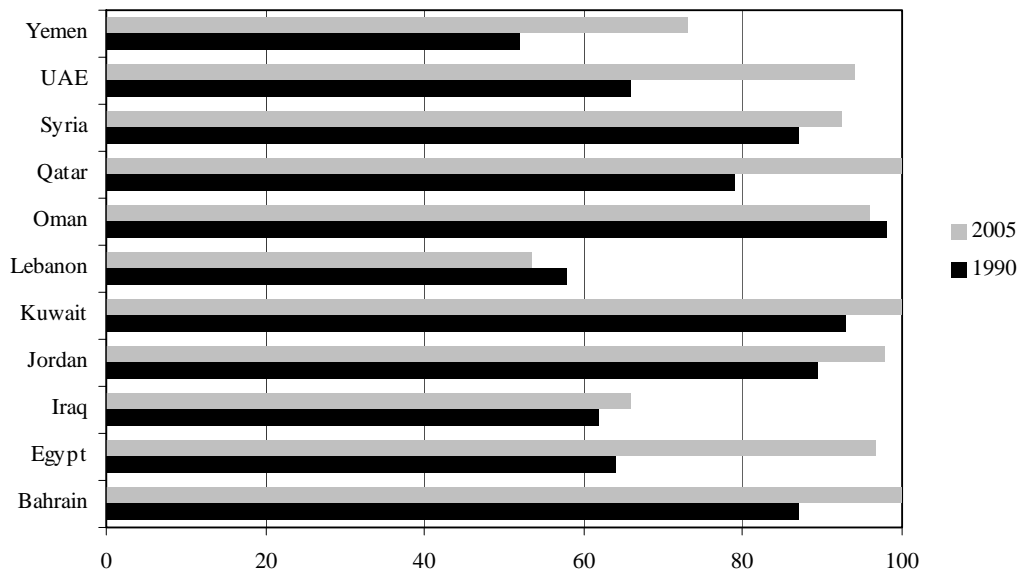
5. Immunization against infectious childhood diseases

Immunization against measles increased from 1990 to 2005 in almost all ESCWA member countries; immunizations in Yemen increased from 52 per cent in 1990 to 73 per cent in 2004; while Bahrain went from 87 per cent in 1990 to 100 per cent in 2005. The Syrian Arab Republic recorded an increase from 87 per cent in 1990 to 92.4 per cent in 2005. Percentages for 2005 were lower for Lebanon, Iraq and Yemen than for other countries, at 53.4 per cent, 66 per cent and 73 per cent, respectively, marking a decrease from previous reporting years.

Conflict, political instability, poor investment in health services and difficulties in implementing the immunization programme are among the main causes for the decreased immunization rates. However, it can be noted that there was little or no gender disparity in almost all countries for which data are available, meaning that almost the same percentage of females and males were immunized against measles.

Annex table 10 presents figures for the immunization against measles in ESCWA member countries. Figure 11 illustrates the immunization against measles in selected ESCWA member countries for 1990 and 2005, while figure 12 highlights the immunization rates, by sex, in selected ESCWA member countries for 2005.

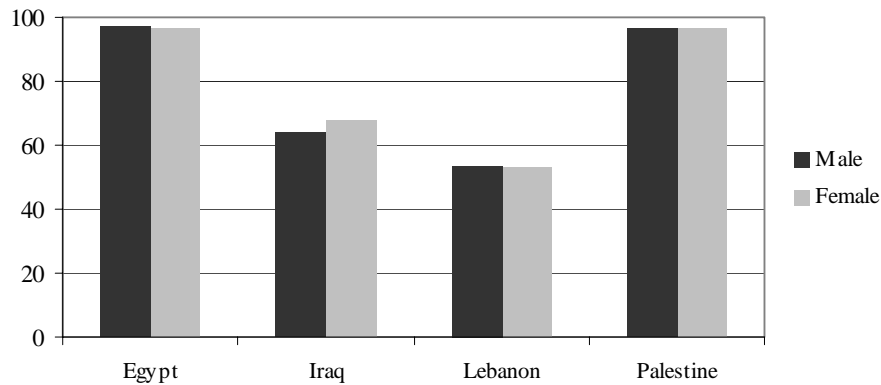
Figure 11. Immunization against measles for selected ESCWA member countries, 1990 and 2005



Sources: National data sets, namely, statistical yearbooks; family health surveys; demographic health survey; and national MDG reports.

Note: 2005 series data for Iraq and Palestine pertain to 2006; for Lebanon and Yemen to 2004.

Figure 12. Immunization against measles, by sex, for selected ESCWA member countries, 2005



Sources: National data sets, namely, statistical yearbooks; family health surveys; demographic health survey; and national MDG reports.

Note: 2005 series data for Iraq and Palestine pertain to 2006; for Lebanon to 2004.

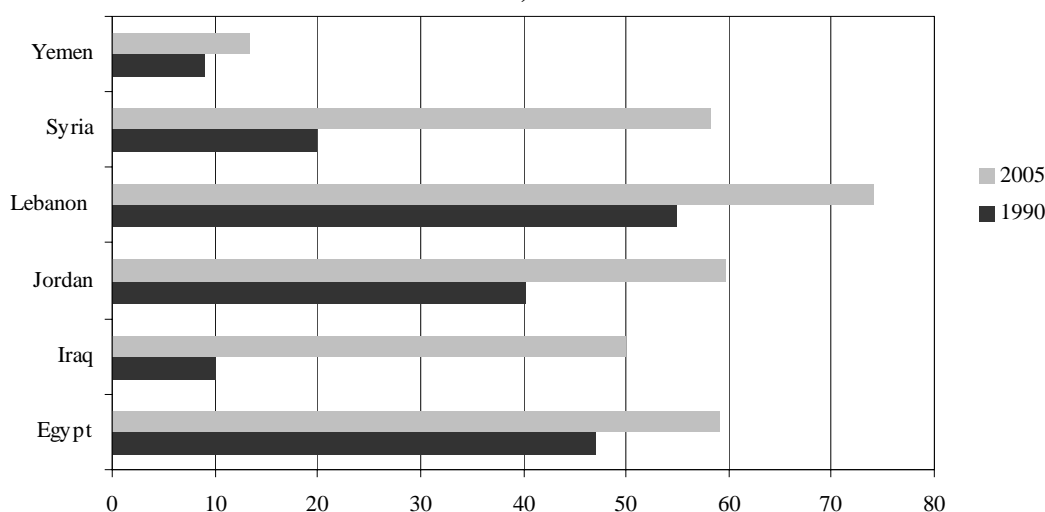
6. Contraceptive prevalence rate

Contraceptive prevalence rates have increased over time in all countries for which data were available, with the exception of Yemen, where they decreased from 2000 to 2005. Recent data reveal that contraceptive

prevalence rates were highest in Lebanon, at 74.2 per cent in 2004; Jordan, at 59.7 per cent in 2005; Egypt, at 59.2 per cent in 2005; and the Syrian Arab Republic, at 58.3 per cent in 2005. Yemen had the lowest contraceptive prevalence rates, at 13.4 per cent in 2003. Most notably, the rates in Iraq increased from 10 per cent in 1990 to 49.9 per cent in 2006, and in the Syrian Arab Republic from 20 per cent in 1990 to 58.3 per cent in 2005. Successful family planning programmes, access to primary health-care facilities and increases in the education level of women are important precursors for the adoption of contraceptive behaviours, in addition to the availability and accessibility of contraceptive methods. The availability of data, however, remains an issue for this indicator, particularly with regard to most GCC countries and Jordan, where recent rates were not available.

Annex table 11 presents the figures for contraceptive prevalence rates in ESCWA member countries. Figure 13 illustrates contraceptive prevalence rates in selected ESCWA member countries for 1990 and 2005.

Figure 13. Contraceptive prevalence rates for selected ESCWA member countries, 1990 and 2005



Sources: National data sets, namely, statistical yearbooks; family health surveys; demographic health survey; and national MDG reports.

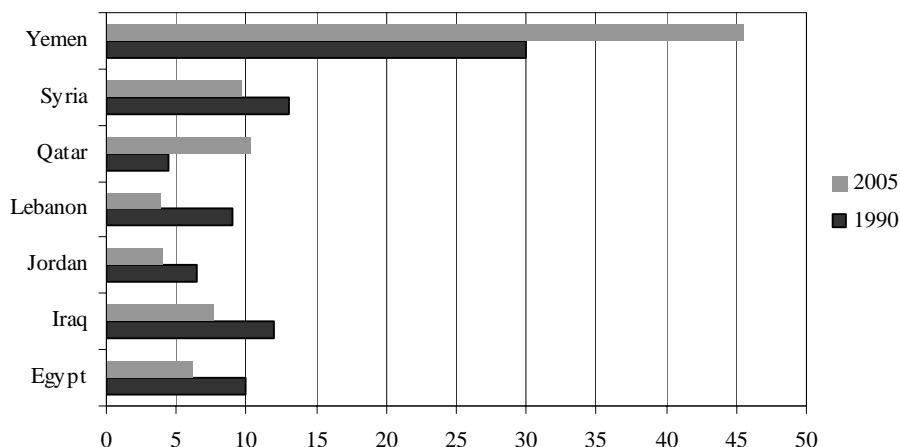
Note: 2005 series data for Iraq and Palestine pertain to 2006; for Lebanon to 2004; and for Yemen to 2003.

7. Nutritional status of children

Nutritional status measures long-term nutritional imbalance and malnutrition, as well as current under-nutrition and obesity, reflecting poor environmental conditions and/or early malnutrition. In the latest year for which data are available, Palestine had the smallest percentage of underweight children, 2.9 in 2006, followed by Lebanon, with 3.9 in 2004; Yemen, however, had the highest percentage, at 45.6 in 2003. During the period 1990-2005, the percentage of underweight under-five-year-old children decreased in all countries, with the exceptions of Kuwait, where it increased from 5 per cent in 1990 to 9.8 per cent in 2000; Qatar, where it went from 4.7 per cent in 1990 to 10.4 per cent in 2004; and Yemen, where it rose from 30 per cent in 1990 to 45.6 per cent in 2003. In some ESCWA member countries, girls are more underweight than boys, for example, in Palestine. Lebanon, however, has more underweight boys than girls. The lack of time-series data for most countries makes it difficult to come to definite conclusions on the achievements of countries in that regard. Malnutrition among infants and children remains a leading cause of under-five mortality. Better access to quality health-care services, increased education among mothers and improved breastfeeding practices are important measures in combating child under-nutrition and reducing related gender disparities.

Annex table 12 presents figures for the percentage of underweight children under the age of five, by sex, in ESCWA member countries. Figure 14 shows the percentage of underweight children in selected ESCWA member countries for 1990 and 2005, while figure 15 highlights gender disparities in underweight children in selected ESCWA member countries for 2005.

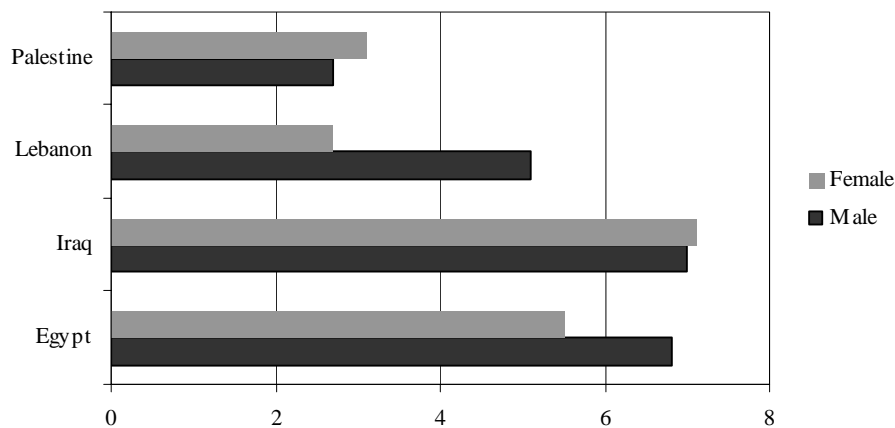
Figure 14. Percentage of underweight children for selected ESCWA member countries, 1990 and 2005



Sources: National data sets, namely, statistical yearbooks; family health surveys; demographic health survey; national MDG reports.

Note: 2005 series data for Iraq, Palestine and the Syrian Arab Republic pertain to 2006; for Lebanon and Qatar to 2004; and for Yemen to 2003.

Figure 15. Gender disparities in underweight children for selected ESCWA member countries, 2005



Sources: National data sets, namely, statistical yearbooks; family health surveys; demographic health survey; and national MDG reports.

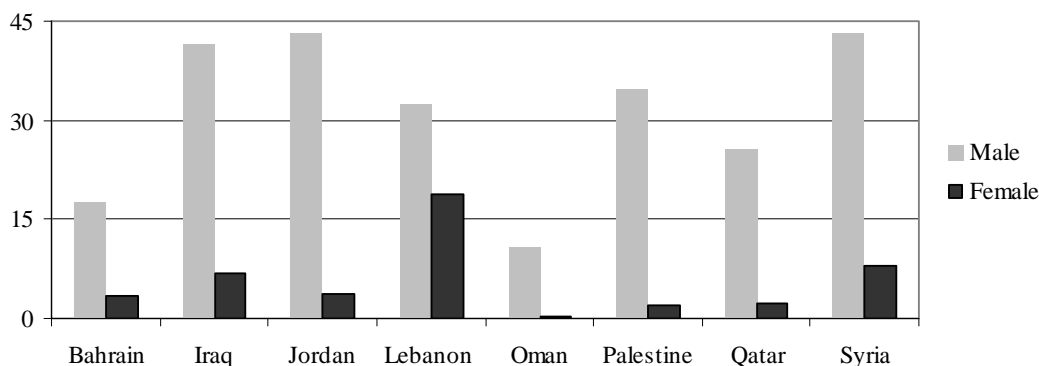
Note: 2005 series data for Iraq and Palestine pertain to 2006; for Lebanon to 2004.

8. Prevalence of tobacco use

Prevalence of tobacco use measures the spread of smoking among the population, which is a major risk factor for diseases of the heart and blood vessels, lung cancer and other diseases. Data were largely missing for this indicator; however, for countries where time series data were available, the rates of smoking have been slightly decreasing during the period 1990-2005 among both men and women. The rate of smoking was highest in Lebanon, at 25.7 per cent in 2004; followed by Jordan, with a rate of 24.2 per cent in 2003; and Iraq, with 21.9 per cent in 2006. It was lowest in Palestine, at 18.3 per cent in 2006, and Qatar, at 13.6 per cent in 2006. In all countries, smoking prevalence was higher among men, ranging between 25.5 per cent in Qatar and 43.4 per cent in Jordan in 2006. Rates of smoking among women varied between 2.1 per cent in Palestine and 6.9 per cent in Iraq in 2006, with Lebanon the only country scoring outside the range with 18.9 per cent of women smoking in 2004. Tobacco control policies, smoking cessation programmes and school education are essential factors that will contribute towards lowering those rates, thus encouraging healthy lifestyles.

Annex table 13 presents figures for the prevalence of tobacco use, by sex, in ESCWA member countries. Figure 16 illustrates smoking rates, by sex, in selected ESCWA member countries for 2005.

Figure 16. Smoking rates, by sex, for selected ESCWA member countries, 2005



Sources: National data sets, namely, family health surveys; demographic health survey.

Note: 2005 series data for Bahrain pertain to 2001, Iraq to 2006, Jordan to 2003 and Oman to 2000.

9. Prevalence of infectious diseases: malaria and tuberculosis

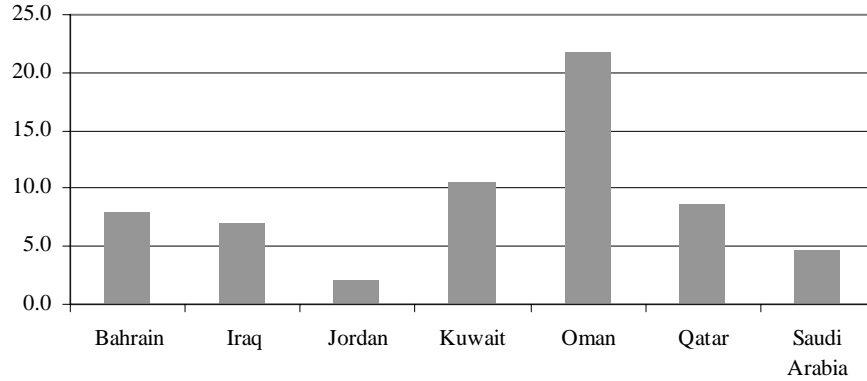
A clear image of the situation in relation to the prevalence of malaria and tuberculosis is difficult to provide owing to a lack of data across the different years.

