ECONOMIC AND SOCIAL COMMISSION FOR WESTERN ASIA (ESCWA)

PROGRESS IN THE ACHIEVEMENT OF THE MILLENNIUM DEVELOPMENT GOALS IN THE ESCWA REGION: A GENDER LENS

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ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
BCPFA	Beijing Conference Platform for Action
BDPFA	Beijing Declaration and Platform for Action
BPFA	Beijing Platform for Action
CEDAW	Convention on the Elimination of all forms of Discrimination against Women
CLI	Civil Liberties Index
FCI	Family Code Index
FWCW	Fourth World Conference on Women
GCC	Gulf Cooperation Council
GEI	Gender Equality Index
GPI	Gender Parity Index
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
MDGs	Millennium Development Goal
NGO	Non-governmental organization
OECD	Organisation for Economic Co-operation and Development
OI	Ownership Index
PII	Physical Integrity Index
PoA	Programme of action
SIGI	Social Institutions and Gender Index
STI	Sexually transmitted infection
U5	Under-five
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNHCR	United Nations High Commissioner for Refugees
UNIFEM	United Nations Development Fund for Women
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
UNSD	United Nations Statistics Division
WHO	World Health Organization

Executive summary

Gender equality and the empowerment of women remains a central issue in progress towards attaining the Millennium Development Goals (MDGs), especially for the member countries of the Economic and Social Commission for Western Asia (ESCWA). It is clear from a review of the progress made since 2000 that the MDGs have been a driving force on a number of development fronts in the ESCWA region, yet despite the progress made, many communities in the region continue to lag well behind.

While certain groups in the region have continued to prosper, there are others – women and girls in particular – who have remained behind and have fallen into extreme poverty. Poverty, unemployment and HIV/AIDS are increasingly becoming issues for women and children. Maternal, infant and child death and disability are, in the main, both easily and cost-effectively preventable, yet they remain worryingly prevalent. Millions of people, predominantly girls and women, remain illiterate.

This report analyses the causes and consequences of the uneven progress in the ESCWA region by providing a detailed examination of the MDG targets and their associated indicators through the prism of a gender lens. The principal hypothesis of the report is that progress towards attaining the MDGs will not materialize if countries fail to adopt gender-responsive and rights-based national development policies and strategies. It also posits that national development policies and programmes that disregard the role played by women in safeguarding human life and nurturing the seeds of development will all too easily reap precisely what they have sown, missing scarce but valuable opportunities for developmental progress.

However, the report also acknowledges that the MDGs themselves are gender deficient and that gender concerns need to be seamlessly streamlined into the eight goals in order to ensure that gender-sensitive indicators are used effectively to track the MDG targets. Unfortunately, the consistent lack of sex-disaggregated data and indicators across social, economic and cultural lines in the region continues to hamper efforts to analyse progress.

The analytical section of the report is framed within the context of the current situation in the ESCWA region, which is presented in chapter I. Chapter II focuses on the complex socio-cultural and geopolitical forces that affect gender equality outcomes and their implications for the MDGs. Four clear deficits are established in the areas of population policy, health systems, cultural norms, and conflict and instability, all of which contribute directly to the low status of women and pervasive gender inequality in the region. Chapter III highlights three areas of concern: first, the general lack of vision in dealing with issues of gender equality and the empowerment of women in the MDGs; second, MDG reporting and monitoring issues; and third, the gender dimension of individual MDGs. Progress towards each MDG is analysed from a gender perspective, using secondary data and drawing findings from existing literature. The report concludes with a brief summary of the successes and failures to date, and a set of recommended actions.

The report highlights the challenges facing ESCWA member countries in terms of incorporating gender into their national policies and programmes in order to achieve the MDGs by the target date. Methods and techniques of data collection and generation of MDG-related indicators employed in the region are rarely disaggregated by sex or other related variables. Development policies based on gender-insensitive data can themselves be considered to be "gender blind". In terms of female employment, a significant mismatch persists between educational outcomes and market requirements. The inability of national economies to translate the academic achievements of girls into effective, productive female engagement in the workforce, with the concomitant income returns for families and society, is not only clearly indicative of continuing gender inequality and the lengthy, difficult path which still lies ahead to the full empowerment of women, but also impedes progress towards achieving the MDGs. Similarly, health systems continue to fail women and adolescent girls, all too frequently compromising their sexual health and reproductive rights. Women also tend to face higher health costs than men as a result of their greater use of health care. Although they constitute the backbone of the health-care and education service delivery systems, their voice

is rarely heard in decision-making circles, their work is generally lower paid and their social security coverage remains more limited than that of men.

Cultural and traditional norms and practices also limit the advancement of women in the region, as they affect matters such as consent to marriage, fertility choices, household power structure and decision-making, private ownership of assets, freedom of movement outside the home, and the incidence and severity of violence against women, including sexual violence and “honour” crimes. In addition, the region faces complex conflict and emergency conditions which are particularly traumatic for women and girls, and which contribute to further restricting the role of women in the economic and social spheres. Instability is also a root cause of gender inequality and the exclusion of women from the development path towards the MDGs.

The report concludes that the slow pace of progress towards achieving the MDGs is largely determined by deficits in gender equality and the empowerment of women, coupled with a lack of capacity and willingness to streamline gender concerns into MDG-based national development plans and poverty reduction strategies. The pivotal role of women in poverty reduction, mitigating the impact of climate change, reducing environmental degradation, improving maternal health and reducing child mortality needs to be fully recognized if the ESCWA region is to have any real chance of attaining the MDGs by the target date of 2015.

I. INTRODUCTION: CONTEXT AND BACKGROUND

In the year 2000, the nations of the world came together at the Millennium Summit (New York, 6-8 September 2000) to agree on a broad development agenda for the next 15 years. A total of 189 countries, including 147 heads of State and Government, adopted the Millennium Declaration.[1] They agreed upon a set of eight time-bound, measurable goals related to poverty and hunger; universal primary education; gender equality and the empowerment of women; child mortality; maternal health; HIV/AIDS, malaria and other diseases; environmental sustainability; and the formation of a global partnership for development. These Millennium Development Goals (MDGs) incorporated key goals and targets agreed upon at previous United Nations summits and conferences, including the International Conference on Population and Development (ICPD) (Cairo, 5-13 September 1994) and the Fourth World Conference on Women (FWCW) (Beijing, 4-15 September 1995). The Secretary-General is mandated to report annually to the General Assembly on progress made towards the achievement of the MDGs, and most signatories to the Millennium Declaration prepare national MDG reports tracking their progress towards the goals.

The original list of MDGs comprised eight goals, 18 targets and 48 indicators, but was sharply criticized from a number of perspectives. It was clear from the list that gender equality was to be set at the heart of the development agenda (MDG 3: Promote Gender Equality and Empower Women), from which it appeared that a fresh promise for progress on gender equality and the empowerment of women permeated the MDGs. However, the targets assigned to MDG 3 focused on eliminating gender disparity in primary and secondary education, preferably by 2005, and at all levels of education by no later than 2015. These targets ignored the fact that gender equality can only be achieved if women are empowered in all spheres of life, whether economic, social or political. Indeed, as has been widely observed, gender parity in education does not necessarily translate into economic and political empowerment for women.

Gender experts also complained that not all data for MDG indicators were disaggregated by sex and that the indicators specified to monitor progress towards the achievement of MDG 3 were inherently problematic. For example, the indicator "share of women in wage employment in the non-agricultural sector" ignored the fact that most women working in agriculture do so in the informal sector, particularly in poor countries. Furthermore, the indicator "proportion of seats held by women in national parliament" ignored the role of women in promoting good governance and female political participation at the grassroots level.[2]

In 2003, the United Nations Development Programme (UNDP) conducted a gender review of 13 national MDG reports[3] in order to assess whether the reports incorporated gender, mentioned women's issues and/or identified gender and women's issues in goals other than MDG 3 and, if so, the ways in which that was done. The review noted that perspectives on gender equality and the empowerment of women were not adequately mainstreamed into the national reports, which continued to focus on traditional gender roles and only viewed improvements in the situation of women as a means of achieving other goals (reducing child mortality, for example). They thus failed to adopt a rights-based approach focused on women's human rights as a primary objective. Given these findings, UNDP considered incorporating gender into the MDGs by adding at least one gender-specific indicator to each target. However, doing so would require overcoming a number of constraints, including a lack of detailed, reliable data; inadequate national capacity; and the increased reporting burden which such a requirement would place on countries, and UNDP therefore opted simply to recommend the use of more sex-disaggregated data to highlight the differences between men and women, and the provision of more qualitative information on gender and women's issues.

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[1] United Nations, 2000a.

[2] ESCWA, 2007, pp. 2-5.

[3] UNDP, 2003.

In 2005, UNDP conducted a similar review of 78 national MDG reports, which reiterated its earlier findings.[4] It identified three areas of concern that needed to be addressed in order to align reporting with strategic priorities for gender equality, namely the range and scope of reporting, the interlinkage between goals, and ownership and "buy-in".

Against this backdrop of rising criticism from experts across a number of disciplines, the Secretary-General recommended in his report[5] on the work of the Organization submitted to the General Assembly in September 2006 the inclusion of the following four additional targets within the MDG framework:

1. Achieve full and productive employment and decent work for all, including women and young people. (Target to be included under Goal 1).

2. Achieve, by 2015, universal access to reproductive health. (Target to be included under Goal 5).

3. Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it. (Target to be included under Goal 6).

4. Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss. (Target to be included under Goal 7).

The Secretary-General also indicated in the report that the Inter-agency and Expert Group (IAEG) on MDG Indicators would undertake the technical work of selecting the appropriate indicators to measure progress under these new targets. The IAEG is responsible for the preparation of data and analysis to monitor progress towards the MDGs. It also reviews and defines methodologies and technical issues in relation to the indicators, produces guidelines, and helps define priorities and strategies to support countries in data collection. The revised MDG monitoring framework, including the new targets and indicators, was presented to Member States at the sixty-second session of the General Assembly in 2007, as an annex to the report of the Secretary-General on the work of the Organization.[6] The number of targets was increased from 18 to 21 and the number of indicators from 48 to 60.[7]

Two new targets, the first related to employment and decent work, and the second to reproductive health, are of particular significance to gender equality and the empowerment of women. The fact that the MDG framework stresses that all indicators should be disaggregated by sex wherever possible also constitutes a significant step forward in terms of incorporating gender into the MDGs.

However, despite the 2007 amendments, gender equality remains poorly served by the MDGs. The United Nations Development Fund for Women (UNIFEM) has highlighted the following lacunæ in the current MDG framework:[8]

1. Most MDGs have either inadequate or no gender-sensitive targets or indicators, which renders them difficult to measure.

2. The target and indicators specified for Goal 3 on gender equality are still limited. Indeed, while they represent a possible means to equality, they do not necessarily reveal the quality of rights enjoyed by women, nor the true extent of the empowerment of women.

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[4] UNDP, 2005a.

[5] United Nations, 2006.

[6] United Nations, 2007a.

[7] The revised list of the MDGs and their targets and indicators can be found in the annex to this report.

[8] UNIFEM, 2008.

3. The stand-alone nature of the MDGs blurs the multisectoral linkage between all the goals, targets and indicators, including cross-cutting gender links. For example, addressing such issues as maternal health and gender disparity in education without addressing their relationship to broader gender issues, such as the feminization of poverty, gender bias in the economy, gender-based violence and ideologies discriminating against women and girls, could all too easily hamper progress towards gender equality and the empowerment of women, thus jeopardizing the achievement of all the Goals.

With just four years remaining before the 2015 target for attaining the MDGs, it is evident from the progress achieved since 2000 that their very existence has provided a real spur to progress for many countries. However, progress has been uneven and urgent action is necessary if the goals are to be achieved by the target date.

This report analyses progress in the achievement of the MDGs in the member countries of the Economic and Social Commission for Western Asia (ESCWA)[9] from a gender perspective. Its objectives are threefold: first, to track progress towards the MDGs in ESCWA member countries from 1990 until the end of 2010; second, to identify and analyse the major successes and failures in this regard, including an assessment of the prospects of attaining each goal by the target date; and third, using gender as a cross-cutting issue, to propose specific policy recommendations to member countries with a view to supporting them to achieve the MDGs by 2015.

The data and statistics used in the compilation of the report were extracted from the following sources:

(a) International sources: United Nations Statistics Division (UNSD) and other United Nations specialized agencies;

(b) Regional sources: ESCWA, United Nations agencies in the ESCWA and Arab regions, the League of Arab States and other specialized regional sources;

(c) National statistical offices;

(d) Other reports covering the ESCWA region, including national, regional and global MDG reports.

The methodology of data collection, verification and use was guided primarily by UNSD. Thus, in the case of conflict between data sources and methodologies, preference was given to those used by UNSD.

[9] The member countries of ESCWA are Bahrain, Egypt, Iraq, Jordan, Kuwait, Lebanon, Oman, Palestine, Qatar, Saudi Arabia, the Sudan, the Syrian Arab Republic, United Arab Emirates and Yemen.

II. STRUCTURAL CONTEXT OF GENDER AND DEVELOPMENT GOALS

Gender equality and the empowerment of women are critical to national and global strategies for achieving sustainable development objectives. Gender equality is not just a goal in its own right, but it is also central to achieving all development goals, including the MDGs.

Raising the educational level of women has positive ripple effects on their propensity to join the labour force and their ability to increase productivity and household income, with a knock-on effect on poverty reduction strategies and maternal and child health. Furthermore, providing women with equal opportunities to fill administrative, managerial and political positions, and to acquire fair representation on legal and constitutional bodies promotes female participation in decision-making processes and fosters individual civic and political rights.

However, the influence of gender equality on other development goals should not preclude the importance of adopting the reverse pathway analysis. From the viewpoint of development policies and programmes, it is imperative to assess the underlying social, cultural and geopolitical forces which drive gender equality outcomes, gauging results (such as the rate of female representation in national parliaments) and processes (including procedural and regulatory reviews, constitutional amendments and advocacy activities for streamlining the Convention on the Elimination of all forms of Discrimination against Women (CEDAW) in national plans).

This chapter sets out the underlying structural determinants of gender equality and female empowerment across the ESCWA region. The structural determinants are sufficiently broad to encompass underlying socio-cultural, political and economic policies and politics that have an important bearing on gender equality and the empowerment of women. Some operate directly on shaping the level and trend of such outcomes (gender-responsive economic and social policies and programmes, for example), while others operate indirectly through social norms and traditions. Many are externally reinforced (economic and political sanctions, global economic recessions and climate change, for example), while others originate and develop internally (these include national efforts to change – positively or negatively – the political, legislative, regulatory and normative processes, procedures and policy responses to human development issues such as population and development policies, economic and administrative reforms, good governance, democratization and human rights).

A. DEMOGRAPHICS, POLICIES AND IMPLICATIONS FOR GENDER EQUALITY

Over the last four decades, the ESCWA region has experienced a period of rapid demographic change, which has had major implications for the size, composition, distribution and well-being of its population. This rapid transition has resulted in a rise in the total population of the region from 88.5 million in 1970 to 262 million in 2010 (see table 1).

The transition has also brought about changes in demographic outcomes, including rapid growth of the adolescent and youth population, increasing numbers of women reaching productive and reproductive age, changing trends in internal and external regional migration, accelerated urbanization and a rise in inadequate housing.

Such demographic and social profiles, coupled with the effects of economic recession and climate change, have not only affected the carrying capacity of land, water and the environment, but also the need for greater investment in human development goals, including gender equality, the elimination of poverty, universal access to basic education, reduction of maternal and child mortality, and protection against HIV/AIDS and other diseases.

TABLE 1. TOTAL POPULATION, ESCWA MEMBER COUNTRIES, 1970-2015
(*Thousands*)

Country	1970	1980	1990	2000	2005	2010	2015
Bahrain	220	347	493	650	728	807	882
Egypt	35 575	44 433	57 785	70 174	77 154	84 474	91 778
Iraq	10 210	14 024	18 079	24 652	28 238	31 467	35 884
Jordan	1 623	2 225	3 254	4 853	5 566	6 472	6 957
Kuwait	744	1 375	2 143	2 228	2 700	3 051	3 378
Lebanon	2 443	2 785	2 974	37 772	4 082	4 255	4 426
Palestine	1 096	1 476	2 154	3 149	3 762	4 409	5 090
Oman	747	1 187	1 843	2 402	2 618	2 905	3 198
Qatar	111	229	467	617	885	1 508	1 630
Saudi Arabia	5 745	9 604	16 259	20 808	23 613[a/]	26 246[b/]	28 933
The Sudan	15 039	20 509	27 091	34 904	38 698	43 192	47 730
Syrian Arab Republic	6 371	8 971	12 721	16 511	19 121	22 505	24 494
United Arab Emirates	225	1 015	1 867	3 238	4 089	4 707	5 193
Yemen	6 391	8 381	12 314	18 182	21 024	24 256	27 819
Total	88 510	118 541	161 434	242 140	234 283	262 264	289 407

Source: Adapted from UN-DESA Population Division, *World Population Prospects: The 2008 Revision*.

a/ 23,118,000 in 2005. *Source of data*: Ministry of Economy and Planning, Saudi Arabia.
b/ 27,136,000 in 2010. *Source of data*: Ministry of Economy and Planning, Saudi Arabia.

Against this backdrop, ESCWA member countries have responded to a varying degree to the policy recommendations and proposed programmes of action emanating from the global meetings of the 1990s, in particular the 1994 ICPD and the 1995 FWCW, and their respective +5 and +10 reviews. At both global meetings, the concepts of gender equality and the empowerment of women, and the broadly defined concepts of reproductive health and rights took centre stage.

The ICPD Programme of Action (PoA) explicitly recognized reproductive rights as fundamental human rights and stressed the importance of integrating the principles of gender equality, equity and the empowerment of women into population and development strategies.[10]

This consensus was heralded at the time as a paradigm shift. Both the content and rationale of population policy were changed, moving the focus to objectives other than demographic targets and traditional patterns of family planning provision as a means of achieving population control. The health and empowerment of women were seen as ends in their own right, not only as factors affecting population change. This emphasis on rights implied that in addition to the right to decide the number and spacing of their children, women had the right to a full range of accessible and affordable reproductive health services. Such services needed to reflect human rights principles, including those which directly impinge on sexually transmitted infections (STIs), violence against women, maternal mortality and morbidity, and the role and responsibilities of men, both in sexual and gender relations and in responsible parenthood.[11]

The FWCW was the first of the 'women's conferences' to have as its central focus the human rights of women. It consolidated the decisions made by earlier world conferences on women and gender-related statements from conferences in the 1990s which dealt with the environment, human rights, population and social development. The Beijing Declaration and Platform for Action (BDPFA) covered a broad range of issues and required, inter alia, a review and adjustment of macroeconomic policies and a reduction in

[10] United Nations Population Fund (UNFPA), 1994.

[11] Ibid.

excessive military expenditure. Health-care services and violence against women were critical areas of concern and prompted a large number of recommendations for action.[12]

The Beijing+5 and Cairo+5 review meetings both underlined the necessity of additional efforts to address the growing epidemic of HIV/AIDS. With regard to reproductive health, Cairo+5 set goals on the use of contraception, maternal mortality, sexually transmitted diseases and HIV/AIDS. The rights of adolescents to reproductive health information and services were upheld, despite calls from certain Member States to subordinate them to the rights of parents.[13] The Beijing+5 review moved the debate forward by holding that all forms of violence against women, including marital rape, should be treated as a criminal offence; by demanding more effective measures to combat violence, including that caused in the course of armed conflict and human trafficking; and by identifying forced marriage, honour crimes and honour killings as matters requiring State intervention.[14]

Demonstrating disappointingly varying degrees of commitment, ESCWA member countries have engaged in difficult debates to formulate and approve new post-ICPD/FWCW population and development policies and programmes. Traditionally, policymakers and planners in the region have either been demographically driven or have adopted the *laissez-faire* approach which had been the hallmark of population and family planning policies prior to the ICPD. Populous countries in the region, such as Egypt, the Sudan and Yemen, have been both strained and constrained by high population growth rates and, as a response, developed demographically-targeted policies in the last three decades of the twentieth century, notably through the use of fertility control measures. Other modifications were introduced in response to changes in geopolitics, ideology and donor mandates. In contrast, countries such as Iraq, Kuwait, Palestine and the Syrian Arab Republic have consistently adopted a pronatalist policy.

Irrespective of the nature and underlying causes of traditional policies in the region, their implications for gender equality, the empowerment of women, and female reproductive health needs and rights are clear. Countries which focus on population growth and fertility rates severely undermine the status and value of women and their health needs. The most common means of monitoring the rate of population growth is through the provision or restriction of birth control services and information, taking no heed of whether such action is in accordance with the individual choices of women or in harmony with their life-cycle needs.

The hopes and promises of the ICPD PoA and the Beijing Platform for Action (BPFA) are gradually being reflected in population and development policies, strategies and programmes in the region. However, the core policy rationale, objectives and implementation modalities are still deeply rooted in the single-minded focus on fertility reduction through the increased use of contraception which was almost universally the norm from the 1960s to the mid-1990s.

The +10 and +15 reviews of the Cairo and Beijing action plans noted the uneven success to date in drafting and adopting policies and programmes incorporating the recommendations and resolutions made in the PoAs.[15] There is no doubt that there has been a shift towards greater sensitivity to the needs of women, an improvement in the quality of education and health-care services, and the use of policy goals to cater for the empowerment of women. However, all too often the underlying demographic paradigm has not shifted and changes have not only been slow to appear, but have sometimes been reversed. Indeed, in many cases, countries have completely failed to integrate population and gender policies into national development plans. There is growing evidence that population, gender and reproductive health issues continue to be debated in isolation from the legislative and political decision-making processes. This dichotomy has undoubtedly contributed to the alienation of such issues from national development plans and processes, and has produced results which are either divergent or conflicting.

