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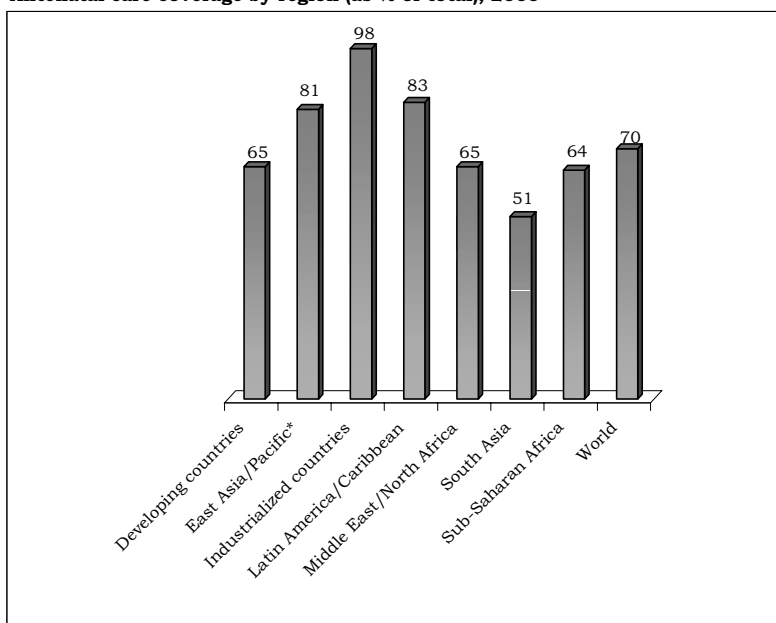
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16.1 Antenatal care

Inadequate or non-existent antenatal care has negative repercussions in increasing the risks for the mother's survival and reproductive health. There is a substantial gap between the care provided in the more developed countries and in developing countries. Examination of the figures for women aged 15-49 receiving health care at least once during pregnancy from a doctor, nurse or midwife shows that this takes place in practically 100% of cases in the industrialized world but only in 65% in developing countries. Practically the same figure is registered for Sub-Saharan Africa and for North Africa and the Middle East.