The rates of malaria have decreased since 1990 and were low overall in all countries. In 2005, the rates ranged from 2.1 per 100,000 population in Jordan, 4.7 per 100,000 in Saudi Arabia, 10.6 per 100,000 in Kuwait and 21.7 per 100,000 in Oman. The exception was Yemen, where the rates were 770 per 100,000 in 2006.

The rates of tuberculosis generally decreased during the period 1990-2005, with the exception of Bahrain, where rates rose from 18.2 in 1990 to 23.6 per 100,000 population in 2005, and Iraq, where rates went from 2 in the year 2000 to 12.4 per 100,000 population in 2006. In 2005, the rates were also low overall in most countries, ranging from 1.9 per 100,000 in the United Arab Emirates to 46 per 100,000 population in the Syrian Arab Republic. Yemen reported high rates of tuberculosis prevalence, with 136 per 100,000 in 2005.

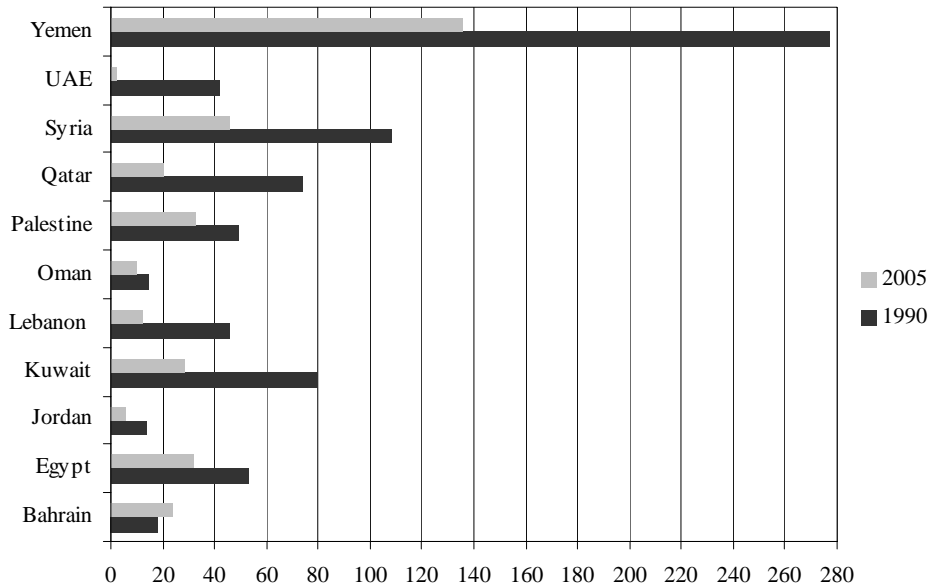
Annex tables 14 and 15 show the prevalence of malaria and tuberculosis per 100,000 population, respectively. Figure 17 illustrates malaria prevalence rates per 100,000 population in selected ESCWA member countries for 2005. Figure 18 highlights tuberculosis prevalence rates in selected ESCWA member countries for 1990 and 2005.

Figure 17. Malaria prevalence rates per 100,000 population for selected ESCWA member countries, 2005



Sources: National data sets, namely, statistical yearbooks; family health surveys; demographic health survey; and national MDG reports.

Figure 18. Tuberculosis prevalence rates for selected ESCWA member countries, 1990 and 2005



Sources: National data sets, namely, statistical yearbooks; family health surveys; demographic health survey; national MDG reports.

Note: 2005 data series for Iraq pertains to 2006; 1990 data series for Oman pertains to 1993.

C. EDUCATION

Countries in the ESCWA region have made important strides towards universalizing primary education, improving access to secondary education for girls and boys, and eradicating illiteracy. While increased access to primary education has resulted in higher literacy rates, girls and women continue to be more vulnerable to illiteracy than boys and men.

Since 1990, net enrolment levels in both primary and secondary education have generally improved for girls and boys alike, and the gender gap in enrolment has narrowed, if not become skewed in favour of girls and women, especially at the tertiary level.

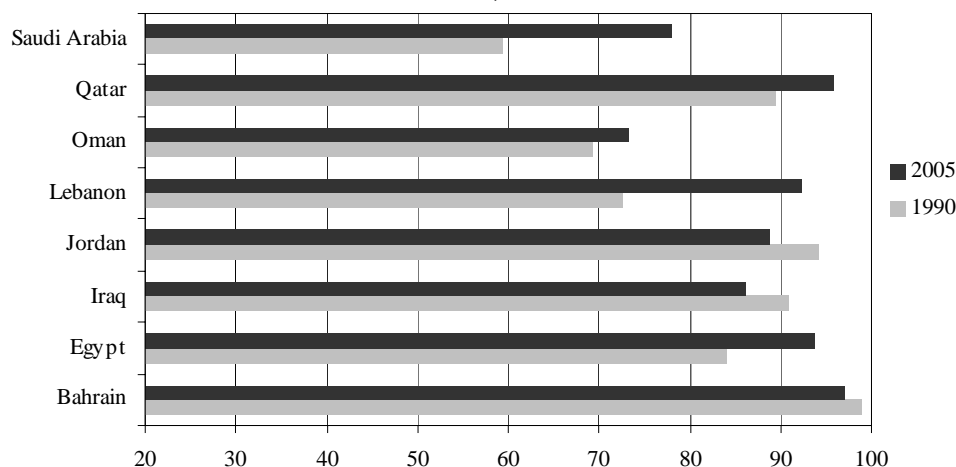
1. Net enrolment ratios in primary education, by sex

The priority accorded to achieving universal primary education within both national development plans and international development goals has resulted in significant improvements in the registration of primary school-age children in the ESCWA region. In 2005, Bahrain, Kuwait, Qatar and the United Arab Emirates were closest to achieving universal primary education with NERs almost reaching or exceeding 97 per cent. Those countries were followed by Egypt and Lebanon, where 93.7 per cent and 92.4 per cent of children of primary school-age respectively, were registered. NER in primary education increased in more than half of the ESCWA member countries between 1990 and 2005, albeit in varying degrees, ranging from 3 to 20 percentage points. However, notable declines were reported in Iraq and Jordan.

The gender gap in primary education has been bridged in most ESCWA member countries, with more than one third of the countries achieving parity in enrolment in primary education in 2005. In Jordan, Kuwait, Oman and Saudi Arabia, girls have a slight advantage over boys. However, that advantage of girls over boys masks overall low levels of participation in primary education in Oman and Saudi Arabia, where less than 80 per cent of children of primary school-age were enrolled in 2005. On the opposite end of the spectrum, low access to and gender disparities in primary education were witnessed in Iraq, where war, occupation and internal strife have led to decreasing levels of participation in primary education between 1990 and 2005.

Annex table 16 shows NER in primary education, by sex, in ESCWA member countries. Figure 19 illustrates NER in primary education for selected ESCWA member countries for 1990 and 2005. Figure 20 highlights the gender parity index (GPI) for NER in primary education in ESCWA member countries for 2005.

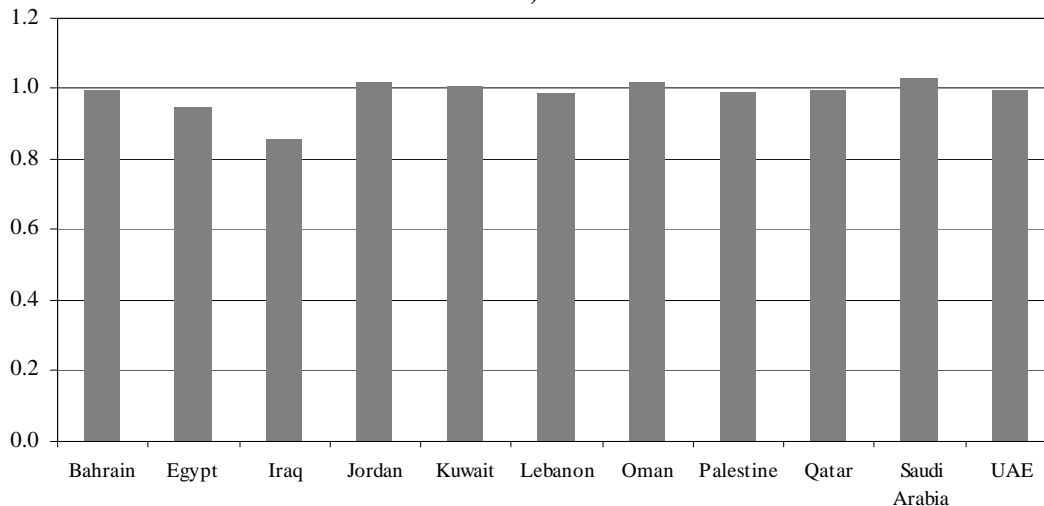
Figure 19. NER in primary education for selected ESCWA member countries, 1990 and 2005



Source: United Nations Educational, Scientific and Cultural Organization (UNESCO) Institute for Statistics Data base Centre, available at: <http://stats.uis.unesco.org/unesco/TableViewer/tableView.aspx?ReportId=177> (nationally corroborated).

Notes: 2005 data series for Oman pertain to 2006.

Figure 20. GPI for NER in primary education for ESCWA member countries, 2005



Source: UNESCO Institute for Statistics Data base Centre, available at: <http://stats.uis.unesco.org/unesco/TableViewer/tableView.aspx?ReportId=177> (nationally corroborated).

Notes: *a/* The gender parity index (GPI) measures gender disparities in a particular level of education, and is calculated as the ratio of girls' enrolment to that of boys. A GPI of 1 implies equality, less than 1 implies that levels are skewed in favour of boys, and greater than 1 indicates that girls' enrolment exceeds that of boys; and *b/* 2005 series data for Oman pertain to 2006.

2. Net enrolment ratios in secondary education, by sex

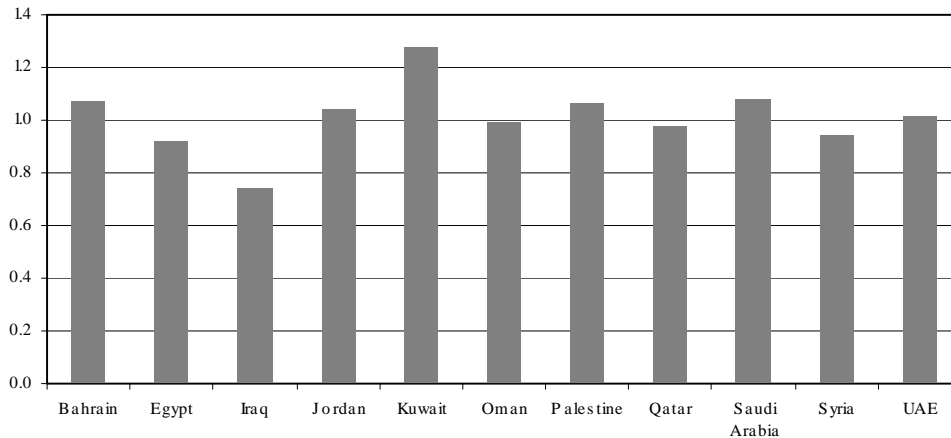
The premium placed on more advanced skills and knowledge in the labour market has led to a greater impetus towards achieving universal secondary education as a means of improving the human asset base of developing countries. In keeping with the generally upward trend in NERs in primary education, improvements in NER in secondary education in the ESCWA region ranged between 5 to 20 percentage points during the period 1990-2005. In 2005, the highest levels were observed in Palestine, Qatar and Bahrain, which were close to achieving universal secondary education, with NERs of 94.8 per cent, 90.1 per cent and 90.0 per cent, respectively.

In 6 of the 13 ESCWA member countries, namely, Bahrain, Jordan, Kuwait, Palestine, Saudi Arabia and the United Arab Emirates, girls' participation in secondary education exceeded that of boys in 2005. Both Oman and Qatar have almost achieved gender parity in secondary school enrolment levels. In Iraq and Yemen, enrolment in secondary education was low, predictably more so among girls.

A comparison of gender disparities between primary and secondary education levels shows that, with the exception of Oman and Qatar, in countries where parity in primary education is achieved ($GPI \geq 0.99$) or gender imbalances are in favour of girls, the gap tends to widen in favour of girls at the secondary level, as reflected by 2005 data for Bahrain, Jordan, Kuwait, Palestine, Saudi Arabia and the United Arab Emirates. Similarly, a broadening of the gender gap in favour of boys is witnessed in countries where wide gender disparities in favour of boys in primary education prevail, for example, in Iraq and Yemen.

Annex table 17 presents figures for NER in secondary education in ESCWA member countries, by sex. Figure 21 illustrates GPI for NER in secondary education in selected ESCWA member countries.

Figure 21. GPI for NER in secondary education for selected ESCWA member countries, 2005



Source: UNESCO Institute for Statistics Data base Centre, available at: <http://stats.uis.unesco.org/unesco/TableViewer/tableView.aspx?ReportId=177> (nationally corroborated).

Notes: a/ Gender parity index (GPI) measures gender disparities in a particular level of education, and is calculated as the ratio of girls' enrolment to that of boys. A GPI of 1 implies equality, less than 1 implies that levels are skewed in favour of boys, and greater than 1 indicates that girls' enrolment exceeds that of boys; and b/ 2005 series data for Oman pertain to 2006.

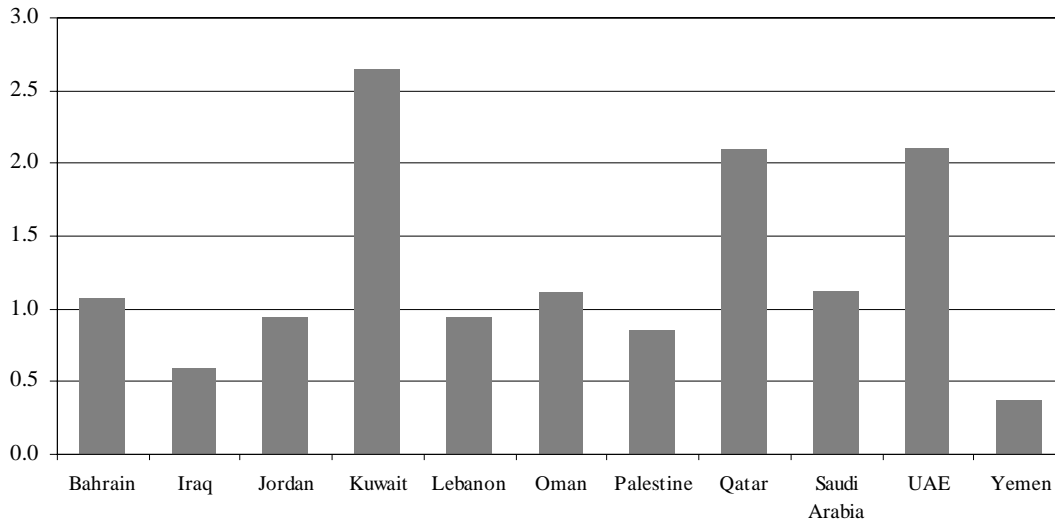
3. Gross enrolment ratios in tertiary education, by sex

Enrolment levels in tertiary education have generally improved between 1990 and 2005 in all countries for which data were available. In 2005, GERs in tertiary education were highest in Bahrain, at almost 100 per cent, followed by Lebanon and Qatar, with 60.5 per cent and 50.2 per cent, respectively, in 2004.

Six of the eleven countries reporting data for 2005, namely, Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates, reveal that women's enrolment in tertiary education exceeded that of men. For example, in Kuwait and Qatar, women's participation in tertiary education was more than twice that of men. However, there is a tendency in the region for men to travel abroad to seek higher education and that is not reflected in national data. Furthermore, in some countries, limited job opportunities, or social restrictions and barriers to women's work, may create a push factor for women's pursuit of tertiary education.

Annex table 18 presents GER in tertiary education in ESCWA member countries, by sex. Figure 22 illustrates GPI for GER in tertiary education for selected ESCWA member countries for 2005.

Figure 22. GPI for GER in tertiary education for selected ESCWA member countries, 2005



Source: UNESCO Institute for Statistics Data base Centre, available at: <http://stats.uis.unesco.org/unesco/TableViewer/tableView.aspx?ReportId=177> (nationally corroborated).