[12] United Nations, 2001.

[13] Ibid.

[14] Ibid.

[15] UNFPA, 2010.

The Regional Arab Population Forum (Beirut, 19-21 November 2004),[16] held to mark the tenth anniversary of the ICPD, found that a small number of countries in the Arab region had begun to take measures to integrate population and gender issues into national and sectoral policies, strategies and plans. Of the 17 countries responding to the Inquiry, only seven had initiated far-reaching measures to adopt an integrated planning approach to improve quality of life, promote the status and empowerment of women, and provide humane, equitable and acceptable health services. The remaining countries either had no explicit population and gender policy or did not tailor national planning processes to address post-ICPD/FWCW platforms.[17]

Furthermore, research in the region has found evidence that the work of certain policymakers, programme directors and researchers is imbued with intellectual ambiguity, ideological contrasts and cultural misinterpretations with respect to the principles, methods and procedures of streamlining gender equality and the empowerment of women into development planning frameworks.[18] The resulting lack of consistent, cohesive positions on gender-related matters has had a negative impact on national policy and planning responses to gender equality goals and targets.

Thus, while many countries claim to have adopted proactive gender equality policies or strategies by intensifying efforts towards improving the education of girls, they ignore the importance of expanding employment opportunities for women and linking their potential with overall societal development. In other cases, countries occasionally document rapid progress in building up national institutions, such as national machineries for women, while continuing to register setbacks in areas of legislation, regulation and social conduct which underpin gender equality and the empowerment of women. At a time when national non-governmental organizations (NGOs) and women's organizations are fighting for the rights of women with regard to such issues as the minimum legal age for marriage and the physical mobility of women within and across national borders to be enshrined in institutional conduct, processes and practices, national parliaments in a number of Arab and ESCWA member countries continue to take an opposing stance. Regrettably, while several countries in the region have endorsed the eradication of discriminatory acts against women – such as female genital mutilation, female genital cutting, honour crimes and honour killings – social norms and familial practices mean that such acts continue to be perpetrated on girls and women.

In conclusion, it is vital that national Governments, civil society organizations and private sector institutions in the ESCWA region exert tireless efforts to incorporate issues of gender and the empowerment of women into policy and programme design. They should also amend policies to bring them into line with the MDG frameworks and to take full advantage of the opportunities offered by the global conferences and their reviews.

B. SOCIETIES AND HEALTH SYSTEMS FALL SHORT OF HEALTH GOALS FOR WOMEN

Improving the health of women is not only instrumental for their social, physical and mental well-being, but a necessary and effective approach to strengthening health systems overall, which in turn benefits everyone in society. Addressing the health concerns of women has positive repercussions for women, their families, communities and society at large.

Over the past four decades, the ESCWA region has seen steady gains in health indicators. Life expectancy at birth has advanced at an unprecedented pace, and infant mortality and child mortality rates have registered a remarkable decline. Nonetheless, health improvement is by no means guaranteed for all citizens on equal terms, and it tends to be women who suffer most from neglect and gender-biased traditions and practices.[19]

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[16] ESCWA, 2004.

[17] UNFPA, 2008.

[18] UNDP, 2006.

[19] UNDP, 2009.

Certain health systems in the Arab region are hampered by bureaucratic inefficiency, lack of professional capability, underfunding and increasing health risks from infectious diseases. Health systems in the region tend to be based on hospital and curative care models, focusing on the treatment of disease, rather than on preventative and promotional care services.[20] These health systems are generally characterized by a lack of intersectoral linkage which could bring about indirect but vital health determinants, particularly for the most vulnerable groups in society, including the disadvantaged, marginalized and, in particular, women. Furthermore, such systems suffer from embedded shortfalls pertaining to accessibility, acceptability and affordability of services, especially for the underprivileged and rural communities; inefficient use of scarce resources, with public funds often directed to services of limited cost-effectiveness and with disproportionate financing of secondary and tertiary health care at the cost of primary health care; and a deficit in the provision of essential reproductive health services packages.[21] Such shortfalls can all too easily result in a failure to uphold the health-related rights of women as enshrined in such internationally agreed texts as the Universal Declaration of Human Rights, CEDAW, the ICPD PoA and the Beijing Conference Platform for Action (BCPFA).

One of the most notable features of the MDGs is the prominence they give to health, with an emphasis on the health of women and girls of all ages.[22] Of the eight MDGs, four are directly related to health: Goal 4 (reduce child mortality), Goal 5 (improve maternal health), Goal 6 (combat HIV/AIDS, malaria and other diseases) and Goal 7 (ensure environmental sustainability, including halving the proportion of people without sustainable access to safe drinking water and basic sanitation), while a further two are closely related to health: Goal 1 (eradicate extreme hunger and poverty) and Goal 8 (develop a global partnership for development). The remaining two goals also arguably have an indirect impact on health: Goal 2 (achieve universal primary education) and Goal 3 (promote gender equality and empower women).

The health of women is thus central to poverty reduction and other human development goals, while at the same time being reinforced by those goals. However, it is more than a simple question of cause and effect, as personal health is an individual human right.

Viewed from a multidimensional perspective, the ability of health systems in the ESCWA region to meet the interwoven needs and rights of women is limited. By and large, the health needs of women are greater than those of men in terms of both variety and complexity. Women tend to face higher health costs than men simply as a result of their greater use of health-care facilities. Yet at the same time, they are more likely than their male counterparts to be poor, unemployed, engaged in part-time work or working in the informal sector with no health benefits. The flaws in the health systems of the region compound the problems experienced by women in accessing basic health and social services and amenities. Access is affected by a multiplicity of factors, including physical access or availability of services, individual physical mobility, financial power and the social status of women. For example, the distance from home to a health-care facility and the lack of transport or adequate roads between the two may pose a major challenge for pregnant women living in rural areas or conflict zones.[23] Even if transportation and infrastructure are available, travel and accommodation costs, in addition to indirect costs such as wages lost by family members in accompanying women to medical appointments or for treatment, may prove prohibitive.[24] Levying fees for maternal health services penalizes and discriminates against poor women and their families more than well-to-do families.[25]

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[20] Ibid.

[21] UNFPA, 2008, op. cit.

[22] Hunt, 2007.

[23] United Nations, 2009.

[24] United Nations Children's Fund (UNICEF), 2009.

[25] World Health Organization (WHO), 2009.

Although women constitute the backbone of most health-care systems, being major contributors as caregivers in both the formal and informal sectors, they rarely occupy managerial or decision-making positions in the field. Female employees tend to be concentrated in low-level occupations, with lower salaries and greater health risks. In the informal sector, however, they are even more disadvantaged, as their work as informal caregivers at home or in the community is all too frequently unrecognized, unsupported and unremunerated. The health of women is severely affected when they are discriminated against by society or when they are subjected to violence. When they are excluded by law from the ownership of land or property or from the right to divorce, their social or physical vulnerability is further compromised and, at its most extreme, social and cultural gender bias can lead to violent death or infanticide.

C. CULTURAL ATTRIBUTES FAIL WOMEN

Economic and geographical inaccessibility is not the only obstacle to swift progress towards achieving the health-related MDGs and the targets for gender equality and the empowerment of women. Socio-cultural research scientists in the region have increasingly recognized that human development outcome variables, including those of the health and gender equality MDGs, are often determined by the cultural norms, traditions and practices that have historically pervaded the family, marriage systems and power relations across and within social hierarchies in the region.[26]

A wide range of socio-cultural studies in a number of social settings in the region have confirmed the existence of a clear relationship between the poor health performance of women and the degree of familial and societal infringement on their autonomy.[27, 28] Throughout the region, issues such as the prevalence of early marriage, conflicting parental attitudes towards childbearing and childrearing, unmet needs for family planning, lack of involvement of women in household budget management, the low propensity of women to take up non-agricultural paid employment and frequent restrictions on their physical mobility outside the home, can all be seen as clear indicators of the low status of female autonomy and the repressive gender system that continues to prevail in many parts of the region.

Conceptually, it is posited that traditional cultural forces, primarily operating invisibly at household and community levels, dictate the pattern of gender equality and the status of women by influencing a set of root causes instigated by national political and social institutions. Farah and Maas[29] conducted research in Yemen which indicated that a culturally led over-emphasis on the traditional role of women is the source of the power shift from women to their husbands and to their families of origin in decisions pertaining to marriage, reproduction, family planning, production and consumption.[30] Such evidence indicates a striking divergence in spousal attitudes with regard to a number of critical issues relating to gender and reproductive health. Ostensibly, women are more receptive than men to the concepts of late marriage and small family size, and more perceptive to the needs and desires of adolescents in the family, yet through culturally inbuilt power, men are able to impose their views and will on women to ensure that they comply with the patriarchal family code.

The Farah and Maas study confirmed the lack of general autonomy enjoyed by Yemeni women, and this is even more evident when considered in relation to internationally agreed reproductive health and socio-economic rights. A significant number of husbands were found to reinforce conservative measures against the autonomy of women. For example, 10 per cent of husbands were reported to enforce strict restrictions on the right of their wives to visit health facilities and or to use social amenities. It was noted that younger

[26] Farah and Faour, 2011.

[27] Hay, 1999, pp. 243-279.

[28] Farah and Maas, 2006.

[29] Ibid.

[30] Ibid.

women were more disadvantaged in terms of autonomy than older women, while those with more children and a higher proportion of male children were shown to have greater power within and beyond their family circle.

D. CONFLICT AND GENDER EQUALITY

In order to protect the rights of women and girls in situations of armed conflict, the BPFA set out a number of strategic objectives, including the following:

- Increase the participation of women in conflict resolution at decision-making levels and protect women living in situations of armed and other conflict or under foreign occupation;
- Reduce excessive military expenditure and control the availability of armaments;
- Promote non-violent forms of conflict resolution and reduce the incidence of human rights abuse in conflict situations;
- Provide protection, assistance and training to refugee women, other displaced women in need of international protection and internally displaced women.

Adverse conditions during and following situations of conflict make it difficult for policymakers and planners to address the basic needs and aspirations of society, let alone devote time to planning the ways in which social and economic development objectives, including gender equality and the MDGs, can be achieved.

Women and girls constitute some 49 per cent of all refugees, internally displaced people and other populations under the jurisdiction of the Office of the United Nations High Commissioner for Refugees (UNHCR).[31] For a variety of reasons, women and girls tend to be at greater risk of death in natural disasters in societies in which they already suffer multiple forms of discrimination. Insecure, crowded camps for displaced people often lack basic sanitation and health services, making women more vulnerable to HIV infection, unwanted pregnancy, unsafe abortion, maternal mortality and gender-based violence. Following a number of widely-publicized episodes of sexual violence in conflict situations in recent years, the United Nations Security Council passed resolution 1820 in 2008 and resolution 1888 in 2009. The former identifies sexual violence as a war crime and demands its complete cessation, while the latter specifically mandates peacekeeping missions to protect women and children from sexual violence during armed conflict and authorizes the immediate adoption of additional protective mechanisms.

Yet in spite of elaborate global policy frameworks and instruments, women and children around the world still face immense challenges to their personal safety, health and empowerment. These were set out at the Beijing +10 review[32] and include the following:

(a) Lack of participation by women in peace processes, decision-making structures and environmental initiatives;

(b) Increased sexual and gender-based violence against women and girls during and after conflicts and disasters;

(c) Lack of adequate attention to the challenges faced by refugees and displaced women, including the differential impact of disasters on men and women;

(d) Low profile and low resources for gender issues within international organizations.

[31] United Nations High Commissioner for Refugees (UNHCR), 2009.

[32] United Nations, 2005.

In recent years, several ESCWA member countries have experienced some of the most complex conflict, emergency and security situations in the world. The consequences of those in countries such as Iraq, Lebanon, Palestine, the Sudan and Yemen have naturally had a deleterious effect on the extent to which countries are able to achieve human, economic and gender equality goals. Even for stable countries in the region, the cross-border effects of conflict are evident. Conflict thus not only undermines the capacity of conflict-prone countries, but through its spill over effects also mars that of neighbouring countries.[33]

The longest-standing refugee situation globally – that of the Palestinians – continues to be a destabilizing factor in the region. In 2008, there were some 7.5 million refugees in the Arab region, the largest number (primarily Palestinians and Iraqis) being found in Jordan, Palestine and the Syrian Arab Republic. Internally displaced persons in the region, of whom there are some 9.8 million, primarily in Iraq, Lebanon, the Sudan, the Syrian Arab Republic and Yemen, are more widespread geographically than the refugees, but share many of the signs of insecurity common among refugees: loss of livelihood, status, family and sometimes life itself.[34]

The resources of conflict-affected countries have been heavily taxed and their human development indicators have plummeted. As shown in box 1, Iraq has recently passed through a destructive period of sanctions, invasion and conflict, which has not only taken its toll on human life, but has also compromised the human and infrastructural capacity of the country.

Box 1. The longstanding vulnerability of Iraq to conflict

Thirty years ago, Iraq ranked among the most developed countries in the Middle East. Today, after three decades of war, armed violence, invasion, insecurity, neglect of State functions, misallocation of public goods and a decade of economic sanctions, human development indicators have plummeted. Since the 2003 US-led military offensive against Iraq and the subsequent occupation and armed conflict, profound political and social divisions have arisen out of the ensuing political, security and institutional vacuum.

The result has been the destruction and neglect of infrastructure and the loss of human and institutional capacity throughout the economy, polity and society. Conflict has reinforced existing divisions, deeply traumatized the population and further reduced trust in the State.

A clear example of the impact of the conflict in Iraq is that life expectancy at birth today is 58 years (down from the average of 65 registered 30 years ago), 10 years less than the average for the region (67.5 years) and the world (68 years). When comparing its developmental progress with its neighbours, Iraq can be seen to have fallen behind, stagnated or progressed more slowly. For example, Iraq is the only country within the immediate region (the ESCWA member countries, Iran and Turkey) to show a decline in access to a source of safe drinking water between 1990 and 2006 (from 83 per cent to 77 per cent). Over the same period Iraq also fell below the regional access average for Western Asia (86 per cent in 1990 and 90 per cent in 2006), while its other neighbours kept pace with or exceeded this improving regional trend. The reported 2008 maternal mortality rate for Iraq is considerably higher than that of neighbouring countries (84 deaths per 100,000 live births compared with 41 and 65 in Jordan and the Syrian Arab Republic respectively) – a significant reversal for a country once renowned as a regional leader in medical service provision.

Source: Adapted from information from the United Nations Assistance Mission for Iraq at www.uniraq.org.

The impact of violence can also alter the demographics of families and communities. Such changes may affect the normal age and sex composition of the population, as well as family and household structure. An illustration of this was the return of large numbers of emigrants, predominantly men, to Yemen after the first Gulf War in the early 1990s, which not only reduced the ratio of female-headed households in the country, but also resulted in a decrease in female labour force participation.[35] These increases in male-

[33] UNFPA, 2008, p. 9.

[34] UNDP, 2009.

[35] Central Statistical Organization of Yemen, 1991.

headed households and female unemployment rates have contributed to further constraining the status of women in the country.

In situations of conflict and emergency, the reproductive health needs and rights of women are rarely given priority. Indeed, conflict breeds conditions which operate to discourage the allocation of resources for promoting public and reproductive health services, as greater emphasis is given to expanding curative and ambulant services, and as a result, maternal and child mortality and morbidity tend to escalate. Conflict leads troubled countries to deplete their meagre educational resources, lose opportunities to nurture skills for the next generation and reduce the speed of progress towards education-related MDG targets. This is exacerbated by the fact that persistent violence and insecurity in these countries tend to make parents less willing to send their children, particularly girls, to school.[36]

As conflict continues, households and communities tend to cluster into homogenous groups based on ethnicity, religion and political ideology, with sharp lines of demarcation between the various groups. In countries which experience longstanding conflict, north-south and east-west divisions may occur, and these may have political implications and identity crises, the latter especially common in women in cross-clan or cousin marriages.

Armed conflict is associated with the destruction of physical infrastructure, outflow of capital, unemployment and soaring inflation. The informal sector, which is the major employer of women, is likely to expand at the expense of the formal sector, which further restricts the chances of women obtaining secure, properly remunerated employment.

It has long been established that conflict, wherever and however it occurs, operates as a root cause of the disempowerment of women and girls, and for their exclusion from the stream of development. It is therefore essential that policymakers re-examine the means by which women can be integrated not only into the peace-building process, but also into subsequent reconstruction and rehabilitation policies and programmes. Any policies or programmes that fail to take into account the role played by women in safeguarding human life and nurturing the seeds of development, whether during or after conflict, will inevitably be compromised by their failure to capitalize on this immense source of knowledge and experience. In the absence of a proactive role for women, initiated and consistently visibly supported by policymakers, national efforts for achieving the MDGs and realizing gender equality targets by 2015 will be doomed to failure.

Another issue pertinent to this debate and one which has had an increasing impact in the ESCWA region in recent years, is that of the trafficking of women. In reviewing national progress reports on the implementation of CEDAW submitted by Member States, the CEDAW Committee has highlighted a number of challenges to the implementation of article 6 in certain Arab countries. Article 6 holds: “States Parties shall take all appropriate measures, including legislation, to suppress all forms of traffic in women and exploitation of prostitution of women” and implementation of the article requires both the enactment of domestic legislation specifically prohibiting the trafficking of women as defined by article 3 of the United Nations Protocol to Prevent, Suppress, and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime (2000), and the punishing of perpetrators of such acts.[37] It also requires States Parties to protect victims of trafficking and ensure their physical and psychological rehabilitation and social integration. A number of ESCWA member countries (Lebanon, Oman, Qatar and the Syrian Arab Republic) have ratified the Protocol in recent years and others (Bahrain, Jordan, Oman and the United Arab Emirates) have enacted legislation to combat the trafficking of women.[38] However, notwithstanding this welcome but limited progress, most ESCWA member countries still lack comprehensive strategies to combat the trafficking of women and address its root causes.

[36] ESCWA and League of Arab States, 2007.

[37] United Nations, 2000b.

[38] Ibid.

III. GENDER EQUALITY AND THE MILLENNIUM DEVELOPMENT GOALS: PROGRESS AND CHALLENGES

A. THE TRAJECTORY TO DATE

The trajectory of the MDGs gained further momentum when the 2005 World Summit (New York, 14-16 September 2005) reaffirmed the centrality of the Goals to the broader development agenda. Progress has also flowed from the introduction of new targets and indicators pertaining to universal access to reproductive health, and full and productive employment for all. The new targets were recognized by the Summit as having a strong synergy with not only health and socio-economic development outcomes, but also with the goal of gender equality and the empowerment of women.[39]

Promoting gender equality and the empowerment of women is clearly articulated in the Millennium Declaration and embedded accordingly in the MDGs, which were intended to constitute a global blueprint for guaranteeing the human rights of women, men, girls and boys in all spheres of life and to offer a fresh promise for progress on gender equality and the empowerment of women. In fact, it is a two-way process, as the implementation of such principles is critical to achieving the MDGs.[40]

The MDGs have gained widespread acceptance across the ESCWA region. National Governments, sometimes as a result of external pressure, have gradually adopted the Goals and their associated targets and indicators. At various regional and global forums over the last 10 years, policymakers from ESCWA member countries have voiced their commitment to facing up to the challenges of achieving the MDG targets by 2015.[41] However, progress has been variable at best. On the positive side, a number of MDG-related concepts have been clarified, indicators selected, data compiled, integrated planning and management tools examined, national capacity improved, and processes of democratization and good governance extended. Certain tangible intermediate targets (for example, relating to the education of girls) have been achieved and, in certain limited but noteworthy instances, income poverty has been reduced. Yet overall regional performance is heavily influenced by its most populous States and has not progressed at the pace that was anticipated at the start of the decade. It is arguable that, in large part, this poor performance is attributable to slow progress towards gender equality and the empowerment of women and the low priority given to gender mainstreaming in national development plans.

The remainder of this chapter will review both common and goal-specific status and progress, and explore the role of gender equality and the empowerment of women in the success of the MDGs.

B. ISSUES UNDERLYING MDG REPORTING AND MONITORING

An important facet of the MDGs is that they are time-bound and measurable, through numerical indicators of progress and an institutionalized system of reporting. Member countries have made tangible efforts to report and monitor the status and progress of the MDGs, including national surveys, censuses, administrative information and qualitative data, in addition to standard data collection and analysis.

From a policy and gender rights perspective, such efforts, while still limited, have resulted in an improvement in the empirical basis for gender-sensitive research, advocacy, policy drafting, monitoring and evaluation. Governments across the region have gradually become more active in this field, with technical support from regional and international development partners helping to improve the collection, analysis, utilization and dissemination of population and gender-related data, although such efforts need to be further

[39] Bernstein and Juul Hansen, 2006.

[40] UNIFEM, 2008.

[41] ESCWA, 2008, p. 12.

strengthened to address data gaps and to optimize the design, implementation, monitoring and evaluation of gender-responsive policies and programmes.