Antenatal care coverage by region (as % of total), 2000



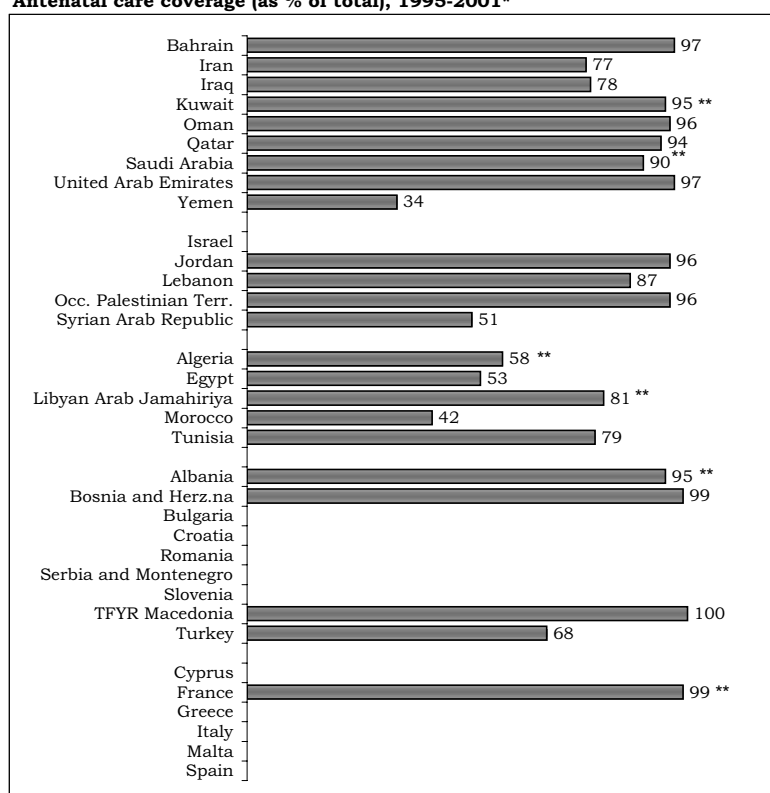
* Excluding China

Source: UNICEF, 2001

16.2 Antenatal care

Antenatal examinations, skilled assistance at delivery, sterile procedures, and physical and economic accessibility to efficient emergency obstetric services constitute the prerequisites for reducing the risks of maternal mortality. Antenatal care coverage is almost universal in the countries in southern Europe, the Arab Gulf States, Jordan and Occupied Palestinian Territory. The coverage drops to 87% in Lebanon, to around 77-81% in Iran, Iraq, Libya and Tunisia, 68% in Turkey, and decreases to around 51-58% in Algeria, Egypt and Syria. The lowest coverage is shown for Morocco (42%), and Yemen (34%).

Antenatal care coverage (as % of total), 1995-2001*



* Data refer to the most recent year available during the period specified in the column heading

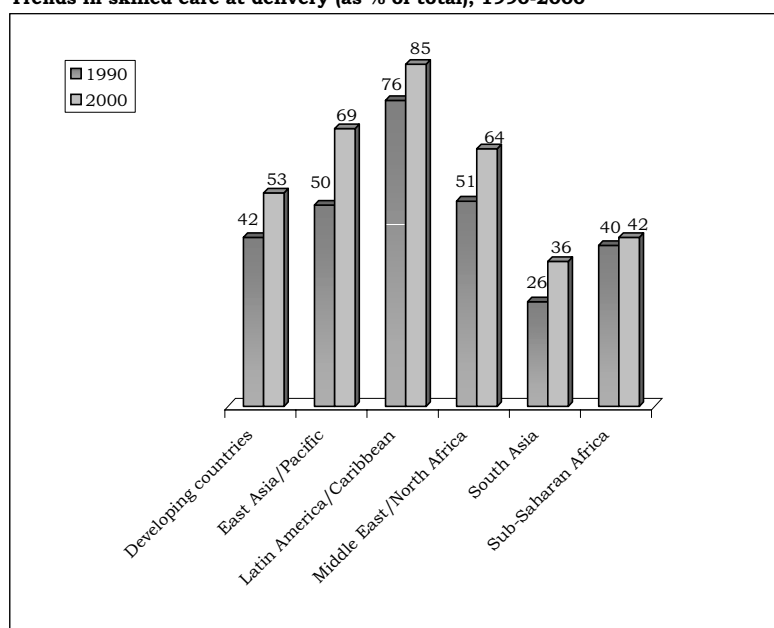
** Data refer to years or periods other than those specified in the column heading differ from the standard definition or refer to only part of a country

Source: UNICEF, 2003

17.1 Skilled attendant at delivery

The number of deliveries attended by qualified medical personnel rose sharply all over the world between 1990 and 2000. Today, however, over half the women living in developing countries still lack access to safe delivery conditions and lack support in coping with complications that might arise during childbirth. The most dramatic situation in this respect is found in South Asia and Sub-Saharan Africa. As a result of increased access to health services over the last few decades, skilled assistance at delivery was available for 64% of the female population in North Africa and the Middle East in 2000, compared to 51% in 1990. It is however, important to bear in mind the aforementioned remarks relating to the disparities in public health services in some of the countries under examination as well as the structural weakness of health facilities in the rural areas of many countries in the Maghreb and the Middle East.

