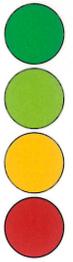


**HEALTH AND MILLENNIUM  
DEVELOPMENT GOALS  
IN THE ESCWA REGION**



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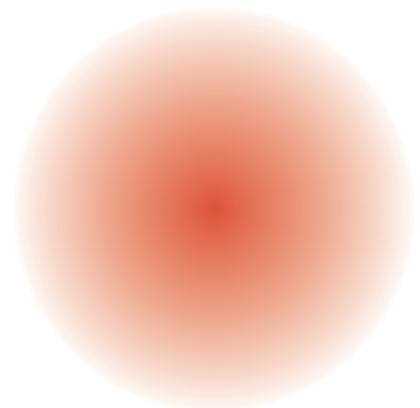
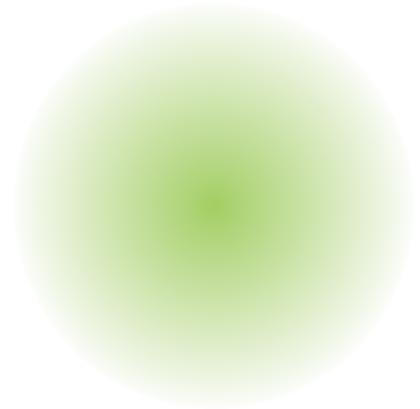
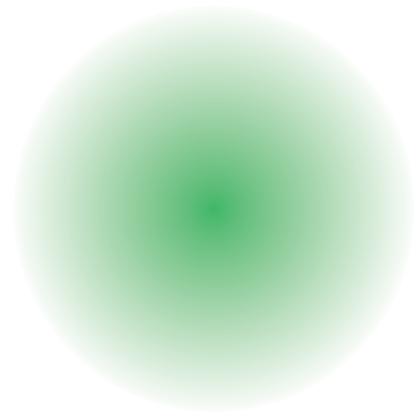
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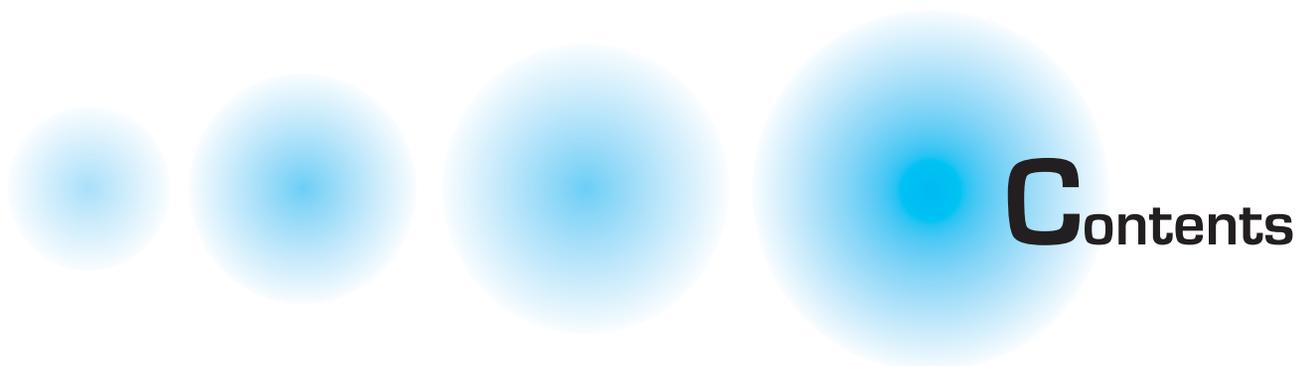
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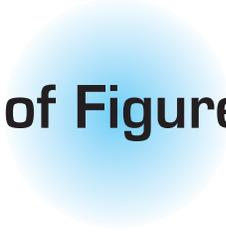
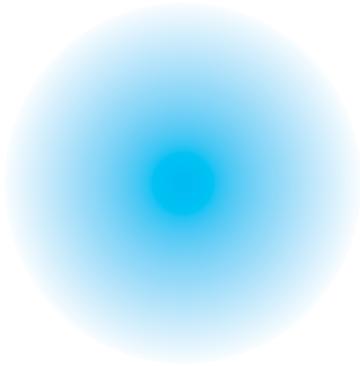
**HEALTH AND  
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**IN THE ESCWA REGION**





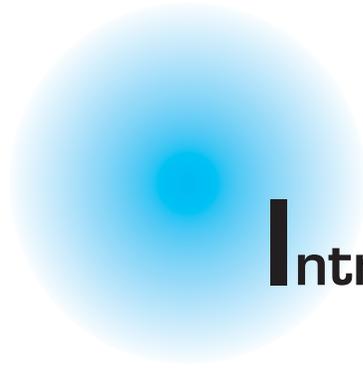
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# **I**ntrouduction

In September 2000, the largest-ever gathering of Heads of State ushered in the new millennium with the adoption of the Millennium Declaration. The Declaration was endorsed by 189 countries and translated into a roadmap setting out goals to be reached by 2015.

The eight Millennium Development Goals (MDGs) build on agreements made at previous United Nations conferences in the 1990s and reaffirm the commitment to reduce poverty and hunger, tackle ill-health, gender inequality, lack of education, lack of access to clean water and environmental degradation.

The pamphlet on Health and MDGs represents one of the concerted efforts of the Statistics Division of the Economic and Social Commission for Western Asia (ESCWA) to provide evidence-based regional information on its member countries in the health sector. It recognizes the contribution made by each country to attain the MDGs in fulfilling their promises to the Declaration. In such a diverse region as ESCWA, attention is to be directed at the most critical areas in order to raise awareness for support and policy-intervention.

The pamphlet consists of three parts. The first part, "*Our Children*" focuses on Goal 1: Eradicate extreme poverty and hunger and Goal 4: Reduce child mortality. The second part, "*Our Mothers*", presents the health situation of women, particularly mothers and those most vulnerable to HIV/AIDS, and covers both Goal 5: Improve maternal health and Goal 6: Combat HIV/AIDS and other diseases of the MDGs. The last part provides

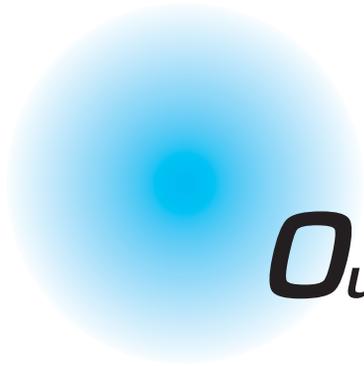
health-related information affecting "*Our Health*", with a focus on Goal 7: Ensure environmental sustainability, and Goal 8: Develop a global partnership for development.

The data, where available, covers the time frame from 1990 to 2006. A questionnaire, based on national MDG Report information, was prepared by the Statistics Division, and sent to the member countries for completion and update. The comprehensive database on health MDGs will be stored in the Statistics Division database, located on the Division's homepage <sup>1</sup>. It will be complemented with extensive metadata.

Analysis of each health-related indicator is presented under each part with related charts. Accomplishments and limitations have been analyzed by country, where data are available. Disaggregated data on gender and rural - urban communities have been included in the analysis. The charts present both the accomplishments of the early 1990s and mid-2000s and the likelihood of reaching the targets by 2015.

In terms of meeting the health MDGs, the challenges ahead need to be overcome by building on the successes already achieved and endeavoring to achieve those that remain unattained, which are summarized in the conclusion.

<sup>1</sup> <http://www.escwa.un.org/divisions/main.asp?division=sd>



# ***O***ur Children

***"We cannot waste our precious children. Not another one, not another day"***

***Nelson Mandela and  
Graca Machel***



## Goal 1. Eradicate extreme poverty and hunger

### Target 2. Halve, between 1990 and 2015, the proportion of people who suffer from hunger

#### Indicator 4. Prevalence of underweight children under five years of age

Child malnutrition, measured as poor child growth, is implicated in more than half of all child deaths at the global level. Malnourished children have lower resistance to infection and are more prone to die from common childhood ailments. Three-quarters of children who die from causes related to malnutrition were only mildly or moderately undernourished, showing no outward sign of their vulnerability<sup>1</sup>.

According to 2006 UNICEF estimates, of the 146 million children who are underweight in the developing world, 8 million of them are in the Middle East and North of Africa (Fig.1). Factors such as poverty, poor education of women, inadequate caring practices for children, poor care during pregnancy, poor access to health services, and poor sanitation are all underlying causes.

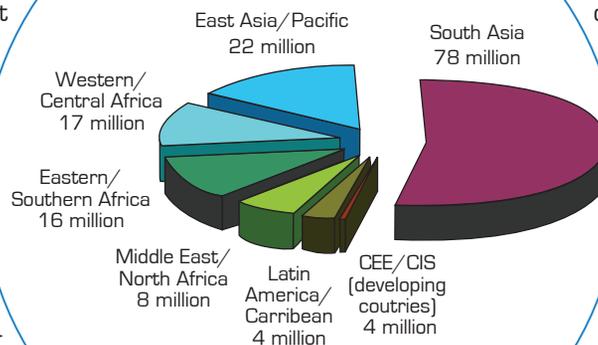
The severity of malnutrition prevalence varies across countries in the ESCWA region and is most pronounced in less developed country such as Yemen, and conflict-ridden ones, such as Iraq. In Yemen, levels of malnutrition increased by 16 per cent points between 1990 and 2003, resulting in almost one-half of children under the age of five malnourished. In Iraq, a combination of war and embargoes in the 1990's drastically impacted child health. Levels of malnutrition in Iraq nearly doubled from 12 per cent in 1990 to 22 per cent in 1999. However, a major decline in child malnutrition began in 2000. As of 2006, the child malnutrition rate in Iraq stands at 8 per cent, only 1.5 percentage points away from the country's target for 2015.

By the mid-2000s, both Bahrain and Lebanon had achieved and exceeded their 2015 targets (4.5%) in mid-2000s. They are followed by four countries namely, Egypt, Iraq, Jordan, and Palestine that have decreased their malnutrition rates and are poised to achieve their set targets ranging from a minimum of 3 per cent to a maximum of 8 per cent. There is no data available for Saudi Arabia in 1990s, however its latest reported rate was 5 per cent in 2004, placing it within the same range as those four countries.

Three countries, on the other hand, reported increases in their malnutrition rates. Malnutrition in both Kuwait and Qatar increased from 5 per cent in 1990 to 10 per cent in the mid-2000s, while Yemen reported an increase of approximately 16 per cent points during the same period. It is interesting to note that despite the prevailing hard conditions in which the Palestinians are living, child malnutrition in Palestine is the lowest in the ESCWA region at 3 per cent in 2006.

Malnutrition in the ESCWA region, therefore, can be categorized in three levels. In the first group, the highest severity level, are Yemen (46%) and Oman (18%), which need to undertake concrete measures to reduce the prevalence of underweight children under the age of five. The second group are those at the medium level of severity (10%), including Kuwait, Qatar, and the Syrian Arab Republic. The majority of ESCWA countries, the third group, including Bahrain, Egypt, Iraq, Jordan, Lebanon, Palestine, and Saudi Arabia, fall into the lowest level of severity (<8%).