Irrespective of the benefits arising from country-specific compilations of MDG-related indicators and cross-country comparisons of progress towards the targets, however, a number of practical and methodological problems remain. Most of these are rooted in data-gathering methods, measurement techniques, non-availability of standardized definitions, ambiguity in the wording of indicators, identification of the unit of analysis (community, household or individual, for example) or the area of coverage (national, or major or minor administrative divisions, for example). These are a direct result of the weakness and fragmentation inherent in the information systems used, which in turn is a reflection of the ongoing underinvestment in this sector by national Governments.

With regard to poverty, the complexities of measurement, both within and across member countries, are well documented in recent research.[42] For instance, the internationally defined poverty line does not reflect the situation in the ESCWA region, where a number of countries are classified as high or high-middle income. Furthermore, most countries lack time-series data on poverty (whether measured in terms of income, ownership of assets or personal capability traits), a factor which impedes tracking of the poverty reduction goal. In addition, data on income poverty is seriously limited from a gender perspective as a result of the lack of sex-disaggregated income data.

A number of MDG indicators measure population-based outcomes (for example, adolescent fertility rate or life expectancy at birth), whose connections to access to reproductive health services and information are not always clear. Certain other indicators measure access to information (for example, knowledge of the means of transmission of HIV), but not its effect on behaviour. Others gauge the actual use of reproductive health products, practices or services (for example, contraceptive prevalence rate or births attended by skilled health personnel) without taking into account their effectiveness, while yet others measure the existence of health or education facilities in aggregate (for example, the number of health centres or schools per 5,000 inhabitants) without reference to their distribution.

Several aggregate programme-based indicators (for example, contraceptive prevalence rate, condom use, immunization coverage or primary school enrolment ratio) are inadequate for monitoring the MDGs at subnational levels. MDG-based development planning and programming requires both a small area and gender-specific data and indicators. For such indicators to be of real use, they need to be supplemented by process indicators (for example, to use data taken from household surveys on the percentage of the population using bed nets as an area-specific or population-specific indicator for malaria prevalence and mortality attributed to malaria).

A further level of complexity in the use of aggregate indicators relates to the relevance of the MDGs to the principles of human rights and equity that underpin community development. Achieving the MDGs at the national level is not the same as achieving the MDGs for all.[43] Disaggregated data is vital if the content and scope of the changes needed to increase efficiency and equity are to be addressed.

C. Analysis of the gender dimension of the MDGs

Gender equality implies that men and women should have equal opportunities to realize their individual potential, contribute to national economic and social development, and benefit from their participation in society. Distinct gender roles and responsibilities all too frequently restrict the resources and

[42] ESCWA, 2005.

[43] Gwatkin, 2005, pp. 813-817.

opportunities available to women in ways that constrict their basic human rights and threaten human development on a broader scale.[44]

However, the manner in which the MDGs, their targets and indicators are structured fails to reflect perspectives of gender equality and the empowerment of women. This deficiency has three facets. First, limiting MDG 3 to one education target and four associated indicators can be considered to be gender-blind, as it excludes other gender targets and indicators that gauge different dimensions of gender equality. Second, most MDGs have either inadequate or no gender-sensitive targets or indicators, which constitutes a further impediment to achieving the Goals. Third, the way in which the MDGs have been set out means that they appear to be stand-alone goals, blurring the multisectoral links between the various Goals, targets and indicators, including the cross-cutting gender link. For example, preoccupation with maternal health and gender disparities in education, without addressing their relationship to feminized poverty, gender bias in the economy, and gendered violence and ideologies, could thwart gender equality and limit the empowerment of women, thus jeopardizing the achievement of all the Goals.[45]

The following sections will provide a gender analysis of the status of and progress towards of each of the eight Goals, with a view to identifying the impact of determinants, including gender-blind data and policies, on the performance of ESCWA member countries towards achieving the Goals. It is hoped that this exercise will shed light on efforts in the region to design more effective gender-responsive and rights-based national policies and programmes which are tailored to fast-track countries towards the MDGs and which can be adopted by all member countries.

1. *Gender analysis of MDG 1: eradicate extreme poverty and hunger*

Goal 1 is customarily viewed as the core MDG to which all other goals and targets contribute, whether directly or indirectly. Yet at the same time, poverty establishes strong negative synergies with other goals and targets, particularly those relating to gender equality and the empowerment of women. It is widely recognized that poverty and hunger not only have a greater impact on women and girls; they are also among the principal contributory factors to gender inequality and the disempowerment of women.

For the Arab region, the recent series of United Nations Arab regional reports on the MDGs and the UNDP *Arab Human Development Report 2009*[46] have demonstrated that while poverty exists at lower levels in ESCWA member countries than in other developing regions, it remains highly concentrated in rural sectors, heavily populated countries and conflict-affected areas. At the family level, poverty is generally "feminized", which has serious repercussions not just for families, but for the wider community. It is notable that the prevalence of poverty and hunger appears to be resistant to purposeful change. Regardless of the method used for estimating poverty and whatever the poverty line selected, the region has made no real progress towards the poverty reduction goal in the last decade. The lack of pro-poor growth policies and gender-responsive and rights based development strategies is a major contributory factor.

The poverty situation is even more ominous when viewed through the prism of the MDG targets and indicators. Labour markets in the region are characterized by some of the highest unemployment rates in the world. The target of halving the proportion of people suffering from hunger is unlikely to be achieved by 2015 in most countries in the region. To reverse this trend requires the redoubling of efforts in several interrelated sectors, including food security, access to clean water, control of infectious diseases, economic productivity, transport, and the development of health systems and population-centred policies and strategies. This trend cannot be reversed without addressing a broad range of gender and human rights issues, both in relation to poverty and hunger in general, and to Goal 1 in particular. However, if gender and human rights are to be galvanized, national data on the targets and indicators for this goal need to be both gender-sensitive and rights-responsive.

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[44] UNDP, 2007, p. 57.

[45] UNIFEM, 2008.

[46] UNDP, 2009.

Box 2. Summary of the status and progress of MDG 1

The Arab countries are on track with respect to halving the proportion of people living below US$1.25-a-day. However, this is not the case when looking at the percentage of the population living below national poverty lines. Moreover, poverty in the Arab least developed countries (36 per cent) is nearly twice the average for the region. It is also noteworthy that the rate of poverty in the Arab Mashreq subregion (19 per cent) in the mid 2000s was more than double that in the Maghreb (7 per cent). At the subnational level, poverty in the Arab region is heavily concentrated in rural areas. The region lags behind all other regions in indicators of full, productive and decent employment, particularly for women and youth. Given the low employment to population ratios, it is not surprising that unemployment is a major development challenge in most Arab countries. There has been insufficient progress to meet the hunger target and serious concerns over the impact of the food crisis on food deprivation, particularly in the least developed countries. Furthermore, neither the region, nor any of the subregions, witnessed any reduction in the depth of hunger, which measures how far the food-deprived population lies below the minimum dietary intake. Despite the overall gloomy picture, however, past trends and future prospects for achieving Goal 1 vary remarkably within the region. Thus, rapid progress on employment and poverty in the Maghreb countries contrasts sharply with limited or no progress in the Mashreq subregion. In the least developed countries subregion, poverty and hunger are expected to have risen since 2005, as a result of rising food and fuel prices.

Source: Adapted from United Nations, 2010, *The Third Arab Report on the Millennium Development Goals 2010 and the Impact of the Global Economic Crises*.

Gender specialists claim that a major limitation of Goal 1 arises from its narrow focus on income/expenditure poverty and hunger; a factor that negates the multidimensional nature of poverty. From a gender and human rights perspective, poverty is the failure to realize and utilize a range of basic capabilities, including the capabilities to avert risks of morbidity and mortality, obtain equitable access to justice, attain self-autonomy, and own land and other property, the realization of which should reinforce progress towards combating poverty.

The significance of personal security in relation to the effective engagement of women in remunerated economic activities, augmentation of productivity, growth of income, participation in household budgetary allocation and distribution, and in exercising their civic rights was highlighted in the 2009 *Arab Human Development Report*.

Beyond the limitations of income/expenditure poverty, most of the targets and indicators of Goal 1 are not disaggregated by gender. Yet it is clear from outcome indicators of poverty such as illiteracy, poor nutrition and health, that larger numbers of women than men are poor. It is therefore vital that Governments revisit the content and scope of their national statistical databases with a view to enabling the disaggregation of the global poverty indicator (proportion of population below US$1 [PPP][47] per day) by sex or other socio-economic category in order to ensure that the extent of the gender gap in poverty-related outcomes is brought to the fore. Supplementing global poverty indicators with qualitative data would also make the analysis more "gender friendly" and may reveal the hidden forces that push women into poverty traps.

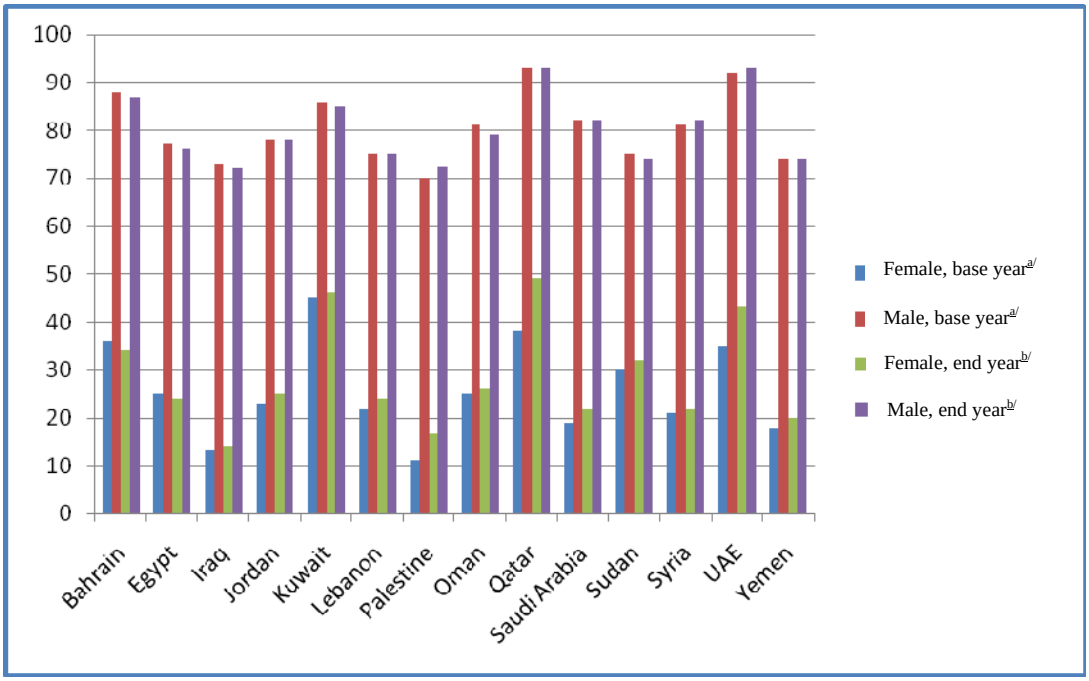
Governments in ESCWA member countries continue to pay lip service to the role of women in development, and to recognize the equal rights and entitlements of women as set out in national constitutions and enshrined in globally-adopted blueprints. Yet there is a sharp contrast between the acknowledged role of women in the economic and political spheres as set out in national constitutional and policy documents and the paltry percentage of women actually involved in such activities.[48] There is clear gender disparity in employment opportunities and political participation across the region, which occupies the penultimate rank

[47] Purchasing power parity (PPP) is a theory that uses the long-term equilibrium exchange rate of two currencies to equalize their purchasing power.

[48] UNDP, 2009.

on the United Nations Development Programme's Gender Empowerment Measure,[49] a means of evaluating progress in advancing the standing of women in political and economic forums. Not only are the female economic participation rates the lowest of all the developing regions, they are conspicuously lower than those of their male counterparts in each of the countries in figure I. The male to female differentials are more prominent in countries such as Iraq, Palestine, Saudi Arabia, the Syrian Arab Republic and Yemen than in the other countries featured and gender disparities of such proportions imply low family income, diminution of gross domestic product and widespread poverty.

Figure I. Labour force participation rate, by gender



Note: Primary source of data: World Bank Databank, supplemented by information provided by member countries following the expert group meeting on Progress in Achievement of the MDGs in the ESCWA region - A Gender Lens (Beirut, 25-26 January 2011).

a/ Closest available year to 2000.
b/ Closest available year to 2010.

The root causes of such low levels of female economic participation, as well as similar levels of participation in the social and political spheres, are many and complex. Some originate from macroeconomic policies; others stem from local cultural traditions; some grow out of geopolitical ideologies, social and institutional systems and norms; yet others are rooted in flawed statistical systems. An improved understanding of the factors underlying the levels and patterns of female labour force participation would optimize the effectiveness of national poverty reduction strategies for gender equality and the empowerment of women. The remainder of this section will therefore examine four of the principal mechanisms by which these root causes influence the economic activity of women.

First, the conventional macroeconomic approach adopted in the region in recent decades, heralding economic liberalization and free trade, has arguably retarded the development of pro-poor policies in ESCWA member countries. Such policies hold duty bearers, including Governments, NGOs and other development partners, accountable for the entitlements of rights holders, which include women's groups,

[49] De Jong and Shepard, 2006, pp. 67-90.

young people and community leaders. Duty bearers are under an obligation to provide non-discriminatory supportive acts, processes and services and to secure equal opportunities, so that both men and women become effective agents of change and equal beneficiaries of national development outcomes. Activating pro-poor policies, as opposed to gender-blind conventional economics, effectively drives the process of involving men and women, each according to their individual needs and capabilities, in national socio-economic development and in combating poverty and hunger. One of the mechanisms through which women can exercise their full potential in national development activities is through recognition by the authorities of their role in the unpaid care economy, in which they undertake the vast majority of the work. However, poverty reduction strategies rarely target them and their work remains predominantly undocumented in national labour force statistics.

In general, labour statistical systems reveal neither the economic, nor the social roles of women in the community. Across the ESCWA region, as in other developing regions, data collection procedures traditionally exclude a substantial proportion of women who are actively engaged within the family or informal sectors in the production of commodities and services that add a real – but not officially counted – value to the national gross domestic product. In such sectors, women frequently spend much of their working day producing or assisting in the production of goods and services that are indispensable for combating hunger and reducing poverty at both familial and societal levels. It is therefore vital that statistical reform processes in member countries should continue to address the negative consequences of data limitations on the work of women in rural and local communities, across formal and informal sectors, and within the home. Time use surveys and the adoption of the time use statistical approach in general should be encouraged, with a view to improving the accuracy and utility of gender-responsive employment and poverty data. Since it is difficult to disaggregate the most widely-used indicators of income poverty by sex, adopting a time use approach would complete many of the data gaps which currently pose a challenge to the gender analysis of a number of the MDGs.

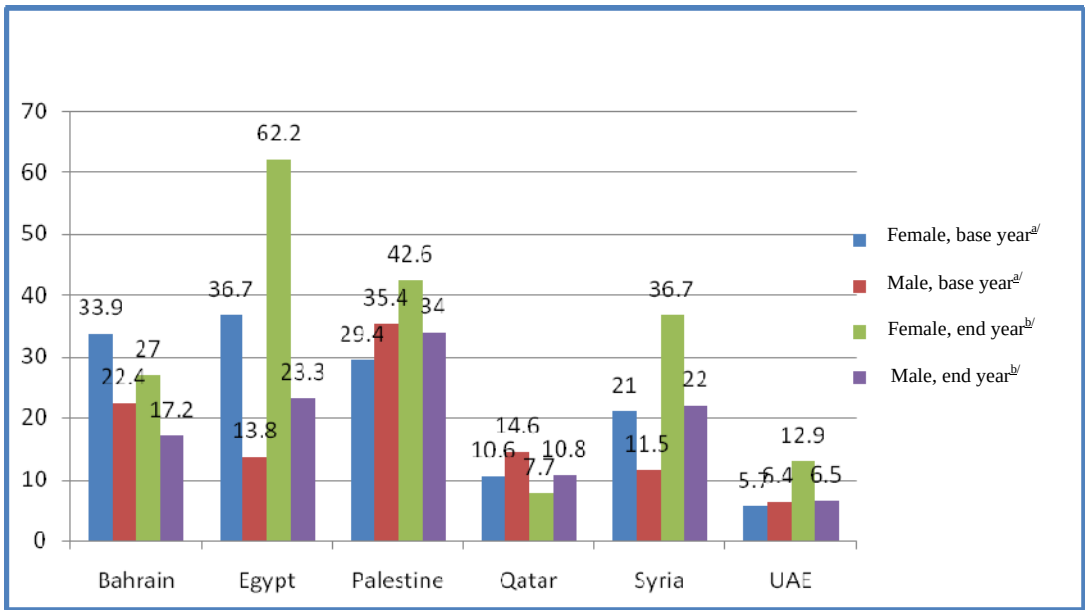
Second, the tendency of women in the region to join the labour force outside the home, especially in the more modern sectors, is greatly constrained by traditional gender norms, in which the roles of women are largely confined to childbearing and child-rearing. Such traditional roles, particularly in urban areas where the presence of the extended family is diminishing, operate to hinder the employability of women and girls and to place pressure on them to withdraw from the labour force. As has already been noted, female unemployment across the region is in great part shaped by the attitudes of the more conservative-minded in society towards the physical mobility of women, particularly the unmarried, which in turn restricts employment opportunities for women and girls.

Figure II and table 2 demonstrate that unemployment rates for young women are not only high across the ESCWA region, but in all countries for which data are available, and the trend is rising. While this phenomenon cannot be attributed solely to traditional gender norms, it is undeniable that they act as strong explanatory variables for the trend. To a significant extent, female unemployment rates are determined by the State and market conditions on the one hand, and the personal demographic and socio-cultural attributes and positions of family members and relatives on the other hand.

Another issue pertinent to the question of gendered poverty analysis is that of the value assigned to the work of women by their own communities. Although Arab women who work are increasingly well-educated and qualified for various types of employment, their work is typically assigned a lower value than that of men. Women who have the same qualifications, experience and job responsibilities as men are often paid substantially less, in great part because men are still viewed as the breadwinners.[50] There is a negative correlation between the gender pay gap and female participation in the workplace. While the involvement of women in the labour force has increased in all countries in the region since 1990, the educational choices of girls and young women all too frequently limit their access to certain types of employment, further entrenching wage differentials.

[50] World Bank, 2004.

Figure II. Youth unemployment rates, selected ESCWA member countries



Note: Primary source of data: United Nations Statistics Division and national MDG reports, supplemented by information provided by member countries following the expert group meeting on Progress in Achievement of the MDGs in the ESCWA region - A Gender Lens (Beirut, 25-26 January 2011).

a/ Closest available year to 2000.
b/ Closest available year to 2010.

Women living and working in rural agricultural areas perform a crucial function in both the family and the national economy, yet they generally have less control over decision-making, household revenue and family property than women in urban areas. Indeed, across the region, women – the old and widowed, the poor, young and unmarried – carry out most of the agricultural work on family-owned land and in subsistence farming. As table 2 shows, the most recent data demonstrates that 43 per cent of employees in the agricultural sector in Egypt are women, compared with 28 per cent for men; in Palestine, the figures are 35 per cent for women and 11 per cent for men; and in the Syrian Arab Republic, the figures stand at 49 per cent for women and 23 per cent for men. Similar differentials in agricultural sector employment can also be seen in other countries in the region, including Iraq, the Sudan and Yemen.

TABLE 2a. MDG 1 GENDER-RELATED INDICATORS, ESCWA REGION

	Employment-to-population ratio, women (*percentage*)		Employment-to-population ratio, men (*percentage*)		Employment-to-population ratio, women aged 15-24 (*percentage*)[a/]		Employment-to-population ratio, men aged 15-24 (*percentage*)[a/]	
Country	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010
Bahrain	30.4	30.2	82.4	81.2	17	17.6	43.8	41.3
Egypt	16.6	18.2	68.2	66.9	10.8	13.3	36.5	32.6
Iraq	10.2	12.4	59.8	62.1	6.3	6.7	42.4	39
Jordan	11.1	13	62.6	63.2	6.9	7.1	36.6	31.9
Kuwait	42.3	42	83	79.8	24.1	23.4	38	35.9
Lebanon	21.4	22.3	72.5	71.4	11.5	12.1	47.8	44.9
Palestine	9.3	11.3	57.5	52.2	4.5	4.5	37.2	25.5
Oman	20.4	22.6	73.8	71.2	17.3	18.3	41	39.3

TABLE 2a (*continued*)

Country	Employment-to-population ratio, women (*percentage*)		Employment-to-population ratio, men (*percentage*)		Employment-to-population ratio, women aged 15-24 (*percentage*)[a/]		Employment-to-population ratio, men aged 15-24 (*percentage*)[a/]	
	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010
Qatar	33.4	39.6	87.7	90.7	7.2	18.5	43.5	55.8
Saudi Arabia	15.6[b/]	17.7[c/]	76.3[d/]	76.1[e/]	6.8[f/]	7.6[g/]	44.3[h/]	41.5[i/]
The Sudan	26.1	27.9	68.4	66.7	19.8	18.2	33.4	28.5
Syrian Arab Republic	17.5	16.7	78.8	72.7	16.8	14.8	60.9	49.2
United Arab Emirates	33.2	37.3	90.2	90.2	22.3	24.9	60.5	61.2
Yemen	17.2	20.3	59.1	57.5	13.4	16.1	29.3	27.4

Sources of data: United Nations Statistics Division and national MDG reports.

a/ *Source*: World Bank Databank.
b/ 14.4 per cent (date closest to 2000). *Source*: Ministry of Economy and Planning, Saudi Arabia.
c/ 14.6 per cent (date closest to 2009). *Source*: ibid.
d/ 72.4 per cent (date closest to 2000). *Source*: ibid.
e/ 71.5 per cent (date closest to 2009). *Source*: ibid.
f/ 5.2 per cent (date closest to 2000). *Source*: ibid.
g/ 2.9 per cent (date closest to 2009). *Source*: ibid.
h/ 22.4 per cent (date closest to 2000). *Source*: ibid.
i/ 19.0 per cent (date closest to 2009). *Source*: ibid.