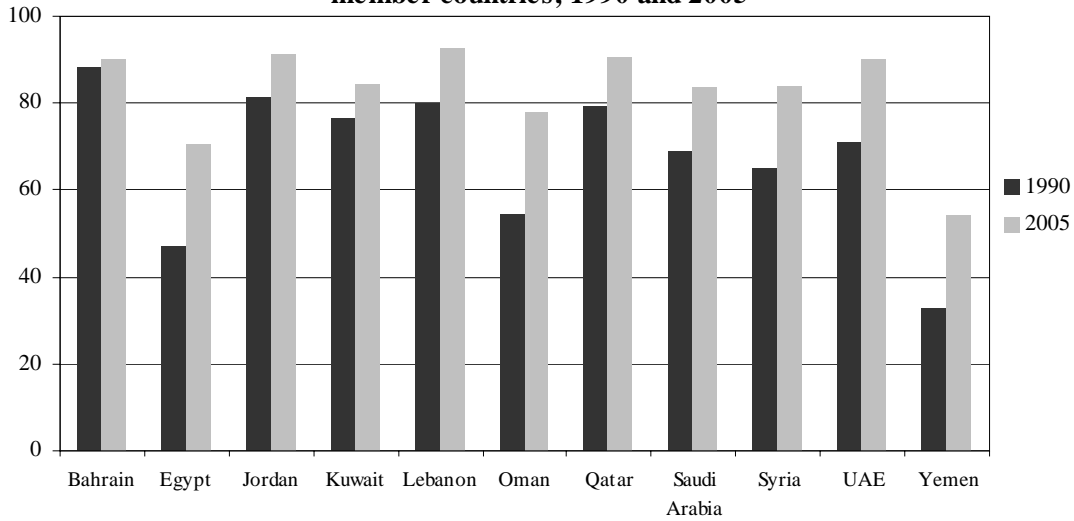
Notes: a/ Gender parity index (GPI) measures gender disparities in a particular level of education, and is calculated as the ratio of girls' enrolment to that of boys. A GPI of 1 implies equality, less than 1 implies that levels are skewed in favour of boys, and greater than 1 indicates that girls' enrolment exceeds that of boys; and b/ 2005 series data for Lebanon pertain to 2004, and for Palestine to 2006.

4. Adult literacy rate, by sex

While adult literacy rates increased between 1990 and 2005, major intraregional and gender discrepancies still exist. In 2005, 90 per cent or more of the population aged 15 and over was literate in Bahrain, Jordan, Lebanon, Palestine, Qatar and the United Arab Emirates. However, more than a quarter of adults in Egypt and almost a half in Yemen could not read or write. Adult illiteracy among women is correspondingly highest in Egypt and Yemen, where no more than 60 per cent and 34.6 per cent of women, respectively, are able to read and write.

Annex table 19 presents adult literacy rates for those aged 15 and over, by sex, in ESCWA member countries. Figure 23 illustrates literacy rates among adults, those aged 15 and over, in selected ESCWA member countries for 1990 and 2005. Figure 24 highlights GPI in relation to adult literacy, those aged 15 and over, in selected ESCWA member countries for 2005.

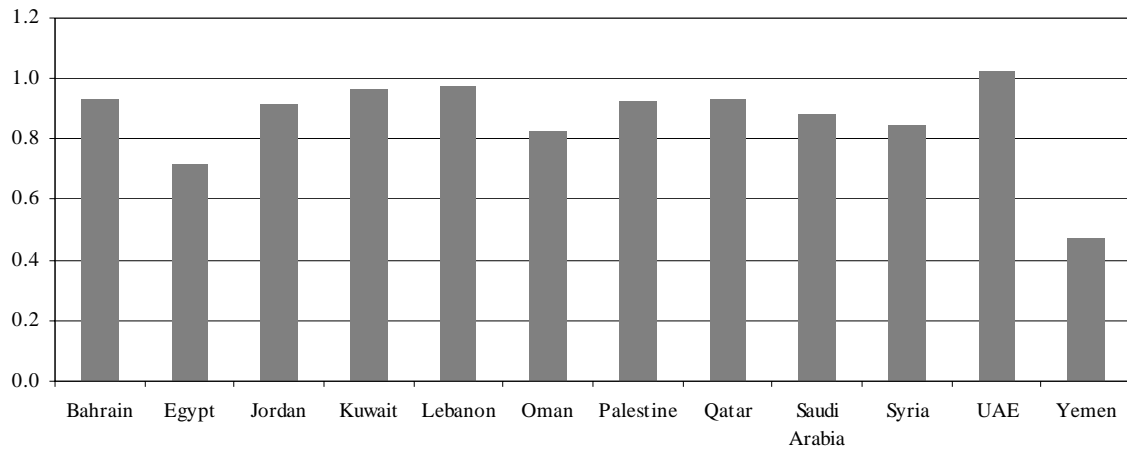
Figure 23. Adult (15 and above) literacy rates for selected ESCWA member countries, 1990 and 2005



Sources: ESCWA, *Statistical Abstract of the ESCWA Region*, twenty-sixth issue (E/ESCWA/SCU/2007/1); and UNESCO Institute for Statistics Data base Centre, available at: <http://stats.uis.unesco.org/unesco/TableViewer/tableView.aspx?ReportId=177> (nationally corroborated).

Notes: 1990 series data for Bahrain pertain to 1991; 2005 series data for Egypt pertain to 2006, for Lebanon and Yemen to 2004 and for Oman to 2003.

Figure 24. GPI in adult (15 and above) literacy for selected ESCWA member countries, 2005



Source: ESCWA, *Statistical Abstract of the ESCWA Region*, twenty-sixth issue (E/ESCWA/SCU/2007/1); and UNESCO Institute for Statistics Data base Centre, available at: <http://stats.uis.unesco.org/unesco/TableViewer/tableView.aspx?ReportId=177> (nationally corroborated).

Notes: Data for Palestine pertain to 2006, for Lebanon and Yemen to 2004, and for Oman to 2003.

D. DEMOGRAPHICS

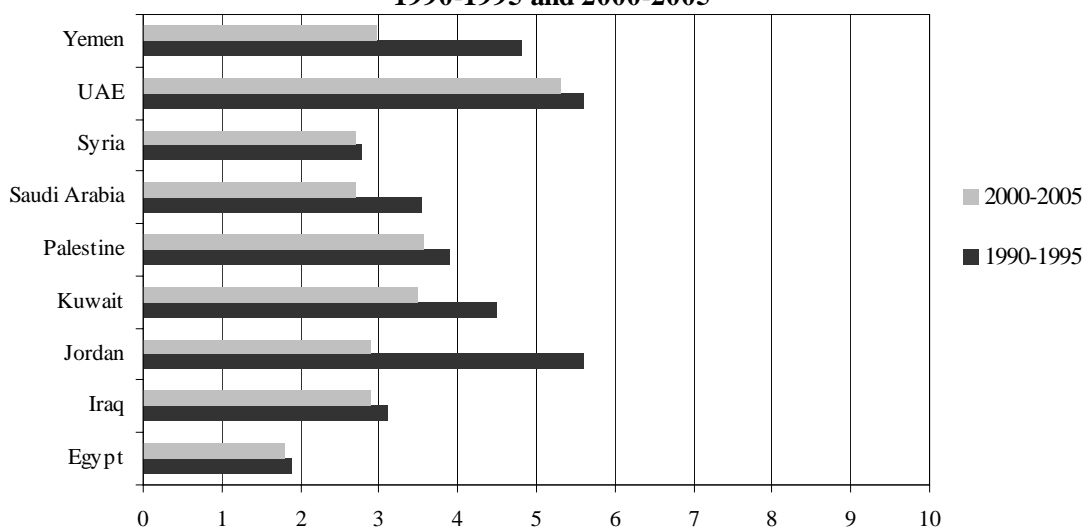
Demographics have been considered with regard to three indicators of growth in relation to population, fertility and dependency ratios.

1. Population growth rate

Calculations indicate that all countries in the region will demonstrate a positive growth rate over the period 2005-2010, ranging from 2.3 per cent in Jordan to 5.6 per cent in Qatar for 2002. It is projected that rates will have declined between the two periods 2000-2005 and 2005-2010 in most countries, with the exception of Iraq, the United Arab Emirates and Yemen, where the rates are expected to level off at 2.9 per cent, 5.3 per cent and 3.0 per cent, respectively. Qatar is the only country showing an increase, with population size expected to grow from 4 per cent during 2000-2005 to 5.6 per cent during 2005-2010. That means that if the current rate of growth remains constant, the population of Qatar would take about 12.5 years to double. An increased population growth generally constitutes problems for a country in that it is associated with increased need for food, infrastructure and services. Those are expenses that most high-growth countries have little ability to provide today, let alone if the population rises dramatically.

Annex table 20 presents the population growth rate in ESCWA member countries for four periods of time, up to 2005-2010. Figure 25 illustrates the growth rate in selected ESCWA member countries for the periods 1990-1995 and 2000-2005.

Figure 25. Growth rate for selected ESCWA member countries, 1990-1995 and 2000-2005



Source: United Nations Department of Economic and Social Affairs, Population Division, *World Population Prospects: The 2006 Revision* (corroborated by countries).

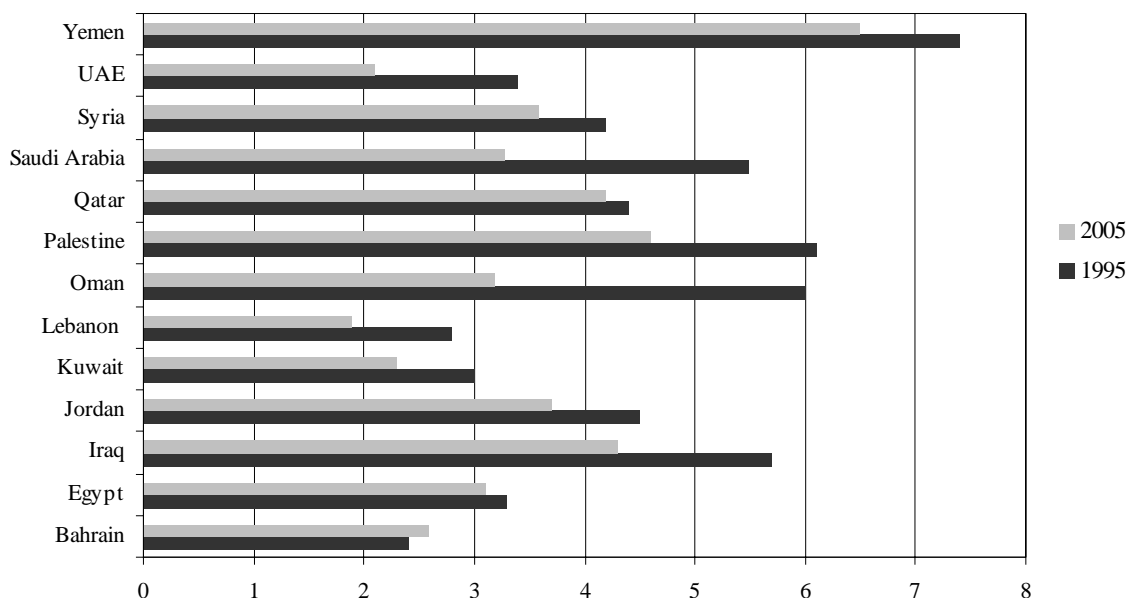
2. Total fertility rate

Fertility rates have declined in all ESCWA member countries since 1990. A reduction in fertility rates was most significant in Saudi Arabia, where fertility rates decreased from 6.7 to 3.3 children per woman between 1990 and 2005. There was also a significant reduction in the United Arab Emirates, where fertility dropped from 5.1 to 2.1 children per woman over the same period. Yemen continues to have the highest fertility rate of all ESCWA member countries, with 6.5 children per woman, while Lebanon has the lowest fertility in the region, with 1.9 children per woman in 2004. Taking the benchmark of 2.1 children per woman as the level of fertility ensuring population replacement, fertility levels in three ESCWA member countries were below, or almost below the replacement level in 2005, whereas no single country had similarly low levels of fertility in 1990. Social and economic forces may have contributed to the decline of

fertility. Those include advances in education and rational decisions by families, changes in the benefits and costs of children, and the emergence of new economic roles for women.

Annex table 21 shows the total fertility rate in ESCWA member countries over the period 1990-2005. Figure 26 illustrates the total fertility rate in ESCWA member countries for 1995 and 2005.

Figure 26. Total fertility rate for ESCWA member countries, 1995 and 2005



Source: United Nations Department of Economic and Social Affairs, Population Division, *World Population Prospects: The 2006 Revision* (corroborated by countries).

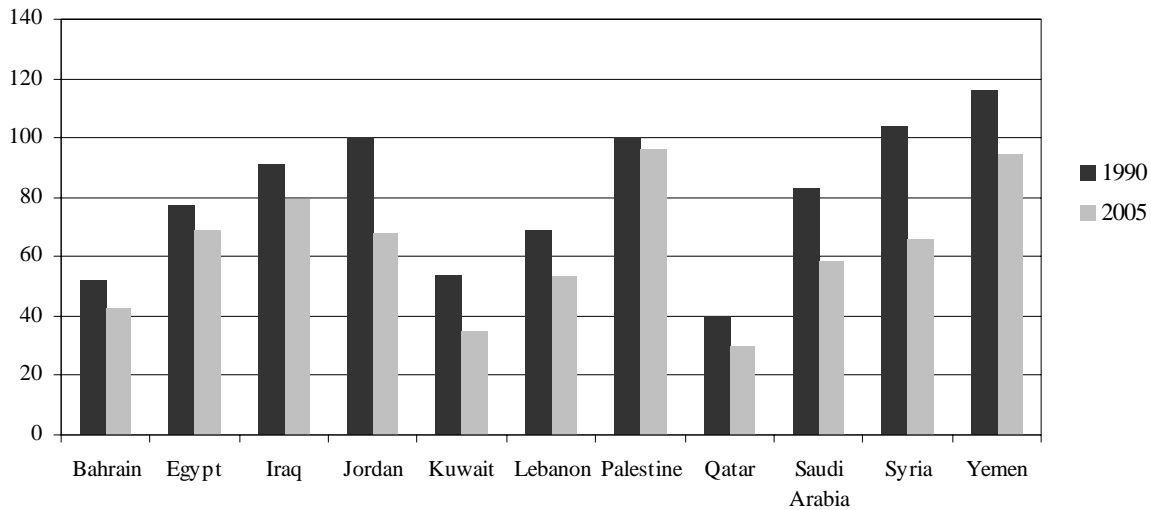
Notes: 2005 series data for Egypt, Oman and Palestine pertain to 2006; for Lebanon to 2004; and for Qatar and Yemen to 2002.

3. Dependency ratio

The dependency ratio is highest in Palestine and Yemen, with more than 96 and 94.1 dependents, respectively for every 100 people in the working-age population, namely, those aged 15-64, in 2005 and 2004. In contrast, there were approximately 30 dependents for every 100 people aged 15-64 in Kuwait and Qatar during the same year. Overall, all countries experienced a change in their dependency ratios, particularly Jordan, Kuwait and the Syrian Arab Republic, where the ratios have fallen by more than one third since 1990. Governments have been encouraged to exert efforts to reach levels where the working-age population outnumbers the young and old populations, thus alleviating some of the economic strain on the age group that is considered economically active or independent. While the largely young population in the ESCWA region puts pressure on the economy in the short run through increased demand for social services and high demand for employment, it represents a dividend for a productive labour force in the long run if Governments have developed plans to absorb the high percentage of working-age adults into the local economy through improved work opportunities, while at the same time decreasing their total fertility rates.

Annex table 22 shows the dependency ratio per 100 people for ESCWA member countries. Figure 27 illustrates the dependency ratio in selected ESCWA member countries for 1990 and 2005.

Figure 27. Dependency ratio for selected ESCWA member countries, 1990 and 2005



Source: United Nations Department of Economic and Social Affairs, Population Division, *World Population Prospects: The 2006 Revision* (corroborated by countries).

Note: 2005 series data for Lebanon and Yemen pertain to 2004.

E. ECONOMIC DEVELOPMENT

Economic development was measured by three indicators of employment, namely, employment-population ratio, employment status and share of women in wage employment in the non-agricultural sector.