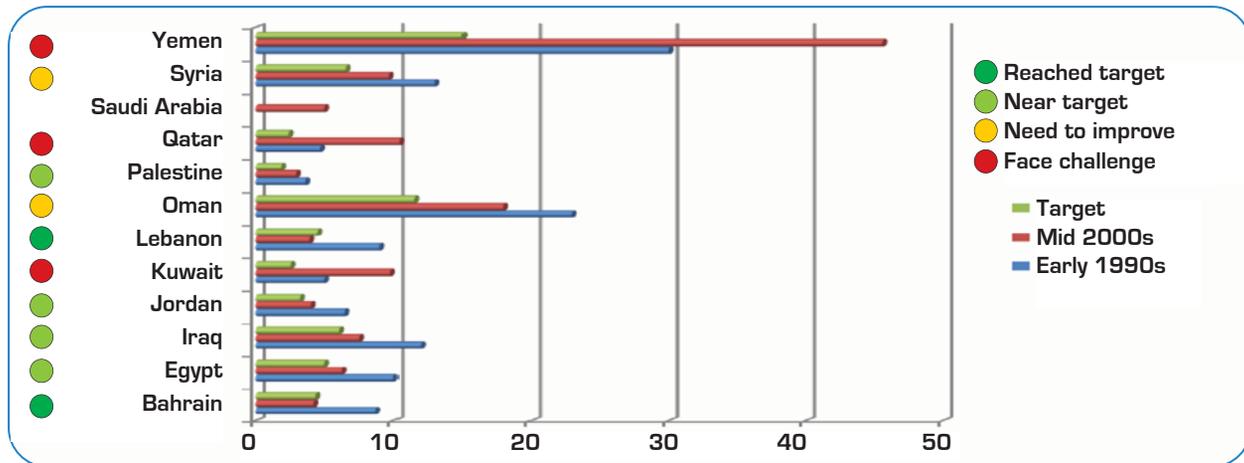
**Fig. 1 Number of underweight children in the developing world, 2006**



Source: UNICEF analysis of the number of underweight children in the developing world, 2006

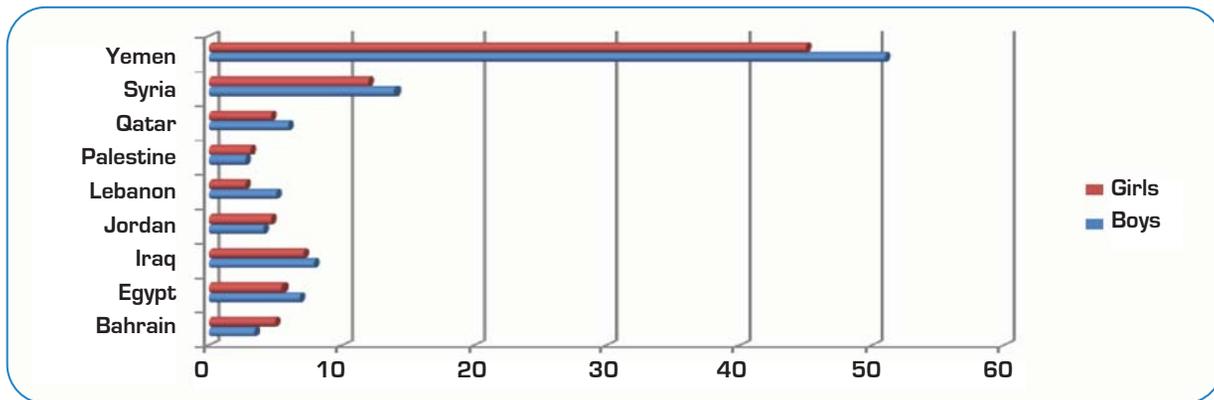


**Fig. 2 Prevalence of underweight children under five years of age in selected ESCWA countries (%)**



According to available sex-disaggregated data from countries, there is no gender gap in child malnutrition in the ESCWA region.

**Fig. 3 Prevalence of underweight children under five years of age in selected ESCWA countries, by sex, last available year (%)**



There are however, large disparities between urban and rural areas in the level of child malnutrition in some member countries, according to available data, with the exception of Egypt and Palestine, where the difference is less than 1 percentage points. Although prevalence rates in Jordan decreased between 1990 and 2002 in both urban and rural areas, the proportion of malnourished children under the age of five in rural areas remains at 7 per cent more than 1.75 times that of urban areas.

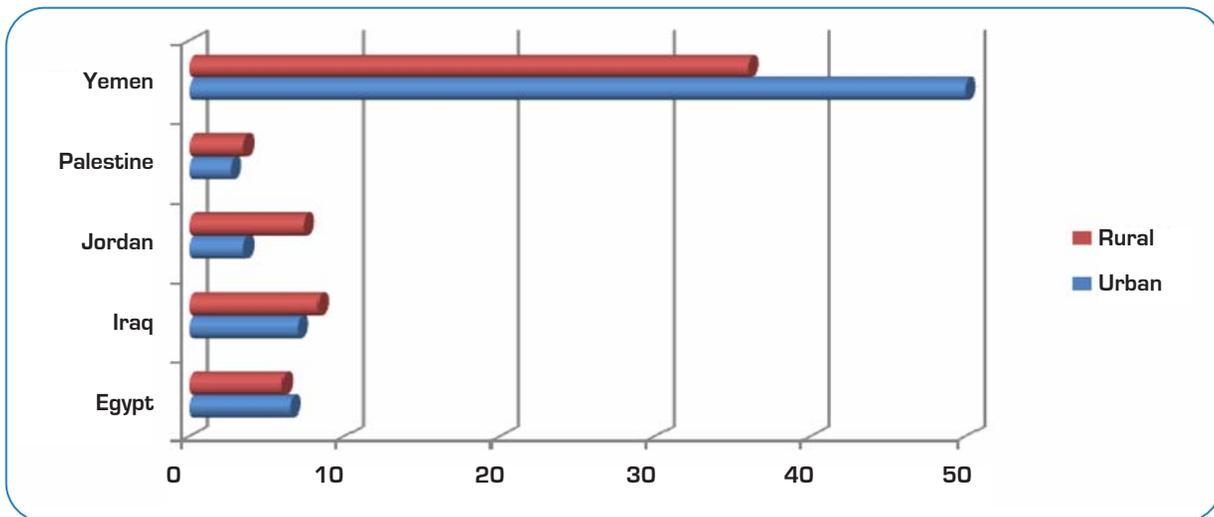
Conversely, the prevalence of malnutrition among under-five year olds in Egypt fluctuated over the years in both urban and rural areas. In 1992, the rural rate was 11 per cent higher than the 7 per cent urban rate. In the late 1990s, malnutrition prevalence in Egypt surged to 13 per cent in rural areas and 10 per cent in urban areas. However, by 2006, malnutrition levels in the country dropped to 6.5 per cent in urban areas and 6 per cent in rural areas, and the urban-rural gap narrowed to a 0.5 percentage point difference.



Although child malnutrition is generally higher in rural than urban areas Yemen remains an exception to this rule. In addition to being a country with the highest reported malnutrition rates in the region, in 1997 Yemen reported a higher urban rate of 50 per cent compared to a lower rural rate of 36 per cent. This

may be because Yemen is still a mainly agricultural society where home-grown and owned agricultural products are available in the country side, whereas the urban population may face food deprivation due to wide spread poverty in the cities.

**Fig. 4 Prevalence of underweight children under five years of age in selected ESCWA countries, rural - urban, last available year (%)**





## Goal 4. Reduce child mortality

### Target 5. *Reduce by two thirds, between 1990 and 2015, the under-five mortality rate.*

#### Indicator 13. *Under-five mortality rate & Indicator 14. *Infant mortality rate.**

Each year, globally, more than 10 million children die before their fifth birthday. Nearly 4 million of these deaths occur during the neonatal period. Of these deaths, an estimated 6.5 million could be prevented using proven, cost-effective interventions<sup>2</sup>.

Since 1990, under-five mortality (U5M) and infant mortality rates (IMR) in almost all ESCWA member countries have declined rapidly. Six countries including Bahrain, Egypt, Kuwait, Lebanon, and the Syrian Arab Republic have nearly halved their mortality levels. So far, Egypt have made the largest reduction in U5M (44 percentage points) and IMR (35 percentage points). Yemen also reduced its U5M substantively (30 percentage points), although it did not make similar progress in reducing its IMR (6 percentage points) during the same period.

**Under-five mortality rate:** The probability of children dying between birth and their fifth birthday, expressed as per 1,000 children born alive.

**Infant mortality rate:** The number of deaths of infants, under one year of age, in a given period of time, per 1,000 live births in the same amount of time.

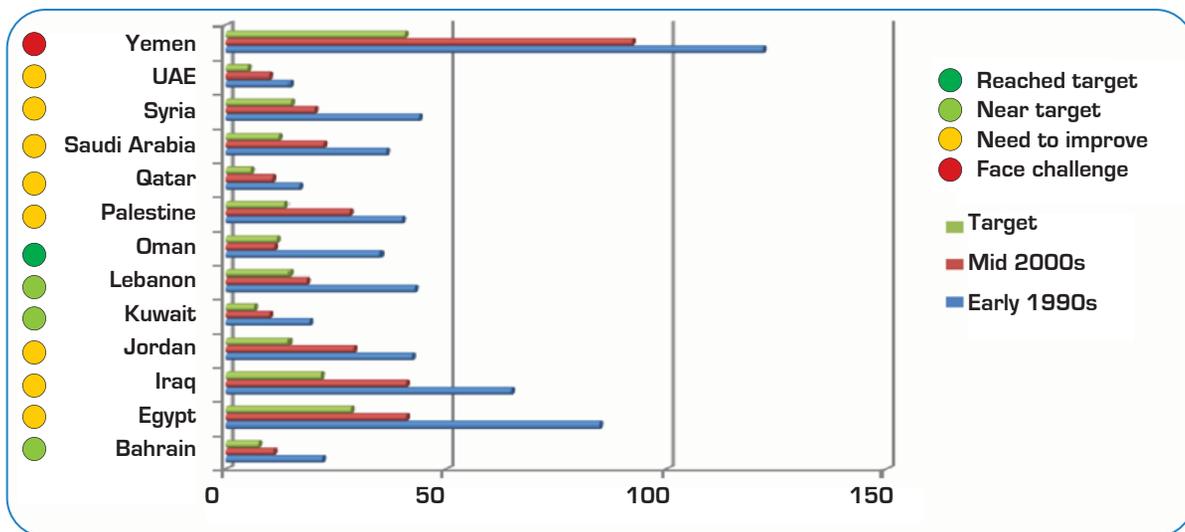
Iraq, Lebanon, Oman and the Syrian Arab Republic reduced their U5M by around 24 percentage points since the 1990s. IMR reductions were also made in Lebanon and Oman (18 percentage points each) and Iraq (12 percentage points). The Syrian Arab Republic's 26 percentage point decrease in IMR makes it second to Egypt as a fastest achiever of IMR reduction in the region since the 1990s.

These marked reductions in child and infant mortality rates have, however been unevenly distributed. The oil-producing and exporting countries of the Gulf Cooperation Council (GCC), with the exception of Saudi Arabia, have the lowest deaths per 1,000 live births, with U5M at  $\leq 11$  and IMR at  $\leq 10$ , according to the latest reported data. Despite being a country with a high level of socio-economic development, Saudi Arabia's U5M and IMR were moderate in 2006, at 22 deaths and 19 deaths per 1,000 live births, respectively. The second category of countries undergoing economic transition with moderate U5M and IMR includes Lebanon, Jordan, Palestine, and the Syrian Arab Republic with deaths ranging between 20-29. These countries are followed by Egypt and Iraq with relatively high U5M (41 deaths) and IMR (33-35 deaths). Finally, Yemen, in the low socio-economic development category, has a very high U5M and IMR, 92 and 77 deaths per 1,000 live births, respectively.