TABLE 2b. MDG 1 GENDER-RELATED INDICATORS, ESCWA REGION

Country	Female youth (aged 15-24) unemployment rate		Male youth (aged 15-24) unemployment rate		Female agricultural employees (*percentage of total female employment*)[a/]		Male agricultural employees (*percentage of total male employment*)[a/]	
	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010
Bahrain	33.9	27	22.4	17.2	0	0	3	2
Egypt	36.7	62.2	13.8	23.3	39	43	27	28
Iraq	..	..	..	..	..	33	..	14
Jordan	..	..	..	..	4	2	5	4
Kuwait	..	..	..	..	..	..	..	..
Lebanon	..	..	..	..	..	1.4[b/]	..	5.6[b/]
Palestine	29.4	42.6	35.4	34	34.6	36	9.8	10.8
Oman	..	..	..	..	5	..	7	..
Qatar	10.6	7.7	14.6	10.8	0	0	4	4
Saudi Arabia	..[c/]	..[d/]	..[e/]	..[f/]	2[g/]	0[h/]	7[i/]	5[j/]
The Sudan	..	..	..	..	..	..	..	..
Syrian Arab Republic	21	36.7	11.5	22	62	49	26	23
United Arab Emirates	5.7	12.9	6.4	6.5	0	0	9	6
Yemen	9.8	..	20.2	..	88	..	43	..

Sources of data: United Nations Statistics Division and national MDG reports.

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

a/ *Source*: World Bank Databank.
b/ *Source*: MDG report, Lebanon.
c/ 32.6 per cent (date closest to 2000). *Source*: Ministry of Economy and Planning, Saudi Arabia.
d/ 54.8 per cent (date closest to 2009). *Source*: ibid.
e/ 23.0 per cent (date closest to 2000). *Source*: ibid.
f/ 23.5 per cent (date closest to 2009). *Source*: ibid.
g/ 2.3 per cent per cent (date closest to 2000). *Source*: ibid.
h/ 0.2 per cent (date closest to 2009). *Source*: ibid.
i/ 6.7 per cent (date closest to 2000). *Source*: ibid.
j/ 4.7 per cent (date closest to 2009). *Source*: ibid.

TABLE 2c. MDG 1 GENDER-RELATED INDICATORS, ESCWA REGION

Country	Labour force participation rate, female (*percentage of total female population aged 15-64*)[a/]		Labour force participation rate, male (*percentage of total male population aged 15-64*)[a/]		Labour force, female (*percentage of total labour force*)[a/]	
	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010
Bahrain	36	34	88	87	21	20
Egypt	25	24	77	76	24	24
Iraq	13	14	73	72	15	16
Jordan	23	25	78	78	21	23
Kuwait	45	46	86	85	23	24
Lebanon	22	24	75	75	23	25
Palestine	11.1	16.7	70	72.4	13.2	18
Oman	25	26	81	79	15	18
Qatar	38	49	93	93	15	12
Saudi Arabia	19[b/]	22[c/]	82[d/]	82[e/]	14[f/]	16[g/]
The Sudan	30	32	75	74	28	30
Syrian Arab Republic	21	22	81	82	20	21
United Arab Emirates	35	43	92	93	12	15
Yemen	18	20	74	74	19	21

a/ *Source*: World Bank Databank.
b/ 16.7 per cent (date closest to 2000). *Source*: Ministry of Economy and Planning, Saudi Arabia.
c/ 18.2 per cent (date closest to 2009). *Source*: ibid.
d/ 76.5 per cent (date closest to 2000). *Source*: ibid.
e/ 76.0 per cent (date closest to 2009). *Source*: ibid.
f/ 14.2 per cent (date closest to 2000). *Source*: ibid.
g/ 14.9 per cent (date closest to 2009). *Source*: ibid.

Third, an additional factor limiting the status of women in the ESCWA region and impeding the progress of gender equality stems from the nature and intensity of social institutions, mirrored by societal practices and legal norms, which result in gender inequality. The Organisation for Economic Co-operation and Development (OECD) and the University of Göttingen recently developed a composite measure, the Social Institutions and Gender Index (SIGI), for capturing the gender inequality and discrimination imposed by such practices and norms.[51]

Box 3. SIGI indicators of gender inequality

- Family code, measuring factors which influence the decision-making of women in a household with respect to early marriage, polygamy, parental authority and inheritance;
- Civil liberties, measuring freedom of social participation for women through freedom of movement and freedom of dress;
- Physical integrity, comprising different indicators on violence against women and the existence of female genital mutilation;
- Son preference, reflecting the economic valuation of women, based on the "missing women" variable, which measures gender bias in mortality resulting from sex-selective abortions or insufficient care given to baby girls;
- Ownership rights and de facto access to different types of property, including three variables: the access of women to land, property and credit.

Source: Adapted from OECD, 2010, *Atlas of Gender and Development: How Social Norms Affect Gender Equality in Non-OECD Countries.*

[51] OECD, 2010.

The SIGI is based on five sub-indices, ranging from a value of 0 when there is no or very low discrimination to 1 when there are high levels of inequality. The SIGI and sub-indices scores for ESCWA member countries are set out in table 3.

Gender discrimination in social institutions is clearly alarmingly high across the ESCWA region, with all the SIGI-ranked countries in the high discrimination zone. Discrimination is particularly evident in the civil liberties, family code and physical integrity indicators.

TABLE 3. SOCIAL INSTITUTIONS AND GENDER INDEX, ESCWA REGION

Country	SIGI	Family code	Civil liberties	Physical integrity	Son preference	Ownership rights
Bahrain	19.6	32.1	59.8	38.6	50	34.8
Egypt	21.7	26.6	30.0	82.2	50	0
Iraq	27.5	47.3	59.8	51.9	50	52.2
Jordan	..	51.7	59.8	..	50	52.2
Kuwait	18.6	50.5	59.8	25.7	50	0
Lebanon	..	..	59.8	38.6	0	17.3
Palestine	..	48.6	59.8	..	0	34.8
Oman	..	45.3	29.8	..	50	34.8
Qatar	..	..	..	..	..	..
Saudi Arabia	..	45.3	92.4	..	50	52.2
The Sudan	67.7	67.9	74.0	82.2	50	..
Syrian Arab Republic	13.8	40.2	30.0	25.7	50	34.8
United Arab Emirates	26.5	56.1	59.8	53.1	50	34.8
Yemen	32.7	59.4	78.0	38.6	50	52.2

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

It is arguable that the performance of a country on MDG 1 is, to a significant extent, influenced by the implications of the high SIGI values on the economic roles of women. Measuring the magnitude and direction of the relationship between SIGI values on the one hand and the targets and indicators of MDG 1 on the other hand would assist in identifying the underlying social institution-related causes influencing those targets and indicators. The Pearson's correlation coefficients of the Family Code Index (FCI) with data on moderately or severely undernourished children aged under five is -0.67 for ESCWA member countries and -0.69 for Member States of the League of Arab States, while the coefficient for the female labour force in non-agricultural employment is -0.55 for Member States of the League of Arab States.[52]

TABLE 4. MDG 1 INDICATORS, ESCWA REGION
(*Percentage*)

	Children under five moderately or severely underweight		Population undernourished		Population below US$1 (PPP) per day		Share of poorest quintile in national income or consumption		Proportion of own-account and contributing family workers in total employment, both sexes	
Country	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010
Bahrain	8.7[a/]	4.2[b/]	..	..	..	..	..	..	..	..
Egypt	4	7.5	5	5	2	2	9	9	22.9	24.8
Iraq	15.9	7.6	..	..	..	..	..	..	..	..
Jordan	5.1	4.4	5	5	2	2	7.5	7.2	..	..
Kuwait	9.8	..	5	5	0	0	8.45	8.5	..	..
Lebanon	3	3.9	5	5	..	..	..	..	..	..

[52] Data on undernourishment of children aged under five are reported in table 4.

TABLE 4 (*continued*)

Country	Children under five moderately or severely underweight		Population undernourished		Population below US$1 (PPP) per day		Share of poorest quintile in national income or consumption		Proportion of own-account and contributing family workers in total employment, both sexes	
	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010
Palestine	2.5	2.9	8	15	7	17.1	7.3	7.2	29.2	36.2
Oman	17.8	..	..	..	..	..	..	..	..	..
Qatar	6	..	..	..	..	..	..	..	0.7	0.4
Saudi Arabia	5.1	5.7	2.6	2.2	..	..	..	..	..	..
The Sudan	40.7	31	24	21	..	..	..	..	..	..
Syrian Arab Republic	6.9	9.7	5	5		..	..	..	..	42.4
United Arab Emirates	14.4	..	5	5	..	..	..	..	..	..
Yemen	46.1	45.6	31[c/]	32	12.9	17.5	7.4	7.2	31.3	..

Source of data: United Nations Statistics Division and national MDG reports.

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

a/ 2006 figure: 4.2. *Source*: 2009 Health Statistics, Bahrain Ministry of Health.
b/ 2009 figure: 7.6. *Source*: ibid.
c/ 34 per cent. *Source*: National Committee of Women, Republic of Yemen.

Another strong correlation coefficient can also be observed between the ownership rights of women to land, properties other than land and credit on the one hand and the children under age 5 moderately or severely undernourished on the other hand (+0.52 for ESCWA member countries and +0.49 for League of Arab States Member States). The two key elements of poverty reduction – reducing hunger and increasing the share of women in non-agricultural employment – are thus, in large part, determined by family code, female age at first marriage, polygamy, parental authority, the suppression of women's rights and inheritance. Any gender analysis of poverty or poverty eradication strategy must therefore take into account such considerations if it is to be truly effective.

Fourth, women and girls in conflict, post-conflict and other situations of crisis, particularly refugees and internally displaced persons, are among the most vulnerable groups, experiencing some of the highest levels of poverty and hunger. All too often, they become direct targets for gender-based violence, not only from males within their own communities, but also from men in opposing groups. Yet women and girls can be instrumental in reducing hunger and the impact of poverty on families and communities in crisis and conflict through their role as caregivers to the young, the elderly and persons with disabilities. Failure to address female poverty through gender-responsive approaches in such situations will make it even more difficult to achieve MDG 1.

In conclusion, the following recommendations should be taken into account in tailoring national poverty reduction strategies to the needs of women and girls, particularly those in minority and disadvantaged groups:

(a) Macroeconomic policies must be pro-poor, gender-sensitive and rights-based to avoid the negative impact which many conventional neo-classical economic policies have had on the poor, particularly women and girls;

(b) The use of time use statistics should be considered, along with other proven approaches, to improve the gender-responsiveness of poverty indicators;

(c) Qualitative data collection approaches should be adopted to complement quantitative data on poverty;

(d) Better access to transport and the wider use of time-saving devices for housework, especially in rural areas, should be promoted in order to liberate more time for women to undertake other activities that can contribute to household income and poverty reduction;

(e) The access of women to paid employment should be promoted through both the supply and demand sides of economic activities. In particular, traditional cultural barriers making it difficult or impossible for women to join the labour force and remain in it should be reduced;

(f) The access of women to land, property, credit and other resources should be reconsidered with a view to increasing individual productivity and income;

(g) Female empowerment should be viewed as an effective strategy for gender equality and poverty reduction, and harnessed accordingly;

(h) Activities towards the elimination of gender discrimination in social institutions, a common problem across the region, should be increased;

(i) Particular attention should be paid to the rights and needs of women and girls in situations of conflict and crisis.

2. *Gender Analysis of MDG 2: achieve universal primary education*

With less than five years to go before the target date for achieving the MDGs, tremendous efforts are still required if the countries of the ESCWA region are to achieve the goal of universal primary education by ensuring that children everywhere, boys and girls alike, are able to complete a full course of primary schooling (target 2.A). Achieving this goal is essential, not only as a fundamental basis for the social and economic development of a nation and its peoples, but – equally importantly – as a basic right for all children and a pivotal factor in empowering girls and women at the social, economic and political levels.

On the positive side, countries in the ESCWA and Arab regions, whether rich or poor, have made substantial progress in primary education and literacy in recent decades. Indeed, since 1975 the share of gross domestic product spent on education has been higher in the Arab world than in other developing regions.[53] According to this source, expenditure on education has averaged some 5 per cent, compared with 2-3 per cent in other developing countries. Concurrently, the average length of schooling has increased significantly across the region and disparities (both between countries and between girls and boys) have narrowed, though they persist and remain considerable.[54] Between 1999 and 2007, the average primary net school enrolment ratio for the region increased from 78 per cent to 84 per cent, and the absolute gross number enrolled reached some 41 million children (a period increment of some 5.1 million). Moreover, youth illiteracy rates in the region have declined to less than half those for adults.[55]

However, many serious challenges remain, posing obstacles to national and regional efforts to achieving MDG 2 by the target date. The nature and gravity of those challenges varies, depending on the level of economic development in individual countries, between urban and rural sectors, between socio-economic groups and between the sexes within those socio-economic groups. As has frequently been reported, poor families in the region, especially in rural areas and vulnerable groups, are often faced with

[53] United Nations, 2007c, pp. 120-125.

[54] Barro and Lee, 2000.

[55] United Nations Educational, Scientific and Cultural Organization (UNESCO), 2010.

difficult choices about how to allocate their scarce resources for their children's education.[56] Such decisions, based largely on the extent to which communities value the education of girls, are invariably more inclined to concentrate educational expenditure on boys, on the assumption that boys are more likely to "repay" the investment by becoming breadwinners for the family.[57] Regrettably, the impressive increase in primary school enrolment noted above is all too often followed by relatively low secondary enrolment rates, particularly in least developed countries. This is attributable to a number of factors, not the least of which are the levels of poverty experienced by many communities across the region.[58] Yet irrespective of income levels or the stage of socio-economic development in a country, the negative influence on the education of girls and young women is consistently greater on girls and young women than on boys and young men.

TABLE 5a. MDG 2 GENDER-RELATED INDICATORS, ESCWA REGION

	Total net enrolment ratio in primary education		Total net enrolment ratio in primary education, girls		Total net enrolment ratio in primary education, boys		Pupils starting grade 1 who reach last grade of primary, all (*percentage*)		Pupils starting grade 1 who reach last grade of primary, girls (*percentage*)		Pupils starting grade 1 who reach last grade of primary, boys (*percentage*)	
Country	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010
Bahrain	98	99.4	99.8	99.6	96.3	99.3	94.9	98.7	94.2	97.4	95.7	100
Egypt	96.8	97.6	93.8	95.3	99.8	99.8	99	96.8	99.2	96	98.8	94
Iraq	83.3	88.6	76.5	81.8	89.8	95.2	49.4	70.1	47.2	61.1	51.3	78.3
Jordan	95.9	92.9	96.4	93.7	95.5	92.1	96.9	99.1	96.8	95.1	97	95.6
Kuwait	88.4	94.1	89.4	93	87.5	95.1	94.8	99.5	94.5	99.1	95.1	100
Lebanon	89	83.7	88.6	83.4	89.4	84.1	96.9	89.2	98.8	92.7	95.2	85.9
Palestine	99.1	77.4	99.1	77.6	99.2	77.1	98.5	98.7	100	98.5	97.1	98.8
Oman	82.9	75	83.4	75.9	82.5	74.2	94.5	97.6	95.3	98.2	93.8	97.1
Qatar	97	98.3	96.8	98.7	97.2	98	88	96.75[d/]	88.6	100[d/]	89	93.6[d/]
Saudi Arabia	81.1	84.9[a/]	79.7	84.3[b/]	82	85[c/]	91	95.9	..	92.86[a/]	..	100[d/]
The Sudan	44	..	39.8	..	47.9	..	77.1	62.1	81.5	60.3	73.6	63.7
Syrian Arab Republic	98.7	98	98.5	97.9	98.9	98.1	88.7	95.2	89.1	95.7	88.4	94.7
United Arab Emirates	80.7	98.3	79.8	97.9	81.4	98.6	96.9	100	97.3	100	96.6	100
Yemen	58.6	75.4	46.4	65	70.2	85.4[e/]	80.4	59.5	64	56.8	72.1	61.2

Sources of data: United Nations Statistics Division and national MDG reports.

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

a/ 86.32 per cent (date closest to 2009). *Source*: Ministry of Economy and Planning, Saudi Arabia.
b/ 84.99 per cent (date closest to 2009). *Source*: ibid.
c/ 87.65 per cent (date closest to 2009). *Source*: ibid.
d/ *Source*: World Bank Databank.
e/ 97 per cent. *Source*: Republic of Yemen, *Fourth National Plan 2011-2015*.

[56] ESCWA and League of Arab States, 2009.

[57] Ibid.

[58] United Nations, 2010.

TABLE 5b. MDG 2 GENDER-RELATED INDICATORS, ESCWA REGION

Country	Literacy rates, both sexes, 15-24 years (*percentage*)		Literacy rates, women, 15-24 years (*percentage*)		Literacy rates, men, 15-24 years (*percentage*)		Primary completion rate, girls		Primary completion rate, boys	
	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010
Bahrain	97	99.8	97.3	99.8	96.8	99.8	100.4	117	95.7	116.6
Egypt	73.2	84.9	76.4	81.8	83.2	87.9	94.4	95.9	101.8	100.9
Iraq	84.8	..	80.5	..	88.9	..	47	63.5	58	86
Jordan	98.8	99	98.9	99	99.3	98.9	97.9	102.5	96.7	101.1
Kuwait	99.65	98.4	90.2	98.5	93.8	98.4	97.3	98.4	94	97.9
Lebanon	97.5	98.7	..	99.1	..	98.4	91.7	83.3	90.5	79.8
Palestine	98.4	99	97.8	98.9	99	99.1	103.6	82.8	102.4	82.8
Oman	97.3	98.4	96.7	97.9	97.9	98.8	80.6	88	82.2	88.3
Qatar	94.8	99.1	95.8	99	94.1	99.1	89.4	102.5	89.2	104.9
Saudi Arabia	95.9	96.8	93.7	95.9	98.1	98.1	87.2	90.8	90.1	95.9
Sudan	77.2	..	71.4	..	84.6	..	35.5	46.2	39.4	53.6
Syrian Arab Republic	94.8	93.7	92.5	92	97.1	95.4	83	113.1	89.4	115.5
United Arab Emirates	..	97.7	..	96.5	..	98.6	80	106.4	80.3	103.4
Yemen	75.2	80.4	58.9	66.8	90.7	93.4	36.2	46.2	73.5	73.9

Sources of data: United Nations Statistics Division and national MDG reports.

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

TABLE 5c. MDG 2 GENDER-RELATED INDICATORS, ESCWA REGION

County	Literacy rate, adult female (aged 15 and above)[a/] (*percentage*)		Literacy rate, adult male (aged 15 and above)[a/] (*percentage*)		Female teachers, primary education[a/] (*percentage*)		Female teachers, secondary education[a/] (*percentage*)		Female teachers, tertiary education (*percentage*)	
	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010
Bahrain	84	89	89	92	72	76	52	54	36[b/]	41
Egypt	44	58	67	75	52	56	40	42	..	..
Iraq	64	69	84	86	72	72	69	58	30[b/]	35
Jordan	85	89	95	95	64	64	56	58	15[b/]	23
Kuwait	74	93	81	95	74	89	55	53	27[b/]	27
Lebanon	..	86	..	93	85	86	54	55	27[b/]	37[b/]
Palestine	79.7	90.9	92.2	97.1	58.7	66.6	49.7	48.6	14[b/]	17
Oman	74	81	87	90	54	64	50	57	29[b/]	30
Qatar	81	90	84	94	75	85	57	56	32[b/]	37
Saudi Arabia	69	80	87	90	52	51	53	53	35[b/]	33
Sudan	52	60	71	79	52	61	49	55	23	..
Syrian Arab Republic	74	77	91	90	68	66	51	60	..	..
United Arab Emirates	..	91	..	89	73	85	55	55	27[b/]	31
Yemen	35	43	74	79	20	..	19	21	..	16

Sources of data: United Nations Statistics Division and national MDG reports.

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

a/ *Source*: World Bank Databank.
b/ *Source*: UNESCO_UIS Database, Sept 2007.

Decades of conflict, political instability and war have not only halted progress towards universal primary education in certain ESCWA member countries, but have acted to reverse it. Research has shown that a number of countries in the region, including Lebanon, Oman and Palestine, have shown regressive tendencies with respect to net enrolment ratios.[59] As shown in table 5, this effect has been greatest in conflict-affected countries, which exhibit clear gender differentials for the percentage of enrolled students reaching the last grade of primary school. Furthermore, a distinct pattern of gender gaps in literacy among both adults and young people aged 15-24 in almost all ESCWA member countries emerges from table 5. With the sole exception of the United Arab Emirates, all country-specific male adult literacy rates are higher, albeit with low margins, than those of female adults. More conspicuously, however, male youth literacy rates are higher, and with greater margins, than those of female youth. The wider gender literacy gap in the younger generation compared with that of adults calls for a detailed assessment of the underlying causes, with a view to tailoring educational and training strategies to comply with national commitments to gender-responsive policies and planning. This empirical observation is also substantiated, though analysed differently, by other sources. As has been reported by UNESCO,[60] gender disparities in education exist across the region, with illiteracy rates for young women twice as high as those for young men. The youth gender gap in literacy almost matches that of adults in most ESCWA countries, suggesting that patterns of illiteracy are extending across generations.