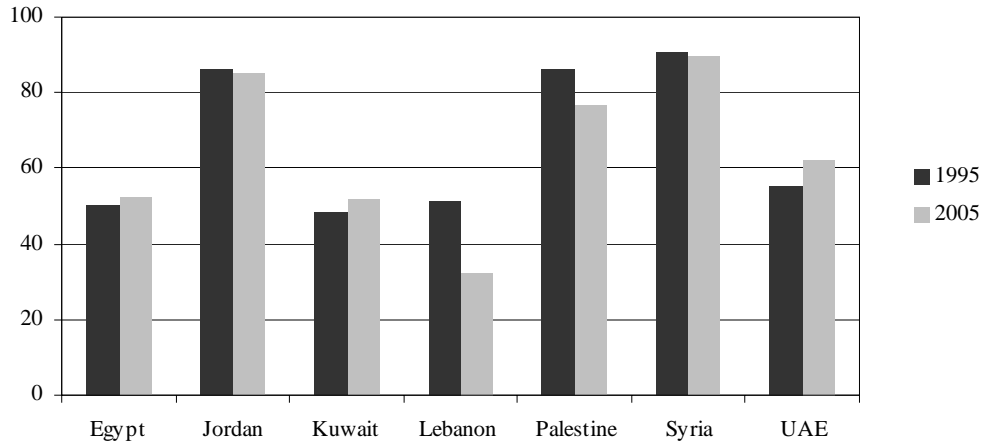
1. *Employment-population ratio, by sex*

Approximately half of ESCWA member countries had employment-population ratios between 50 per cent and 75 per cent in 2005. The only countries which had very high ratios of employment to population, namely, above 85 per cent, are Saudi Arabia and Jordan. At the other end of the spectrum, Lebanon and Yemen had the lowest employment ratios, with less than 45 per cent of the working-age population employed in 2005. The low ratios for those countries can be attributed to extremely low female employment-to-population ratios. Over the past decade, employment-population ratios have increased for Iraq, Jordan, Kuwait and the United Arab Emirates, decreased for Lebanon and Palestine, and showed little change, that is 1 percentage point, for Bahrain, Egypt, Qatar, the Syrian Arab Republic and Yemen.

Employment-to-population ratios are of particular interest when broken down by sex, as the ratios for men and women can provide information on gender differences in labour market activity. In general, ratios for men declined in the past 10 years, while those for women rose. Increasing female employment ratios can be attributed to a multitude of factors, including the increase in female enrolment in tertiary education and the enactment of laws against discrimination on the basis of sex, and reductions in gender stereotyping in occupations and education. Nevertheless, large variations persist between the genders, with men more likely to be employed than women. In 2005, gender differences were minimal in some ESCWA member countries, for example, less than 5 percentage points in Palestine. However, the differences tended to be larger in other countries, for example more than 50 percentage points in Egypt, Iraq, Oman, Qatar, the Syrian Arab Republic and the United Arab Emirates, indicating that there is a large unexploited potential of women in the region.

Annex table 23 presents employment-population ratios, by sex, in ESCWA member countries. Figure 28 illustrates the employment-population ratio in selected ESCWA member countries for 1995 and 2005. Figure 29 highlights gender disparities in the employment-population ratio in selected ESCWA member countries for 2005.

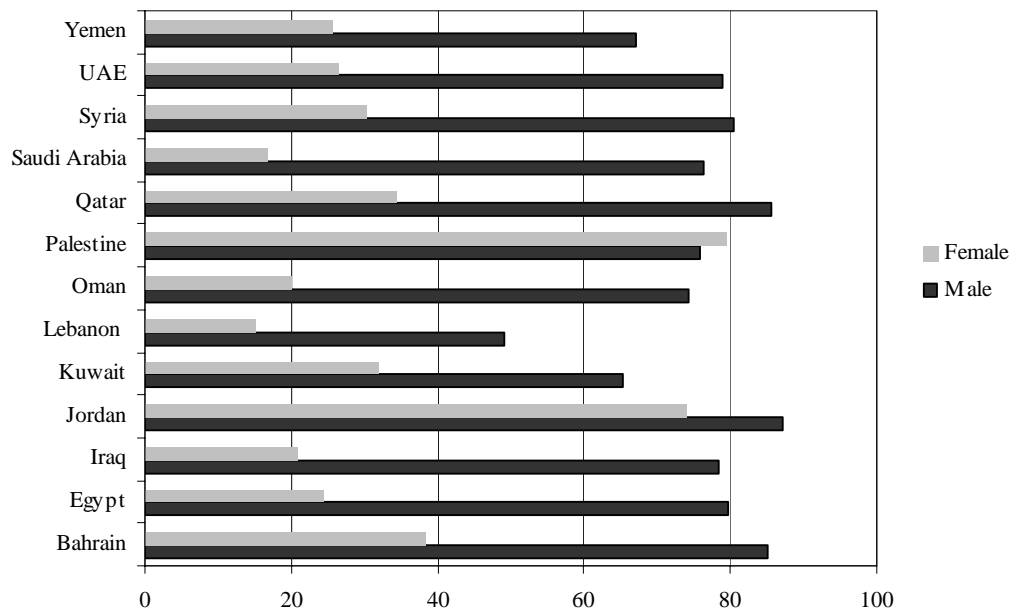
Figure 28. Employment-population ratio for selected ESCWA member countries, 1995 and 2005



Sources: Labour force surveys in ESCWA member countries.

Notes: 2005 series data for Iraq and Palestine pertain to 2006.

Figure 29. Gender disparities in employment-population ratio for selected ESCWA member countries, 2005



Source: Labour force surveys in ESCWA member countries.

Notes: 2005 series data for Iraq and Palestine pertain to 2006.

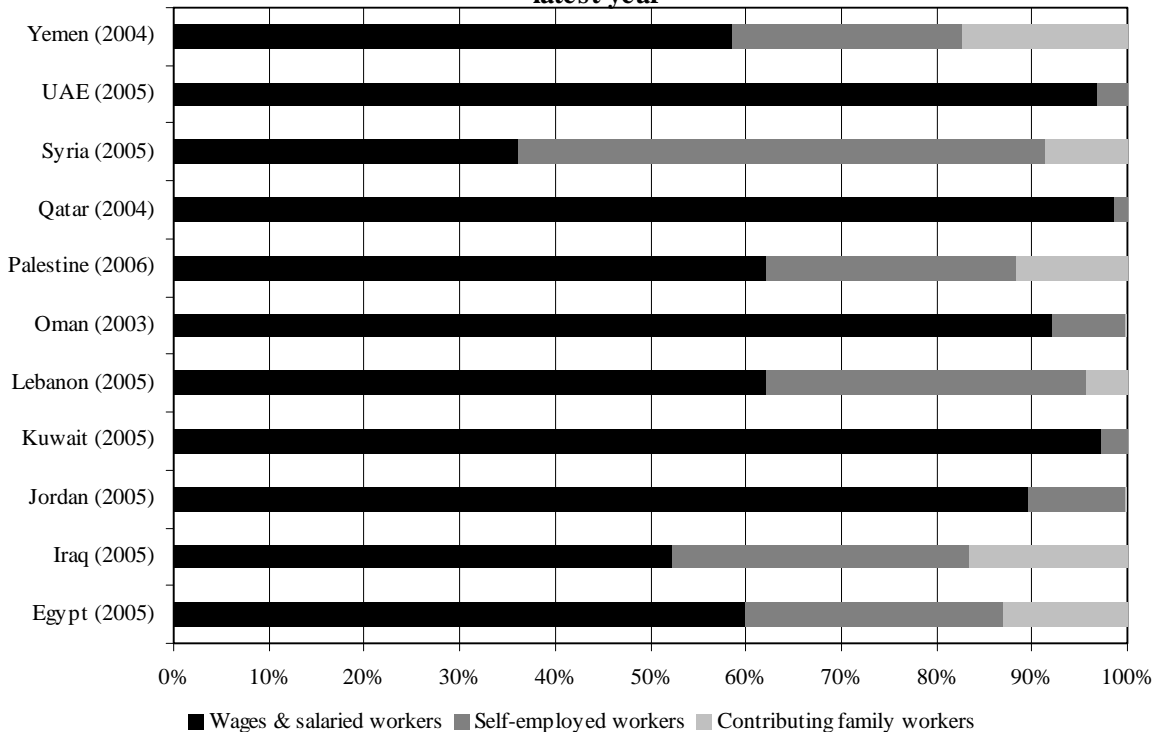
2. Employment status, by sex

A clear majority of workers are engaged in wage and salaried employment in all ESCWA member countries. In 2005, wage and salaried workers constituted more than 80 per cent of those employed in Jordan, Qatar, Kuwait, Oman and the United Arab Emirates, whereas they constituted some 60 per cent of those employed in Egypt, Lebanon, Palestine and Yemen. Approximately half of those employed in Iraq were waged and salaried in 2005. Literature shows that there is generally a positive relationship between the type of employment and the level of development as measured by income per capita. For instance, GCC countries, which have the highest income per capita in the region, have the highest percentage of wage and salaried workers.

The breakdown of status of employment, by sex, shows differences in the labour market place between men and women. Firstly, women are more likely than men to hold wage and salaried jobs, with the exception of women in Egypt, Palestine, the United Arab Emirates and Yemen, where the proportion of women employees in employment was less than the corresponding proportion for men. Secondly, women constituted the bulk of contributing family workers in agriculture-based economies, namely, in Egypt, Palestine, the Syrian Arab Republic and Yemen.

Annex table 24 shows the percentage of wage and salaried workers in ESCWA member countries, annex table 25 highlights the percentage of self-employed workers in the region, and annex table 26 illustrates the percentage of contributing family workers for all countries in the region. Figure 30 illustrates the distribution of workers, by status, in ESCWA member countries for the latest year available.

Figure 30. Distribution of workers by status for ESCWA member countries, latest year



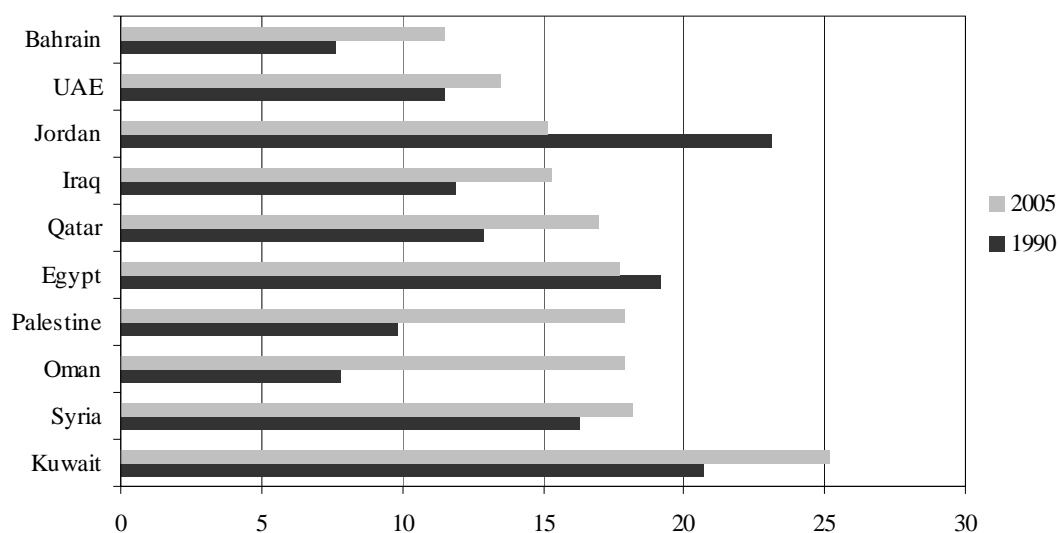
Source: Labour force surveys in ESCWA member countries.

3. Share of women in wage employment in the non-agricultural sector

Women's access to wage employment in the non-agricultural sector is still lower than men's in all ESCWA member countries. Women across all countries hold less than 25 per cent of wage employment compared to men in non-agricultural sectors, with the lowest share in Yemen, at 3.2 per cent in 2004, and the highest in the Syrian Arab Republic, at 18.2 per cent. Overall, the proportion of women in paid employment has improved in most ESCWA member countries since 1990, with the exceptions of Egypt, Jordan and Yemen, where the share declined respectively by 1.5, 7.9 and 3.3 percentage points from 1990. Despite progress made over time, the share of women in paid employment remains modest, and radical policies are required to attract women to contribute more considerably in that sector and to minimize the barriers of their participation.

Annex table 27 shows the share of women in wage employment in the non-agricultural sector in the ESCWA region. Figure 31 highlights the share of women in wage employment in the non-agricultural sector in selected ESCWA member countries for 1990 and 2005.

Figure 31. Share of women in wage employment in the non-agricultural sector for selected ESCWA member countries, 1990 and 2005



Sources: Labour force surveys in ESCWA member countries.

Notes: 1990 series data for Oman pertain to 1993; 2005 series data for Iraq and Palestine pertain to 2006, for Qatar and Yemen to 2004, and for Oman to 2003.

III. CONCLUSION

Given the findings of this *Compendium*, concerted efforts must be exerted to achieve sustainable development in the ESCWA region. Fostering collaboration and building partnerships among countries are essential in paving the way for more harmonious progress towards the achievement of international goals and targets, including MDGs. Good governance and investment in social services on the one hand, and political stability and security on the other, are top priorities in that they are essential precursors to sustainable development.

Throughout the region, poor nutrition and poor access to health services in rural and poor urban areas remain important factors that must be addressed in order to achieve better health. Improving access to sanitation and drinking water is vital to promoting better health, reducing poverty and hunger, facilitating better school enrolment, promoting gender equality and women's empowerment, and ensuring sustainable development. Moreover, increasing access to safe water sources frees women and children, who typically fetch water, to engage in income-generating activities and to attend school. Ensuring proper sanitation facilities in schools is also a means of facilitating higher school attendance among girls. In countries where enrolment levels are high and gender parity has almost been achieved, efforts and resources are needed to improve the quality of education with a view to ensuring that future labour market entrants are equipped with the required technical and life skills and appropriate knowledge. Additional efforts and resources targeting poor and rural communities, and conflict-stricken and least developed countries, must be exerted to improve accessibility and equality in education as an investment in the human capital of the region.

In addition, it is crucial for Governments to implement long-term policies to address high fertility and growth rates and to alleviate poverty. In the short run, the region must implement family planning programmes aimed at reducing fertility rates to the replacement level, or below, while simultaneously creating, in the long run, sufficient employment opportunities to absorb its burgeoning working-age population. Despite improvements, women's share of employment remains modest and, thus, radical policies are required to encourage women to participate more considerably in the workforce and to minimize barriers to their participation. Gender equality is an essential element in the development process. Governments have a dual challenge of providing decent employment opportunities to women and men alike, and ensuring equal pay and good working conditions for all.

The considerable lack of data, including the lack of sex-disaggregated data, and data by urban and rural areas, impedes the institutionalization of a culture of evidence-based decision-making, which is needed at both the regional and the national levels. Quality statistics are crucial for the formulation, implementation, monitoring and evaluation of national policies and programmes, including the setting of benchmarks and targets. With that in mind, data availability, especially time series data, was a major challenge in producing this *Compendium*. External sources were sought to supplement national data, particularly in relation to poverty and health indicators. Building the capacities of Governments to collect routine quality data, disaggregated by various social determinants, for example, by age, sex and geographic location, is crucial and must accompany efforts towards sustainable development in the region. Similarly, efforts must be made to harmonize data collection and reporting with a view to ensuring consistency in data, within the framework of both national and regional endeavours.

Annex I

TABLES

ANNEX TABLE 1. POVERTY: INCOME POVERTY

Countries	Population living below the national poverty line (Percentage)			
	1990	1995	2000	2005
Bahrain	0	0	0	0
Egypt	25	22.9 (1996)	20	..
Iraq	..	..	..	54 (2003)
Jordan	15 (1991)	11.7 (1997)	..	14.2 (2002)
Kuwait	..	..	..	..
Lebanon	..	6.3	..	..
Oman	..	..	..	..
Palestine	..	..	21	36.1 (2006)
Qatar	..	..	..	..
Saudi Arabia	..	..	..	..
Syrian Arab Republic	..	14.3 (1997)	..	11.39 (2004)
Yemen	..	41.8 (1996)	10.2 (1998)	..

Sources: National MDG reports; figures in italics are from United Nations Statistics Division website for MDG Indicators, available at: <http://mdgs.un.org/unsd/mdg/Data.aspx> (8 October 2007).

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 2. POVERTY: INCOME POVERTY

Countries	Proportion of the population living below the international poverty line (Percentage)			
	1990	1995	2000	2005
Bahrain	0	0	0	0
Egypt	4.0	3.0	3.1	..
Iraq	..	..	..	..
Jordan	2 (1992)	2 (1997)	..	2 (2003)
Kuwait	..	..	..	..
Lebanon	..	..	..	..
Oman	..	..	..	..
Palestine	..	..	..	..
Qatar	..	..	..	..
Saudi Arabia	..	..	..	..
Syrian Arab Republic	..	..	..	..
Yemen	3.6 (1992)	..	15.7 (1998)	..

Sources: National MDG reports; figures in italics are from United Nations Statistics Division website for MDG Indicators, available at: <http://mdgs.un.org/unsd/mdg/Data.aspx> (8 October 2007).