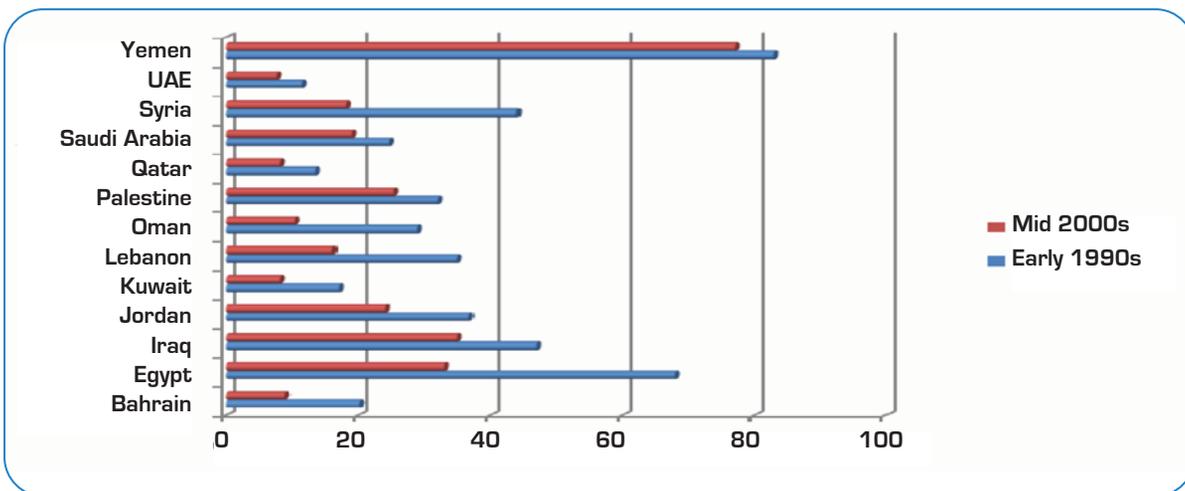
Contrary to the progress achieved in member countries regarding Indicator 4. Prevalence of underweight children under five years of age in Goal 1, only Oman succeeded in meeting its set U5M target for 2015. Almost half of the remaining member countries would have to make extra effort to reduce U5M to meet their set targets for 2015.



**Fig.5 Under-five mortality rate (per 1,000 live births) in ESCWA member countries**



**Fig.6 Infant mortality rate (per 1,000 live births) in ESCWA member countries**



There are no major gender gaps in either U5M and IMR rates in member countries. Most of the countries with sex-disaggregated data have slightly higher rates for boys than girls. In Jordan, for example, U5M for boys was 30 deaths per 1,000 live births, and that of girls was at 28 deaths per 1,000 live births in 2003. Similarly, in 2002, IMR in Jordan was 25 deaths per 1,000 live births among boys and 23 deaths per 1,000 live births among girls. In Palestine, 2006 U5M rates among boys were almost 1.2 times higher than that of girls, at 30 deaths per 1,000 live births. Similarly, IMR

for boys was 27 deaths while that of girls was 23 deaths per 1,000 live births. Comparable trends are noted in Bahrain, Qatar, Saudi Arabia and the Syrian Arab Republic.

A significant rural-urban gap in both U5M and IMR is noted in the ESCWA region. For example, in Jordan, 1997 U5M rates were 46 deaths in rural areas compares to 31 deaths per 1,000 live births in urban areas. Although rates in both urban and rural Jordan declined over the years, the gap in U5M persists. In 2003, U5M



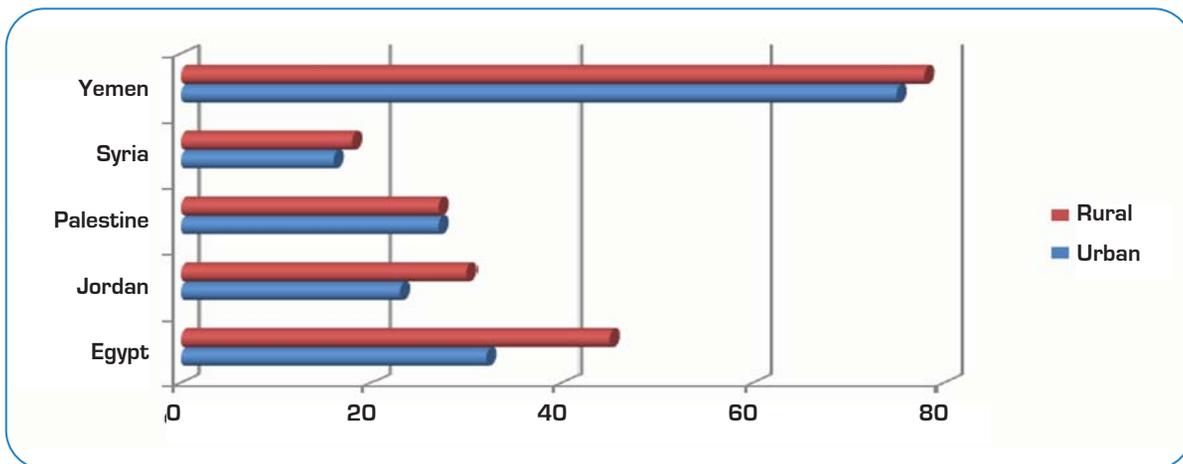
in rural areas of Jordan was 36 deaths per 1,000 live births, whereas in urban areas of Jordan there were 27 deaths. Under-five mortality in rural Egypt decreased by more than half, dropping from 132 deaths in 1992 to 56 deaths per 1,000 live births in 2005. During the same period, U5M in urban Egypt declined from 71 to 39 deaths per 1,000 live births. In 1997, the U5M rate in urban areas of Yemen was higher than that of the rural areas at 112 and 98, respectively. In 2004, however, rural rates (94 deaths) became higher than urban rates (89 deaths) in Yemen.

In Jordan, the rural-urban difference in the proportion of infants dying before reaching their first birthday

is commensurate with that of the probability of a child dying before the age of five. In 1997, IMR in rural areas was 39 deaths per 1,000 live births, compared to approximately 27 deaths in urban areas. By 2002, IMR in rural and urban areas decreased to 30 and 23 deaths per 1,000 live births, respectively.

In Egypt, IMR figures for 2005 stood at 45 in rural areas and at 32 death per 1,000 live births in urban areas. It is noteworthy that Egypt has made significant reductions in its infant mortality rate since the 1990s. Between 1992 and 2005, a decline of 51 percentage points was reported in rural areas and 22 percentage points in urban areas.

**Fig.7 Infant mortality rate (per 1,000 live births) in selected countries, rural - urban (last available year)**



### Indicator 15. *Proportion of 1 year-old children immunized against measles*

Immunization has been considered as the most successful and cost-effective intervention in public health. The spread of immunization services has remarkably improved child survival and reduced child mortality rates related to infectious diseases. In addition, World Health Organization (WHO) expects that by 2010 every country will have achieved 90 per cent routine immunization of diphtheria, poliomyelitis and tetanus (DPT3) at the national level, and 80 per cent immunization at the district level<sup>3</sup>.

Ten member countries including Bahrain, Egypt, Jordan, Kuwait, Oman, Palestine, Qatar, Saudi Arabia, the Syrian Arab Republic and UAE have nearly achieved universal immunization (>92%). In Yemen, immunization against measles increased by around 21 percentage points between 1990 and 2004, reaching a rate of 73 per cent.

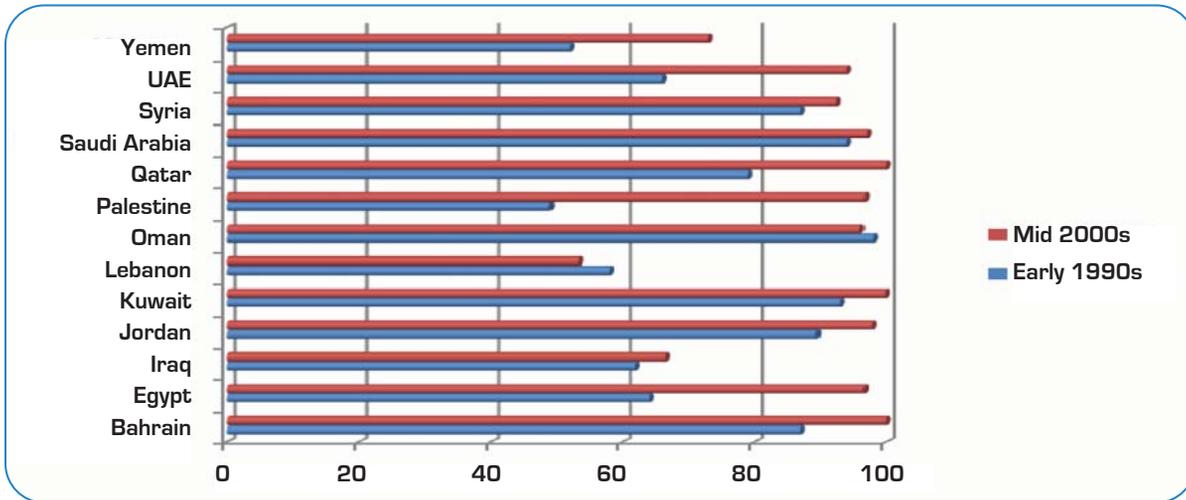
However, two member countries experienced set-



backs in immunization coverage after having maintained a constant increase from the early 1990s through the mid-2000s. Iraq increased its immunization rate from 62 per cent in early 1990s to over 90 per cent in 2000. However, in 2005 the rate of immunization in

Iraq deteriorated to 67 per cent. A similar situation was noted in Lebanon where the rate increased steadily from 58 per cent in 1990 to 94 per cent in 2001, only to decline sharply, by more than 40 percentage points, to 53 per cent in 2004 .

**Fig.6 Infant mortality rate (per 1,000 live births) in ESCWA member countries**



According to WHO, childhood deaths by disease can be classified into five types: pertussis, poliomyelitis, diphtheria, measles, and tetanus (Table1). Immunization can prevent all these diseases and contribute to the reduction in child mortality. In Yemen, the proportion of childhood deaths stands at 16 deaths per 100,000

population and is due to the fact that the presence of these 5-cluster diseases in Yemen is the highest in the region, followed by Iraq (6 deaths) and Egypt (2.8 deaths). In these countries, Pertussis is the leading cause for childhood death, as the table below shows<sup>4</sup>.

**Table 1. Childhood-cluster diseases: Estimated deaths per 100,000 population by causes**

Childhood-cluster diseases		Egypt	Iraq	Jordan	Lebanon	Oman	Qatar	Saudi Arabia	Syria	UAE	Yemen
		2.8	5.8	0.2	0.1	0	0.1	0.3	0.4	0.1	16.1
a	Pertussis	1	3.7	0.1	0.1	0	0	0.1	0	0	6.8
b	Poliomyelitis	0	-	-	-	-	-	-	-	-	-
c	Diphtheria	-	0	-	0	-	-	-	0	-	0
d	Measles	1.4	0.3	0	0	0	0.1	0	0.2	0	5.6
e	Tetanus	0.4	1.7	0.2	0	-	-	0.2	0.2	-	3.7

Source: WHO, Department of Measurement and Health Information, 2004 (Table 3)  
 (-) not available



## ***O***ur Mothers

***"No woman should die  
giving life"***

***UNFPA***



## Goal 5: Improve maternal health

### Target 6. Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio.

#### Indicator 16. Maternal mortality ratio.

The maternal mortality ratio (MMR) indicates the obstetric risk of death a woman faces with each pregnancy. In order to achieve Goal 5 and reduce the MMR by three-quarters, it is vital to prioritize improving health care for women, expanding access to emergency services and providing universal access to sexual and reproductive health services.

According to the latest available data, MMR in the ESCWA region is lower than the world average of 400 deaths per 100,000 live births. Moreover, MMR in almost one-half of ESCWA countries is commensurate with, or lower than, the European average of 39 deaths per 100,000 live births<sup>5</sup>.

Maternal mortality ratio is the number of deaths during a given time period per 100,000 live births during the same time period.

In an assessment of lifetime risk of maternal death conducted by UN Agencies<sup>6</sup> in 171 countries, Kuwait ranked as 22nd (1 death in 9,600) before UK, France and USA, while Qatar ranked 52nd (1 death in 2,700), Saudi Arabia ranked 56th, followed by Bahrain at 61st (1 death in 1,400 and 1,300, respectively). The countries that scored the lowest in maternal mortality were Iraq, which ranked 119th (1 death in 72), and Yemen, which ranked 135th (1 death in 39).