Trends in skilled care at delivery (as % of total), 1990-2000

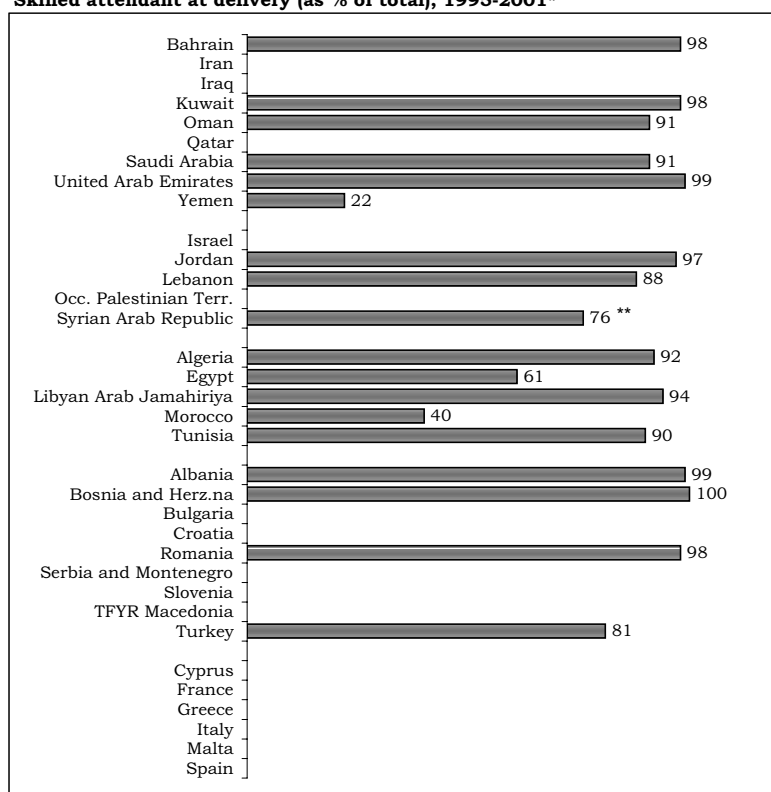


Source: UNICEF, 2001

17.2 Skilled attendant at delivery

Medical attendance at delivery varies greatly from country to country in North Africa, the Middle East and the Arabian peninsula. Shortage of health facilities, particularly in rural areas, insufficient medical attendance at delivery and the prevalence of traditional and unsafe reproductive practices, all contribute to observed regional differences, which are notably accentuated by comparison of town and village. The greatest difference is between the almost universal health care available in the rich states of the Arabian peninsula and the 22% of births attended by qualified medical personnel in Yemen. Another regional disparity is shown for North Africa, where the satisfactory levels of medical attendance at delivery in Libya (94%), Algeria (92%) and Tunisia (90%) contrast sharply with those in Egypt (61%) and Morocco (40%).

Skilled attendant at delivery (as % of total), 1995-2001*



* Data refer to the most recent year available during the period specified in the column heading

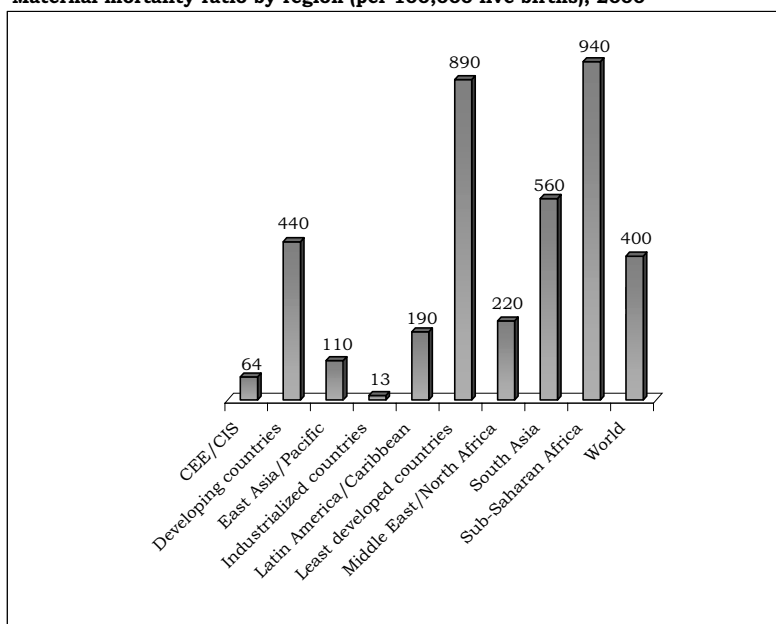
** Data refer to years or periods other than those specified in the column heading differ from the standard definition or refer to only part of a country

Source: UNICEF, 2003

18.1 Maternal mortality

Haemorrhage, septicaemia and obstruction of the vaginal canal are the most frequent causes of childbirth-related death, but these risks could be reduced to a minimum through the prompt provision of skilled assistance. The identification of pregnancies at risk could serve as an initial preventive measure. The devastating effects of inadequate medical and health services can be seen in the high rates of maternal mortality registered in certain areas of the world. The very high level of maternal mortality in Sub-Saharan Africa (940 deaths per 100,000 live births) is drastically reduced to an average of 220 deaths per 100,000 live births in North Africa and the Middle East. The current level of maternal mortality in the MENA region, however, remains alarming and disturbing; it is about one-half of the average level for the developing countries, but it is 17 times as high as the level achieved in industrialized countries.