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 3. POVERTY: SANITATION

Countries	Proportion of the population with access to improved sanitation (Percentage)			
	1990	1995	2000	2005
Bahrain	100	100	100	100
Urban	..	..	..	..
Rural	..	..	..	..
Egypt	85	41.61(1996)	95	48.7(2006)
Urban		74.78(1996)		81.7(2006)
Rural		17.18(1996)		24.5(2006)
Iraq			80(2002)	92.2(2006)
Urban			95(2002)	98.2(2006)
Rural			48(2002)	81.8(2006)
Jordan	93	..	..	93 (2004)
Urban	97	..	..	94 (2004)
Rural	82	..	..	87 (2004)
Kuwait	100(1992)	100	100	100
Urban				
Rural				
Lebanon		37(1996)	100(2002)	96.9(2004)
Urban			98(2002)	
Rural			87(2002)	
Oman	..	85	..	88.5 (2003)
Urban	..	..	..	..
Rural	..	..	..	..
Palestine		31.7	42.8	45.3 (2006)
Urban				58.4 (2006)
Rural				3.5 (2006)
Qatar	100	..	100	100 (2004)
Urban	100	..	100	100 (2004)
Rural	100	..	..	100 (2004)
Saudi Arabia	90.7	93.5	96.3	98.75
Urban	..	..	..	..
Rural	..	..	..	..
Syrian Arab Republic	55		71.8	97.3(2006)
Urban	75.5		96.5	99.7(2006)
Rural	34.5		44.1	94.0(2006)
United Arab Emirates	97	..	100 (2002)	100 (2004)
Urban	98	..	100 (2002)	100 (2004)
Rural	95	..	100 (2002)	100 (2004)
Yemen			38	43.5(2004)
Urban				86(2004)
Rural				26(2004)

Sources: National MDG reports; ESCWA, *Compendium of Environment Statistics in the ESCWA Region* (E/ESCWA/SCU/2007/2), pp. 129-137; and United Nations Statistics Division website for MDG Indicators, available at: <http://mdgs.un.org/unsd/mdg/Data.aspx> (nationally corroborated).

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 4. POVERTY: DRINKING WATER

Countries	Proportion of the population with access to an improved drinking water source (Percentage)			
	1990	1995	2000	2005
Bahrain	100	100	100	100
Urban	..	..	..	..
Rural	..	..	..	..
Egypt	73	81.3 (1996)	87	95.3 (2006 census)
Urban	..	...	96.1	97.8 (2006 census)
Rural	..	...	70.4	93.5 (2006 census)
Iraq	..	..	81 (2002)	79.2 (2006)
Urban	..	..	97 (2002)	91.9 (2006)
Rural	..	..	50 (2002)	57 (2006)
Jordan	92.8	93.5 (1992)	97 (2002)	98.1
Urban	..	..	99 (2002)	..
Rural	..	..	95 (2002)	..
Kuwait	100 (1992)	100	100	100 (2004)
Urban	..	..	100	100 (2004)
Rural	..	..	..	...
Lebanon	..	..	95	100 (2002)
Urban	..	..	..	100
Rural	..	..	..	100
Oman	88 (1993)	..	...	75.3 (2003)
Urban	..	..	..	79.0 (2003)
Rural	..	..	..	63.96
Palestine	..	79.6...	96.2	93.8 (2006)
Urban	..	..	..	96 (2006)
Rural	..	..	..	86.3 (2006)
Qatar	100	..	100	100 (2004)
Urban	100	..	100	100 (2004)
Rural	100	..	..	100 (2004)
Saudi Arabia	94.2	94.7	95.3	95.8
Urban	..	..	..	..
Rural	..	..	..	..
Syrian Arab Republic	65.6	..	84.2	88.3 (2006)
Urban	89.7	91.6 (1994)	94.9	94 (2006)
Rural	41.5	56.1 (1994)	71.9	81 (2006)
United Arab Emirates	..	..	100 (2002)	100
Urban	..	..	..	..
Rural	..	..	..	..
Yemen	34.9	38.9 (1998)	43.7 (2003)	50.6 (2004)
Urban	..	74.5 (1998)	82 (2003)	90.6 (2004)
Rural	..	23.3 (1998)	27.5 (2003)	34.6 (2004)

Sources: National MDG reports; ESCWA, *Compendium of Environment Statistics in the ESCWA Region* (E/ESCWA/SCU/2007/2), pp. 129-137; and United Nations Statistics Division website for MDG Indicators, available at: <http://mdgs.un.org/unsd/mdg/Data.aspx> (nationally corroborated).

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 5. POVERTY: ACCESS TO ELECTRICITY

Countries	Share of households with access to electricity or commercial energy (Percentage)			
	1990	1995	2000	2005
Bahrain	100	100	100	100
Urban	100	100	100	100
Rural
Egypt	93.8 (2003)	99.3 (census)
Urban	99.5 (2006 census)
Rural	99.0 (2006 census)
Iraq	..	97 (1997)	..	97 (2004)
Urban	..	99 (1997)	..	98 (2004)
Rural	..	90 (1997)	..	93 (2004)
Jordan	95 (2003)	99
Urban	99.7
Rural	96.2
Kuwait	100 (2003)	..
Urban
Rural
Lebanon
Urban
Rural
Oman	95.9	94 (2003)
Urban
Rural
Palestine	99.5 (2006)
Urban
Rural
Qatar	95 (2003)	..
Urban
Rural
Saudi Arabia	91.42	93.63	95.48	97.7
Urban
Rural
Syrian Arab Republic	98 (2003)	98.5
Urban	99.7
Rural	97.3
United Arab Emirates	96 (2003)	..
Urban
Rural
Yemen	50 (2003)	..
Urban	71	..	69	67 (2004)
Rural

Sources: ESCWA, *Compendium of Environment Statistics in the ESCWA Region* (E/ESCWA/SCU/2007/2), pp. 129-137; United Nations Statistics Division website for MDG Indicators, available at: <http://mdgs.un.org/unsd/mdg/Data.aspx>; and ESCWA, *Energy for Sustainable Development in the Arab Region: A Framework for Action*, p. 26 (nationally corroborated).

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 6. HEALTH: MORTALITY

Countries	Infant mortality rate, by sex (Per 1,000 live births)			
	1990	1995	2000	2005
Bahrain	20.2	9.7	8.6	8.9
Male	..	..	9.8	9.3
Female	..	..	7.4	8.4
Egypt	68.0	63.0	44.0	33.0
Male	..	73.0	55.0	43.0
Female	..	73.0	54.0	37.0
Iraq	47.0	94.0(1996)	106.0	35.0(2006)
Male	..	34.3(1997)	..	..
Female	..	23.4(1997)	..	..
Jordan	36.8	29.0(1997)	24.0(2002)	24.0
Male	36.4	34.3(1997)	25.0(2002)	..
Female	37.3	23.4(1997)	23.0(2002)	..
Kuwait	17.0	10.9	9.1	8.2
Male	..	12.2	10.3	8.6
Female	..	9.6	7.8	7.9
Lebanon	35.0	33.0	27.0	16.1(2004)
Male	..	..	30.0	13.2(2004)
Female	..	..	24.0	19.2(2004)
Oman	29.0	20.0	16.7	10.3(2006)
Male	..	..	..	..
Female	..	..	..	..
Palestine	32.0	27.3	25.5	25.3(2006)
Male	..	30.0	..	27.1(2006)
Female	..	25.0	..	23.4(2006)
Qatar	13.5	10.6	11.7	8.2
Male	14.9	12.1	12.0	8.9
Female	10.8	9.2	11.4	7.5
Saudi Arabia	24.6	22.8	21.0	19.0
Male	23.8	22.4	21.0	19.6
Female	25.8	23.4	21.0	18.4
Syrian Arab Republic	44.0	30.0	24.0	18.1
Male	..	..	24.0(1999)	..
Female	..	..	24.0(1999)	..
United Arab Emirates	11.4	10.0	8.1	7.7
Male	11.6	..	..	8.0
Female	9.5	..	..	7.4
Yemen	83.0	84.0(1994)	79.0(2001)	77.2(2004)
Male	..	91.0(1994)	..	79.1(2004)
Female	..	76.0(1994)	..	75.0(2004)

Sources: National data sets, namely, statistical yearbooks; family health surveys; demographic health survey; and national MDG reports.

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 7. HEALTH: MORTALITY

Countries	Under-five mortality rate, by sex (Per 1,000 live births)			
	1990	1995	2000	2005
Bahrain	22.0	12.1	11.4	10.9
Male	..	..	13.0	11.6
Female	..	..	9.7	10.2
Egypt	85.0	81.0	54.0	41.0
Male	..	93.0	69.0	33.0
Female	..	99.0	70.0	47.0
Iraq	65.0	117.0	131.0	41.0(2006)
Male	..	..	..	44.0(2006)
Female	..	..	..	37.0(2006)
Jordan	42.4	34.0(1997)	29.0(2002)	29
Male	42.2	37.9(1997)	30.0(2002)	..
Female	42.7	29.9(1997)	28.0(2002)	..
Kuwait	19.0	12.5	11.3	9.9
Male	..	14.3	13.3	10.4
Female	..	11.3	10.2	9.4
Lebanon	43.0	40.0	35.0	18.3(2004)
Male	..	39.5	40.0	14.8(2004)
Female	..	41.7	30.0	22.0(2004)
Oman	35.0	27.0	21.7	11.0
Male	..	..	..	..
Female	..	..	..	..
Palestine	40.0	36.0	28.7	28.1(2006)
Male	..	40.0	29.1	30.1(2006)
Female	..	32.0	28.3	26.1(2006)
Qatar	16.6	13.2	13.1	10.6
Male	18.5	14.1	13.6	11.7
Female	14.8	11.3	12.5	9.1
Saudi Arabia	36.3	31.5	26.7	22.3
Male	38.4	32.9	27.4	22.6
Female	32.5	29.0	25.5	21.9
Syrian Arab Republic	44.0	36.0	29.0	20.2
Male	..	..	..	..
Female	..	..	..	..
United Arab Emirates	14.4	12.7	10.3	9.9
Male	15.8	14.4	12.0	10.3
Female	12.3	12.2	9.6	9.4
Yemen	122.0	110.0	99.0(2001)	92.3(2004)
Male	..	..	..	92.9(2004)
Female	..	..	..	91.7(2004)

Sources: National data sets, namely, statistical yearbooks; family health surveys; demographic health survey; and national MDG reports.

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 8. HEALTH: MORTALITY

Countries	Life expectancy at birth, by sex (Years)			
	1990	1995	2000	2005
Bahrain	71.6	72.9	73.8	74.8
Male	69.8	71.1	72.1	73.1
Female	74.1	75.3	76.3	77.3
Egypt	64.1	66.6	68.8	71.0
Male	62.4	64.7	66.7	68.8
Female	65.8	66.5	71.0	73.2
Iraq	62.5	62.5	58.8	58.2(2006)
Male	63.0	63.0	59.0	54.9(2006)
Female	62.0	62.0	58.0	61.6(2006)
Jordan	66.7	69.0	69.0	71.5
Male	64.4	67.0(1994)	68.0	70.6
Female	69.9	69.0(1994)	71.0	72.4
Kuwait	74.7	76.2	76.8	77.5
Male	72.8	73.8	74.9(2000-05)	..
Female	77.5	78.2	79.0(2000-05)	..
Lebanon	68.5	69.9	..	..
Male	66.6	69.0(1996)	..	..
Female	70.5	72.0(1996)	..	..
Oman	65.9	67.4	73.4	74.3(2006)
Male	..	66.8	72.5	73.2(2006)
Female	..	67.7	74.3	75.4(2006)
Palestine	..	..	..	72.5(2006)
Male	..	69.3	70.1(1999)	71.7(2006)
Female	..	72.6	73.3(1999)	73.2(2006)
Qatar	73.5	74.8	74.1	76.3
Male	72.0	73.8	74.1	76.1
Female	74.9	75.2	74.2	76.7
Saudi Arabia	..	70.9	72.0	73.0
Male	..	69.9	71.1	72.0
Female	..	72.0	73.0	74.0
Syrian Arab Republic	67.1	68.8	71.9(2000-05)	72.0
Male	65.2	66.7	70.6(2000-05)	71.0
Female	69.2	71.1	73.1(2000-05)	73.0
United Arab Emirates	71.2	76.4	78.0	77.9
Male	69.8	74.4	76.2	76.7
Female	74.1	79.6	80.5	79.1
Yemen	..	57.3(1994)	62.9(2002)	61.1
Male	53.0	55.8(1994)	..	60.2
Female	52.3	58.9(1994)	..	62.0

Sources: National data sets, namely, statistical yearbooks; family health surveys; and demographic health survey.

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 9. HEALTH: HEALTH-CARE DELIVERY

Countries	Population with access to primary health-care facilities (Percentage)			
	1990	1995	2000	2005
Bahrain	..	100.0(1994)	100.0	100.0
Egypt
Iraq
Jordan
Kuwait	100.0	100.0
Lebanon
Oman	95.0	..
Palestine
Qatar	100.0
Saudi Arabia
Syrian Arab Republic
United Arab Emirates
Yemen

Source: National data sets.

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 10. HEALTH: HEALTH-CARE DELIVERY

Countries	Immunization against measles, by sex (Percentage)			
	1990	1995	2000	2005
Bahrain	87.0	95.0	98.0	100.0
Male	..	..	..	..
Female	..	..	..	..
Egypt	64.0	80.0	96.9	96.6
Male	..	89.7	96.6	96.8
Female	..	88.7	97.2	96.3
Iraq	62.0	95.0	78.2	66.0(2006)
Male	..	..	77.0	64.3(2006)
Female	..	..	79.2	67.5(2006)
Jordan	89.4	89.9(1997)	94.0	97.8
Male	89.5	89.7(1997)	..	..
Female	89.4	90.0(1997)	..	..
Kuwait	93.0	98.0	99.1	99.9
Male	..	..	..	..
Female	..	..	..	..
Lebanon	58.0	88.0	79.2	53.4(2004)
Male	..	87.5(1996)	75.1	53.8(2004)
Female	..	84.1(1996)	83.3	53.0(2004)
Oman	98.0	97.5	99.8	99.0
Male	..	..	..	..
Female	..	..	..	..
Palestine	..	48.9(1996)	92.7	96.7(2006)
Male	..	47.7(1996)	93.0	96.7(2006)
Female	..	50.1(1996)	92.3	96.7(2006)

ANNEX TABLE 10 (*continued*)

Countries	Immunization against measles, by sex (Percentage)			
	1990	1995	2000	2005
Qatar	79.0	86.0	91.0	100.0
Male	..	..	..	..
Female	..	..	..	..
Saudi Arabia	..	..	..	..
Male	..	..	..	..
Female	..	..	..	..
Syrian Arab Republic	87.0	98.0	85.0	92.4
Male	..	..	..	..
Female	..	..	..	..
United Arab Emirates	66.0	79.4	70.3	94.0
Male	..	..	..	..
Female	..	..	..	..
Yemen	52.0	40.0	74.0	73.0(2004)
Male	61.8(1991)	53.2(1997)	..	..
Female	47.2(1991)	52.2(1997)	..	..

Sources: National data sets, namely, statistical yearbooks; family health surveys; demographic health survey; and national MDG reports.

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 11. HEALTH: HEALTH-CARE DELIVERY

Countries	Contraceptive prevalence rate (Percentage)			
	1990	1995	2000	2005
Bahrain	..	..	53.4	..
Egypt	47.0	47.9	56.1	59.2
Iraq	10.0	18(1996)	43.5	49.9(2006)
Jordan	40.2	53.6(1997)	55.8(2002)	59.7
Kuwait	..	35.0(1993)	50.0(2001)	..
Lebanon	55.0	61.0(1996)	62.6	74.2(2004)
Oman	..	24.0	31.8	..
Palestine	..	42.0	51.4	50.2(2006)
Qatar	..	32.0(1997)	43.0	43.0
Saudi Arabia	..	32.0(1996)	..	..
Syrian Arab Republic	20.0	40.0	45.6	58.3
United Arab Emirates	..	..	..	..
Yemen	9.0	10.0(1992)	20.8(1997)	13.4(2003)

Sources: National data sets, namely, statistical yearbooks; family health surveys; demographic health survey; and national MDG reports.