Trends in maternal mortality from the 1990s to the mid-2000s, suggest a rapid decline in MMR in almost all ESCWA member countries. However, significant intra-regional discrepancies in MMR and the likelihood of achieving the target still exist. Both Kuwait and UAE have achieved or exceeded their target of reducing maternal mortality by three-quarters. On the other hand, MMR in Iraq and Yemen have worsened since the 1990s. The majority of ESCWA countries, with the

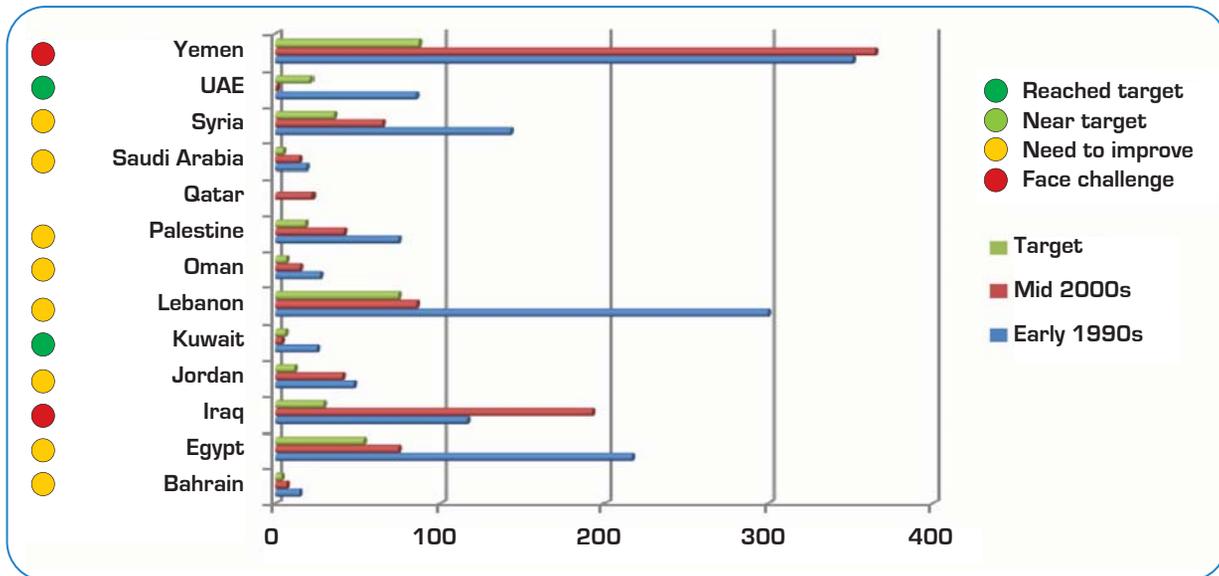
exception of Lebanon, are still far from achieving their set targets by 2015; they therefore need to maintain concerted efforts in order to achieve further reductions. Iraq and Yemen will need to achieve a constant annual decline of 16% and 28%, respectively, in order to reach their targets by 2015.

Five countries have maintained low levels of MMR ( $\leq 15$ ) between the early 1990s and the mid-2000s, namely, Bahrain (7), Kuwait (4), Oman (15), Saudi Arabia (15) and UAE (1). Countries with high MMR have made significant achievements in reducing their rates since the 1990s. Lebanon succeeded in reducing its MMR by an impressive 214 percentage points (from 300 to 86), followed by Egypt which reduced its MMR by 142 percentage points (from 217 to 75). The Syrian Arab Republic and UAE have also made good progress in reducing their MMR since 1990. The Syrian Arab Republic achieved a decrease of 78 percentage points (from 143 to 65), and UAE a decrease of 85 percentage points (from 86 to 1). Palestine and Kuwait have made modest gains in reducing their MMR (33 and 21 percentage point decrease, respectively) during the same period, however reaching different rates 42 and 4 respectively, by the mid-2000s.

In Iraq, instability, and in Yemen, poor socio-economic conditions, pose serious challenges to improving maternal health. In fact, MMR in both countries increased between 1990 and 2003. In Iraq, the proportion of women dying during pregnancy, childbirth or within 42 days of termination of pregnancy rose from 117 to 193 deaths per 100,000 live births. Similarly, in Yemen it rose from 351 to 365 deaths per 100,000 live births.



**Fig.9 Maternal mortality ratio (per 100,000 live births) in ESCWA member countries**



WHO studies show that 80 per cent of maternal deaths in developing countries are direct obstetric deaths, which are, for the most part, preventable. Of these direct obstetric deaths, 25 per cent are due to hemorrhage, 15 per cent to sepsis, 13 per cent to unsafe abortions, 12 per cent to hypertension disorders and 8 per cent to atonic labour. Approximately 20 per cent of maternal deaths from indirect causes are due to complications from diseases such as malaria, viral hepatitis, diabetes, anemia, rheumatic heart disease and AIDS<sup>7</sup>.

There is little reporting on the causes of maternal mortality in the ESCWA region. Estimates reveal that in the Syrian Arab Republic the proportion of direct obstetric-caused deaths varies between 83% and 89%. Hypertensive disorder in pregnancy has been reported to be the primary cause of maternal mortality in Qatar, and the second most common cause in Bahrain<sup>8</sup>. Embolism was reported as the second most common cause of maternal death in Qatar and the third in Bahrain<sup>9</sup>.

### Indicator 17. *Proportion of births attended by skilled health personnel*

Evidence suggests the positive relationship between the presence of a skilled health worker at delivery and the reduction of maternal mortality<sup>10</sup>. It is assumed that the proportion of deliveries attended by skilled health personnel, therefore, is a key indicator for the MDG target of reducing maternal mortality.

WHO estimates of the percentage of births attended by skilled health personnel in Western Asia is 75 per cent higher than both the world average of 63 per cent, and of many other regions<sup>11</sup>. In fact, the proportion of

The term "skilled attendant" refers to "an accredited health professional - such as a midwife, doctor or nurse - who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns" (World Health Organization, 2004).

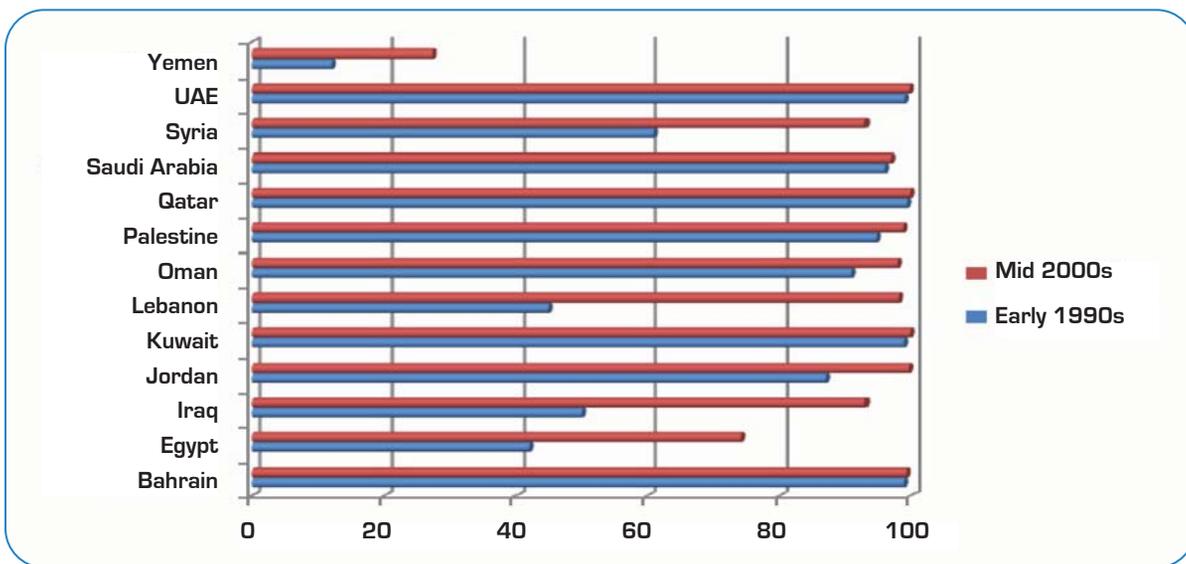


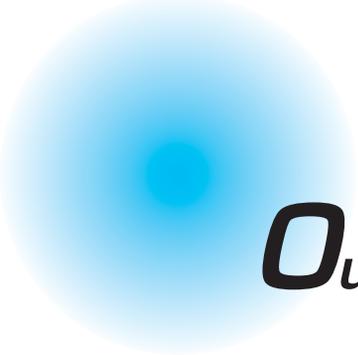
births attended by skilled health personnel in GCC countries has been high since the 1990s and is nearing universality.

In addition, great progress has been made in Iraq, Lebanon and the Syrian Arab Republic. Their rates increased from a very low percentage, ranging from 45 per cent to 61 per cent in 1990, to a high rate of over 90 per cent in their last reported years during the mid-2000s. Egypt has also made a big leap in bridging the

gap by increasing the percentage of skilled health-care providers attending all births, going from a low rate of 42 per cent in 1990 to a high of 74 per cent in 2005. In Yemen, the proportion of births attended by skilled health personnel increased modestly by 12 percentage points between 1991 and 2003, reaching 27 per cent. Both, Egypt and, more importantly, Yemen will need to exert more efforts to provide pregnant women with such services.

**Fig.10 Per cent of births attended by skilled health personnel in ESCWA member countries**





***O***ur Health

***"Our greatest concern must always rest with disadvantaged and vulnerable groups. These groups are often hidden, live in remote rural areas or shantytowns and have little political voice."***

***Dr Margaret Chan  
WHO Director-General***



## Goal 6. Combat HIV/AIDS, Malaria and other Diseases

### Target 7. Halt by 2015 and begin to reverse the spread of HIV/AIDS

#### Indicator 18. HIV prevalence among pregnant women aged 15-24.

Globally, just less than one-half of the people living with HIV are women, and the spread of HIV among women and girls is continuously increasing. Women and girls are more vulnerable to HIV infection mainly due to a lack of power in negotiating safe sex with their partners<sup>12</sup>.

Country data on this indicator in the ESCWA region are lacking. Lebanon, however, reported a prevalence rate of 24 per cent in 1996 and the Syrian Arab Republic reported a rate of approximately 2 per cent in 1999.

Without preventive interventions, roughly one third of infants born to HIV-positive mothers will acquire the virus during pregnancy, labor, delivery or breastfeeding.

Although prevalence rates of HIV in Arab countries are among the lowest in the world, recently all Arab countries have reported increases in HIV/AIDS infections<sup>13</sup>. Estimates show that there were 83,000 new HIV infections registered in Arab countries, compared to 5 million globally in 2003.<sup>2</sup>

Nonetheless, Arab countries have taken positive governmental action to address HIV/AIDS before it becomes a major health problem. Efforts range from improving surveillance in the cases of Jordan, Lebanon and the Syrian Arab Republic, and medicine coverage and transmission in the case of Lebanon to the establishment of a global fund in Jordan. Other non-governmental and community based activities include the establishment of AIDS society and testing centers in Lebanon, an AIDS hotline in Egypt and Lebanon, and the development of media stories for public awareness campaigns in the Syrian Arab Republic and Lebanon<sup>14</sup>.