The table also reveals an imbalance between male and female teachers, especially at primary and tertiary levels. The country-specific percentages of female teachers in tertiary education are extremely low; in contrast, they are extremely high in primary education. As is widely accepted, children need role models of both sexes and it is thus important that education systems establish a good mix of female and male teachers at all levels. The figures in table 5 show a distribution ratio of male to female teachers well beyond what could possibly be considered to be a reasonable range. This skewed balance between male and female teachers in almost all countries of the region, accompanied by a preponderance of male head teachers, is likely to have negative implications for gender equity between teachers and, arguably, on the quality of teacher-pupil interaction.

Many academics and researchers have argued that the quality of education in the region has not improved with the passing of years and it is undeniable that there is a severe mismatch between labour market demands and the skills imparted by the education system. A particularly worrying indicator in this regard is that unemployment tends to be higher among graduates of secondary and tertiary education than among those who are illiterate or who have only completed primary education. Of even greater concern is the fact that this anomaly appears to be more prevalent among young women.[61]

The low quality outcome of education systems in the ESCWA region may be attributed to a number of factors. The home and school environments in which children are brought up are often based on neo-patriarchal attitudes, and this is compounded by a lack of modern didactic methods, which in turn discourages creativity and the development of problem-solving abilities. Low salaries for teachers, scant opportunities for professional development, lack of adequate facilities, overcrowded classrooms, outdated curricula and a range of other factors continue to act as barriers to improving educational standards across the region.

The factors responsible for low educational quality also affect the motivation of girls to start school and to continue their studies. Poorly performing schools and those which do not operate in accordance with acceptable norms and standards are unlikely to attract girls or to keep them productive in their studies. An absence of encouraging and creative methods of teaching, a lack of modern, relevant educational content, and less than optimal teacher-pupil relations constitute serious barriers to the academic progress of girls.

[59] United Nations, 2010.

[60] UNESCO, 2010.

[61] ESCWA, 2009a.

Such issues clearly limit the ability of education systems to contribute positively and powerfully to gender equality and the empowerment of women. For real progress to be made in the education of girls, there is a need for strong advocacy action, targeting both parents and the wider community. All too often, cultural norms and traditions operate not only at home, but throughout society to create, whether directly or indirectly, obstructive mechanisms that keep girls from schooling. These include female genital mutilation, early or forced marriage, limited physical mobility of girls unless escorted by a male relative (even, in certain areas, to school), greater importance being attached to the education of boys, and the imposition of traditional views regarding the role and rights of women by teachers or other pupils. It is increasingly clear that unless the cultural barriers that prevail across the ESCWA region and operate to undermine the education of girls can be overcome, the achievement of universal primary education by 2015 will, quite simply, not be possible.

A clear relationship can be observed between social institutions and development outcomes (SIGI) in ESCWA member countries (see table 3) on the one hand and certain educational outcomes on the other hand. As is explained in greater detail below, the Family Code Index (FCI). Civil Liberties Index (CLI), Physical Integrity Index (PII) and Ownership Index (OI) are heavily correlated with indicators of female educational outcome. For 20 Arab countries with data on SIGI values, the following results have been obtained.

- The Pearson correlation between FCI and the female primary completion rate is (-0.69); for female teachers in tertiary education it is -0.71;
- The Pearson correlation between CLI and the female primary completion rate is -0.61;
- The Pearson correlation between OI and the female primary completion rate is -0.60;
- The Pearson correlation between PII and the female adult literacy rate is -0.57; for female teachers in primary education it is -0.70.

It is not surprising to find that countries with low FCI scores (indicating low levels of discrimination against women in decision-making in the home environment) are also the countries with the fewest cultural barriers to girls completing primary school and a higher percentage of female teachers in tertiary education. At the same time, the female primary completion rate is also negatively influenced by the high inequality value on the CLI as indexed by the freedom of movement of women outside the home and their freedom of dress. It is also constrained by high levels of discrimination in physical integrity, indicating that countries which are successful in areas such as combating discrimination against women and acting to end the practice of female genital mutilation are more likely to promote the education of girls. Countries which increase the access of women to land, bank loans and other properties tend to have a better track record in increasing the numbers of female teachers in tertiary education and female completion rates in primary education.

In conclusion, it is essential that MDG 2 be viewed not only in terms of the progress which has been made towards its achievement, but also in terms of the extent to which that progress has incorporated principles of gender equality and empowerment. The path which countries take to reach the Goal should never be at the expense of the rights and needs of women, but should encompass an equitable distribution of educational resources between men and women, girls and boys.

It is essential that data and indicators for monitoring and tracking progress towards achievement of the Goal be gender-sensitive. Gender blind data are all too frequently doomed to produce gender blind policies and strategies. A significant number of gender issues operate at the micro, familial and individual levels and many of their ramifications on the lives of women are largely invisible. In order to make the “invisibles” visible, it is essential that deep qualitative data be generated to supplement existing quantitative data.

Improved knowledge bases will facilitate the work of policymakers and planners in taking proactive measures to render education planning more gender responsive. Education systems cannot be fully gender

responsive in the absence of an understanding of the cultural barriers that impede the access of women and girls to educational opportunities. Once such barriers have been dismantled and women are able to benefit from higher levels of education, they will become – more than ever – effective agents of change, underpinning the welfare of their families, communities and the nation as a whole.

3. *Gender analysis of MDG 3: promote gender equality and empower women*

The Millennium Declaration positions gender equality and the empowerment of women as one of its central goals. Although it has strong synergies with other human development goals, it comprises a single target: the elimination of gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015. The four indicators for measuring performance towards the Goal are the ratio of girls to boys at primary, secondary and tertiary level; the male-female literacy ratio for young people aged 15-24 years; the share of women in wage employment in the non-agricultural sector; and the proportion of seats held by women in national parliaments.

Many gender and human rights specialists have criticized the indicators of MDG 3 as being severely limited in their capacity to gauge progress towards the Goal.[62] The goal of gender equality and the empowerment of women is far broader than that defined by target 3.A, and the four indicators are inadequate to assess and monitor its multiple dimensions.

According to a publication on gender-responsive national development plans and programmes by the United Nations Development Programme,[63] these dimensions cover three interrelated domains:

- Capabilities: basic abilities as measured by education, health and nutrition. Capabilities are the means through which other forms of well-being can be accessed;

- Access to resources and opportunities: equality of opportunity to use those capabilities through access to economic assets such as land or housing, resources such as income and employment, and political opportunities such as representation in parliaments and other political bodies;

- Security: reduced vulnerability to violence and conflict, which cause physical and psychological harm and reduce the ability of individuals, households and communities to fulfil their potential. Gender-based violence against women and girls is often intended to keep them "in their place" through fear.[64]

The global MDGs focus on the first two of these domains. However, change in all three is critical to achieve gender equality.

According to the *Third Arab Report on the Millennium Development Goals 2010 and the Impact of the Global Economic Crises*, the region has considerably increased its score on the Gender Parity Index (GPI) – the ratio of girls to boys at all levels of education – although the increase has been markedly uneven, both between and within countries, as can be seen from the figures in table 6. For all ESCWA member countries, with the exception of Iraq and Yemen, the GPI value for primary education is above 0.9; in several countries it is over 1.0 for secondary education. At the tertiary level, Gender Equality Index (GEI) values increase even further, forming a distinct pattern in the Gulf countries in particular. However, closing the gender gap in education is not an objective which exists in a vacuum; other principles and processes related to gender and the empowerment of women also matter. As development experts at the United Nations Population

[62] UNDP, 2005a, p. 19.

[63] UNDP, 2005b.

[64] Ibid., p. 2.

Fund have noted, closing gender gaps in education without addressing other gender issues will not result in the achievement of MDG 3.[65]

It should also be borne in mind that there are millions of school age children, predominantly girls, who are not able to attend school. The reasons underlying their inability to join or remain in education or training vary, but may be related to deficiencies in the school system, unfair social and cultural norms and practices, or economic and financial policies that tend to have a disproportionate effect on women and young girls. As has been noted, poverty is not impartial when parents have to make hard choices regarding the allocation of scarce resources for the schooling of their children and they tend to give preference to their sons, while their daughters remain at home to help care for their siblings and older members of the family.

As can be seen from table 6, unemployment rates for women who have attained tertiary level education are also higher than those of their male counterparts. This may be indicative of the fact that their education is less likely to provide a satisfactory match for the job requirements or the needs of the market (particularly as far as the private sector is concerned) or simply that their education is not sufficiently well tailored to the employment needs of women, but irrespective of the reason, the end result has serious implications for the rights and empowerment of women. One clear example of this is the delay which many women experience in attaining the higher levels of income generally associated with higher education. This frequently leads to women having to delay their plans for having a family or for acquiring personal property and to the loss of leverage on decision-making both within and outside the home. Furthermore, high rates of unemployment among educated females can serve to deepen traditional attitudes towards the education of women, and this can all too easily become a vicious cycle.

TABLE 6a. MDG 3 GENDER-RELATED INDICATORS, ESCWA REGION

	Seats held by women in national parliaments (*percentage*)		Gender Parity Index in primary level enrolment		Gender Parity Index in secondary level enrolment		Gender Parity Index in tertiary level enrolment		Share of women in wage employment in the non-agricultural sector	
Country	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010
Bahrain	0	2.5	1.01	0.98[a/]	1.08	1.04	1.76	2.46	12.4	9.8
Egypt	2.0	1.8	0.92	0.95	0.93	0.94	0.54	..	19.0	18.1
Iraq	6.4	25.5	0.82	0.83	0.61	0.66	0.54	0.59	..	21.3
Jordan	0	6.4	1.00	1.02	1.03	1.03	1.12	1.10	23.4	25.9
Kuwait	0	3.1	1.02	0.98	1.03	1.02	2.40	2.32	34.7	39.3
Lebanon	2.3	4.7	0.95	0.97	1.08	1.11[a/]	1.05	1.24[a/]	72.5	83.3
Palestine	5.7	5.7[b/]	1.00	1.00	1.06	1.06	0.92	1.22	13.5	17.0
Oman	2.4	0	0.97	1.01	1.00	0.96	0.79	1.18	19.2	25.3
Qatar	0	0	0.97	0.99	1.07	0.98	3.82	2.87	14.2	15.5
Saudi Arabia	0	0	0.93[a/]	0.96[a/]	0.8	0.91	1.45	1.65[a/]	14	14.8
The Sudan	5.3	18.1	0.85	0.90[a/]	0.96	0.88[a/]	0.92	..	20.1	..
Syrian Arab Republic	10.4	12.4	0.92	0.96	0.92	0.98[a/]	0.65	..	16.1	16.1
United Arab Emirates	0	22.5	0.96	0.99	1.06	1.03	3.12	2.05[a/]	12.9	13.9
Yemen	0.7	0.3	0.63	0.80[a/]	0.42	0.49	0.28	0.42[a/]	7.0	..

Sources of data: United Nations Statistics Division and national MDG reports.

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

a/ Source: World Bank Databank.

b/ Of 132 members of the Palestinian Legislative Council, 17 are women (12.8 per cent). *Source*: Ministry of Women's Affairs, Directorate for Planning and Policies.

[65] UNFPA, 2008.

TABLE 6b. MDG 3 GENDER-RELATED INDICATORS, ESCWA REGION

Country	Female legislators, senior officials and managers as a percentage of all legislators, senior officials and managers		Unemployed women educated to primary level as a percentage of total female unemployment[a/]		Unemployed men educated to primary level as a percentage of total male unemployment[a/]		Unemployed women educated to secondary level as a percentage of total female unemployment[a/]		Unemployed men educated to secondary level as a percentage of total male unemployment[a/]	
	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010
Bahrain	0	22	16	22	51	28	48	39	36	37
Egypt	..	11	..	..	..	..	..	..	..	..
Iraq	..	..	..	..	..	..	..	..	..	..
Jordan	..	..	..	..	..	..	..	..	..	..
Kuwait	..	14	31.0	8.0	48.0	32.0	17.0	51.0	11.0	30.0
Lebanon	..	8	..	..	..	..	..	..	..	..
Palestine	..	10	14.7	12.3	61.8	62.5	8.7	4.3	13.4	16.1
Oman	9	..	20.0	..	53.0	..	70.0	..	22.0	..
Qatar	..	7	16.0	..	28.0	..	35.0	..	26.0	..
Saudi Arabia	..	8	7.0[b/]	4.0[c/]	52.0[d/]	39.0[e/]	50.0[f/]	32.0[g/]	27.0[h/]	52.0[i/]
The Sudan	..	..	..	..	..	..	..	..	..	..
Syrian Arab Republic	..	..	..	..	..	..	..	..	..	..
United Arab Emirates	..	10	13.0	10.0	45.0	30.0	36.0	45.0	21.0	32.0
Yemen	4	..	..	..	..	..	..	..	..	..

Sources of data: United Nations Statistics Division and national MDG reports.

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

a/ *Source*: World Bank Databank.
b/ 0.8 per cent (date closest to 2000). *Source*: Ministry of Economy and Planning, Saudi Arabia.
c/ 0.1 per cent (date closest to 2009). *Source*: ibid.
d/ 4.0 per cent (date closest to 2000. *Source*: ibid.
e/ 1.9 per cent (date closest to 2009). *Source*: ibid.
f/ 13.0 per cent (date closest to 2000). *Source*: ibid.
g/ 8.1 per cent (date closest to 2009). *Source*: ibid.
h/ 5.3 per cent (date closest to 2000). *Source*: ibid.
i/ 4.4 per cent (date closest to 2009). *Source*: ibid.

TABLE 6c. MDG 3 GENDER-RELATED INDICATORS, ESCWA REGION

Country	Unemployed women educated to tertiary level as a percentage of total female unemployment[a/]		Unemployed men educated to tertiary level as a percentage of total male unemployment[a/]		Adult mortality rate, women (per 1,000 adult women)[a/, *]		Adult mortality rate, men (per 1,000 adult men)[a/, *]	
	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010
Bahrain	36.0	33.0	12.0	22.0	82.0	72.1	120.6	102.2
Egypt	..	..	..	..	127.5	107.1	183.4	163.1
Iraq	..	..	..	..	92.6	106.6	151.4	226.1
Jordan	..	..	..	..	140.5	111.5	191.0	162.3
Kuwait	4.0	14.0	2.0	5.0	57.7	51.9	95.1	85.2
Lebanon	..	..	..	..	116.3	100.1	168.9	152.0
Palestine	74.1	81.5	11.1	12.1	111.1	91.5	150.0	127.7
Oman	5	..	4	..	93.0	72.5	126.0	98.3
Qatar	40.0	..	13.0	..	122.6	102.2	158.0	110.9

TABLE 6c (*continued*)

Country	Unemployed women educated to tertiary level as a percentage of total female unemployment[a/]		Unemployed men educated to tertiary level as a percentage of total male unemployment[a/]		Adult mortality rate, women (per 1,000 adult women)[a/, *]		Adult mortality rate, men (per 1,000 adult men)[a/, *]	
	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010
Saudi Arabia	43.0[b/]	65.0[c/]	8.0[d/]	8.0[e/]	110.4	89.2	159.3	139.1
The Sudan	..	..	..	..	270.9	260.9	324.5	306.0
Syrian Arab Republic	..	..	..	..	101.4	82.9	145.5	122.4
United Arab Emirates	49.0	40.0	15.0	14.0	67.9	64.2	89.1	77.2
Yemen	..	..	..	..	243.2	202.4	289.7	251.2

Sources of data: United Nations Statistics Division and national MDG reports.

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

* The adult mortality rate is the probability of dying between the ages of 15 and 60, if subject to current age-specific mortality rates between those ages.

a/ *Source*: World Bank Databank.
b/ 16.2 per cent (date closest to 2000). *Source*: Ministry of Economy and Planning, Saudi Arabia.
c/ 28.7 per cent (date closest to 2009). *Source*: ibid.
d/ 1.9 per cent (date closest to 2000). *Source*: ibid.
e/ 4.4 per cent (date closest to 2009). *Source*: ibid.

Governments and civil society organizations in the ESCWA region still struggle to overcome deep-set institutional, legislative and cultural impediments to full gender equality and the empowerment of women. The female activity rate in the region is among the lowest in the developing world and the share of women in non-agricultural employment remains modest, at less than 20 per cent in most countries. The effect of the persistent differential between men and women in non-agricultural sectors, compounded by the wide-ranging discrimination faced by women, continues to pose a significant obstacle, not only to gender equality, but also to the aim of decent work for all. The employment profiles and sectoral distribution of female workers are largely skewed towards lower-paid occupations in less empowered institutions and often concentrated in the health and education sectors. If progress is to be made, it is vital that policymakers and planners provide an environment that allows women to shift easily to non-traditional careers and engage in decent occupational activities.

Gender equality also continues to fall short in the political and legislative arenas. Across the region, with very few exceptions, women occupy only a small proportion of seats in national parliaments, legislative assemblies and executive bodies. The main exceptions are the Sudan and Iraq, whose systems are based on the quota system and in which women consequently occupy 25 per cent and 26 per cent of seats in national parliaments respectively.[66]

If women are to be enabled and encouraged to take full advantage of educational and economic opportunities, enhance their participation in public life and make strategic choices about their lives, concerted efforts will be necessary to develop and implement national and regional policies and strategies that are gender-responsive and supportive of the rights of women. This requires a set of actions and initiatives, which will primarily be drawn from global blueprints and examples of best practice both nationally and regionally, carefully tailored to the particular needs of the ESCWA region.

[66] United Nations, 2010.

First, policymakers, planners and the public need to understand that for MDG 3 to be attained, gender equality in education, while clearly essential, does not on its own lead to full empowerment of women. For that to be achieved, women must not only have equal access to resources and opportunities, but must also have the capacity and opportunity to make decisions and strategic choices for themselves, their families, their communities and their countries.

Second, they must be able to live without fear of violence or coercion. According to the UNDP *Arab Human Development Report 2009*,[67] there is widespread violence against women in the region, caused by both internal and external factors. These include so-called "honour crimes", the trafficking of girls and women, the rising incidence of forced child marriage, and the vulnerability of women and girls to sexual assault, rape, harassment and domestic violence. In conflict situations, the situation is even worse.

Third, the gender equality and empowerment of women MDG targets and indicators should be streamlined across all MDGs and national programmes. For this to be done with optimal effect, all individual level indicators should be disaggregated by sex, rural/urban location and any other relevant socio-economic variables, with additional emphasis given to poor women, adolescent girls, women in situations of crisis and conflict, and internally displaced persons. Data and indicators on land ownership, male and female access to credit, and domestic violence against women should also be collected and disseminated.

Fourth, as a means of initiating and supporting rights-based development strategies for the achievement of MDG 3, gender-responsive budgeting should be incorporated into existing systems for data collection, monitoring and evaluation.

4. *Gender analysis of MDG 4: reduce child mortality*

Significant progress has been made since 1990 in reducing deaths among infants and children aged under five (U5) in the ESCWA region. According to *The Third Arab Report on the Millennium Development Goals 2010 and the Impact of the Global Economic Crises*,[68] the Arab region saw a reduction in its U5 mortality rate from 83 per 1,000 live births in 1990 to 52 per 1,000 live births in 2008: a reduction of 37 per cent in 18 years. Assuming a similar rate of progress, an U5 mortality rate of 46 per 1,000 live births would be achieved in 2015, the target date for the attainment of the MDGs. However, this is significantly higher than the Arab regional target for MDG 4, which was set at 28 per 1,000 live births by 2015, and without exceptional progress between now and 2015, it is highly unlikely that the region will achieve this Goal.

However, behind these averages lie sizeable variations between subregions and individual countries. As table 7 shows, while all ESCWA member countries witnessed a decline in infant and U5 mortality rates between 2000 and 2010, and the countries of the Gulf Cooperation Council (GCC) are on track to achieve the global target of a two-thirds reduction in U5 mortality by 2015, countries such as Iraq, the Sudan and Yemen are not yet on track and require considerable additional efforts if they are to achieve further reductions in these rates.

[67] UNDP, 2009.

[68] United Nations, 2010.

TABLE 7a. MDG 4 GENDER-RELATED INDICATORS, ESCWA REGION

Country	Under five mortality rate		Infant mortality rate		Infants immunized against measles (*percentage*)		Female child mortality rate (per 1,000 female children aged one)[a/, *]		Male child mortality rate (per 1,000 male children aged one)[a/, *]	
	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010
Bahrain	12[b/]	10[c/]	10[d/]	9[e/]	98	99	..	..	..	..
Egypt	51	36	40	30	98	97	16	5	15	5
Iraq	48	44	38	36	87	69	..	7	..	6
Jordan	30	24	25	21	94	95	7	3	4	2
Kuwait	13	11	11	9	99	99	..	..	..	..
Lebanon	32	29	28	26	79	53	..	..	..	..
Palestine	29	27	26	24	92.7	99	..	3.1	..	2.9
Oman	15	12	12	11	99	97	..	..	..	..
Qatar	19	15	15	12	91	92	..	..	..	..
Saudi Arabia	29	25[f/]	23	20[g/]	94	96	..	4	..	3
The Sudan	115	109	73	69	58	79	63	30	62	38
Syrian Arab Republic	22	17	19	15	96	98	..	3	..	5
United Arab Emirates	10	8	9	7	94	92	..	..	..	..
Yemen	98	73	71	55	71	74	36	11	33	10

Sources of data: United Nations Statistics Division and national MDG reports.