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 12. HEALTH: NUTRITIONAL STATUS

Countries	Underweight children under 5 years of age, by sex (Percentage)			
	1990	1995	2000	2005
Bahrain	..	8.7	4.2	..
Male	..	7.4	3.4	..
Female	..	10.7	5.0	..
Egypt	10.0	12.4	4.0	6.2
Male	..	12.7	4.4	6.8
Female	..	12.2	3.6	5.5
Iraq	12.0	23.4(1996)	19.5	7.6(2006)
Male	..	..	..	7.0(2006)
Female	..	..	..	7.1(2006)
Jordan	6.4	5.1(1997)	4.4(2002)	4.0
Male	6.7	4.6(1997)	4.1(2002)	..
Female	6.2	5.5(1997)	4.7(2002)	..
Kuwait	5.0	2.0	9.8	..
Male	..	..	..	..
Female	..	..	..	..
Lebanon	9.0	3.0	..	3.9(2004)
Male	..	3.3	..	5.1(2004)
Female	..	2.8	..	2.7(2004)
Oman	..	23.6	18.0	..
Male	..	..	..	..
Female	..	..	..	..
Palestine	..	3.6	2.5	2.9(2006)
Male	..	3.1	2.2	2.7(2006)
Female	..	4.0	2.8	3.1(2006)
Qatar	4.7	6.0	5.5	10.4(2004)
Male	..	..	..	..
Female	..	..	..	..
Saudi Arabia	..	..	11.0(2003)	5.0
Male	..	..	..	..
Female	..	..	..	..
Syrian Arab Republic	13.0	12.9	12.9	9.7(2006)
Male	..	..	..	..
Female	..	..	..	..
United Arab Emirates	..	..	..	..
Male	..	..	..	..
Female	..	..	..	..
Yemen	30.0	46.0	46.1	45.6(2003)
Male	..	..	..	..
Female	..	..	..	..

Sources: National data sets, namely, statistical yearbooks; family health surveys; demographic health survey; and national MDG reports.

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 13. HEALTH: HEALTH STATUS AND RISK

Countries	Prevalence of tobacco use, by sex (Percentage)			
	1990	1995	2000	2005
Bahrain
Male	22.1(1991)	..	17.7(2001)	..
Female	5.2(1991)	..	3.5(2001)	..
Egypt
Male
Female
Iraq	21.9(2006)
Male	41.5(2006)
Female	6.9(2006)
Jordan	..	26.8(1996)	..	24.2(2003)
Male	..	47.7(1996)	..	43.4(2003)
Female	..	10.2(1996)	..	4.6(2003)
Kuwait	..	16.7	..	..
Male	..	32.4	..	..
Female	..	1.5	..	..
Lebanon	25.7(2004)
Male	32.6(2004)
Female	18.9(2004)
Oman	..	8.6	5.5	..
Male	..	15.5	10.7	..
Female	..	1.5	0.4	..
Palestine	..	21.8(1996)	22.1	18.3(2006)
Male	..	40.0(1996)	40.7	34.7(2006)
Female	..	2.7(1996)	3.2	2.1(2006)
Qatar	13.6(2006)
Male	25.5(2006)
Female	2.3(2006)
Saudi Arabia
Male
Female
Syrian Arab Republic	26.2(1999)	..
Male	43.4(1999)	..
Female	8.0(1999)	..
United Arab Emirates	..	10.8	..	..
Male	..	20.9	..	..
Female	..	1.4	..	..
Yemen
Male
Female

Sources: National data sets, namely family health surveys and demographic health survey.

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 14. HEALTH: MORBIDITY OF MAJOR DISEASES

Countries	Prevalence of malaria (Per 100,000 population)			
	1990	1995	2000	2005
Bahrain	36.2	27.5	7.7	7.9
Egypt	..	..	..	..
Iraq	..	5502.0	23.0(2001)	7.0
Jordan	7.5	6.3(1992)	3.0	2.1
Kuwait	..	..	11.4	10.6
Lebanon	..	..	..	..
Oman	..	56.6	..	21.7
Palestine	..	..	..	..
Qatar	28.0	..	24.2	8.6
Saudi Arabia	..	..	35.0	4.7
Syrian Arab Republic	..	..	..	..
United Arab Emirates	..	..	..	..
Yemen	1263	2950(1998)	1532	770(2006)

Sources: National data sets, namely, statistical yearbooks; family health surveys; demographic health survey; and national MDG reports.

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 15. HEALTH: MORBIDITY OF MAJOR DISEASES

Countries	Prevalence of tuberculosis (Per 100,000 population)			
	1990	1995	2000	2005
Bahrain	18.2	16.7	23.2	23.6
Egypt	53.0	46.0	42.0	32.0
Iraq	..	..	2.0	12.4(2006)
Jordan	14.0	11.0(1997)	8.0(2001)	6.0
Kuwait	80.0	68.0	58.0	28.0
Lebanon	46.0	29.0	17.0	12.0
Oman	14.3(1993)	13.2	13.0	10.2
Palestine	49.0	..	12.0	33.0
Qatar	74.0	71.0	26.0	20.3
Saudi Arabia	..	..	11.8	10.3
Syrian Arab Republic	108.0	89.0	60.0	46.0
United Arab Emirates	42.0	0.13	0.13	1.9
Yemen	277.0	236.0	166.0	136.0

Sources: National data sets, namely, statistical yearbooks; family health surveys; demographic health survey; and national MDG reports.

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 16. EDUCATION: EDUCATION LEVEL

Countries	Net enrolment ratios in primary education (Percentage)		
	1990	2000	2005
Bahrain	98.9	95.4	97.1
Male	99.0	93.7	97.1
Female	98.9	97.3	97.1
Egypt	84.0	92.8	93.7
Male	91.3	95.6	96.2
Female	76.4	89.9	91.1
Iraq	90.8	85.4	86.2
Male	93.9	90.7	92.7
Female	87.7	79.8	79.4
Jordan	94.1	92.6	88.9
Male	93.8	92.3	88.1
Female	94.3	93.0	89.6
Kuwait	..	95.6	96.1
Male	..	95.7	95.7
Female	..	95.5	96.4
Lebanon	72.5	94.9	92.4
Male	73.7	95.7	92.9
Female	71.3	94.1	91.8
Oman	69.2	80.6	73.3 (2006)
Male	70.9	80.4	72.5 (2006)
Female	67.5	80.7	74.1 (2006)
Palestine	..	95.8	79.9
Male	..	95.5	80.3
Female	..	96.0	79.5
Qatar	89.4	94.5	95.8
Male	90.3	94.1	96.0
Female	88.5	94.9	95.7
Saudi Arabia	59.3	..	77.9
Male	65.5	..	76.7
Female	52.9	..	79.1
Syrian Arab Republic	90.8	93.3	..
Male	95.1	96.4	..
Female	86.4	90.2	..
United Arab Emirates	..	..	..
Male	95.8	97.9	98.0
Female	98.3	97.8	98.0
Yemen	50.8	59.7	..
Male	72.9	71.5	..
Female	27.5	47.3	..

Source: UNESCO Institute for Statistics Data base Centre, available at: <http://stats.uis.unesco.org/unesco/TableViewer/tableView.aspx?ReportId=177> (nationally corroborated).

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 17. EDUCATION: EDUCATION LEVEL

Countries	Net enrolment ratios in secondary education (Percentage)		
	1990	2000	2005
Bahrain	84.9	87.2	90.0
Male	83.7	83.7	87.1
Female	86.2	90.9	93.1
Egypt	..	..	82.1
Male	..	..	85.2
Female	..	..	78.8
Iraq	26.7	30.3	35.3
Male	29.2	34.9	40.5
Female	24.1	25.5	30.0
Jordan	..	..	78.6
Male	..	..	77.1
Female	..	..	80.3
Kuwait	..	80.6	81.1
Male	..	75.0	71.4
Female	..	86.5	91.4
Lebanon	..	..	..
Male	..	..	..
Female	..	..	..
Oman	..	67.6	76.7 (2006)
Male	..	67.1	76.9 (2006)
Female	..	68.2	76.6 (2006)
Palestine	..	77.4	94.8
Male	..	75.1	91.9
Female	..	79.8	97.8
Qatar	69.5	76.4	90.1
Male	67.5	73.2	91.0
Female	71.7	79.7	89.2
Saudi Arabia	30.9	..	65.8
Male	34.2	..	63.4
Female	27.5	..	68.3
Syrian Arab Republic	42.6	36.3	62.0
Male	48.9	37.7	63.8
Female	36.1	34.9	60.1
United Arab Emirates	..	..	..
Male	..	87.6	87.2
Female	..	86.5	88.3
Yemen	..	33.6	..
Male	..	45.8	..
Female	..	20.8	..

Source: UNESCO Institute for Statistics Data base Centre, available at: <http://stats.uis.unesco.org/unesco/TableViewer/tableView.aspx?ReportId=177> (nationally corroborated).

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 18. EDUCATION: EDUCATION LEVEL

Countries	Gross enrolment ratios in tertiary education (Percentage)		
	1990	2000	2005
Bahrain	83.6	91.3	99.5
Male	83.3	83.9	96.0
Female	83.9	99.1	103.3
Egypt	15.8	36.2 (1999)	..
Male	20.3	..	..
Female	11.1	..	..
Iraq	..	11.9	15.3
Male	..	15.4	19.2
Female	..	8.3	11.3
Jordan	22.9	27.9	39.1
Male	24.3	29.7	40.3
Female	21.7	26.2	38.0
Kuwait	..	23.2 (1999)	19.5
Male	..	14.0 (1999)	10.9
Female	..	33.7 (1999)	29.1
Lebanon	..	..	60.5 (2004)
Male	..	..	62.2 (2004)
Female	..	..	58.9 (2004)
Oman	4.1	12.6	19.3
Male	4.0	..	18.0
Female	4.1	..	20.7
Palestine	..	25.6	40.6 (2006)
Male	..	26.6	43.8 (2006)
Female	..	24.5	37.6 (2006)
Qatar	46.8	52.2	50.2
Male	26.7	30.2	31.8
Female	66.8	74.7	66.6
Saudi Arabia	..	..	25.6
Male	..	..	24.1
Female	..	..	27.2
Syrian Arab Republic	17.6	..	..
Male	21.4	..	..
Female	13.8	..	..
United Arab Emirates	7.5	18.9	41.3
Male	3.5	9.9	26.5
Female	14.3	32.6	55.7
Yemen	..	10.4	9.4
Male	..	15.9	13.6
Female	..	4.4	5.0

Source: UNESCO Institute for Statistics Data base Centre, available at: <http://stats.uis.unesco.org/unesco/TableViewer/tableView.aspx?ReportId=177> (nationally corroborated).

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 19. EDUCATION: LITERACY

Countries	Adult literacy rate for those aged 15 and over (Percentage)			
	1990	1995	2000	2005
Bahrain	88.4 (1991)	85.2	86.5 (2001)	90
Male	88.5 (1991)	89	88.5 (2001)	92.6
Female	73.0 (1991)	79.3	83.5 (2001)	86.4
Egypt	47.1	51.1	55.3	70.7 (2006 census)
Male	60.4	63.5	66.6	83.0
Female	33.6	38.5	43.8	59.3
Iraq	..	..	79.0	...
Male	..	..	84.0	..
Female	..	..	64.1	..
Jordan	81.5	86.5	89.8 (2003)	91.1
Male	90	93.1	95.0 (2003)	95.1
Female	72.1	79.4	84.7 (2003)	87.0
Kuwait	76.7	79	82	84.4
Male	79.3	82	83.9	85.7
Female	72.6	75.7	79.6	82.8
Lebanon	80.3	83.3	86	92.8 (2004)
Male	88.3	90.4	92.1	97.1 (2004)
Female	73.1	76.9	80.3	95.0 (2004)
Oman	54.7	63.7	73.6	78.1 (2003)
Male	67.3	74.1	84.6	85.5 (2003)
Female	38.3	50.6	65.9	70.6 (2003)
Palestine	..	84.3	89.2	93.5 (2006)
Male	..	91.5	94.4	97.1 (2006)
Female	..	77	83.9	89.8 (2006)
Qatar	79.4	83.2	87.8	90.6
Male	85.7	88.4	91.3	93.6
Female	73	78	84.2	87.5
Saudi Arabia	68.8	73.83	78.8	83.4
Male	78.1	81.86	85.0	87.8
Female	54.1	62.04	69.9	77.3
Syrian Arab Republic	64.8	69.9	82.8 (2002)	84
Male	81.8	85.4	91.0 (2002)	90.8
Female	47.5	54.1	74.2 (2002)	76.8
United Arab Emirates	71	80.2	..	90.0
Male	71.2	78.7	..	89
Female	70.6	83.6	..	91.5
Yemen	32.7	37.09 (1994)	40.1	54.0 (2004)
Male	55.2	56.72 (2004)	67.5	73.1 (2004)
Female	12.9	17.06 (1994)	25.3	34.6 (2004)

Sources: UNESCO Institute for Statistics Data base Centre, available at: <http://stats.uis.unesco.org/unesco/TableViewer/tableView.aspx?ReportId=177> (nationally corroborated); data in italics are derived from ESCWA, *Statistical Abstract of the ESCWA Region*, twenty-sixth issue (E/ESCWA/SCU/2007/1).

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 20. DEMOGRAPHICS: POPULATION CHANGE

Countries	Population growth rate (Percentage)			
	1990-1995	1995-2000	2000-2005	2005-2010
Bahrain	3.6 (1991)	..	2.7 (2001)	..
Egypt	1.9	1.9	1.8	1.8
Iraq	3.1	2.9	2.9	2.9
Jordan	5.6	2.2	2.9	2.3
Kuwait	4.5	..	3.5	2.8
Lebanon	3.2	1.6	..	..
Oman*	..	..	1.8 (2003)	..
Palestine	3.9	3.7	3.6	3.2
Qatar	..	4.4 (1997)	4 (2001)	5.6 (2002)
Saudi Arabia	3.6	3.1	2.7	2.4
Syrian Arab Republic	2.8	2.5	2.7	2.5
United Arab Emirates	5.6	5.6	5.3	5.3
Yemen	4.8	3.2	3.0	3.0

Source: United Nations Department of Economic and Social Affairs, Population Division, *World Population Prospects: The 2006 Revision* (corroborated by countries).

Note: * Nationals only.

Two dots (..) indicate that data are not available or not separately reported.

ANNEX TABLE 21. DEMOGRAPHICS: POPULATION CHANGE

Countries	Total fertility rate (Number of children per woman)			
	1990	1995	2000	2005
Bahrain	3.9	2.4	2.5	2.6
Egypt	4.1	3.3(1997)	3.53	3.1
Iraq	..	5.7(1997)	5.6	4.3(2006)
Jordan	5.6	4.5(1996)	3.6	3.7
Kuwait	..	3	2.5	2.3
Lebanon	..	2.8(1996)	..	1.9(2004)
Oman	..	6	4.7	3.19(2006)
Palestine	6.5	6.1	4.9	4.6(2006)
Qatar	5.1	4.4(1997)	4.0(2001)	4.2(2002)
Saudi Arabia	6.7	5.5	4.29	3.28
Syrian Arab Republic	5.1(1991)	4.2(1993)	3.8(2001)	3.58(2004)
United Arab Emirates	5.1	3.4	2.7	2.1
Yemen	8(91-92)	7.4(1994)	6.5	6.5(2002)

Source: United Nations Department of Economic and Social Affairs, Population Division, *World Population Prospects: The 2006 Revision* (corroborated by countries).

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 22. DEMOGRAPHICS: POPULATION CHANGE

Countries	Dependency ratio (Per 100 persons)			
	1990	1995	2000	2005
Bahrain	51.7	48	44	42.5
Egypt	77	77	69	69
Iraq	91	91.1(1997)	84	79
Jordan	100	78	76	68
Kuwait	54	46	38	35
Lebanon	69	62	..	53.3 (2004)
Oman*	..	..	87	70
Palestine	100	99	101	96
Qatar	40	38	37	30
Saudi Arabia	83	74	66	58
Syrian Arab Republic	104	92	77	66
United Arab Emirates	..	37.7	36.2	25.6
Yemen	116	110	103	94.1 (2004)

Source: United Nations Department of Economic and Social Affairs, Population Division, *World Population Prospects: The 2006 Revision* (corroborated by countries).

Note: * Nationals only.

Two dots (..) indicate that data are not available or not separately reported.