#### Indicator 19. Condom use rate of the contraceptive prevalence rate

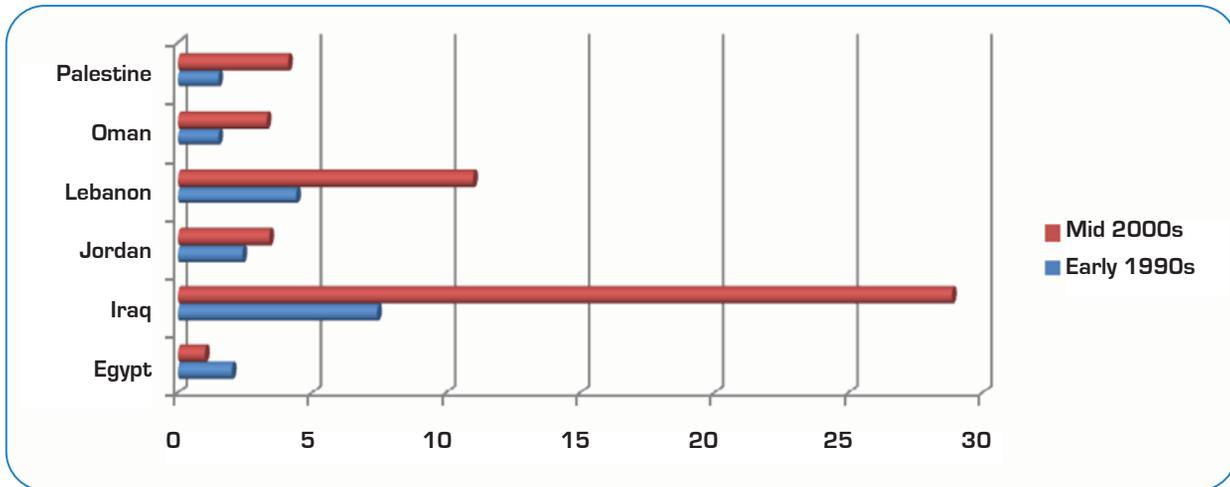
In Arab countries, the campaign for the use of condoms as a strategy for preventing HIV transmission faces a number of obstacles, owing to cultural and religious concerns over the morality of condom use. Few countries report on condom use as a percentage of the contraceptive prevalence rate. According to available data reported by such countries as Egypt, Iraq, Jordan, Lebanon, Oman and Palestine, there has generally been an increasing trend in contraceptive use since the early 1990s in the ESCWA region.

However, the increase was very small (ranging between 1 to 7 percentage points), except for in Iraq which in 2004 reported an increase of around 21 percentage points from its 1998 rate of 7 per cent. According to the latest available data, condom use was highest in Iraq (29%), followed by Lebanon (11%) and Palestine (4%).

<sup>2</sup> The EMR includes the Middle East and North Africa.



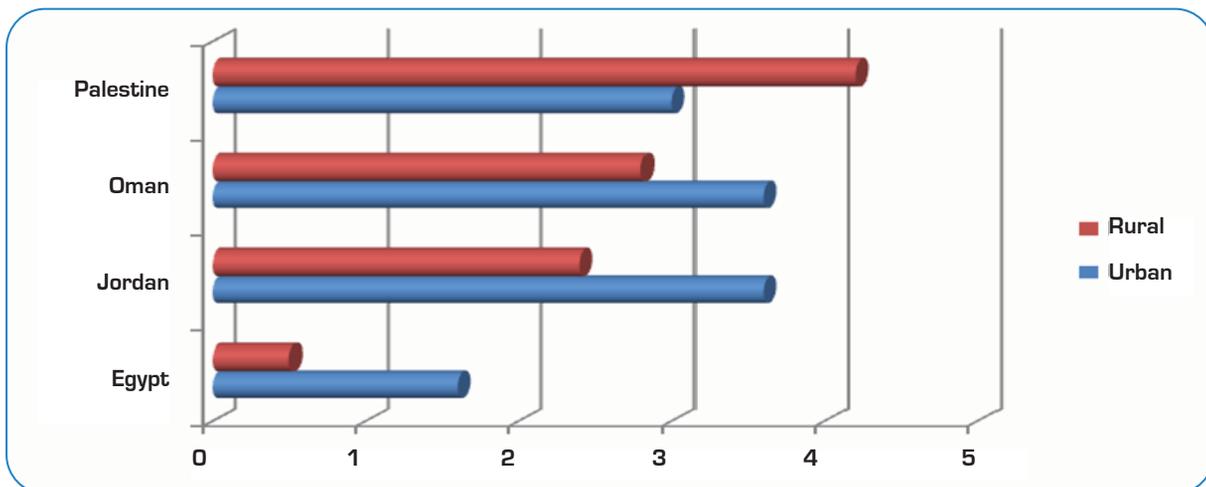
**Fig.11 Condom use rate of the contraceptive prevalence rate in selected ESCWA countries (%)**



Expectedly, a gap in condom use exists between rural and urban areas due to traditional and religious beliefs on using contraceptives in general. However, the differences are not major and the reported increases in both areas have been systematic and continuous with

the overall reported increase. It is interesting to note that in 2006 the rate of condom use in Palestine's rural areas was 4 per cent, higher than its urban rate of 3 per cent.

**Fig.12 Condom use rate of the contraceptive prevalence rate in selected ESCWA countries, rural-urban, last available year (%)**





### Indicator 19c. Contraceptive prevalence rate

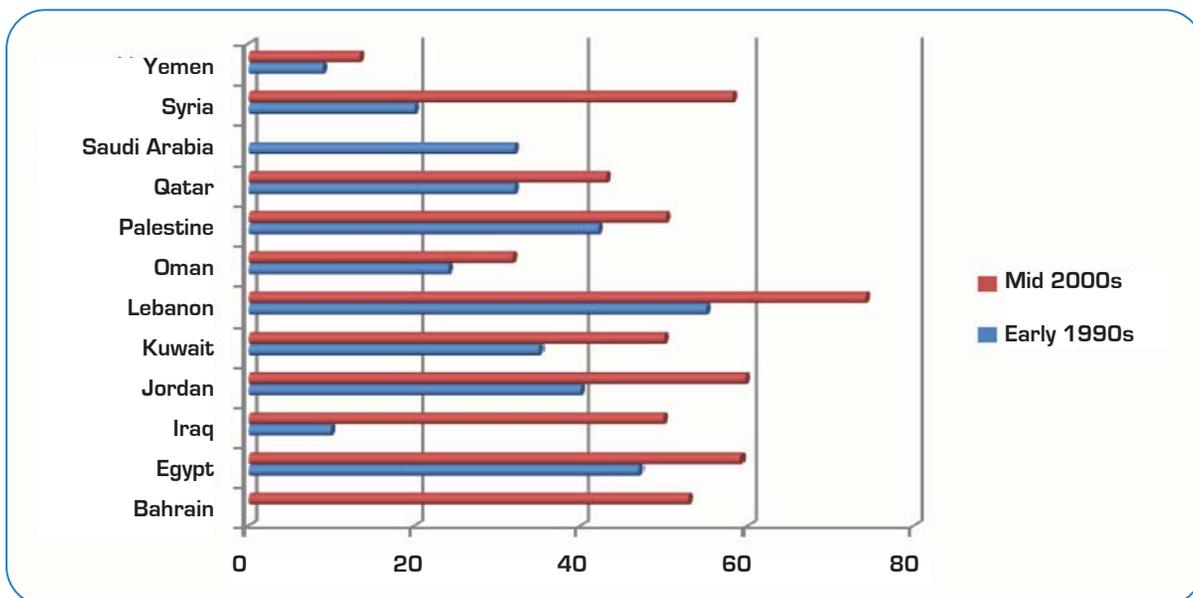
There has been an increasing trend in the use of contraceptives since the early 1990s in the ESCWA region. However, the increase from the early 1990s to mid-2000s was moderate and did not exceed 20 percentage points in all the countries, with the exception of the Syrian Arab Republic and Iraq. A major leap in the rate of contraceptive use was observed in the Syrian Arab Republic (38 percentage points) and Iraq (40 percentage points) during this period.

A small increase in Yemen of 4 percentage points was reported, and double that in both Oman and Palestine. Qatar increased its contraceptive prevalence rate by 11 percentage points and Egypt by 12 percentage points. In addition, Kuwait reported an increase of 15 percentage points over the years, Lebanon 19 percentage points, and Jordan 20 percentage points from the early 1990s to mid-2000s.

The latest available data in the 2000s categorizes ESCWA member countries into three groups of contraceptive use - high, moderate and low. Lebanon has the highest contraceptive prevalence rate of 74 per cent. The majority of ESCWA countries - namely Bahrain, Iraq, Kuwait, Palestine, the Syrian Arab Republic, Egypt, and Jordan, belong to the second group, moderate contraceptive prevalence rate, ranging between 50 per cent and 60 per cent. The last category of low-use rate ( $\leq 50\%$ ) includes Oman, Qatar and Yemen. Saudi Arabia has only one data point available on the contraceptive prevalence rate, that of 32 per cent in 1993.

Similar to the rate of condom use, there is a slight gap between rural and urban areas in the contraceptive prevalence rate consisting of higher rates in urban areas, except for in Palestine. In 2006, the rate in rural Palestine was 53 per cent, slightly higher than the urban rate of 49 per cent.

Fig.13 Contraceptive prevalence rate in selected ESCWA countries [%]





## **Target 8. Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases**

### *Indicator 21. Prevalence and death rates associated with malaria.*

Globally, there are almost 300 million acute cases of malaria each year. More than a million people die because of malaria each year, and malaria is likely to be a contributing factor in another 2 million deaths worldwide<sup>15</sup>. Fortunately, due to effective malaria treatment and preventive measures, including advances made in the health services, the situation in the ESCWA region is on the brighter side.

There have been significant reductions in malaria prevalence rates in all ESCWA countries. Egypt, Jordan, Lebanon, Oman, the Syrian Arab Republic and UAE had negligible numbers or no reported cases. The preva-

lence rates for Bahrain, Kuwait, Qatar and Saudi Arabia do not exceed 10 cases per 100,000 population.

Malaria is a very well known endemic disease in Iraq. Since 1991, following the war, Iraq had a serious outbreak<sup>16</sup>. Iraq achieved a major reduction in its malaria prevalence rate, which dropped from 5,502 cases per 100,000 population in 1995 to 7 in 2004. Although Yemen made significant decreases, from 1,263 cases per 100,000 population in 1990 to 770 cases in 2005, it continues to have the highest malaria prevalence rate in the region.

### *Indicator 23. Prevalence and death rates associated with tuberculosis.*

WHO reported considerable progress in meeting global targets for the control of tuberculosis (TB). In 2005, and after more than a decade of increase, the global annual incidence of the disease appears to have stabilized in some parts of the world and may now be declining<sup>17</sup>. ESCWA countries have shown considerable progress in meeting the targets set for the control of TB, according to the latest available national data.

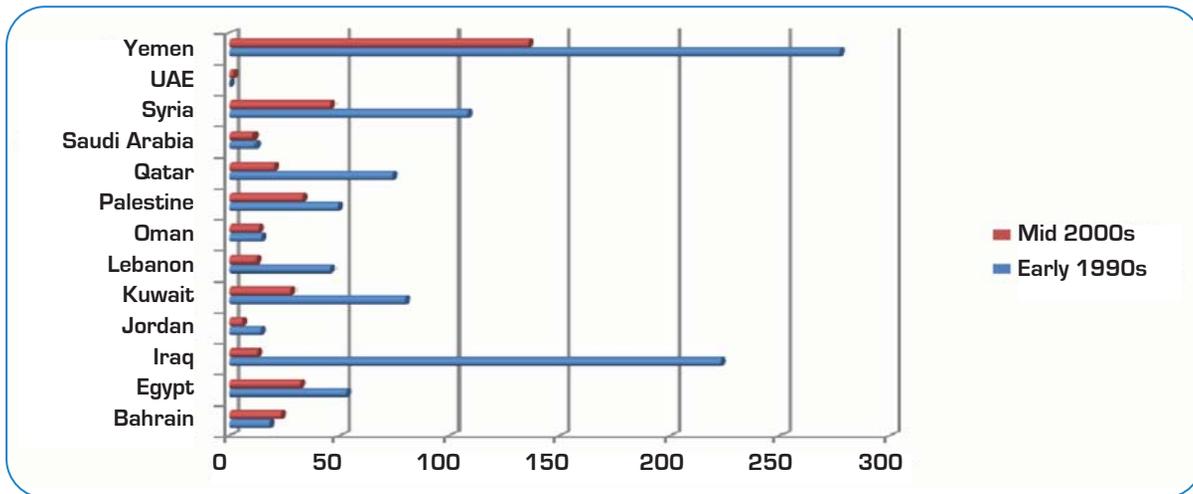
In the early 1990s, four countries in the ESCWA region had very high TB rates: the highest per 100,000 population were in Yemen (227), Iraq (223), and the

Syrian Arab Republic (108). However, all four countries reported significant decreases in TB prevalence by the mid-2000s. Iraq's TB rate decreased by around 211 percentage points, Yemen's by 141 percentage points, and that of the Syrian Arab Republic by 62 percentage points.