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

* The child mortality rate is the probability of dying between the ages of one and five, if subject to current age-specific mortality rates. The probability is expressed as a rate per 1,000.

a/ *Source*: World Bank Databank.
b/ 11.4 per cent in 2000. *Source*: *Health Statistics 2003-2009*, Ministry of Health, Bahrain.
c/ 8.6 per cent in 2009. *Source*: ibid.
d/ 8.6 per cent in 2000. *Source*: ibid.
e/ 7.2 per cent in 2009. *Source*: ibid.
f/ 19.5 per cent *Source*: Ministry of Economy and Planning, Saudi Arabia.
g/ 16.9 per cent *Source*: ibid.

TABLE 7b. MDG 4 GENDER-RELATED INDICATORS, ESCWA REGION

Country	Female life expectancy at birth[a/]		Male life expectancy at birth[a/]		Women aged 15-19 who have been married (*percentage*)		Men aged 15-19 who have been married (*percentage*)	
	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010
Bahrain	76[b/]	78[c/]	73[d/]	74[e/]	6.7	4.2	0.5	0.3
Egypt	70	72	67	68	14.3	12.5	..	..
Iraq	73	72	69	64	15.3	19.4	2.9	..
Jordan	72	75	69	71	12.7	8.9	1.4	1
Kuwait	79	80	75	76	13.2	..	1.3	..
Lebanon	73	74	69	70	..	5.3	..	0.4
Palestine	73	75	70	72	27.1	13.5	2.4	0.5
Oman	75	78	72	74	..	4.2	..	0.4
Qatar	75	77	72	75	6.4	3.6	1.9	2.3
Saudi Arabia	73	75	69	71	7.5	4	0.6	0.3
The Sudan	58	60	54	57	20.6	..	1.8	..

TABLE 7b (*continued*)

Country	Female life expectancy at birth[a/]		Male life expectancy at birth[a/]		Women aged 15-19 who have been married (*percentage*)		Men aged 15-19 who have been married (*percentage*)	
	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010
Syrian Arab Republic	74	76	71	72	10.9	..	0.2	..
United Arab Emirates	78	79	75	77	8.2	..	0.7	..
Yemen	61	65	58	61	23.9	17.2	4.4	3.1

Sources of data: United Nations Statistics Division and national MDG reports.

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

a/ *Source*: World Bank Databank.
b/ 76.3 per cent in 2001. *Source*: *Health Statistics 2003-2009*, Ministry of Health, Bahrain.
c/ 77.3 per cent in 2009. *Source*: ibid.
d/ 72.1 per cent in 2001. *Source*: ibid.
e/ 73.1 per cent in 2009. *Source*: ibid.

As in other developing regions, the highest U5 mortality rates (some 70 per cent) occur in the first year of life. Thus, the overall achievement of MDG 4 will rely heavily on the pace of decline in mortality during the first 12 months of life, particularly during the neonatal period (defined as the first 28 days). This will require countries to take exceptional measures to combat the most common causes of child and infant mortality, including infectious diseases, low birth weight, diarrhoea and maternal health-related complications. The child survival and health improvement goals require access to basic social services and good quality care. Governments therefore need to promote the use of health services and good care practices, including breastfeeding and complementary feeding, improved maternal care and better hygiene. Combating malnutrition is essential, as it has a strong influence on infant and child mortality, both directly and indirectly. Support is also needed to improve and maintain immunization rates, and to ensure that households have easy access to safe water and sanitation, especially in less developed countries and those in situations of conflict.

In order to accelerate the pace of decline in infant mortality rates in the region, universal access to a full course of immunization against common infant diseases – measles in particular – is absolutely indispensable. As table 7 shows, of the 14 ESCWA member countries, 10 have already achieved measles immunization coverage of over 90 per cent, but coverage in Iraq, Lebanon, the Sudan and Yemen remains significantly lower (in Lebanon, it is a paltry 53 per cent).

Comprehensive immunization of infants, diarrheal control, breastfeeding (in combination with supplementary foods), prevention of infection and limitation of communicable diseases are among the most cost-effective measures for improving and protecting life during infancy. However, infant health is also determined by the socio-economic and demographic background of parents, the extent to which they understand the vulnerability of their young children to disease and death, and the actions they take to ensure that their children survive to adulthood and lead healthy lives.

Research has shown that up to 40 per cent of neonatal deaths could be avoided by the use of home and community-based solutions.[69] Integrated intervention, carefully matching demand and supply of health care, and primarily determined by the practices, beliefs and traditions of families and communities, is therefore essential. An integrated approach of this nature could be divided into five groups: family care of the newborn, essential newborn care, resuscitation of the newborn, care for low birth weight babies and emergency care. For this approach to work effectively, there should be no gaps in the continuum of care that starts with prenatal services, moves through the attendance of skilled professionals at the birth, and continues with the provision of follow-up support throughout the first month of the child's life.

[69] Jamison T. and Dean et al. (eds.), 2006, p. 94.

The role of the mother is critical in improving child survival rates. There is increasing research evidence that demonstrates a clear relationship between the number of years of schooling completed by the mother and lower rates of child mortality.[70] High levels of illiteracy among women are also associated with limited knowledge and understanding of the health and psychosocial benefits offered by breastfeeding. The dependence created by laws and practices which operate to oppress women can also be linked to child mortality rates. Cultural restrictions on the movement of women outside the home, their limited knowledge about where to go when a child is ill, or their lack of economic resources to obtain treatment for their children at properly equipped medical centres all have a direct effect on child and infant survival.

It is essential that efforts to reduce infant and child mortality target mothers who are particularly at risk. The most vulnerable include women who are unable to access family planning services or cannot convince their husbands of the benefits of using contraception. Mothers who are socially excluded, marginalized, internally displaced, or who live under occupation, behind segregation walls or in refugee camps, are more likely to suffer from ill-health and their children are at a significantly increased risk of premature mortality. The children of women who reproduce too early, have large numbers of children or whose births are too closely spaced are also at greater risk of morbidity and mortality.

A broader consideration in this area is the problem of the "missing females", which is increasingly becoming a cause of international concern. In certain cultures, discrimination against girls and the preference of families for sons has been facilitated by developments in medical technology which now offer prospective parents greater choice in the sex of their children. The problem has become widespread in certain parts of South-East Asia and has also been observed in Egypt.[71] Possible explanations include higher mortality rates for girls in certain countries and fewer girls being born, whether as a result of pre-implantation sex selection by parents or selective abortion of female fœtuses. Demographic analysis of actual sex ratios, compared with the ratios which would have been expected under equal health conditions for both girls and boys, suggests that there is a female deficit of between 60 million and 100 million worldwide. It is therefore vital that national administrations responsible for the compilation and use of health-related data continue to disaggregate data by sex, and analyse and monitor the data for any evidence of discrimination against the female child, as detailed analysis – particularly when supplemented with qualitative diagnosis – can act as an early warning sign for Governments to take action and impose such controls as may be necessary to limit the problem.

5. *Gender analysis of MDG 5: improve maternal health*

As in other less developed regions of the world, accurate data on maternal mortality are notoriously difficult to collect in the ESCWA region, and finding reliable research on maternal mortality rates and differentials poses even more of a challenge. In many countries, there is neither full registration of deaths, nor proper medical certification of the cause of death. Although household surveys provide a potential alternative source of similar data, the frequent lack of a sufficiently large sample size tends to limit the use of survey data for tracking maternal mortality trends.

According to the United Nations Children's Fund (UNICEF),[72] an estimate of 377 maternal deaths per 100,000 live births was forecast for the full Arab region in 2002, a reduction from the 1990 figure of 465 per 100,000 live births. Since then, the World Health Organization (WHO), UNICEF, the United Nations Population Fund (UNFPA), and World Bank have begun to revise country-specific maternal mortality data across all geographic regions. In almost all developing countries, the revised estimates are higher than the officially reported maternal mortality rates. For 2005, the revised forecasts have resulted in an estimated 536,000 maternal deaths worldwide, compared with 576,000 in 1990.[73] For the same year, the maternal

[70] Farah and Maas, 2006.

[71] Fathallah, 2008.

[72] UNICEF, 2005.

[73] WHO, UNICEF, UNFPA and World Bank, 2007.

mortality rate for all developing countries combined was estimated at 450 per 100,000 live births, in stark contrast to 9 per 100,000 live births in the developed world. The highest maternal mortality rate (900 per 100,000 live births) was recorded in sub-Saharan Africa, followed by 490 for South Asia, 430 for Oceania, 160 for South-Eastern Asia, 150 for North Africa, 130 for Latin America and the Caribbean, and 50 for East Asia.

For the Arab and ESCWA regions, as in most developing regions of the world, there is as yet little or no evidence of an established path towards achieving the MDG 5 target of reducing the maternal mortality rate by 75 per cent between 1990 and 2015. The absence of a consistent, well-paced decline in maternal mortality rates is supported by proxy indicators, such as the proportion of births attended by skilled personnel, current contraceptive use, the adolescent fertility rate and unmet needs for family planning (see table 8). Based on those indicators and others, *The Third Arab Report on the Millennium Development Goals 2010* concluded that most Arab countries will not achieve the MDG 5 target by 2015. To reverse such a pessimistic situation in time for the goal to be achieved by the target date would require tremendous efforts on the part of all ESCWA member countries, particularly the least developed countries, as many parts of the region remain characterized by high levels of illiteracy, ill-informed health-related behaviour by mothers and other care providers, poor access to nutrition and environmental health facilities, and limited maternity services, including emergency obstetric care.[74]

TABLE 8a. MDG 5 GENDER-RELATED INDICATORS, ESCWA REGION

	Births attended by skilled health personnel (*percentage*)		Current contraceptive use among married women aged 15-49, any method (*percentage*)		Adolescent fertility rate (births per 1,000 women aged 15-19)[a/]		Antenatal care coverage, at least one visit (*percentage*)		Antenatal care coverage, at least four visits (*percentage*)	
Country	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010
Bahrain	99.6[c/]	99.4[d/]	61.8[e/]	..	19.92	16.57	97.1	..	..	..
Egypt	60.9	78.9	56.1	60.3	50.91	38.37	52.9	73.8	41[b/]	65.1
Iraq	72.1	88.5	43.5	49.8	62.09	84.00	76.7	83.9	78[b/]	..
Jordan	96.7	99	52.6	57.1	33.18	24.33	95.6	98.8	90.9	94.1
Kuwait	100	100	52	..	17.68	13.12	95	..	..	..
Lebanon	96	98	62.7	58	25.92	16.05	93.9	95.6	87[b/]	..
Palestine	97.4	98.9	51.4	50.2	100.38	77.19	95.6	98.8	..	..
Oman	94.7	98.1	23.7	..	29.68	10.39	99.6	..	..	83.3
Qatar	99.96	99.98	43.2	..	21.53	15.81	62[b/]	..	58[b/]	..
Saudi Arabia	91	97	19.5	23.8	36.13	25.81	90	..	..	..
The Sudan	87	49.2	7	7.6	77.33	55.78	60	63.7	75[b/]	..
Syrian Arab Republic	86.5	93	45.8	58.3	68.54	59.49	71.2	84	51[b/]	..
United Arab Emirates	99.2	..	27.5	..	28.47	15.77	96.8	..	..	..
Yemen	21.6	35.7[f/]	20.8	27.7	91.29	66.99	34.3	47	11.4	..

Sources of data: United Nations Statistics Division and national MDG reports.

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

a/ *Source*: World Bank Databank.
b/ WHO Core Health Indicators Database, July 2007.
c/ 98 per cent in 2000. *Source*: *2009 Health Statistics*, Bahrain Ministry of Health.
d/ 99.5 per cent in 2009. *Source*: ibid.
e/ 53.8 per cent, age group not specified. *Source*: Bahrain Multiple Indicator Cluster Survey 2000.
f/ 36 per cent. *Source*: National Committee of Women, Republic of Yemen.

[74] United Nations, 2010.

TABLE 8b. MDG 5 GENDER-RELATED INDICATORS, ESCWA REGION

Country	Unmet need for family planning, total (*percentage*)		Current contraceptive use among married women aged 15-49, modern methods (*percentage*)		Total fertility rate (births per woman)*		Teenage mothers (women aged 15-19 who have had children or are currently pregnant)* (*percentage*)		Number of weeks of maternity leave*	
	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010
Bahrain	..	..	30.6	..	3	2	47	40	6	6
Egypt	11.2	10.3	53.9	57.6	3	3	8.5	9.4	7	13
Iraq	..	..	25.4	32.9	5	4	54	..	9	9
Jordan	14.2	11.9	37.7	40.5	4	3	5.7	4.1	6	10
Kuwait	..	..	39.3	..	2	2	..	..	10	10
Lebanon	..	..	40.4	34	2	2	..	..	6	7
Palestine	..	..	36.7	38.9	5.84	5.036	49	..	..	..
Oman	..	..	18.2	..	4	3	..	..	..	..
Qatar	..	..	32.3	..	3	2	..	..	9	7
Saudi Arabia	..	..	28.5	..	4	3	..	..	10	10
The Sudan	26	5.7	5.4	5.7	5	4	10.9	..	8	8
Syrian Arab Republic	30.6	..	35.1	42.6	4	3	51	..	11	7
United Arab Emirates	..	..	23.6	..	3	2	..	..	6	12
Yemen	38.6	..	9.8	19.2[a/]	6	5	14.1	15.5	9	9

Sources of data: United Nations Statistics Division and national MDG reports.

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

a/ 19 per cent. *Source*: National Committee of Women, Republic of Yemen.

***** *Source*: World Bank Databank.

TABLE 8c. MDG 5 GENDER-RELATED INDICATORS, ESCWA REGION

Country	Abortion laws by grounds on which abortion is permitted (1: Yes; 0: No)					
	Foetal impairment	On request	Rape or incest	To preserve mental health	To preserve physical health	To save the life of the mother
Bahrain	1	1	1	1	1	1
Egypt	0	0	0	0	0	1
Iraq	0	0	0	0	0	1
Jordan	1	0	0	1	1	1
Kuwait	1	0	0	1	1	1
Lebanon	0	0	0	0	0	1
Palestine	..	..	..	..	..	..
Oman	0	0	0	0	0	1
Qatar	1	0	0	1	1	1
Saudi Arabia	0	0	0	1	1	1
The Sudan	0	0	1	0	0	1
Syrian Arab Republic	0	0	0	0	0	1
United Arab Emirates	0	0	0	0	0	1
Yemen	0	0	0	0	0	1

Source: Adapted from United Nations Department of Economic and Social Affairs Population Division, *World Abortion Policies 2007*.

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

Structural factors which can have an effect on maternal mortality and morbidity include poverty; marginalization of women; discrimination against women; social exclusion of girls and adolescents; restricted governance; the repercussions of the global economic and financial crisis; climate change; and war, conflict and political instability both between and within countries.

The social environment of adolescent girls requires particular attention. Many adolescents in the region, especially females, lack access to decent-quality health information and services, and are consequently vulnerable to sexual and reproductive ill-health. Indeed, there is mounting evidence in the region and elsewhere that adolescent girls aged 15-19 are twice as likely to die during pregnancy and childbirth as other pregnant women, and those under 15 are five times as likely to die during childbirth as women in their twenties.[75] Though the age at first marriage is generally rising in the Arab world, the proportion of adolescent girls married at what has been established as an unsafe age for reproduction is still high and remains a cause for concern in many parts of the region. Targeted, coordinated efforts by national Governments and local communities are thus vital if those maternal deaths that are attributable to adolescent lifestyle, health illiteracy and pregnancy at too young an age are to be avoided.

An unconscionably large proportion of women of all ages in the region lack knowledge regarding methods of fertility regulation, have little or no access to the contraceptives of their choice, are severely limited in their freedom of mobility outside the home to obtain health information and services, and suffer in numerous ways as a result of their lack of involvement in reproduction-related decision-making, both at home and in the community. The UNDP *Arab Human Development Report 2009* drew attention – once again – to the fact that traditional cultural norms and practices in the region continue to dictate a set of norms and behaviours that condone a wide variety of gender-discriminatory practices, including violence against women and female genital mutilation, which, both individually and in combination, operate to undermine the rights of young women and girls.

In recognition of the importance of understanding such considerations in order to deal optimally with the challenges they raise, there has been a growth in recent years in social research into the connection between the empowerment of women and changes in maternal mortality levels and differentials. Various factors related to public health measures and income growth have a direct relationship on the employment of women.[76] A recent study examined 99 developing countries, including 20 Arab countries, and used bivariate and multivariate analyses in order to explain cross-country variations in maternal mortality rates, drawing the following conclusions.

First, both analytical strategies confirmed that country-specific per capita income (PPP US$) is inversely correlated with national maternal mortality rates. On average, mortality falls as income rises. However, the link between income and maternal mortality is not automatic and the explanatory power of income on the mortality variance loses statistical significance when other non-income variables are taken into account. In real terms, countries at similar levels of income display large variations in maternal mortality, possibly as a result of the application of public health measures and technologies, and/or because of increased political and social commitment to the empowerment of women. Therefore, income growth alone cannot account for all the changes in cross-country maternal mortality, nor can it be viewed as a guaranteed route to faster progress towards the achievement of MDG 5.

Second, the analysis found that public health measures work actively to bring about substantial gains in maternal health, even when economic growth is slow or stagnant. Three health-related variables – skilled attendance at birth, health expenditure per capita and the level of contraceptive use – emerge as powerful predictors of mortality changes. The implications of this finding for safe motherhood strategies and progress towards MDG 5 are remarkable. At a given level of income, countries can allocate greater financial

[75] WHO, 2007.

[76] Shiffman, 2000, and Farah and Rasheed, 2009.

resources to health and, within the health sector, to maternal and child health services in particular. Family planning, by reducing unwanted or unintended pregnancies, and skilled attendance at birth, by promoting safe delivery, were found to be instrumental in maternal mortality transition.

Third, it was established that the empowerment of women variable in the regression model was a clear predictor of cross-country variations in maternal mortality, and thus plays a significant role in bringing about maternal health benefits. Each of the empowerment proxy variables, including female school enrolment and female age at first marriage, was found to have a significant impact on maternal mortality transition across the countries studied. The policy implications of this finding are clear. Less-developed countries are less likely to make rapid, sustained progress towards achieving MDG 5 if development practitioners and policymakers do not fully appreciate that maternal mortality is clearly correlated and highly sensitive to women's human rights. Only when these internationally enshrined rights are universally respected and the health needs of women effectively catered for, will the required speed of progress towards MDG 5 become a plausible premise.

These findings provide hope to those who are striving to tailor their national development plans towards realizing target 5.A of MDG 5, as it has now been demonstrated beyond question that even poor countries or countries riven with political turbulence or violence can circumvent poverty and other structural barriers to the realization of significant maternal health gains if the status of women, including their political rights, education and other forms of empowerment, are promoted, the health sector is made more women-friendly and the service delivery system adopts a rights-based approach, which, by definition, should address the right to universal access to reproductive health for all by 2015 (a new target introduced under MDG 5 in 2005).

Evidence-based understanding of the role of women in maternal mortality transition can also be used as a tool by policymakers in their efforts to empower women. The access of women to education, paid work, food security, shelter, sanitation and high-quality health services are all essential factors, not only in empowering women, but also in contributing to changing traditional and cultural barriers affecting choices, such as age at first pregnancy, inter-pregnancy intervals, frequency of pregnancy, desirability of pregnancy and place of pregnancy termination, as well as pre-pregnancy dangers occasioned by such conditions as inadequate nutrition, anæmia, diabetes mellitus, reproductive tract infections, sexually transmitted infections, HIV/AIDS or harmful practices such as female genital mutilation.

Policymakers planning efforts to promote gender in national policies to achieve the MDGs should also consider introducing innovative approaches to reducing the cost of general and reproductive health services, and to allocating additional resources to broaden service packages. These could include removing payment for treatment at the point of service, making health insurance schemes more widely available, adopting gender-responsive budgeting and providing free basic reproductive services to all women. Practical policymaking considerations aside, it is also essential to promote local cultural and community networks to empower women and girls to circumvent the traditional barriers which prevent them from accessing general and reproductive health services. The importance of this cannot be over-estimated, as increased levels of autonomy have been proven to enable women to overcome the four principal delays leading to maternal mortality – delays in recognizing danger signs, deciding to seek care, reaching care and receiving care at a properly equipped health facility.[77]

6. *Gender analysis of MDG 6: combat HIV/AIDS, malaria and other diseases*

The spread of STIs, HIV/AIDS and other infectious diseases is widely considered to be one of the greatest failures of national health policies, both in the ESCWA region and the broader Arab region. Although the spread of HIV/AIDS in the region has occurred at a slower rate than in other regions, statistics

[77] Ransom and Yinger, 2002.

indicate that HIV infections are increasing in all countries of the region.[78] The majority of cases reported involve unprotected sexual contact between young adults; however there is increasing evidence of a growing epidemic among injecting drug users and sexual partners.

In 2009, some 75,000 people were newly infected with HIV in the Middle East and North Africa region and there were 23,000 HIV/AIDS-related deaths.[79] Most of the cases reported in the ESCWA region involve infected men, meaning that women and children tend to become the prime bearers of the disease burden. In the Sudan, by contrast, the female share of adults aged 15 and over living with HIV is some 59 per cent (see table 9). The situation is exacerbated by the fact that access to antiretroviral treatment is only available for a small fraction of those living with HIV and, as shown in table 9, the preventive use of condoms is rare across the region.