ANNEX TABLE 23. ECONOMIC DEVELOPMENT: EMPLOYMENT

Countries	Employment-population ratio (Percentage)			
	1990	1995	2000	2005
Bahrain	65.9 (1991)	..	65.7 (2001)	66.4
Male	89.4 (1991)	..	86.0 (2001)	85.2
Female	29.4 (1991)	..	35.5 (2001)	38.4
Egypt	53.4	52.2	50.1 (2001)	52.4
Male	76.2	79.7	77.6 (2001)	79.7
Female	30.0	23.9	21.7 (2001)	24.4
Iraq	..	33.9	34.6	49.7 (2006)
Male	..	55.6	56.5	78.3 (2006)
Female	..	11.7	12.3	20.7 (2006)
Jordan	..	43.4	86.3	85.2
Male	..	64.9	87.7	87.2
Female	..	19.1	79.0	74.1
Kuwait	..	48.3	70.2	51.7
Male	..	62.6	85.1	65.3
Female	..	28.6	43.5	32.0
Lebanon	..	92.1 (1997)	51.4	32.2
Male	..	..	81.7	49.1
Female	..	..	22.1	15.1
Oman	..	55.4	53.4	51.8
Male	..	77.6	75.6	74.2
Female	..	15.3	17.5	20.1

ANNEX TABLE 23 (continued)

Countries	Employment-population ratio (Percentage)			
	1990	1995	2000	2005
Palestine	..	81.8	85.9	76.4 (2006)
Male	..	81.5	85.3	75.8 (2006)
Female	..	83.8	87.7	79.5 (2006)
Qatar	..	71.1	69.3	71.0
Male	..	87.1	85.6	85.5
Female	..	31.7	31.7	34.4
Saudi Arabia	..	51.3	50.7	51.2
Male	..	76.5	75.9	76.4
Female	..	14.1	15.2	16.7
Syrian Arab Republic	..	54.0	54.4	55.5
Male	..	79.7	79.6	80.4
Female	..	28.3	29.0	30.4
United Arab Emirates	..	55.4	74.5	62.3
Male	..	73.4	90.0	78.9
Female	..	19.4	33.3	26.5
Yemen	..	44.9	45.9	46.5
Male	..	66.1	67.0	67.1
Female	..	23.6	24.5	25.7

Source: Labour force surveys in ESCWA member countries; and figures in italics are from International Labour Organization estimates, *Key Indicators of the Labour Market, Fifth Edition*.

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 24. ECONOMIC DEVELOPMENT: EMPLOYMENT STATUS

Countries	Wage and salaried workers (Percentage)			
	1990	1995	2000	2005
Bahrain	96.5	..	98.4	..
Male	95.9	..	98.1	..
Female	99.5	..	99.6	..
Egypt	53.3	57.1	59.9	60.0
Male	58.4	58.1	57.2	62.2
Female	38.7	52.9	60.6	50.8
Iraq	..	..	..	52.2
Male	..	..	..	44.1
Female	..	..	..	80.0
Jordan	..	..	80.5	82.7
Male	..	..	78.7	80.9
Female	..	..	91.1	94.3
Kuwait	..	97.8	..	97.3
Male	..	97.1	..	96.5
Female	..	99.7	..	99.5
Lebanon	..	..	..	62.0
Male	..	..	..	55.5
Female	..	..	..	83.4
Oman	85.8 (1993)	86.6 (1996)	87.8	90.2 (2003)
Male	85.3 (1993)	86.0 (1996)	87.8	90.0 (2003)
Female	91.3 (1993)	92.0 (1996)	87.8	91.4 (2003)

ANNEX TABLE 24 (continued)

Countries	Wage and salaried workers (Percentage)			
	1990	1995	2000	2005
Palestine	..	62.0	67.4	59.3 (2006)
Male	..	62.2	70.0	60.3 (2006)
Female	..	61.3	52.9	55 (2006)
Qatar	..	98.7 (1997)	..	98.8 (2004)
Male	..	98.7 (1997)	..	98.7 (2004)
Female	..	98.5 (1997)	..	99.9 (2004)
Saudi Arabia
Male
Female
Syrian Arab Republic	49.3 (1991)	..	..	..
Male	45.7 (1991)	..	..	..
Female	50.1 (1997)	..	..	..
United Arab Emirates	..	94.1	..	96.9
Male	..	82.8	..	84.1
Female	..	11.4	..	12.8
Yemen	58.6 (2004)
Male	54.6 (2004)
Female	4.0 (2004)

Source: Labour force surveys in ESCWA member countries.

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 25. ECONOMIC DEVELOPMENT: EMPLOYMENT STATUS

Countries	Self-employed workers (Percentage)			
	1990	1995	2000	2005
Bahrain	3.4	..	1.6	..
Male	4.0	..	1.9	..
Female	0.4	..	0.3	..
Egypt	26.7	29.7	28.6	27.0
Male	30.2	..	31.3	29.3
Female	16.6	17.3	16.8	17.7
Iraq	..	..	..	31.2
Male	..	..	..	22.2
Female	..	..	..	10.1
Jordan	..	..	9.9	9.5
Male	..	..	11.0	10.5
Female	..	..	3.5	2.5
Kuwait	..	2.2	..	2.7
Male	..	2.8	..	3.5
Female	..	0.3	..	0.5
Lebanon	..	..	..	33.7
Male	..	..	..	40.4
Female	..	..	..	11.2
Oman	10.9 (1993)	10.7 (1996)	9.6	7.6 (2003)
Male	11.2 (1993)	10.8 (1996)	9.6	7.7 (2003)
Female	5.6 (1993)	6.3 (1996)	9.3	7.4 (2003)

ANNEX TABLE 25 (continued)

Countries	Self-employed workers (Percentage)			
	1990	1995	2000	2005
Palestine	..	21.0	18.4	25.0 (2006)
Male	..	22.9	20.0	27.7 (2006)
Female	..	10.0	10.0	12.7 (2006)
Qatar	..	0.72 (1997)	..	1.3 (2004)
Male	..	1.2 (1997)	..	1.1 (2004)
Female	..	0 (1997)	..	0.1 (2004)
Saudi Arabia
Male
Female
Syrian Arab Republic	30.9 (1991)	..	55.5	55.3 (2006)
Male	5.7 (1991)	..	57.4	53.2 (2006)
Female	36.5 (1991)	..	46.8	69.5 (2006)
United Arab Emirates	..	5.8	..	3.1
Male	..	5.6	..	2.9
Female	..	0.2	..	0.2
Yemen	24.1 (2004)
Male	23.0 (2004)
Female	1.1 (2004)

Source: Labour force surveys in ESCWA member countries.

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 26. ECONOMIC DEVELOPMENT: EMPLOYMENT STATUS

Countries	Contributing family workers (Percentage)			
	1990	1995	2000	2005
Bahrain	0.1	..	0.0	..
Male	0.1	..	0.0	..
Female	0.0	..	0.0	..
Egypt	20.0	13.2	11.5	13.0
Male	11.4	9.3	11.5	8.5
Female	44.7	29.8	22.6	31.5
Iraq	..	..	..	16.6
Male	..	..	..	6.7
Female	..	..	..	9.9
Jordan	..	..	0.5	0.2
Male	..	..	0.4	0.1
Female	..	..	1.3	0.7
Kuwait	..	0.0	..	0.0
Male	..	0.1	..	0.0
Female	..	0.0	..	0.0
Lebanon	..	..	..	4.3
Male	..	..	..	4.0
Female	..	..	..	5.3
Oman	0.3 (1993)	0.4 (1996)	0.8	0.2 (2003)
Male	0.2 (1993)	0.3 (1996)	0.6	0.1 (2003)
Female	0.3 (1993)	1.3 (1996)	2.3	0.5 (2003)

ANNEX TABLE 26 (continued)

Countries	Contributing family workers (Percentage)			
	1990	1995	2000	2005
Palestine	..	10.2	10.0	11.1 (2006)
Male	..	7.2	5.1	6.1 (2006)
Female	..	27.7	36.5	31.5 (2006)
Qatar	..	0 (1997)	..	0 (2004)
Male	..	0 (1997)	..	0 (2004)
Female	..	0 (1997)	..	0 (2004)
Saudi Arabia
Male
Female
Syrian Arab Republic	13 (1991)	..	16.8	8.7 (2006)
Male	34.5 (1991)	..	10.2	7.2 (2006)
Female	8.3 (1991)	..	47.2	28.7 (2006)
United Arab Emirates	..	0.0	..	0.0
Male	..	0.0	..	0.0
Female	..	0.0	..	0.0
Yemen	17.3 (2004)
Male	22.4 (2004)
Female	94.9 (2004)

Source: Labour force surveys in ESCWA member countries.

Note: Two dots (..) indicate that data are not available or are not separately reported.

ANNEX TABLE 27. ECONOMIC DEVELOPMENT: EMPLOYMENT WAGE

Countries	Share of women in wage employment in non-agricultural sector ^{a/} (Percentage)			
	1990	1995	2000	2005
Bahrain	7.6	9.7	12.4	11.5
Egypt	19.2	19	19	17.7
Iraq	11.9 ^{b/}	..	..	15.3 (2006)
Jordan	23.1 ^{c/}	23.4	16.2	15.2
Kuwait	20.7	22.1	23.9	25.2
Lebanon	25.9 ^{b/}	..	..	..
Oman	7.8 (1993)	..	..	17.9 (2003)
Palestine	9.8	14.5	13.6	17.9 (2006)
Qatar	12.9	13.5 (1997)	..	17 (2004)
Saudi Arabia	..	..	..	..
Syrian Arab Republic	16.3 ^{c/}	16.9	17.6	18.2
United Arab Emirates	11.5 ^{d/}	12.6	13.8	13.5
Yemen	..	..	6.5 (1999)	3.2 (2004)

Source: Labour force surveys in ESCWA member countries.

Notes: Two dots (..) indicate that data are not available or are not separately reported.

a/ Unless otherwise stated, figures are imputed using statistical models.

b/ Economically active population in non-agriculture.

c/ Total employment.

d/ Total employment in non-agriculture.

Annex II

GLOSSARY OF TERMS

A. POVERTY

1. *Percentage of population living below the national poverty line*

Definition and concept: This indicator represents the prevalence of poverty by measuring the proportion of the population for whom consumption, or any other suitable measure of living standard, is below the poverty line as defined by the national Government. An increase in this indicator implies a worsening of the poverty situation, with a greater proportion of the population falling below the poverty line.

In order to compute the percentage of the population living below the poverty line, estimates of individual economic welfare and the poverty line are required.

Individual welfare: The approaches to measuring welfare differ in terms of the importance attached to the individual's own judgment of well-being versus a concept of welfare decided upon by somebody else. They also differ according to how difficult it is to obtain certain types of data in specific settings. Consumption per equivalent male adult and under-nutrition are common methods for measuring individual standards of living.

Defining the poverty line: In practice, there are a number of alternative approaches to defining poverty lines, for example: (a) absolute poverty lines: An absolute poverty line is one which is fixed in terms of the living standard indicator being used (consumption, nutrition). It is fixed over the entire domain of comparison; that is, a poverty line which assures the same level of economic welfare would be used to measure and compare poverty across provinces or different situations. The poverty line may still vary, but only so as to measure the differences in the cost of a given level of welfare; (b) relative poverty lines: many studies have used a poverty line which is set at, for example, 50 per cent of the national mean income. When the poverty line is fixed as a proportion of the national mean, if all incomes increase by the same proportion, there would be no change in relative inequalities and the poverty line would simply increase by the same proportion; that is, the poverty measure will not change. The concept of absolute poverty appears to be more relevant to low-income countries, while relative poverty is of more relevance to high-income countries.

Purpose: It assesses overall performance from the point of view of the poor. The indicator can be decomposed into poverty measures for various sub-groups of the population, for example by gender region of residence, employment sector, education level, or ethnic group. That is important for poverty-reduction policies, and is relevant to regional or sectoral priorities for public spending.

Measurement method: The percentage of the population living below poverty line (H) is calculated as the proportion of the population whose economic welfare (y) is less than the poverty line (z). If (q) people are deemed to be poor in a population of size (n), then $H=q/n$.

Unit of measurement: Per cent.

2. *Proportion of population living below the international poverty line*

Definition and concept: This indicator represents the proportion of the population with a standard of living below the international poverty line of \$1 per day, using purchasing power parity (PPP) exchange rates from 1993.

Purpose: It assesses overall performance from the point of view of the poor. The main purpose of this indicator is to allow for international comparisons of poverty.

Measurement method: The proportion of the population living below poverty line (H) is calculated as the proportion of the population whose economic welfare (y) is less than the poverty line (z) of \$1 per day,

using PPP exchange rates from 1993. If (q) people are deemed to be poor in a population of size (n), then $H=q/n$.

Unit of measurement: Per cent.

3. *Proportion of population with access to an improved sanitation facility, urban and rural*

Definition and concept: This indicator represents the proportion of population with access to a private sanitary facility for human excreta disposal in the dwelling or immediate vicinity. A sanitation facility is a unit for disposal of human excreta, which isolates faeces from contact with people, animals, crops and water sources. Suitable facilities range from simple, but protected pit latrines, to flush toilets with sewerage. All facilities, to be effective, must be correctly constructed and properly maintained. The population covered includes the urban and rural population served by connections to public sewers and, for example, pit privies, pour-flush latrines and septic tanks.

Purpose: It monitors progress in the accessibility of the population to sanitation facilities. Accessibility to adequate excreta disposal facilities is fundamental to decrease the faecal risk and frequency of associated diseases. When broken down by geographic, namely, rural/urban zones, or social or economic criteria, it also provides tangible evidence of inequities.

Measurement method: The proportion of the population with access to an improved sanitation facility is calculated as the ratio of the number of people with improved excreta-disposal facilities over the total population, calculated for the whole population first, then for urban and rural areas separately.

Unit of measurement: Per cent.

4. *Proportion of population with sustainable access to an improved water source*

Definition and concept: This indicator represents the proportion of the population with access to an improved drinking water source in a dwelling or located within a convenient distance from the user's dwelling. The population covered includes the urban and rural population served by house connections, or without house connections but with reasonable access to other sources. Sustainable access to water refers to a distance of not more than 200 metres from a house to a public stand post or any other adequate point source in urban areas. In rural areas, sustainable access implies that people do not have to spend a disproportionate part of the day fetching water for the family's needs. Safe water is the water that does not contain biological or chemical agents at concentration levels directly detrimental to health. It is likely that treated surface waters and such water as that from protected boreholes, springs and sanitary wells are safe. Untreated surface waters, for example streams and lakes, should be considered safe only if the water quality is regularly monitored and considered acceptable by public health officials.

Purpose: It monitors progress in the accessibility of the population to improved water sources. Accessibility to improved water sources is fundamental to decrease the faecal risk and frequency of associated diseases. When broken down by geographic, namely, rural/urban zones, or social or economic criteria, it also provides tangible evidence of inequities.

Measurement method: The proportion of population with sustainable access to an improved water source is calculated as the ratio of the number of persons with access to an adequate amount of safe drinking water in a dwelling or located within a convenient distance from the user's dwelling over the total population.

Unit of measurement: Per cent.

B. HEALTH

1. Infant mortality rate

Definition and concept: The infant mortality rate is typically defined as the number of infants dying before reaching the age of one year per 1,000 live births in a given year.

The infant mortality rate is considered to be a more robust estimate than the under-five mortality rate if the information is drawn from vital statistics registration. In developing countries, household surveys are essential to the calculation of the indicator, but there are some limits to their quality. Survey data are subject to recall error, and surveys estimating infant deaths require large samples because such incidences are uncommon and representative households cannot ordinarily be identified for sampling. Moreover, the frequency of the surveys is generally only every three to five years. Therefore, when using household survey estimates, it is important to take sampling errors into account.

Purpose: Infant mortality rates measure child survival. They also reflect the social, economic and environmental conditions in which children (and others in society) live, including their health care. Since data on the incidence and prevalence of diseases (morbidity data) frequently are unavailable, mortality rates are often used to identify vulnerable populations.

Measurement method: The indicator is the number of deaths of infants under one year of age in the indicated year per 1,000 live births in the same year. For data from vital statistics registrations (when reliable), the number of live births and deaths in the same year of children under one year old are estimated. The number of deaths is divided by the number of births and the result is multiplied by 1,000. For data from household surveys, infant mortality estimates are obtained directly (using birth history, as in Demographic and Health Surveys) or indirectly (Brass method, as in Multiple Indicator Cluster Surveys). When estimated indirectly, the under-one mortality estimates must be consistent with the under-five mortality estimates.

Unit of measurement: Per 1,000 live births.

2. Under-five mortality rate

Definition and concept: This indicator represents the probability of a child born in a specified year dying before reaching the age of five if subject to current age-specific mortality rates. Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which after such separation breathes or shows any other evidence of life, namely, the beating of the heart, pulsation of the umbilical cord, of definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered live-born regardless of gestational age. Death is the permanent disappearance of all evidence of life at any time after live birth has taken place; in other words, the post-natal cessation of vital functions without capability of resuscitation.

Purpose: It measures the risk of dying in infancy and early childhood. In high-mortality settings, a large fraction of all deaths occur at ages under five years. The gap between more and less developed countries is larger in proportional terms for death rates in early childhood than during adult ages. Under-five mortality levels are influenced by poverty; education, particularly of mothers; the availability, accessibility and quality of health services; health risks in the environment, namely, access to safe water and sanitation; and nutrition, among other factors.

Measurement method: The mortality rate under five years of age is calculated as the ratio of total deaths of children under five in a given year over the total number of live births in that year. Data for this indicator are derived from estimates of births and deaths gathered in vital statistical systems, censuses and surveys. Where data on deaths and births are complete, or adjustments for age misstatement and incompleteness can be made, the under-five mortality rate can be calculated directly.