The latest figure for Yemen is still high at 136 per 100,000 population. The rest of the ESCWA member countries have managed to maintain a rate below 50 per 100,000 population, with the lowest rate being of 2 per 100,000 in UAE in 2005.



Fig.14. Prevalence rates of tuberculosis in ESCWA countries (%)



In the early 1990s, death rates associated with TB per 100,000 population were highest in Iraq (12), followed by the Syrian Arab Republic (8), then Palestine and Qatar (6), and Egypt, Kuwait and Lebanon (4). All countries were able to reduce death rates by the mid-

2000s, except for Iraq, where rates dropped by only one 1 percentage point, and Qatar, where the rate remains unchanged. The lowest TB death rates in the mid-2000s ( $\leq 1$  per 100,000 population) were reported in Bahrain, Kuwait, Jordan, Lebanon, Oman and UAE.

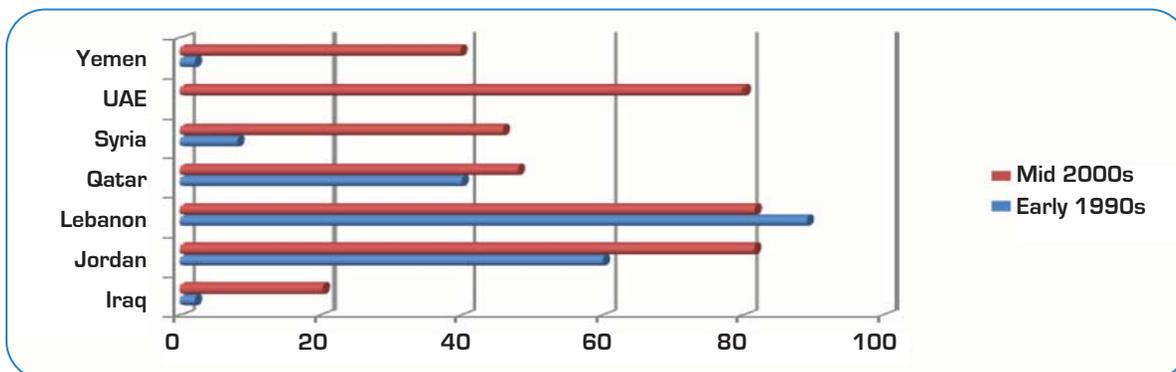
Indicator 24. Proportion of tuberculosis cases detected and successfully treated under DOTS.

It seems that concerted efforts in fighting TB have been paying off. This is indicated by two important factors: the percentage of cases detected and the rates at which patients are being cured. WHO reported 100% DOTS coverage for all countries in the ESCWA region, except for Iraq (87%), UAE (20%) and Yemen (93%)<sup>18</sup>.

rates in some ESCWA member countries rose significantly. The greatest increase in TB detection was reported in the Syrian Arab Republic and Yemen (38 percentage points each), followed by Jordan (22 percentage points), Iraq (18 percentage points) and Qatar (8 percentage points). On the other hand, during this period Lebanon's detected cases of TB decreased from 89 per cent to 82 per cent in 2004.

Between the early 1990s and mid-2000s, detection

Fig.15 Per cent of tuberculosis cases detected in selected ESCWA countries

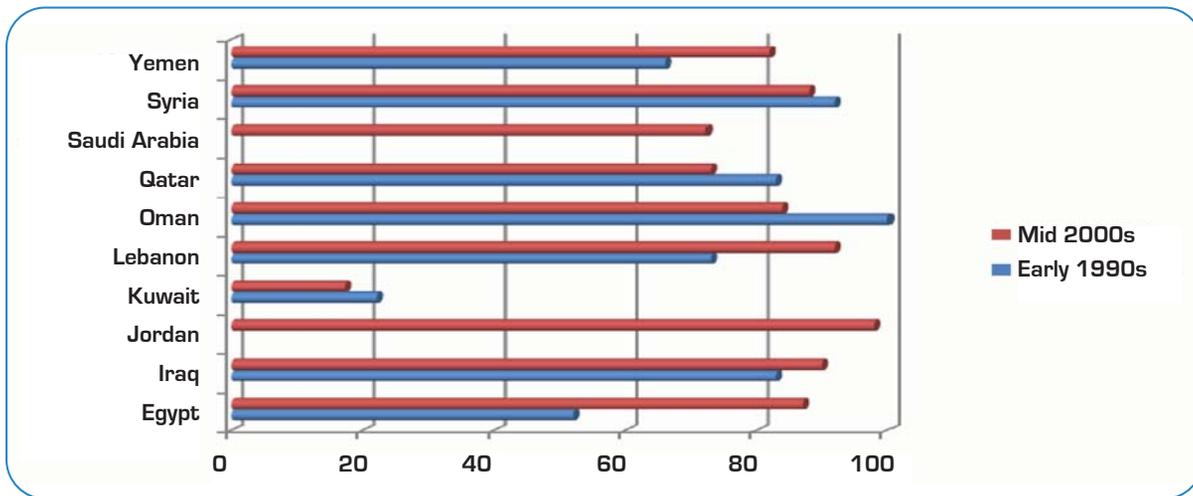




The increase in the number of newly detected cases is paralleled with a similar increase in the rate of successful treatment of the disease. As per the latest available data from the 2000s, the proportion of TB cases successfully treated under DOTS exceeded 90 per cent in Iraq, Jordan and Lebanon. In Egypt, Oman, Yemen and

the Syrian Arab Republic, the successful treatment rate ranged from 82 per cent to 88 per cent. In Saudi Arabia and Qatar, 72 per cent and 73 per cent respectively of TB cases were cured successfully under DOTS. The lowest rate of successful treatment under DOTS was reported by Kuwait.

**Fig.16 Per cent of tuberculosis cases successfully treated under DOTS in selected ESCWA countries**



## Goal 7: Ensure environmental sustainability

### Target 9. *Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources*

#### Indicator 29. *Proportion of population using solid fuels*

The use of solid fuels in households is associated with increased mortality from pneumonia and other acute lower respiratory diseases among children, as well as increased mortality from chronic obstructive pulmonary disease and lung cancer in places where coal is used among adults.

Only three member countries reported on the proportion of population using solid fuels namely Iraq, Palestine and Yemen. Although data are still scarce for monitoring purposes, available data reflect the impor-

tance of using solid fuels in ESCWA member countries, especially in rural areas where use is higher than that of urban areas. In Yemen, where the proportion of the population using solid fuels is highest in the ESCWA region, rates increased by 20 percentage points over two years, from 42 per cent in 2002 to 62 per cent in 2004. On the other hand, in Palestine, the rate decreased from 42 per cent in 2003 to 29 per cent in 2006. In 2003, 35 per cent of the Iraqi population was reliant on solid fuels as a source of energy.



## Target 10. Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

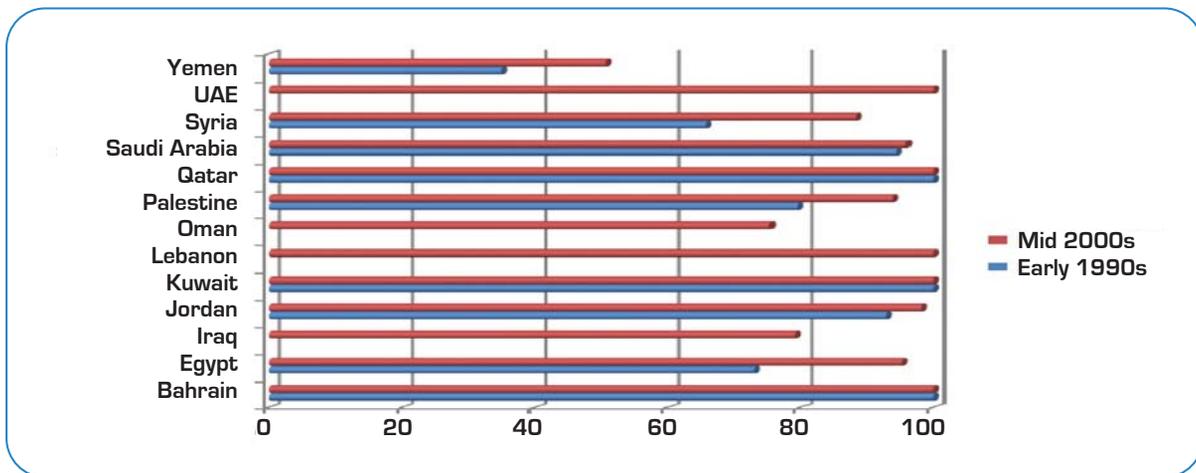
### Indicator 30. Proportion of population with sustainable access to an improved water source

Unsafe drinking-water and inadequate sanitation are linked to large numbers of diseases transmitted by viruses and bacteria that cause illness and deaths, largely in infants and young children, in the developing world.

The latest available data from the mid-2000s show

that the over 90 per cent of the population of almost all ESCWA member countries have sustainable access to an improved water source. Countries below the 90 per cent line include the Syrian Arab Republic (88 %), Iraq (79 %), Oman (75 %), and Yemen (51 %). Yemen needs a further increase of 17 percentage points to achieve its target by 2015.

Fig. 17 Per cent of population with sustainable access to an improved water source in the ESCWA countries

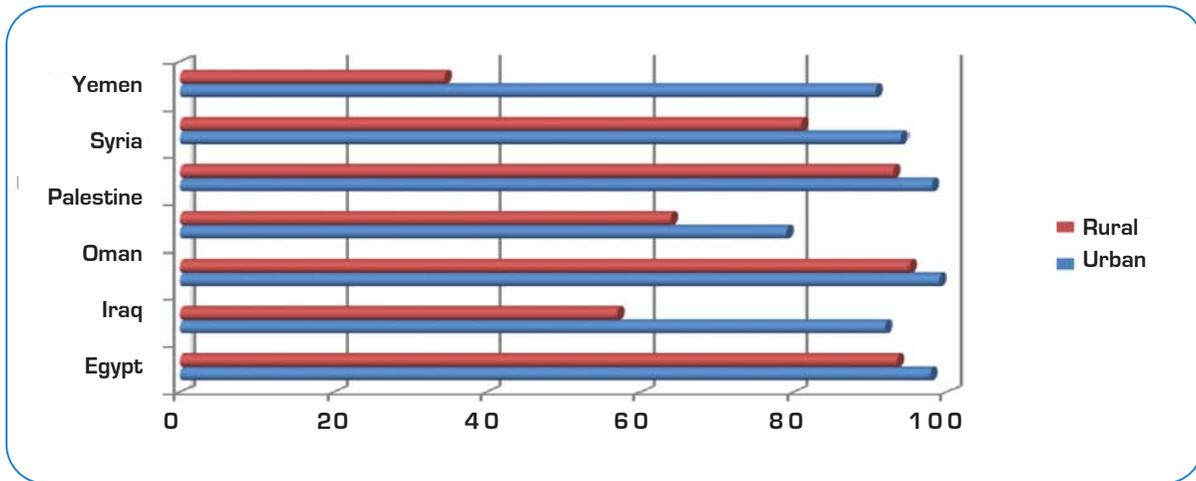


In some countries in the region, disaggregated data show a marked discrepancy in the proportion of population with sustainable access to an improved water source in urban and rural areas. In 2006, Iraq reported that 92 per cent of its urban population had access to safe water, compared to only 57 per cent of its rural population. Yemen also reported a similar discrepancy: 91 per cent access in urban areas compared to 35 per cent in rural areas in 2004.

In the Syrian Arab Republic, the urban-rural divide in access to clean water is less pronounced. In 2006, 94 per cent of the Syrian Arab Republic's urban population had access to safe water, compared to 81 per cent of its rural population; a difference of 13 percentage points. In Oman, a similar case is observed: 79 per cent of the urban population had access to clean water, in comparison to 64 per cent of the rural population, in 2003.