TABLE 9. MDG 6 GENDER-RELATED INDICATORS, ESCWA REGION

	Tuberculosis prevalence rate (*per 100,000 population*)		Tuberculosis treatment success rate under DOTS (*percentage*)		Tuberculosis death rate per annum (*per 100,000 population*)		Tuberculosis detection rate under DOTS (*percentage*)		Condom use to overall contraceptive use among currently married women aged 15-49 (*percentage*)		Women aged 15+ with HIV as a share of all adults aged 15+ with HIV (*percentage*)	
Country	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010	Date closest to 2000	Date closest to 2010
Bahrain	57.3[b/]	59.6[c/]	72.7	85.7	4.7[d/]	4.7[e/]	16.6[f/]	79.5[g/]	15.5	..	..	..
Egypt	35.9	26.6	86.7	86.9	3.2	2.4	53.9	72.2	1.8	1.2	26.79[a/]	28.8
Iraq	70.9	78.9	91.9	84.5	9.8	11	50.6	37.3	1.6	2.2	..	..
Jordan	10.8	9	89.9	71.2	0.9	0.8	69.8	80.9	6.1	9.3	..	..
Kuwait	33.2	25	69.4	78.2	2.9	2.4	65	90.3	3	5.6	..	..
Lebanon	35.3	23	91.6	90.2	2.9	2	65.2	61.7	..	..	45.4	33.3
Palestine	39.7	31.1	100	93.8	3.9	3.1	14.9	5.3	5.4	7.5	..	..
Oman	12.6	14.2	92.9	86.4	0.9	1.1	123.1	125.4	6.3	..	..	..
Qatar	77.6	81.4	66	68.7	6.5	7.2	29.1	43.9	6.7	..	..	..
Saudi Arabia	66.7	64.7	72.8	69.1	5.5	5.4	35.9	38.5	2.8	..	..	..
The Sudan	374.8	401.8	79.4	81.7	64	71.2	31.7	30.6	0	3.9	56[a/]	58.6
Syrian Arab Republic	40.7	26.8	79.1	86.2	3.3	2.2	84.4	80.4	1.9	2.7	..	..
United Arab Emirates	27.4	23.8	74	78.8	2.1	1.8	27.1	18	7.3	..	..	..
Yemen	164	129.7	74.6	83	12.5	9.8	54.7	45.7	1.4	1.4	..	..

Source of data: United Nations Statistics Division.

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

a/ *Source*: World Bank Databank.
b/ 16.8 per cent in 2001. *Source*: *Health Statistics 2001-2009*, Bahrain Ministry of Health.
c/ 18.2 per cent in 2008. *Source*: ibid.
d/ 0.3 per cent in 2003. *Source*: ibid.
e/ 0.5 per cent in 2008. *Source*: ibid.
f/ 16 per cent in 2001. *Source*: ibid.
g/ 77 per cent in 2009. *Source*: ibid.

[78] Joint United Nations Programme on HIV/AIDS (UNAIDS), 2005.

[79] UNAIDS, 2009.

In comparison with other regions of the world, the Arab region has the widest gap in information and skills for HIV/AIDS prevention and protection. This allows misconceptions about the disease, its paths of transmission and its means of prevention to flourish. UNFPA research in 2003 showed that only eight per cent of Sudanese women and 18 per cent of Palestinian women knew where they could obtain an HIV test.[80]

Governments have now, albeit somewhat tardily, begun to acknowledge the increasing trend of the pandemic and take steps to contain it. However, the region is characterized by a large number of factors which operate to obstruct governmental commitment to halt and reverse the spread of HIV/AIDS by 2015.[81] These include the absence of effective national surveillance systems; a lack of voluntary counselling and testing services; socio-cultural norms that prevent acknowledgement of risky sexual behaviour, and breed stigma and misconceptions regarding transmission and protection, thus negatively affecting care and support to infected individuals; the multiplicity of groups vulnerable to HIV/AIDS and STIs, encompassing adolescents and youth, migrants, refugees, sex workers and intravenous drug users; and the expansion in poverty and unemployment.

In order for Government efforts to succeed in limiting the expansion of HIV/AIDS, reducing its impact to a minimum, raising awareness on its means of transmission and prevention, fighting stigma and discrimination against infected people, and intensifying research on ways of combating the disease, it is vital that they guarantee that all segments of the population, women and young people in particular, have free access to information, education and services to develop the skills needed to prevent HIV/AIDS, including access to male and female condoms, voluntary testing, counselling and monitoring.

As understanding grows of the fact that gender inequality is fuelling the epidemic, the gender dimension of HIV/AIDS is becoming a global concern.[82] Stigma and discrimination are at the heart of the AIDS pandemic, as fear, shame and ignorance keep people from using preventative practices and seeking care. Women are biologically more susceptible to HIV infection, yet are frequently not in a position to protect themselves from HIV-infected husbands and may face violence if they raise the subject. Women in many societies face the double stigma of poverty and discrimination regarding HIV/AIDS. Although internationally supported programmes are increasingly promoting the use of condoms, women are often unable to negotiate such protection because of fears of abandonment. HIV-positive women may also be stigmatized when they seek reproductive health care. HIV-positive women who are pregnant may be denied prenatal or delivery care and in certain situations women are put under pressure to undergo an abortion rather than risk having an HIV-positive baby.

It is frequently posited that the conservative social norms which are pervasive across the ESCWA region are one of the reasons for the underreporting of HIV cases, in part as a result of their contribution to the general attitude of denial and in part because of the stigmatization and social ostracism inflicted on people living with HIV/AIDS. However, it is clear from recent data that conservative cultural practices do not necessarily mean that countries are at low risk of a generalized HIV/AIDS epidemic, as increasing numbers of people in groups which include labour migrants, young people in refugee camps, injecting drug users and lorry drivers, start to engage in risky behaviour.

In conclusion, if ESCWA member countries are to attain MDG 6, they must adopt gender-responsive and rights-based national health development strategies. To this end, the share of health expenditure in the national budget needs to be increased considerably and health allocation spent effectively in order to reach all sectors of society, including women and vulnerable groups. Efforts should also be focused on eliminating discrimination and stigma, and protecting the human rights of women living with HIV.

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[80] UNFPA, 2003.

[81] Farah, Najem Kteily and al-Zo'ubi, 2004.

[82] Fathalla, 2008.

7. *Gender analysis of MDG 7: ensure environmental sustainability*

The aim of MDG 7 is to ensure environmental sustainability through the achievement of four targets, namely integrating the principles of sustainable development into country policies and programmes and reversing the loss of environmental resources; reducing biodiversity loss; improving access to a safe water supply and sanitation services; and significantly improving the lives of slum dwellers. These targets are to be monitored through the use of 10 indicators, set out in the annex to this publication.

There is an increasing body of research which demonstrates a mix of progression and regression along the path towards the achievement of MDG 7.[83] A brief review of the major findings of such research in terms of its implications for gender equality and the empowerment of women follows.

(a) Target 7.A, which calls for the integration of the principles of sustainable development into country policies and programmes, and reversing the loss of environmental resources, poses a major problem for ESCWA member countries, albeit to varying degrees. Currently, national development plans, poverty reduction strategies, and political and administrative reform processes address, rather than redress, the relationship and synergies between what can be considered the three pillars of sustainable development: population, development and environment. This problem is compounded when MDG-based planning itself disregards the embryonic linkage between MDG 7 and MDG 3. Gender equality and the empowerment of women are essential for environmental sustainability and environmental sustainability is critical for the welfare of women and their families. The Arab region is home to some 5 per cent of the world's population, but has less than 1 per cent of the world's renewable fresh water; within the region, the majority of the population live in areas in which water is scarce, energy sources are limited and, as the culmination of decades of drought, desertification and land degradation, there is little arable land. Women and girls, particularly the poorest, are adversely affected by this situation and the destitute conditions experienced by families mean that many women and girls spend a considerable part of their day collecting water, wood and other household essentials, which in turn places a heavy burden on their physical health, safety and general well-being. In the absence of female-friendly sustainable development action by Governments, poor women may adopt mitigating strategies, such as using contaminated water or cutting, rather than simply collecting, wood – actions that contribute to the depletion of environmental resources. The serious water and energy deficits experienced in many parts of the region, especially in the least developed countries, also subject already limited environmental resources to further degradation through over-exploitation;

(b) Factors such as fast population growth, the demographic pressures associated with rapid urbanization and internal migration, the changing age composition of society and new patterns of consumption constitute major cross-cutting issues and operate as a common cause to further complicate the relationship between the three pillars of sustainable development. The complex, interactive and dynamic relationship between the pillars contributes to poverty and unemployment, both of which affect women disproportionately and all too frequently result in women's share of the world's natural and environmental resources diminishing and their living conditions further deteriorating;

(c) In many countries of the region, women form the majority of farmers, although statistics do not reveal the true magnitude of their labour in agricultural work. Women are also largely responsible for providing water and fuel for their household needs, and are therefore particularly dependent on environmental resources and especially affected by the way in which those resources are managed. Yet despite the fact that women tend to have a closer physical relationship with the natural environment than men in the ESCWA region, and in clear contravention of the well-established fact that excluding women from environmental management efforts frequently leads to setbacks in progress, MDG-based planning initiatives in the region continue to assign a low value to the role of women in managing the environment, regarding them as passive recipients of resource endowments such as soil, water, forests and energy, rather than active

[83] ESCWA and League of Arab States, 2007.

partners in their management. It is essential that women be involved in decision-making processes concerning environmental sustainability at all levels. To carry out that role effectively, they need to be provided with access to training on environmental management and to be sensitized to the need to integrate the principles of sustainable development into national development planning policies and strategies;

(d) Access to safe drinking water and basic sanitation has improved over the last decade, but remains deficient, particularly in rural communities and among groups such as the poor, internally displaced persons, and residents of urban slums and refugee camps; within each group, women are the most affected. Furthermore, women who are engaged in traditional household activities, such as cooking, washing, cleaning and caring for other family members, are exposed to in-house air pollution and the gases generated by traditional cooking stoves. These conditions are known to lead to health problems including diarrhoea, cholera, typhoid, parasitic infections and respiratory tract infections, not only affecting their physical well-being, but also their employability outside the home;

(e) The recent global financial crisis has, without question, delayed progress towards attaining the MDGs.[84] Women who are in ecologically volatile situations are likely to remain consigned to poverty if Governments do not adopt significant short-term mitigation strategies, backed up by long-term economic reform policies. Even in normal economic conditions, women in the ESCWA region are all too often the last to be considered for paid work and the first to be dispensed with in tighter economic times;

(f) As was highlighted in *The Third Arab Report on the Millennium Development Goals 2010 and the Impact of the Global Economic Crises*, climate change has the potential to reverse a number of hard-earned development gains, including those contributing towards achieving the MDGs. Developmental setbacks, according to the World Bank, will result from factors including water scarcity, intense tropical storms and storm surges, floods, rising sea levels and food shortages.[85] In May 2009, an article in *The Lancet* medical journal identified climate change as "the biggest global health threat of the twenty-first century" and forecast that "[t]he epidemiological outcome of climate change on disease patterns worldwide will be profound, especially in developing countries".[86] The incidence of vector-borne diseases, for example, will increase and millions more people may be affected by malaria, as rising temperatures allow disease-carrying mosquitoes to survive in higher altitudes. Changing rainfall and temperature patterns in the coming decades are also likely to make access to clean water and good sanitation even more difficult;

(g) In its publication *State of World Population 2009 – Facing a Changing World: Women, Population and Climate*,[87] UNFPA argued that it was vital not to allow gender to be an underrepresented variable in the debate on the impact of climate change, as climate change was likely to affect men and women in different ways and to differing extents, the overall effect being stronger on women than on men. It is clear, therefore, that policies which aim to address any aspect of climate change will be less effective if they fail to incorporate due gender considerations; gender blind policies may also exacerbate the problems associated with climate change by widening the inequalities between men and women.

In conclusion, policymakers in the region need to be more attentive to national development policies and poverty reduction strategies that will streamline the gender issues implicated by environmental hazards and climate change. Gender-inclusive policy measures for addressing environmental resource management and climate change need to be put in place. Such measures should be built on the recognition that women are important actors and agents of change in sustaining an optimal balance between population factors, development and the environment. It is vital that women be represented at all levels of decision-making.

[84] UNDP, 2009.

[85] World Bank, 2008.

[86] Costello, A. et al., 2009, pp. 1693-1733.

[87] UNFPA, 2009.

For policy formulation to be properly designed and effectively supported, further efforts are required to ensure that data collection and analysis is disaggregated by sex and that indicators are generated that are sensitive to the gender inequality ramifications of environmental stress and climate change.

8. *Gender analysis of MDG 8: develop a global partnership for development*

One of the most remarkable changes in the ESCWA region in the last three decades has been the growing recognition of the importance of building partnerships with local and international agencies and donors in pursuit of the human development agenda. The MDGs have acted as an operational framework for invigorating partnerships between developed and developing countries to create an environment at both national and international levels which is conducive to development and the elimination of poverty. A broad goal, MDG 8 deals with macroeconomic and general economic policy issues; the role of donors and international financial institutions in working with developing countries to support development through global partnership; and access to drugs and new technologies.

Broadening partnerships for achieving the MDGs has entailed a variety of actions, including enacting legislation on reproductive rights and reproductive health; developing, implementing and monitoring population, education and health development policies and plans; strengthening alliances between national bodies, NGOs and international organizations; providing training on techniques to integrate reproductive health and gender issues into policies and plans; involving parliamentarians and local community networks in human rights-based development policies; and easing administrative and regulatory barriers to the effective mobilization and allocation of critical financial contributions to improve quality of life for individuals and communities. Efforts have also included encouraging national and international private sector initiatives in health, family planning, literacy campaigns, education and advocacy; youth protection and development programmes; poverty reduction strategies; and co-financing internationally agreed development goals and objectives.

Yet despite the positive changes seen in recent years, a number of major obstacles, including the external debt burden and the decline in official development assistance (ODA), continue to obstruct the effective working of the partnerships which underpin progress towards achieving the MDGs. An increase in financial aid is essential to accelerate economic growth and achieve the MDGs, yet the average aid per capita for the least developed countries of the region is considerably lower than the average for middle-income countries. However, two promising elements in the face of dwindling foreign aid have been the recent increase in interregional aid flow from the GCC countries to the least developed countries, and the increased share of national budgets allotted for the implementation of the MDGs.

Taking into consideration the implications of demographic transition in the region and the projected population growth, the coming decade is likely to see increasing levels of unmet reproductive health needs, including safe motherhood and family planning services. It is therefore of the utmost importance that intensive efforts be directed towards the development and effective mobilization of national and international resources in support of programmes which are firmly focused on reproductive health-related services, information and education, and on the building of national capacity in the fields of population, development and gender.

The liberalization of trade affects a broad spectrum of sectors, industries and occupations, and its effects are, regrettably, rarely gender neutral. Women are frequently disadvantaged in a more open market in which they find they are unable to compete and when jobs are being cut, women are often the first to lose theirs, as employers assume that men are the main breadwinners for their families. To minimize such problems, member countries should analyse the effects of the decline in certain industries on the employment of women and propose appropriate remedies to assist women in moving into businesses, occupations and sectors which are expanding. The macroeconomic policies promoted by many development donors that include the privatization of public sector services also have a negative impact on women, as women, especially the poor and marginalized, generally find it easier to access public services than private services.

To date, cuts in public sector funding, financial liberalization and the growth of free trade have failed resoundingly to deliver poverty reduction or increase gender equality in many poor countries. It is therefore clear that all such policies should be subjected to gender-responsive, rights-based analysis with a view to identifying costs and benefits, examining the way in which they are distributed and making decisions based on their potential impact on poor women and other vulnerable groups.

In the poorest countries and for the poorest women and girls, it is indisputable that the MDGs are not achievable within current national budgets. For a variety of reasons, gender is not regarded by all ESCWA member countries as a priority issue. It is therefore vital that United Nations agencies and international financial institutions step up to fill that gap by increasing their support for gender-sensitive data collection, analysis and dissemination, and by offering additional support through ODA and technical assistance in such areas as policy development, data collection and training.

All major donor countries have a commitment to gender equality under CEDAW and BPFA and it is essential that that commitment be translated into their aid programmes. All national targets and indicators under MDG 8 should incorporate a gender-responsive, rights-based element in order to identify whether aid programmes are successfully integrating those commitments. If gender analysis is being routinely applied, gender statistics are being used across all sectors, and appropriate allocation of resources is being made for the promotion of gender equality and the empowerment of women, thus fulfilling their right to receive an adequate share of common resources, donors can be confident that gender equality is being successfully integrated into their aid programmes.

IV. THE MDGS AND GENDER EQUALITY: SUCCESSES, OBSTACLES AND RECOMMENDED ACTIONS

A. PROGRESS TO DATE

In the past decade, MDG-related policies and plans have gained increasing political support in the ESCWA region, primarily in response to donor community initiatives and internal pressure for improvement in the spheres of social welfare and security. Government efforts towards honouring the promises made at the 2000 Millennium Summit have resulted in a degree of success in certain areas and failure in others in creating the conditions which are necessary for achievement of the MDGs by the target date of 2015.

While the region has made progress in a number of MDG-related targets and indicators, such progress has significantly slowed for many others and, in some cases, has even reversed. While the rich have increased in number, the poor – predominantly women – have increased even faster. School enrolments have expanded and gender gaps in education narrowed, yet the number of young people who have not attended school or are illiterate remains high and, once again, they are predominantly women and girls.

The labour market in the region not only fails women to a greater extent than men, but also fails in particular to capitalize on the skills and knowledge brought to the employment market by educated women. Evidence indicates that female youth unemployment tends to correlate both negatively and significantly with education levels; unemployment is higher among tertiary educated women than women with only primary or secondary education. There is a clear mismatch between educational outcome and employment requirements, which operates as a disempowering factor for women and serves to deplete the human resources required for member countries to advance rapidly towards the MDGs.

Unpaid work is arguably the greatest contribution made by women in the region to the national economy, both historically and still today, even though their access to paid employment has increased slightly in recent years. However, assessing the contribution of women to national income accounts remains a significant challenge, as it is all too frequently seriously devalued by conventional statistical accounting practices or simply not counted. Time spent in the informal labour sector or in non-market work (such as home care) is not counted in monetary terms, even though the opportunity cost of that time is tremendously high for women and their families in particular and for the national economy in general.

The implications for the status and empowerment of women in undervaluing their income are potentially serious. If their contribution to national income accounts is not recorded monetarily, the economic role and social status due to them as a result of that contribution are likely to remain unrecognized, and their involvement in decision-making at home and in the community may consequently be unjustifiably limited. To counter this situation, it is essential that member countries utilize time use data analysis, in conjunction with the analysis of traditional household survey and census data, to provide sex-disaggregated information with a view to improving knowledge-based plans and programmes that are responsive to gender issues and human rights.

Across the region, a large proportion of women have been and continue to be subjected to a range of inequality measures and practices for which data and indicators need to be further qualified and disaggregated by gender. Wage discrimination, for example, is a common form of gender inequality and it is not infrequent to find that the medical benefits of female employees do not extend to their spouse and children, a restriction which does not apply to male employees. It is widely accepted that gender-based violence is common in families and communities across the region, although it all too frequently goes unreported. It affects women's autonomy, health and productivity; limits their ability to care for themselves and others; curtails poverty reduction efforts; and restricts progress towards much-needed improvements in education, health and economic productivity. Yet despite the severe effects which gender-based violence exerts on women and their families, the availability and reliability of related data and indicators is, regrettably, consistently questionable, partly as a result of the absence of standardized methods and

instruments for data collection, and partly as a reflection of the attitudes and perceptions of women themselves towards such violence.

More than ever before, policymakers and health practitioners recognize the importance of reproductive health in achieving the MDGs. Their renewed commitment to integrating reproductive health services and information into primary health care has, albeit slowly, started to yield encouraging results. Fertility has declined, the use of modern family planning methods has increased, child mortality has continued to decline and life expectancy at birth has increased appreciably.

Yet while progress in recent years has been positive, much remains to be done. Forecasts for achieving the health-related MDGs, particularly MDG 5 (improve maternal health), as established in donor-driven health development strategies and the national development policies of several ESCWA member countries, are looking distinctly over-optimistic and unlikely to be achieved unless a solid, broad-based, fully integrated system of sexual and reproductive health delivery is adopted across the region. Failure to do so threatens to fragment the reproductive health agenda which was agreed at the 1994 ICPD, ignoring its common biological and behavioural foundations and health-care requirements, and sapping vital resources from basic sexual and reproductive health services, rather than strengthening the capacity of member countries to provide them.

Given the deficits in the national health systems and the lack of intersectoral coordination and good governance in the region, the U5 mortality rate (MDG 4) remains disappointingly high and the general trend, while downward, is still sluggish in many countries. Child mortality rates, which are frequently a reflection of changing family structure (from the extended family to the nuclear family, for example), are also highly sensitive to changes in socio-economic conditions, which have recently been significantly eroded by local and international financial shocks and political instability. The data and analysis set out in this report are a clear illustration that, controlling for all competing explanatory variables, those variables specifically linked to the empowerment of women strongly shape the probability of child survival and predict the future trend of child mortality transition. It is thus evident that altering intra-household power structures and reducing the patriarchal influence on the attitudes, behaviour and mobility of women would offer the triple benefit of not only empowering women, but also boosting the survival chances of children and easing the path of member countries towards the attainment of MDG 4.