Unit of measurement: Per 1,000 live births.

3. *Life expectancy at birth*

Definition and concept: This indicator represents the average number of years that a newborn could expect to live, if he or she were to pass through life subject to the age-specific death rates of a given period.

Purpose: It measures how many years on average a newborn baby is expected to live, given current age-specific mortality risks. Life expectancy at birth is an indicator of mortality conditions and, by proxy, of health conditions. Mortality, with fertility and migration, determines the size of human populations, their composition by age, sex and ethnicity, and their potential for future growth. Life expectancy, a basic indicator, is closely connected with health conditions, which in turn are an integral part of development.

Measurement method: Life expectancy at birth is calculated based on age-specific death rates for a particular calendar period. The death rates are commonly tabulated for ages zero to one year, one to five years and for five-year age groups for ages five and above. Several steps are needed to derive life expectancy from age-specific death rates; the details can be found in demographic or actuarial references that describe the construction of life tables.

Unit of measurement: Years of life.

4. *Percentage of the population with access to primary health-care facilities*

Definition and concept: This indicator represents the proportion of population with access to primary health-care facilities. Primary health care is essential health care made accessible at a cost the country and community can afford, with methods that are practical, scientifically sound and socially acceptable. The population covered is all the population living in the service area of the health facility. Definition of accessibility may vary between countries, for different parts of the country and for different types of services.

Purpose: It monitors progress in the access of the population to primary health care. Accessibility of health services, going beyond physical access, and including economic, social and cultural accessibility and acceptability, is of fundamental significance in that it reflects on health system progress, equity and sustainable development.

Measurement method: The percentage of the population with access to primary health-care facilities is calculated as the ratio of the number of persons living within a convenient distance to primary care facilities over the total population.

Unit of measurement: Per cent.

5. *Immunization against infectious childhood diseases*

Definition and concept: This indicator represents the percentage of the eligible population that have been immunized according to national immunization policies. The definition includes three components: (a) the proportion of children immunized against diphtheria, tetanus, pertussis, measles, poliomyelitis, tuberculosis and hepatitis B before their first birthday; (b) the proportion of children immunized against yellow fever in affected countries of Africa; and (c) the proportion of women of child-bearing age immunized against tetanus. A child is considered adequately immunized against a disease when he or she has received the following number of doses: tuberculosis (one dose); diphtheria, tetanus and pertussis (DTP) (two or three doses according to the immunization scheme adopted in the country); poliomyelitis (three doses of live or killed vaccine); measles (one dose); hepatitis B (three doses); and yellow fever (one dose). A pregnant woman is considered adequately immunized against tetanus if she has received at least two doses of tetanus toxoid during pregnancy or was already previously immunized.

Purpose: It monitors the implementation of immunization programmes. Good management of immunization programmes is a basic measure of Government commitment to preventative health services

essential to the reduction of morbidity and mortality from major childhood infectious diseases, and is integral to the achievement of sustainable development.

Measurement method: The immunization against infectious childhood diseases for children is calculated as the ratio of the number of infants fully immunized with the specified vaccines over the number of infants surviving to age one. For immunizations against tuberculosis the denominator would be the number of live births. If the national schedule provides for immunization in a different age group, for example, measles in the second year of age, the value should be the percentage of children immunized in the target age group. For the proper management of immunization programmes, it is, however, essential to be able to break down the data in such a way as to show the percentage covered in the first year of life (or second year for measles immunization). For women of child-bearing age, the numerator is the number of women immunized with two or more doses of tetanus toxoid during pregnancy x 100, while the denominator is the number of live births.

Unit of measurement: Per cent.

6. Contraceptive prevalence rate

Definition and concept: This indicator represents the percentage of women of reproductive age, those aged 15-49, using any method of contraception at a given point in time. It is usually calculated for married women of reproductive age, but sometimes for other base population, for example, all women of reproductive age at risk of pregnancy.

The standard indicator is the percentage currently using any method of contraception among married women aged 15-49 or 15-44. In that context, the married group usually includes those in consensual or common-law unions in societies where such unions are common. Contraceptive prevalence is also frequently reported for all women of reproductive age, and statistics are sometimes presented for men instead of, or in addition to women.

Users of contraception are defined as women who are practising, or whose male partners are practising, any form of contraception. They include female and male sterilization, injectable and oral contraceptives, intrauterine devices, diaphragms, spermicide, condoms, rhythm, withdrawal and abstinence, among others. For this indicator, "too early" is defined as under age 15. Such adolescents are five to seven times more likely to die in pregnancy and childbirth than women in the lowest risk group of 20-24 years. "Too closely spaced" means women who become pregnant less than two years after a previous birth. Greater adverse consequences to women and their children are experienced under such circumstances. Women who have had five or more pregnancies, "too many" or who are over 35 "too late" also face a substantially higher risk than the 20-24 age group. When presenting information about contraceptive use, it is useful to show the data according to specific type of contraception; by social characteristics, namely, rural/urban or region of residence, education and marital status; by five-year age groups, including specific attention to adolescents under age 18; and by family size.

Purpose: It measures the extent of people's conscious efforts and capabilities to control their fertility. Increased contraceptive prevalence is, in general, the single most important proximate determinant of intercountry differences in fertility, and of ongoing fertility declines in developing countries.

Contraceptive prevalence can also be regarded as an indirect indicator of progress in providing access to reproductive health services, including family planning, one of the eight elements of primary health care. It does not capture all actions taken to control fertility as, for example, induced abortion is common in many countries. Current contraceptive practice depends not only on people's fertility desires, but also on availability and quality of family planning services; social traditions that affect the acceptability of contraceptive use; and other factors, for example, marriage patterns and traditional birth-spacing practices, that independently influence the supply of children.

Measurement method: The contraceptive prevalence rate is calculated as the ratio of the number of women aged 15-49 in marital or consensual unions who report that they are practising (or whose sexual

partners are practising) contraception, over the total number of women aged 15-49 (and same marital status, if applicable) in the survey.

Unit of measurement: Per cent.

7. *Nutritional status of children*

Definition and concept: This indicator represents the children under age five whose weight-for-age and height-for-age is either between 80 per cent and 120 per cent of the reference value of the country, or within two standard deviations of this value. A national or international reference population is used to calculate the indicators for weight-for-age and height-for-age. That data may be used for children up to five years of age, on the basis that the influence of ethnic or genetic factors on young children is considered insignificant. Low weight and low height are defined as less than the value corresponding to two standard deviations below the median of the respective frequency distributions for healthy children

Purpose: It measures long-term nutritional imbalance and malnutrition, as well as current under-nutrition and obesity. Anthropometric measurements to assess growth and development, particularly in young children, are the most widely used indicators of nutritional status in a community. The percentage of low height-for-age reflects the cumulative effects of under-nutrition and infections since birth, and even before birth. This measure, therefore, should be interpreted as an indication of poor environmental conditions and/or early malnutrition. The percentage of low weight-for-age reflects both the cumulative effects of episodes of malnutrition or chronic under-nutrition since birth and current under-nutrition. Thus, it is a composite indicator which is more difficult to interpret.

Measurement method: The proportion of children under five with acceptable weight-for-age (or height-for-age) can be calculated by using the following formula: "numerator", namely number of children under five with acceptable weight-for-age (or height-for-age) x 100; and "denominator", namely, total number of children under five weighed. For height, supine length is measured in children under two, and stature height in older children.

Unit of measurement: Per cent.

8. *Prevalence of tobacco use*

Definition and concept: This indicator represents the number of current tobacco smokers among the population. Current smoking includes both daily and non-daily or occasional smoking of cigarettes, cigars, pipes or any other smoked tobacco products.

Purpose: It measures the spread of tobacco use in the population. Tobacco use remains the leading preventable cause of death and disease in our society. It is a major risk factor for diseases of the heart and blood vessels, chronic bronchitis and emphysema, lung cancer and other diseases.

Measurement method: The prevalence of tobacco use is calculated as the ratio of the number of current tobacco smokers over the total population.

Unit of measurement: Per cent.

9. *Prevalence of infectious diseases: malaria and tuberculosis*

(a) *Prevalence of malaria*

Definition and concept: Prevalence of malaria is the number of cases of malaria per 100,000 people.

Purpose: The indicator allows highly endemic countries to monitor disease from malaria, which have been increasing over the last two decades owing to deteriorating health systems, growing drug and

insecticide resistance, periodic changes in weather patterns, civil unrest, human migration and population displacement.

Measurement method: Where the only prevalence data available are reported through the administration of health services, they are expressed per 100,000 population, using population estimates as the denominator.

Unit of measurement: Per 100,000 people.

(b) *Prevalence of Tuberculosis*

Definition and concept: Tuberculosis prevalence is the number of cases of tuberculosis per 100,000 people.

Purpose: Detecting tuberculosis and curing it are key interventions for addressing poverty and inequality. Prevalence and deaths are more sensitive markers of the changing burden of tuberculosis than incidence (new cases), although data on trends in incidence are far more comprehensive and give the best overview of the impact of global tuberculosis control.

Measurement method: Where the only data available are data reported through the administration of health services, they are expressed per 100,000 population, using population estimates as the denominator. Where the data come from household surveys, prevalence is expressed per 100,000 population, using the total population in the survey as the denominator. Tuberculosis prevalence is sometimes expressed in absolute numbers of cases.

Unit of measurement: Per 100,000 people.

C. EDUCATION

1. *Net enrolment ratios in primary education*

Definition and concept: This indicator represents the ratio of the number of children of official school age, as defined by the national education system, who are enrolled in primary school to the total population of children of official school age.

Purpose: It measures the proportion of children of primary school age who are enrolled in primary school. Net enrolment refers only to children of official primary school age, and excludes children of other age groups enrolled in primary school age as well as children of primary school age enrolled in other levels of education.

Measurement method: The net enrolment rate in primary education is calculated as the number of enrolled students within the appropriate age cohort according to school records as reported to ministries of education, divided by the number of children of primary school age.

Unit of measurement: Per cent.

2 and 3. *Enrolment in secondary and tertiary education*

Definition and concept: This indicator represents the proportion of the population of working age, those aged 25-64, who have completed at least (upper) secondary education in addition to the proportion of the population of working age, those aged 25-64, who have completed at least the first stage (as defined by the International Standard Classification of Education) of tertiary education.

Purpose: It measures of the quality of the human capital stock within the adult population of approximately working age. For instance, those who have completed upper secondary education can be

expected either to have an adequate set of skills relevant to the labour market, or to have demonstrated the ability to acquire such skills. The indicator can be made more dynamic by presenting the results in 10-year age bands, namely, 25-34, 35-44, 45-54 and 55-64, in order to give an indication of changes over time in actual secondary education completion rates.

Measurement method: Enrolment in secondary and tertiary education is calculated as the ratio of the number of adults aged 25-64 who have completed secondary or tertiary education over the corresponding total population aged 25-64.

Unit of measurement: Per cent.

4. Adult literacy rate, by sex

Definition and concept: This indicator represents the proportion of the adult population aged 15 and over that is literate. A person is literate who can, with understanding, both read and write a short simple statement related to his/her everyday life. A person is functionally literate who can engage in all those activities in which literacy is required for effective functioning of his/her group and community and also for enabling him/her to continue to use reading, writing and calculation for his/her own and the community's development. Persons who do not fulfil those two criteria are termed illiterate or functional illiterate, respectively. Adult literacy, in international practice, applies only to the population aged 15 and over, classified by sex, by five-year age groups and by urban/rural zones.

Purpose: It measures the stock of literate persons within the adult population who are capable of using written words in daily life and to continue to learn. It reflects the accumulated accomplishment of education in spreading literacy. Any shortfall in literacy would provide indications of efforts required in the future to extend literacy to the remaining adult illiterate population.

Measurement method: The adult literacy rate is calculated as the ratio of the number of literates aged 15 and above over the corresponding total population aged 15 and above.

Unit of measurement: Per cent.

D. DEMOGRAPHICS

1. Population growth rate

Definition and concept: This indicator represents the average annual rate of change of population size during a specified period.

Purpose: It measures how fast the size of population is changing. The dramatic growth of urban populations, caused by high rates of natural increase (excess of births over deaths) in urban areas, as well as migration from rural to urban areas and the transformation of rural settlements into urban places, is of concern in many countries. Rapid population growth can place strain on a country's capacity for handling a wide range of issues of economic, social and environmental significance, particularly when rapid population growth occurs in conjunction with poverty and lack of access to resources, or unsustainable patterns of production and consumption, or in ecologically vulnerable zones

Measurement method: The rate of population growth, r , between two times, $t1$ and $t2$, is calculated as an exponential rate of growth, conventionally expressed in units of per cent per year: $r = 100 \ln (P2 / P1) / (t2 - t1)$

Where $P1$ and $P2$ are the number of persons at times 1 and 2, respectively, and the time interval $(t2 - t1)$ is expressed in years. For a country, the estimate is generally based on either (a) an inter-censal population growth rate calculated from two censuses, each adjusted for incompleteness; or (b) from the components of population growth (adjusted for incompleteness, when necessary) during a period; the components are numbers of births, deaths and migrants. Inter-censal growth rates can also be calculated for subnational areas.

Unit of measurement: Per cent.

2. Total fertility rate

Definition and concept: This indicator represents the average number of children a hypothetical cohort of women would have at the end of their reproductive period if they were subject during their whole lives to the fertility rates of a given period and if they were not subject to mortality.

Purpose: It monitors future population change. It is also used to indicate the replacement level fertility.

Measurement method: The total fertility rate (TFR) is calculated using a life table. It is the sum of single-year age-specific-fertility rates (ASFRs). If rates are for five-year age groups then: $TFR = 5 \sum_i ASFR_i$, with $ASFR_i$ equalling the quotient of total births born to women in age i over the mid-year number of women in age i .

Unit of measurement: Children per woman.

3. Dependency ratio

Definition and concept: This indicator represents the relation between the number of children aged 0-14 and older persons aged 65 or over, to the working-age population aged 15-64.

Purpose: It monitors the potential effects of changes in population age structures for social and economic development, pointing out broad trends in potential social support needs. A high dependency ratio indicates that the economically active population and the overall economy may face a greater burden in supporting young and/or older economically dependent populations.

Measurement method: The dependency ratio is calculated as the ratio of the sum of the total number of children aged 0-14 and the total number of people aged 65 and above, over the number of the working-age population aged 15-64.

Unit of measurement: Per cent.

E. ECONOMIC DEVELOPMENT

1. Employment-population ratio, by sex

Definition and concept: This indicator represents the proportion of a country's working-age population that is employed.

Purpose: It monitors the ability of an economy to create employment. Employment is viewed as the desired portion of the economically active population (labour force). Employment-to-population ratios are related to differences in labour market activity in a given country.

Measurement method: The employment-population ratio is calculated as the number of people who are employed, divided by the total number of people in the selected age interval for working age, generally those aged 15-64. The ratio is calculated for the total population first, then for males and females separately.

Unit of measurement: Per cent.

2. Employment status, by sex

Definition and concept: This indicator distinguishes between three categories of the total employed. These are: (a) wage and salaried workers, also known as employees; (b) self-employed workers, namely, employers, own-account workers and members of producers' cooperatives; and (c) contributing family workers, also known as unpaid family workers.

Purpose: It monitors the distribution of the workforce, by status in employment. A high share of wage and salaried workers can signify advanced economic development and high shares of own-account-workers. A high share of contributing family workers is often associated with poor development, little job growth, widespread poverty and often a large rural economy.

Measurement method: The employment status is calculated as the ratio of the total number of workers in each of the three groups outlined above, over the total number of people employed. The ratios are calculated for the total population first, then for males and females separately.

Unit of measurement: Per cent.

3. *Share of women in wage employment in the non-agricultural sector*

Definition and concept: This indicator represents the share of female workers in the non-agricultural sector compared to the total employment in the sector. The non-agricultural sector includes industry and services. Following the International Standard Industrial Classification of All Economic Activities, industry includes mining and quarrying (including oil production), manufacturing, construction, electricity, gas and water. Services include wholesale and retail trade; restaurants and hotels; transport, storage and communications; financing, insurance, real estate and business services; and community, social and personal services.

Purpose: It measures the degree to which labour markets are open to women in industry and service sectors, which affects not only equal employment opportunities for women but also economic efficiency through flexibility of the labour market and therefore the economy's ability to adapt to change.

Measurement method: The share of women in wage employment in the non-agricultural sector is calculated as the ratio of the total number of women in paid employment in the non-agricultural sector over the total number of people in paid employment in that same sector.

Unit of measurement: Per cent.