Fig. 18 Per cent of population with sustainable access to an improved water source in selected ESCWA countries, rural - urban (last available year)



### Indicator 31. *Proportion of population with access to improved sanitation*

Access to improved sanitation in the ESCWA member countries is similar to that of clean water, with most countries reporting levels in excess of 90 per cent. However Egypt, Palestine and Yemen still lack adequate access to improved sanitation (49 %, 45 %, and 44 %, respectively).

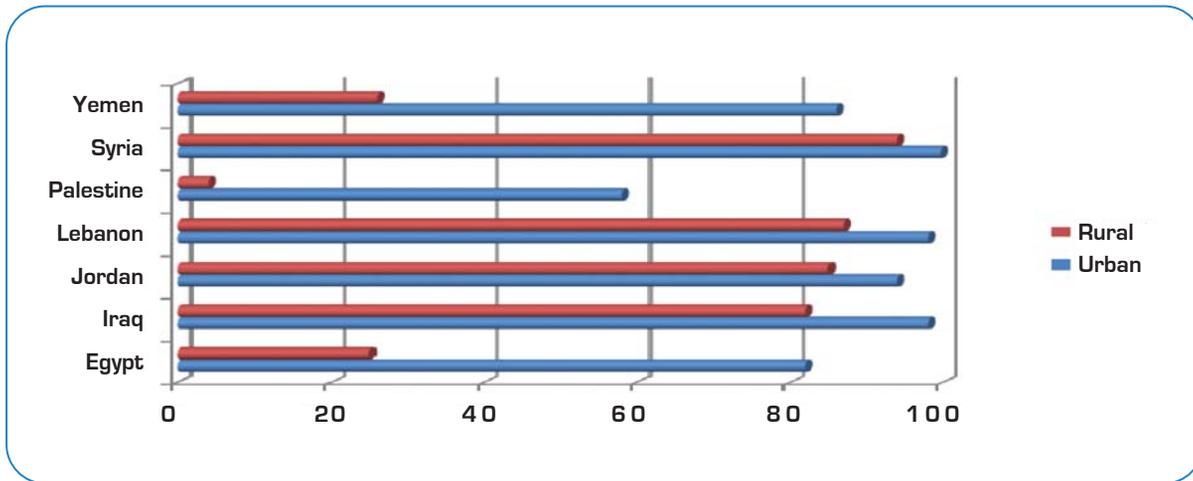
In Egypt, less than one-half of the population enjoy have access to sanitation: 82 per cent of them are in urban areas while only a quarter are in rural areas. However, the Government is working on improving living

conditions and the environment in rural areas by extending water and sanitation networks. The Egyptian Government is making heavy investments in the water sector through major irrigation projects, drinking water supplies and sanitation infrastructure<sup>19</sup>.

Similarly, in Yemen, 44 per cent of population had access to sanitation in 2004. The proportion of the population with access to improved sanitation was 86 per cent in urban areas, and less than one-third in rural areas (26%).



**Fig. 19 Per cent of population with access to improved sanitation in selected ESCWA countries, rural - urban (last available year)**



Although Palestine reported that over 90 per cent of its population had access to safe water, the situation is rather grim regarding to access to improved sanitation. In 1995, the proportion of the population with access to improved sanitation was 32 per cent. Over a period of ten years, the proportion increased by 13 percentage points only. In addition, 60 per cent of the urban population had access to improved sanitation compared to only 4 per cent of the rural population. Such conditions have exacerbated the prevalence of diseases due to the deterioration in environmental health, particularly with regard to waste collection and disposal

and central sewage systems, with many areas totally deprived of such services<sup>20</sup>.

Sanitation infrastructure in Iraq and the Syrian Arab Republic is good in both rural and urban areas. In 2006, 92 per cent of the Iraqi population has access to sanitation. Access was near universal (98 %) in Iraq urban areas and above 80 per cent in rural areas. Similarly, in 2006, the Syrian Arab Republic reported that 97 per cent of its population had access to improved sanitation which included 99.7 per cent in urban areas and 94 per cent in the rural ones.

## Goal 8: Develop a global partnership for development

### Target 17. *In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries*

#### Indicator 46. *Proportion of population with access to affordable essential drugs on a sustainable basis*

Data reported on the proportion of population with access to affordable essential drugs is scarcely reported on by ESCWA member countries. Some GCC countries reported 100% access to affordable essential drugs on a sustainable basis, including Bahrain, Kuwait, Oman, Qatar and UAE. In 2002, the Syrian Arab

Republic recorded a rate of 87 per cent, which declined sharply after two years to 32 per cent. In 2000, Lebanon reported a 95 per cent access to affordable essential drugs. In 2001, Yemen reported low access to drugs.



**Health MDGs Traffic Chart for  
ESCWA Member Countries (Mid-2000s)**

	Bahrain	Egypt	Iraq	Jordan	Kuwait	Lebanon	Oman	Palestine	Qatar	Saudi A.	Syria	UAE	Yemen	SCALE			
4. Prevalence of underweight children under-five years of age	4.2	6.2	7.5	4.0	9.8	3.9	18.0	2.9	10.4	5.0	9.7		45.6	<5	6-10	11-20	>21
13. Under-five mortality rate	10.9	41.0	41.0	29.0	9.9	18.3	11.1	28.1	10.6	22.3	20.2	9.9	92.3	<10	11-20	21-50	>50
14. Infant mortality rate	8.9	33.0	35.0	24.0	8.2	16.1	10.3	25.3	8.2	19.0	18.1	7.7	77.2	<10	11-20	21-50	>50
15. Proportion of 1 year-old children immunized against measles	100.0	96.6	66.5	97.8	99.9	53.4	96.0	96.7	100.0	97.0	92.4	94.0	73.0	>90	80-89	70-79	<70
16. Maternal mortality ratio	7.0	75.0	193.0	41.0	3.9	86.3	15.4	42.0	22.4	14.9	65.0	1.0	365.0	<10	11-20	21-50	>50
17. Proportion of births attended by skilled health personnel	99.4	74.2	93.0	99.8	100.0	98.2	98.0	98.9	100.0	97.0	93.0	99.9	27.3	>90	80-89	70-79	<70
19. Condom use rate of the contraceptive prevalence rate		1.0	28.9	3.4		11.0	3.3	4.1						>50	20-50	10-20	<10
19c. Contraceptive prevalence rate	53.5	59.2	49.9	59.7	50.0	74.2	31.8	50.2	43.0		58.3		13.4	>50	20-50	10-20	<10
21a. Malaria prevalence, notified cases per 100,000 population	7.7		7.0	2.1	10.6		21.7		8.6	4.5			770.0	<10	11-20	21-50	>50
23a. Tuberculosis prevalence rate per 100,000 population	23.6	32.0	12.4	6.0	28.0	12.0	13.1	33.0	20.3	10.8	46.0	1.9	136.0	<10	11-20	21-50	>50
23b. Death rate associated with tuberculosis per 100,000 population	0.8	3.0	11.0	1.0	0.7	1.0	0.8	4.0	6.0		4.0	0.1	13.0	<1	2-5	6-10	>10
24a. Proportion of tuberculosis cases detected under DOTS			20.3	81.5	82.6	81.6			48.0		45.8	80.0	39.8	>90	80-89	70-79	<70
24b. Proportion of tuberculosis cases successfully treated under DOTS		87.0	90.0	98.0	17.2	92.0	84.0		73.0	72.3	88.0		82.0	>90	80-89	70-79	<70
30. Proportion of population with sustainable access to an improved water source	100.0	95.3	79.2	98.1	100.0	100.0	75.3	93.8	100.0	95.8	88.3	100.0	50.6	>90	80-89	70-79	<70
31. Proportion of population with access to improved sanitation	100.0	48.7	92.2		100.0	96.9	88.5	44.7	100.0	98.8	97.3		43.5	>90	80-89	70-79	<70
46. Proportion of population with access to affordable essential drugs on a sustainable basis	100.0				100.0	95.0	100.0		100.0		32.0	100.0		>90	80-89	70-79	<70



**C**onclusion

It is not surprising to witness such diverse a state of affairs regarding health in ESCWA member countries. A glimpse at the health MDG Traffic chart of the member countries reveals the heterogeneity of the situation at hand. It shows that the region is characterized by three levels of socio-economic status: a high level that includes the GCC, a medium level that includes the Mediterranean countries, and a low level that includes conflict-stricken countries and the least developed in the region.

At the midpoint between the Millennium Declaration of 2000 and the promise ESCWA member countries made for 2015, marked achievements have been made since the 1990s. This could have only been maintained by peace and progress in our societies. The present situation calls for focusing on those who are in dire need and lack resources to break loose from vicious cycles. Yemen, in almost all the health indicators, is lacking seriously behind the other countries. Yemen needs significant support, seeing as children, their mothers, and the Yamani people at large face a present full of challenges.

Iraq has been trying to rebuild itself since the last series of wars. There is a light at the end of the current dark period. Other member countries, namely Egypt, Lebanon, and the Syrian Arab Republic, are staggering behind in meeting the challenge of keeping mothers alive when giving birth. Population growth, internal migration and underdeveloped infrastructure are the main causes of this situation.

Looking at the Millennium Development Goals we realize that "Our Children" are the most vulnerable group and therefore need to be taken care of. Under-five mortality and infant mortality in almost half of the

countries must decrease. Studies show that there is a strong relationship between malnutrition, the education level of both parents, and family assets. In order to improve children's nutrition it is necessary to focus on development projects including maternal income and general education, addition to advocating breastfeeding. At the same time, reducing child mortality requires both a strong political commitment and effective strategies to improve the situation of women and children. The main tenet of the strategy would be to attack poverty and provide mothers and children access to health services.

The gains made during the past years in terms of controlling malaria, except in the cases of Iraq and Yemen, have been over-shadowed by the high rate of TB in many countries in the region. In order to halt and reverse the rate of TB, and incidences of malaria in Yemen, it is imperative to pay attention to "Our health" by achieving political commitment and financial support with the help of strong leadership from relevant agencies.

Despite the scarcity of financial resources, weak infrastructure, lack of sewage systems, especially in villages and camps, health indicators have been improving in the Palestinian territories. There is a need, however, to strengthen infrastructure in Palestine, Egypt and Yemen to provide society with a healthy environment, free of diseases and ailments.

Meeting the challenges in health MDGs will be achieved by building on the successes already achieved and endeavoring to pursue those that remain unattained.