The maternal mortality target of a 75 per cent reduction by 2015 will unquestionably be difficult for all countries in the region to achieve and, in all likelihood, impossible for developing countries globally. Maternal mortality transition is not only a health issue, but strongly linked to and determined by the level of living standards and women's autonomy within the household and beyond. Crucially, most maternal deaths are preventable with current knowledge and at low cost. However, eliminating preventable maternal deaths is not simply a question of access to medical care. Most of the determinants of maternal mortality lie beyond the health sector, encompassing gender equality and access to education. With political will and community support, therefore, there is no reason why even the poorest countries or those riven by political turbulence or violence should not be able to reduce maternal mortality rates significantly by providing women-friendly services, working hard to improve the gender equality balance and securing the empowerment of women for the good of all.

The spread of STIs, HIV/AIDS and other infectious diseases is widely considered to be one of the greatest failures of national health policies in the ESCWA region. Statistics indicate that the rate of HIV infection continues to rise in most, if not all, countries in the region and is disproportionately concentrated among women and young people. In the ESCWA and Arab regions, it is arguable that for a variety of reasons, a significant percentage of women and girls are extremely limited in their ability to adopt protective strategies against the virus and many, if not most, men are unaware of the ways in which they can prevent transmission to their wives.

Progress towards the MDGs, including MDG 3, has been heavily influenced by the recent global economic and financial crisis. The effects of the crisis have eroded food and energy security and diminished opportunities for reducing poverty, unemployment, and maternal and child mortality, as well as those for ensuring environmental sustainability and the continuity of global partnerships in support of national MDG-related policies and plans. This can be seen, for example, in the fact that while there have been increases in ODA for developing countries, such commitments still fall far short of what is needed for those countries to fully implement the MDGs. To a varying degree, many countries in the ESCWA region have failed to improve their macroeconomies or step up the fight against the gender gap and the spread of poverty. Yet there are vast opportunities which could be harnessed to speed up the process towards achieving the MDGs. Foremost amongst these are the importance of developing and effectively implementing properly integrated, gender-sensitive sustainable development policies and plans, and the need to transform the increasing awareness of the economic and social benefits arising from investment in the protection and empowerment of young people into a means of creating new opportunities for sustainable development and poverty reduction.

Finally, a large proportion of people in the region are currently or have recently lived through civil war, occupation or other situations of conflict. The effects of this on the MDGs (MDG 3 in particular) have extracted a heavy toll, as severe restrictions have been placed on the already-limited financial and human resources of affected countries, with funds redirected to military and security budgets at the expense of productive investment in sustainable human development. There is clear evidence that in situations of conflict, women and girls are disproportionately affected, frequently losing their hard-earned rights and seeing their opportunities for playing a full part in national, social and economic development severely compromised.

B. RECOMMENDED ACTIONS

In the light of the findings and analysis presented above, the following actions are recommended with a view to strengthening gender-responsive MDG-based policies and plans in ESCWA member countries.

First and foremost, it is imperative that all Governments in the region recognize that without advancement of gender equality and the empowerment of women, full attainment of the MDGs will be all but impossible to achieve. Irrespective of social, cultural or economic setting, the empowerment of women is a basic requisite for economic growth, poverty reduction and health improvement. It is widely agreed by development practitioners and human rights advocates that gender equality not only constitutes a goal in its own right, but also represents a tool for the achievement of the MDGs. Furthermore, individual, institutional and other providers of financial aid have accepted that neither the agenda of the Millennium Declaration, nor the MDGs themselves will be achievable in the absence of equality of capacity, opportunity and voice for all men and women.[88]

Second, in order to advance gender equality and the empowerment of women, and to fully exploit the synergy of MDG 1 with the other MDGs, member country Governments should ensure that adequate financing is provided for programmes that both respond to the real needs of women and integrate a gender perspective into poverty reduction strategies and national development plans. In this regard, gender-responsive budgeting and gender-responsive budget analysis have been proven to be instrumental in two specific areas in particular: first, in the reallocation of resources to address the needs and rights of women to health care, education and employment, and second, in analysing the differing impact of Government action on men and women with a view to enabling Governments to readjust priorities in order to reduce gender inequality.

[88] World Bank, 2007.

Third, member country Governments should redouble their efforts to reduce the pervasive gender discrimination imposed by social, cultural and religious institutions across the ESCWA region. Furthermore, Governments should work with local community networks to provide women and girls with the wherewithal to circumvent traditional barriers to accessing general and reproductive health services.

Fourth, while many member countries have made good progress towards providing universal basic education for children of both sexes in recent years, without significant additional investment in all facets of education and learning, illiteracy rates will continue to grow. In this regard, it should be a priority for every country to provide its young people with opportunities for a better education, the acquisition of skills and full participation in society with a view to, inter alia, obtaining productive employment and leading self-sufficient lives. Particular attention should be paid to the expansion of basic education, skills training and literacy among vulnerable groups, including children with disabilities, street children, internally displaced persons and children living in refugee camps. To overcome the negative effects of the current mismatch between educational outcomes and market requirements – especially among women – vigilant strategies are required, not only to improve the quality of education, but also to tailor it to changing market demands.

Fifth, as a basis for regular monitoring, Governments should prepare and disseminate national MDG reports, linked to CEDAW reports, national plans of action for women and national gender equality programmes. In this regard, the involvement of women's groups should be promoted, encouraging them to play a more active role in (a) monitoring national MDG indicators on a regular basis; (b) identifying and analysing factors contributing to slow progress in this area; (c) promoting the adoption of more gender-responsive, rights-based indicators; (d) ensuring that all data and indicators are disaggregated by sex; and (e) using the results obtained from monitoring activities to inform and support lobbying and advocacy work with decision makers and communities.

Sixth, Governments should make systematic efforts to promote sex-disaggregated indicators for monitoring and evaluation, programming, funding, policy and advocacy. Such data and analysis are a prerequisite for gender-sensitive MDG-based planning, implementation and reporting. National capacity in this area requires significant improvement, drawing upon both qualitative and quantitative parameters to track those MDG indicators that are "gender blind". The contribution of women to national income accounts, their share in employment, and gender gaps in wage and self-employment all require particular attention. It is imperative that educational gender gaps at all levels be significantly reduced without further delay and eventually eradicated completely. Reliable, sex-disaggregated data and indicators are needed on the time spent by women in fetching water and collecting fuel, and land and home ownership data should be broken down to show land and property held by men alone, that held by women alone and that held jointly. Female sexual and reproductive health needs should be monitored using credible parameters, both qualitative and quantitative. It is vital that the incidence of gender-based violence and other procedures or activities which are widely considered to be in breach of human rights, including female genital mutilation, "honour" killings, other "honour" crimes against women, and other forms of discrimination against young girls, be measured through innovative statistical approaches, including rapid assessment techniques and focus group studies.

Seventh, the establishment of an effective partnership between Government, the market and civil society at all levels of sustainable development programming is a prerequisite for achieving the MDGs, but for this to be fully effective, the commitment and capacity of all parties must be strengthened. To this end, action is required by member country Governments to raise the quality and performance of institutions that deal with such issues as information technology, research, planning and coordination insofar as they relate to MDG-based development planning processes. Such processes should, naturally, be pro-poor, pro-vulnerable, responsive to gender equality and human rights principles, and embody the values which underpin the Millennium Declaration. It should be noted, however, that the creation of strong partnerships is not an end in itself, but a means of achieving effective and equitable health and social systems on the path towards the attainment of the MDGs, and it is therefore vital that they set clear priorities for human

development, combat social exclusion, foster sound governance, support decentralization, protect the environment and ensure effective management of natural resources.

Eighth, member country Governments should implement special measures in situations of conflict and crisis to protect women and girls from violence, and provide protective mechanisms against rape, sexual violence and human trafficking.

Ninth, ensuring that women are directly and effectively targeted when economic recovery measures are being planned and making genuine efforts to help women to mitigate hardship through measures such as cash transfers, extension of employment and health benefits, and the provision of a safety net against risks to their livelihood, is indispensable for protecting the rights of women and accelerating progress towards the achievement of the MDGs.

Annex

MILLENNIUM DEVELOPMENT GOALS, TARGETS AND INDICATORS

Effective 15 January 2008

Goals and targets (from the Millennium Declaration)	Indicators for monitoring progress
Goal 1: Eradicate Extreme Poverty and Hunger	
Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	1.1 Proportion of population below $1 (PPP) per day[*] 1.2 Poverty gap ratio 1.3 Share of poorest quintile in national consumption
Target 1.B: Achieve full and productive employment and decent work for all, including women and young people	1.4 Growth rate of GDP per person employed 1.5 Employment-to-population ratio 1.6 Proportion of employed people living below $1 (PPP) per day 1.7 Proportion of own-account and contributing family workers in total employment
Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	1.8 Prevalence of underweight children under-five years of age 1.9 Proportion of population below minimum level of dietary energy consumption
Goal 2: Achieve Universal Primary Education	
Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	2.1 Net enrolment ratio in primary education 2.2 Proportion of pupils starting grade 1 who reach last grade of primary 2.3 Literacy rate of 15-24 year-olds, women and men
Goal 3: Promote Gender Equality and Empower Women	
Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	3.1 Ratios of girls to boys in primary, secondary and tertiary education 3.2 Ratio of literate women to men, 15-24 years old 3.3 Share of women in wage employment in the non-agricultural sector 3.4 Proportion of seats held by women in national parliament
Goal 4: Reduce Child Mortality	
Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	4.1 Under-five mortality rate

[*] For monitoring country poverty trends, indicators based on national poverty lines should be used where available.

Goals and targets (from the Millennium Declaration)	Indicators for monitoring progress
	4.2 Infant mortality rate
	4.3 Proportion of 1 year-old children immunized against measles
Goal 5: Improve Maternal Health	
Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality rate	5.1 Maternal mortality rate
	5.2 Proportion of births attended by skilled health personnel
Target 5.B: Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive prevalence rate
	5.4 Adolescent birth rate
	5.5 Antenatal care coverage (at least one visit and at least four visits)
	5.6 Unmet need for family planning
Goal 6: Combat HIV/AIDS, Malaria and Other Diseases	
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	6.1 HIV prevalence among population aged 15-24 years
	6.2 Condom use at last high-risk sex
	6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS
	6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	6.6 Incidence and death rates associated with malaria
	6.7 Proportion of children under 5 sleeping under insecticide-treated bed nets
	6.8 Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs
	6.9 Incidence, prevalence and death rates associated with tuberculosis
	6.10 Proportion of tuberculosis cases detected and cured under directly observed treatment short course
Goal 7: Ensure Environmental Sustainability	
Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	7.1 Proportion of land area covered by forest
	7.2 CO_2 emissions, total, per capita and per $1 GDP (PPP)

Goals and targets (from the Millennium Declaration)	Indicators for monitoring progress
Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	7.3 Consumption of ozone-depleting substances 7.4 Proportion of fish stocks within safe biological limits 7.5 Proportion of total water resources used 7.6 Proportion of terrestrial and marine areas protected 7.7 Proportion of species threatened with extinction
Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	7.8 Proportion of population using an improved drinking water source 7.9 Proportion of population using an improved sanitation facility
Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	7.10 Proportion of urban population living in slums[**]
Goal 8: Develop a Global Partnership for Development	
Target 8.A: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Includes a commitment to good governance, development and poverty reduction – both nationally and internationally	*Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries and small island developing States* *Official development assistance (ODA)*
Target 8.B: Address the special needs of the least developed countries Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction	8.1 Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income 8.2 Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation) 8.3 Proportion of bilateral official development assistance of OECD/DAC donors that is untied
Target 8.C: Address the special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)	8.4 ODA received in landlocked developing countries as a proportion of their gross national incomes 8.5 ODA received in small island developing States as a proportion of their gross national incomes

[**] The actual proportion of people living in slums is measured by a proxy, represented by the urban population living in households with at least one of the following four characteristics: (a) lack of access to improved water supply; (b) lack of access to improved sanitation; (c) overcrowding (three or more persons per room); and (d) dwellings made of non-durable material.

Goals and targets (from the Millennium Declaration)	Indicators for monitoring progress
Target 8.D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	*Market access* 8.6 Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty 8.7 Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries 8.8 Agricultural support estimate for OECD countries as a percentage of their gross domestic product 8.9 Proportion of ODA provided to help build trade capacity *Debt sustainability* 8.10 Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative) 8.11 Debt relief committed under HIPC and MDRI Initiatives 8.12 Debt service as a percentage of exports of goods and services
Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	8.13 Proportion of population with access to affordable essential drugs on a sustainable basis
Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	8.14 Telephone lines per 100 population 8.15 Cellular subscribers per 100 population 8.16 Internet users per 100 population

The Millennium Development Goals and targets are set out in the Millennium Declaration, signed by representatives of 189 countries, including 147 heads of State and Government, in September 2000 (http://www.un.org/millennium/declaration/ares552e.htm) and from further agreement by Member States at the 2005 World Summit (General Assembly resolution A/RES/60/). The goals and targets are interrelated and should be seen as a whole. They represent a partnership between the developed countries and developing countries to create an environment – at the national and global levels alike – which is conducive to development and the elimination of poverty.

BIBLIOGRAPHY

Barro, R. and Jong-Wha Lee. 2000. *International Data on Educational Attainment: Updates and Implications*. Harvard University Center for International Development Working Paper No. 42. Cambridge, Massachusetts: Harvard University.

Bernstein and Juul Hansen. 2006. *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals*. New York: UNDP.

Central Statistical Organization of Yemen. 1991. *Population and Development in the Republic of Yemen, Proceedings of the First National Population policy Conference*. 2: 36-43. Sana'a: Government of Yemen.

Costello, A. et al. 2009. Managing the Health Effects of Climate Change. *The Lancet*. 373 (9676): 1693-1733.

De Jong, J. and Shepard, B. 2006. Youth, Gender and Family in the Arab World in *Arab Youth Strategising for the Millennium Development Goals*. New York: UNDP.

ESCWA. 2008. *Gender in the Millennium Development Goals: Information Guide for Arab Millennium Development Goal Reports*. New York and Geneva: United Nations.

ESCWA. 2007. *ESCWA Centre for Women Newsletter: Gender and the MDGs.* 1(6): 2-5.

ESCWA. 2005. *The Millennium Development Goals in the Arab Region 2005*. New York and Geneva: United Nations.

ESCWA. 2004. *Report on the Regional Arab Population Forum.* New York and Geneva: United Nations.

ESCWA and League of Arab States. 2009. *Consolidated Arab Report on the Implementation of the Beijing Platform for Action: +15.* New York and Geneva: United Nations.

ESCWA and League of Arab States. 2007. *The Millennium Development Goals in the Arab Region 2007: A Youth Lens*. New York and Geneva: United Nations.

Farah, A-A. and Faour, T. 2011. Life-course Approach to Women's Health in *Arab Family Health and Population*. IV (10): 1-34.

Farah, A-A. and Maas, B. 2006. *Women's Autonomy and Reproductive Health Behavior in Yemen*. Paper presented at the Global Health Forum for Health Research (Cairo, 29 October-2 November 2006).

Farah, A-A. and Rasheed, H. 2009. *Determinants of Cross-country Variation in Maternal Mortality in Developing Countries.* Paper presented at the Second Arab Statistical Conference: No Development Without Statistics (Sirte, Libyan Arab Jamahiriya, 2-4 November 2009).

Fathallah, M. 2008. *Issues in Women's Health and Rights: International, Arab Regional and Egyptian Perspectives*. International Planned Parenthood Federation.

Gwatkin, D. 2005. How Much Would Poor People Gain from Faster Progress Towards the Millennium Development Goals for Health? *The Lancet*. 365 (9445): 813-817.

Hay, M.C. 1999. Dying Mothers: Maternal Mortality in Rural Indonesia, *Medical Anthropology*. 18 (3): 243-279.

Hunt, P. 2007. *The Millennium Development Goals and the Right to the Highest Attainable Standard of Health.* Chicago: John D. and Catherine T. MacArthur Foundation.

Jamison, D.T. et al. (eds). 2006. *Priorities in Health*. Washington D.C.: World Bank Publications.

Organisation for Economic Co-operation and Development (OECD). 2010. *Atlas of Gender and Development: How Social Norms Affect Gender Equality in Non-OECD Countries*. Paris: OECD.

Ransom, E. and Yinger, N. 2002. *Making Motherhood Safer: Overcoming Obstacles on the Pathway to Care*. Washington: Population Reference Bureau.

Shiffman, J. 2000. Can Poor Countries Surmount High Maternal Mortality? *Studies in Family Planning*. 3 (4) 274-289.

United Nations. 2010. *The Third Arab Report on the Millennium Development Goals 2010 and the Impact of the Global Economic Crises*. New York and Geneva: United Nations.

United Nations. 2009. *United Nations Iraq Common Country Assessment*. New York and Geneva: United Nations.

United Nations. 2007a. *Report of the Secretary-General on the Work of the Organization to the Sixty-second Session of the General Assembly. Supplement No. 1*. New York and Geneva: United Nations.

United Nations. 2007b. *World Abortion Policies 2007*. New York and Geneva: United Nations.

United Nations. 2007c. *World Youth Report 2007 – Young People's Transition to Adulthood: Progress and Challenges*. New York and Geneva: United Nations.

United Nations. 2006. *Report of the Secretary-General on the work of the Organization to the Sixty-first Session of the General Assembly. Supplement No. 1*. New York and Geneva: United Nations.

United Nations. 2005. *Beijing at Ten and Beyond.* New York and Geneva: United Nations.

United Nations. 2001. *Beijing Declaration and Platform for Action with the Beijing +5 Political Declaration and Outcome Document*. New York and Geneva: United Nations.

United Nations. 2000a. *United Nations General Assembly resolution 55/2*: *United Nations Millennium Declaration*. New York and Geneva: United Nations.

United Nations. 2000b. *Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention Against Transnational Organized Crime.* New York and Geneva: United Nations.

United Nations Children's Fund (UNICEF). 2009. *The State of the World's Children 2009: Maternal and Newborn Health*. New York: UNICEF.

UNICEF. 2005. The *State of the World's Children 2005: Childhood Under Threat*. New York: UNICEF.

United Nations Development Fund for Women (UNIFEM). 2008. *Making the MDGs Work for All: Gender-responsive Rights-based Approaches to the MDGs*. New York: UNIFEM.

UNIFEM and UNDP. 2009. *Making the MDGs Work Better for Women: Implementing Gender-responsive National Development Plans and Programmes*. New York: UNIFEM.

United Nations Development Programme (UNDP). 2009. *Arab Human Development Report 2009*. New York: UNDP.

UNDP. 2007. *Measuring Human Development: Guidelines and Tools for Statistical Research, Analysis and Advocacy.* New York: UNDP.

UNDP. 2006. *Arab Youth Strategising for the Millennium Development Goals*. New York: UNDP.

UNDP. 2005a. *En Route to Equality: A Gender Review of National Millennium Development Goal Reports 2005*. New York: UNDP.

UNDP. 2005b. *Taking Action: Achieving Gender Equality and Empowering Women*. New York: UNDP.

UNDP. 2003. *Millennium Development Goals – National Reports: A Look Through a Gender Lens*. New York: UNDP.

United Nations Educational, Scientific and Cultural Organization (UNESCO). 2010. *Education for All Global Monitoring Report 2010: Reaching the Marginalized.* Paris: UNESCO and Oxford: Oxford University Press.

UNESCO. 2010. *EFA Global Monitoring Report 2010: Reaching the Marginalized.* Paris: UNESCO.

United Nations High Commissioner for Refugees (UNHCR). 2009. *2008 Global Trends: Refugees, Asylum-seekers, Returnees, Internally Displaced and Stateless Persons*. New York: UNHCR.

United Nations Joint Programme on HIV/AIDS (UNAIDS). 2009. *UNAIDS Epidemic Update 2009: Middle East and North Africa*. Geneva: UNAIDS.

UNAIDS. 2005. *UNAIDS Epidemic Update 2005: Middle East and North Africa*. Geneva: UNAIDS.

United Nations Population Fund (UNFPA). 2010. *Beijing at Fifteen – UNFPA and Partners: Charting the Way Forward*. New York and Geneva: United Nations.

UNFPA. 2009. State *of World Population 2009 – Facing a Changing World: Women, Population and Climate*. New York: UNFPA.

UNFPA. 2008. *Regional Programme Action Plan for Arab States: June 2008-2011*. New York: UNFPA.

UNFPA. 2003. *State of World Population 2003 – Making 1 Billion Count: Investing in Adolescents' Health and Rights*. New York: UNFPA.

UNFPA. 1994. *International Conference on Population and Development Programme of Action.* New York: United Nations.

World Bank. 2008. *Development and Climate Change: A Strategic Framework for the World Bank Group.* Washington D.C.: World Bank.

World Bank. 2007. Global Monitoring Report 2007 – *Millennium Development Goals: Confronting the Challenges of Gender Equality and Fragile States.* Washington, D.C.: World Bank.

World Bank. 2004. *MENA Development Report: Unlocking the Employment Potential in the Middle East and North Africa – Towards a New Social Contract*. Washington D.C.: World Bank.

World Health Organization (WHO). 2009. *Women and Health: Today's Evidence, Tomorrow's Agenda*. Geneva: WHO.

WHO. 2007. *Neonatal and Prenatal Mortality: Country, Regional and Global Estimates 2004*. Geneva: WHO.

WHO, UNICEF, UNFPA and World Bank. 2007. *Maternal Mortality in 2005*. Geneva: United Nations.