Maternal mortality ratio by region (per 100,000 live births), 2000

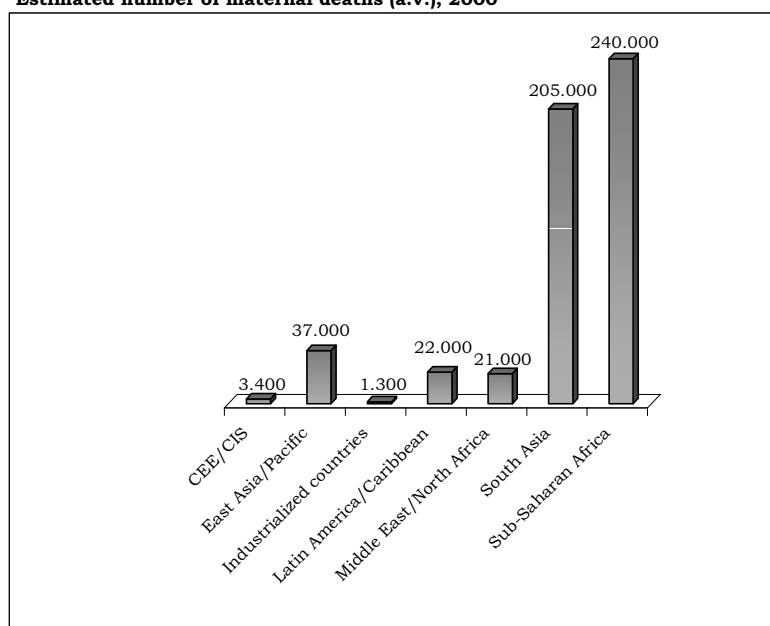


Source: WHO, UNICEF and UNFPA, 2001

18.2 Maternal mortality

Over half a million women die every year in the world because of complications related to pregnancy and childbirth. For every one of these women, at least 13 remain alive in a severely impaired state of health. This phenomenon is greatly reduced, albeit not eliminated, in countries that ensure a good level of access to emergency services and prevention in the field of reproductive health. Complications during pregnancy are widespread, but the difference between one health system and another lies in the ability to reduce the risk of the mother's death to a minimum. Most maternal deaths take place in developing countries and especially in Sub-Saharan Africa and South Asia. Comparison of the 21,000 deaths in North Africa and the Middle East with the 1,300 in the industrialized countries underscores the gap in terms of health prospects and health care coverage between the the countries to the north and south of the Mediterranean.

Estimated number of maternal deaths (a.v.), 2000



Source: WHO, UNICEF and UNFPA, 2003

18.3 Maternal lifetime risk

Complications due to pregnancy and childbirth are among the major causes of maternal death and illness in most of the developing countries. Complications during labour, post-delivery infections and haemorrhages are major health risks for women in the poorest countries, where labour and puerperal septicaemia are respectively the sixth and seventh causes of death (as against 12th and 14th in the developed countries, accounting for barely 2% of total illnesses). Prompt intervention in cases of pregnancy-related emergency is impracticable in many areas of the world. The resulting potential risk of death for women is highest in Sub-Saharan Africa (1 in 16) and considerably lower in North Africa and the Middle East (1 in 100), compared to the extremely low risk of 1 in 4,000 prevailing in the industrialized countries.

Lifetime risk of dying in pregnancy or childbirth*, 1995

Region	Lifetime risk of dying
CEE/CIS	1 in 770
Developing countries	1 in 61
East Asia/Pacific	1 in 360
Industrialized countries	1 in 4,000
Latin America/Caribbean	1 in 160
Least developed countries	1 in 17
Middle East/North Africa	1 in 100
South Asia	1 in 43
Sub-Saharan Africa	1 in 16
World	1 in 74