# Statistical Annex

## Goal 1. ERADICATE EXTREME POVERTY AND HUNGER

**Target 2.** *Halve, between 1990 and 2015, the proportion of people who suffer from hunger*

### Indicator 4

Prevalence of underweight children under-five years of age

	Early 1990s	Mid 2000s	Target	Urban	Rural	Year
Bahrain	8.7	4.2	4.4			
Egypt	10.0	6.2	5.0	6.5	6.0	2005
Iraq	12.0	7.5	6.0	7.0	8.3	2006
Jordan	6.4	4.0	3.2	3.5	7.4	2002
Kuwait	5.0	9.8	2.5			
Lebanon	9.0	3.9	4.5			
Oman	23.0	18.0	11.5			
Palestine	3.6	2.9	1.8	2.7	3.5	2006
Qatar	4.7	10.4	2.4			
Saudi Arabia		5.0				
Syria	13.0	9.7	6.5			
UAE						
Yemen	30.0	45.6	15.0	50.0	36.0	1997

## Goal 4. REDUCE CHILD MORTALITY

**Target 5.** *Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate*

### Indicator 13

Under-five mortality rate

	Early 1990s	Mid 2000s	Target	Urban	Rural	Year
Bahrain	22.0	10.9	7.3			
Egypt	85.0	41.0	28.3	39.0	56.0	2005
Iraq	65.0	41.0	21.7			
Jordan	42.4	29.0	14.1	27.0	36.0	2003
Kuwait	19.0	9.9	6.3			
Lebanon	43.0	18.3	14.3			
Oman	35.0	11.1	11.7			
Palestine	40.0	28.1	13.3	30.0	30.0	2006
Qatar	16.6	10.6	5.5			
Saudi Arabia	36.3	22.3	12.1			
Syria	44.0	20.2	14.7			
UAE	14.4	9.9	4.8			
Yemen	122.0	92.3	40.7	89.0	94.0	2004

## Indicator 14

### Infant mortality rate

	Early 1990s	Mid 2000s	Urban	Rural	Year
<b>Bahrain</b>	20.2	8.9			
<b>Egypt</b>	68.0	33.0	32.0	45.0	2005
<b>Iraq</b>	47.0	35.0			
<b>Jordan</b>	36.8	24.0	23.0	30.0	2002
<b>Kuwait</b>	17.0	8.2			
<b>Lebanon</b>	35.0	16.1			
<b>Oman</b>	29.0	10.3			
<b>Palestine</b>	32.0	25.3	27.0	27.0	2006
<b>Qatar</b>	13.5	8.2			
<b>Saudi Arabia</b>	24.6	19.0			
<b>Syria</b>	44.0	18.1	16.0	18.0	2006
<b>UAE</b>	11.4	7.7			
<b>Yemen</b>	83.0	77.2	75.0	78.0	2004

## Indicator 15

### Proportion of 1 year-old children immunized against measles

	Early 1990s	Mid 2000s
<b>Bahrain</b>	87.0	100.0
<b>Egypt</b>	64.0	96.6
<b>Iraq</b>	62.0	66.5
<b>Jordan</b>	89.4	97.8
<b>Kuwait</b>	93.0	99.9
<b>Lebanon</b>	58.0	53.4
<b>Oman</b>	98.0	96.0
<b>Palestine</b>	48.9	96.7
<b>Qatar</b>	79.0	100.0
<b>Saudi Arabia</b>	94.0	97.0
<b>Syria</b>	87.0	92.4
<b>UAE</b>	66.0	94.0
<b>Yemen</b>	52.0	73.0

## Goal 5. IMPROVE MATERNAL HEALTH

**Target 6.** *Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio*

### Indicator 16

#### Maternal mortality ratio

### Indicator 17

#### Proportion of births attended by skilled health personnel

	Early 1990s	Mid 2000s	Target	Early 1990s	Mid 2000s
Bahrain	15.0	7.0	3.8	99.0	99.4
Egypt	217.0	75.0	54.3	42.0	74.2
Iraq	117.0	193.0	29.3	50.0	93.0
Jordan	48.0	41.0	12.0	87.0	99.8
Kuwait	25.0	3.9	6.3	99.0	100.0
Lebanon	300.0	86.3	75.0	45.0	98.2
Oman	27.0	15.4	6.8	91.0	98.0
Palestine	75.0	42.0	18.8	94.7	98.9
Qatar		22.4		99.5	100.0
Saudi Arabia	19.4	14.9	4.9	96.0	97.0
Syria	143.0	65.0	35.8	61.0	93.0
UAE	86.0	1.0	21.5	99.1	99.9
Yemen	351.0	365.0	87.8	12.0	27.3

## Goal 6. COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES

**Target 7.** *Have halted by 2015 and begun to reverse the spread of HIV/AIDS*

### Indicator 19

Condom use rate of the contraceptive prevalence rate

	Early 1990s	Mid 2000s	Urban	Rural	Year
Bahrain					
Egypt	2.0	1.0	1.6	0.5	2005
Iraq	7.4	28.9			
Jordan	2.4	3.4	3.6	2.4	2002
Kuwait					
Lebanon	4.4	11.0			
Oman	1.5	3.3	3.6	2.8	2000
Palestine	1.5	4.1	3	4.2	2006
Qatar					
Saudi Arabia					
Syria					
UAE					
Yemen					

### Indicator 19c

Contraceptive prevalence rate

	Early 1990s	Mid 2000s	Urban	Rural
Bahrain		53.4		
Egypt	47.0	59.2	62.6	56.8
Iraq	10.0	49.9		
Jordan	40.0	59.7	57.1	50.5
Kuwait	35.0	50.0		
Lebanon	55.0	74.2		
Oman	24.0	31.8	34.5	24.5
Palestine	42.0	50.2	49.4	53.4
Qatar	32.0	43.0		
Saudi Arabia	32.0			
Syria	20.0	58.3	63.5	51.8
UAE				
Yemen	9.0	13.4		

**Target 8. Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases**

**Indicator 21a**

**Malaria prevalence, notified cases per 100,000 population**

**Indicator 21b**

**Malaria death rate per 100,000**

**Indicator 23a**

**Tuberculosis prevalence rate per 100,000 population**

**Indicator 23b**

**Death rate associated with tuberculosis per 100,000 population**

	Indicator 21a		Indicator 21b	
	Malaria prevalence, notified cases per 100,000 population		Malaria death rate per 100,000	
	Early 1990s	Mid 2000s	Early 1990s	Mid 2000s
<b>Bahrain</b>	36.2	7.7	0.0	0.1
<b>Egypt</b>			0.0	1.0
<b>Iraq</b>	5502.0	7.0		15.0
<b>Jordan</b>	7.5	2.1	0.0	0.0
<b>Kuwait</b>	41.3	10.6	0.0	0.0
<b>Lebanon</b>				0.0
<b>Oman</b>	218.8	21.7		
<b>Palestine</b>				0.0
<b>Qatar</b>	28.0	8.6		0.0
<b>Saudi Arabia</b>	35.0	4.5	0.0	0.0
<b>Syria</b>			5.0	5.0
<b>UAE</b>			0.0	0.0
<b>Yemen</b>	1263.0	770.0		24.0

	Indicator 23a		Indicator 23b	
	Tuberculosis prevalence rate per 100,000 population		Death rate associated with tuberculosis per 100,000 population	
	Early 1990s	Mid 2000s	Early 1990s	Mid 2000s
<b>Bahrain</b>	18.2	23.6	1.5	0.8
<b>Egypt</b>	53.0	32.0	4.0	3.0
<b>Iraq</b>	223.0	12.4	12.0	11.0
<b>Jordan</b>	14.0	6.0	1.0	1.0
<b>Kuwait</b>	80.0	28.0	4.0	0.7
<b>Lebanon</b>	46.0	12.0	4.0	1.0
<b>Oman</b>	14.3	13.1	1.0	0.8
<b>Palestine</b>	49.0	33.0	6.0	4.0
<b>Qatar</b>	74.0	20.3	6.0	6.0
<b>Saudi Arabia</b>	11.8	10.8	5.0	
<b>Syria</b>	108.0	46.0	8.0	4.0
<b>UAE</b>	0.1	1.9	0.6	0.1
<b>Yemen</b>	277.0	136.0		13.0

## Indicator 24a

### Proportion of tuberculosis cases detected under DOTS

## Indicator 24b

### Proportion of tuberculosis cases successfully treated under DOTS

	Indicator 24a		Indicator 24b	
	Proportion of tuberculosis cases detected under DOTS		Proportion of tuberculosis cases successfully treated under DOTS	
	Early 1990s	Mid 2000s	Early 1990s	Mid 2000s
<b>Bahrain</b>				
<b>Egypt</b>			52.0	87.0
<b>Iraq</b>	2.0	20.3	83.0	90.0
<b>Jordan</b>	60.0	81.5		98.0
<b>Kuwait</b>		82.6	22.2	17.2
<b>Lebanon</b>	89.0	81.6	73.0	92.0
<b>Oman</b>			100.0	84.0
<b>Palestine</b>				
<b>Qatar</b>	40.0	48.0	83.0	73.0
<b>Saudi Arabia</b>				72.3
<b>Syria</b>	8.0	45.8	92.0	88.0
<b>UAE</b>		80.0		
<b>Yemen</b>	2.0	39.8	66.0	82.0

## Goal 7. ENSURE ENVIRONMENTAL SUSTAINABILITY

**Target 10.** *Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation*

## Indicator 30

### Proportion of population with sustainable access to an improved water source

## Indicator 31

### Proportion of population with access to improved sanitation

Indicator 30					
Proportion of population with sustainable access to an improved water source					
	Early 1990s	Mid 2000s	Urban	Rural	Year
<b>Bahrain</b>	100.0	100.0			
<b>Egypt</b>	73.0	95.3	97.8	93.5	2006
<b>Iraq</b>		79.2	91.9	57.0	2006
<b>Jordan</b>	92.8	98.1	99.0	95.0	2002
<b>Kuwait</b>	100.0	100.0			
<b>Lebanon</b>		100.0			
<b>Oman</b>		75.3	79.0	64.0	2003
<b>Palestine</b>	79.6	96.6	98.0	93.0	2005
<b>Qatar</b>	100.0	100.0			
<b>Saudi Arabia</b>	94.4	95.8			
<b>Syria</b>	65.6	88.3	94.0	81.0	2006
<b>UAE</b>		100.0			
<b>Yemen</b>	34.9	50.6	90.6	34.5	2004

Indicator 31

Proportion of population with access to improved sanitation

	Early 1990s	Mid 2000s	Urban	Rural	Year
<b>Bahrain</b>	100.0	100.0			
<b>Egypt</b>	85.0	48.7	82.0	25.0	2006
<b>Iraq</b>		92.2	98.0	82.0	2006
<b>Jordan</b>		93.0	94.0	85.0	2002
<b>Kuwait</b>	100.0	100.0			
<b>Lebanon</b>	37.0	96.9	98.0	87.0	2002
<b>Oman</b>	85.0	88.5			
<b>Palestine</b>	31.7	44.7	58.0	4.0	2006
<b>Qatar</b>	100.0	100.0			
<b>Saudi Arabia</b>	91.8	98.8			
<b>Syria</b>	55.0	97.3	99.7	94.0	2006
<b>UAE</b>					
<b>Yemen</b>		43.5	86.0	26.0	2004

## Goal 8. DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

**Target 17.** *In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries*

### Indicator 46

Proportion of population with access to affordable essential drugs on a sustainable basis

	Early 1990s	Mid 2000s
<b>Bahrain</b>	100	100
<b>Egypt</b>		
<b>Iraq</b>		
<b>Jordan</b>		
<b>Kuwait</b>	100	100
<b>Lebanon</b>		95
<b>Oman</b>	100	100
<b>Palestine</b>		
<b>Qatar</b>	100	100
<b>Saudi Arabia</b>		
<b>Syria</b>		32
<b>UAE</b>		100
<b>Yemen</b>		



# End notes

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<sup>3</sup> Zuhair Hallaj, Achieving the Millennium Development Goals, Report of an inter-country meeting, Cairo, Egypt, 17-19 October 2005.

<sup>4</sup> Estimated death per 100,000 population by cause and member states, 2002 (a)[table 3]. WHO Department of measurement and health information Dec. 2004.

<sup>5</sup> WHO, World Health Statistics, 2007.

<sup>6</sup> Maternal Mortality Scorecard, Global Conference 18-20 October 2007,  
[http://www.womendeliver.org/fact/MM\\_Country\\_Rankings\\_factsheet\\_\[A4\].pdf](http://www.womendeliver.org/fact/MM_Country_Rankings_factsheet_[A4].pdf)

<sup>7</sup> WHO, The World Health Report, 2005.

<sup>8</sup> New estimates of maternal mortality. Weekly epidemiological record, 1996, 71(13):97-100.

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<sup>12</sup> WHO, Health and Millennium Development Goals, 2005.

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<sup>15</sup> WHO webpage on the Millennium Development Goals, Goal 6: Malaria,  
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<sup>16</sup> Farid J. Shamo, Malaria Programme Iraq 2000, Malaria in Iraq, Coordination Meeting on Malaria Programmes, 31 May - 1 June 2000.

<sup>17</sup> WHO, Year in Review, 2006.

<sup>18</sup> WHO, Global Tuberculosis Control, Report 2007.

<sup>19</sup> Abdullah Assa'edi, Assistant Regional Director, WHO Regional Office for the Eastern Mediterranean, "Achieving the Millennium Development Goals Report of an intercountry meeting, Cairo, Egypt, 17-19 October 2005.

<sup>20</sup> Achieving the Millennium Development Goals, Report of an inter-country meeting, Cairo, Egypt, 17-19 October 2005.



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