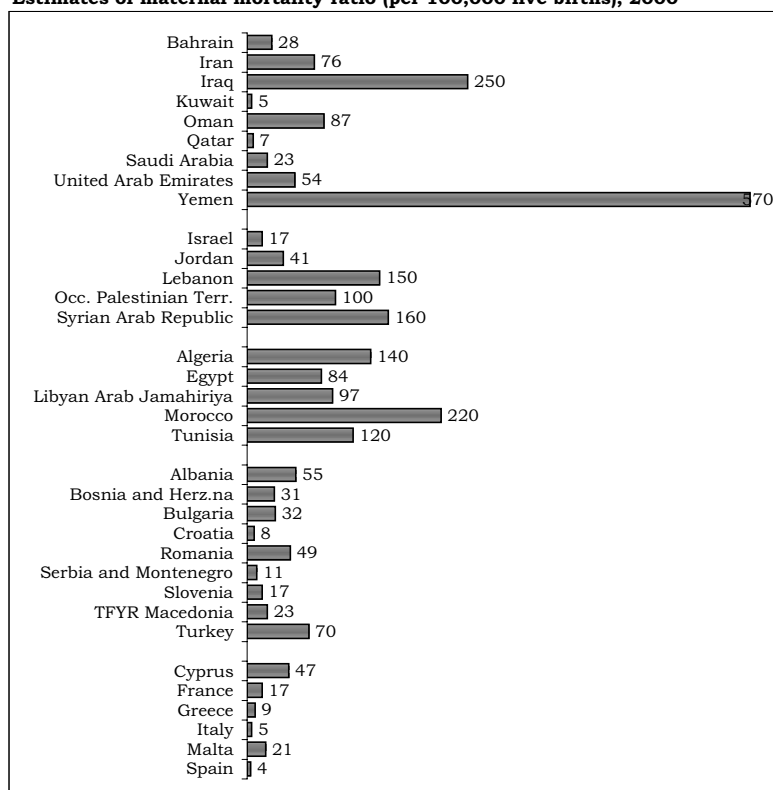
*Affected not only by maternal mortality rates but also by the number of birth per woman

Source: WHO, UNICEF and UNFPA, 2003

18.4 Maternal mortality

Recent estimates of maternal mortality rates (maternal deaths per 100,000 live births) highlight an alarming gap in the provision of maternal health care between Europe and the countries south of the Mediterranean. Relatively high levels of maternal mortality are still recorded, however, in the Balkan region of Europe for Albania, Romania and especially Turkey. The most positive figures south of the Mediterranean are shown for Kuwait and Qatar while the highest rates are shown Yemen, followed by Iraq and Morocco. High rates of maternal mortality are also shown for Algeria, Lebanon and Syria.

Estimates of maternal mortality ratio (per 100,000 live births), 2000

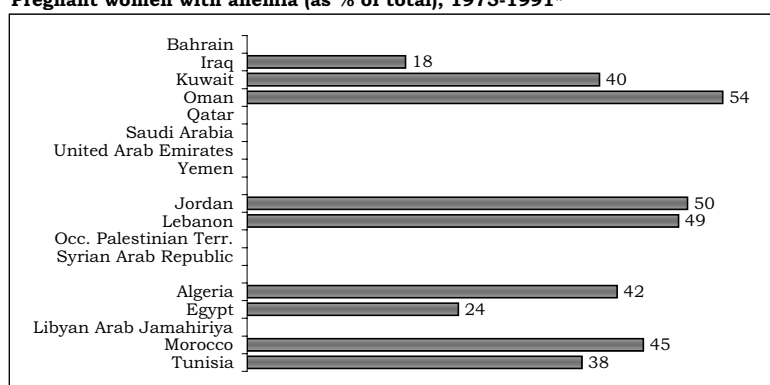


Source: WHO, UNICEF and UNFPA, 2003

19. Pregnant women with anemia

Data on the prevalence of anemia in pregnant women are scanty and fragmentary. An anemic woman is at risk in the event of a haemorrhage during childbirth and is more likely to contract infections. The fetus is also adversely affected by the limited amount of oxygen received through the mother's blood and thus possibly at risk of premature birth. The reported proportion of anemic women in some Arab countries is around 50%. This figure is clearly subject to underestimation due to difficulties related to the availability of data and the possibility of diagnostic analysis, especially in rural areas. All this is further affected by local diet and dietary customs, which can make it difficult to provide women at risk with foods rich in iron, protein, vitamins B and C, and supplementary doses of folic acid to counter their anemic condition.

Pregnant women with anemia (as % of total), 1975-1991*



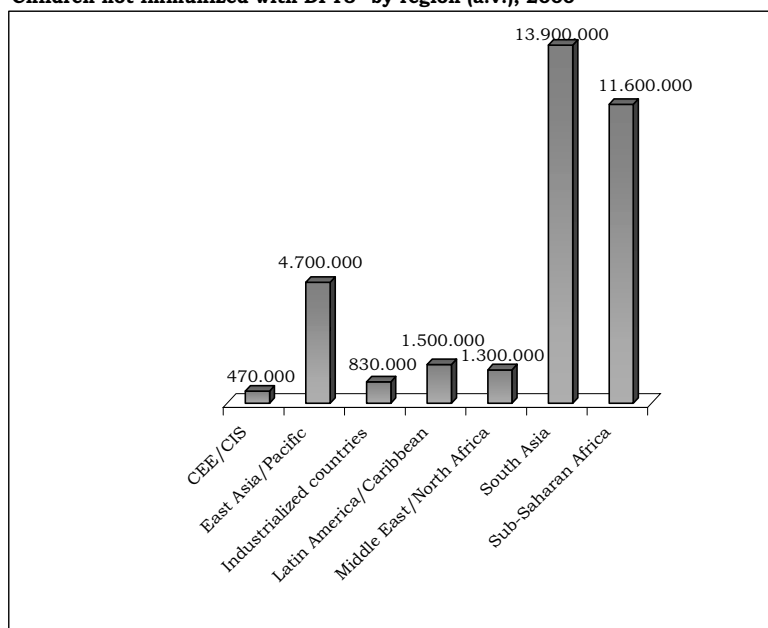
* Data refer to the most recent year available during the period specified.

Source: Arab Human Development Report, UNDP 2002

20.1 Immunization

The DPT vaccine against diphtheria, pertussis and tetanus is administered in three injections at intervals of up to six months, starting from the age of three months. This standard practice in the more developed countries with efficient national health systems is much less common in poor rural areas of the developing world. Logistic and organizational problems of the health machinery, physical and economic accessibility, the reliability of services, distrust of vaccination, and cultural compatibility with traditional forms of neonatal care are some of the reasons accounting for differences in the coverage of immunization. The values shown below must obviously be correlated with the demographic weight of the different regions involved. While South Asia and Sub-Saharan Africa display the lowest levels of immunized children, DPT coverage in North Africa and the Middle East appears to be fairly high with a value of around 87% as against the average of 71% for developing countries.

Children not immunized with DPT3* by region (a.v.), 2000



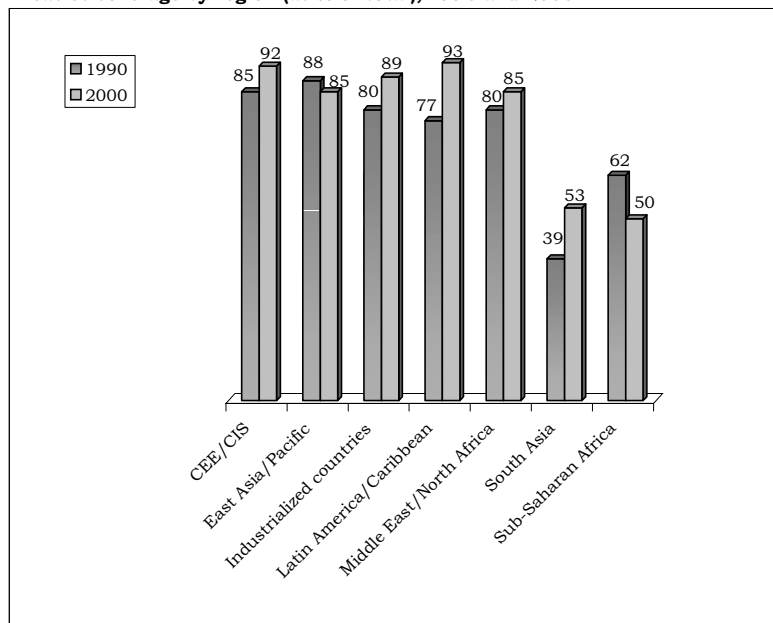
* DPT refers to the combined diphtheria, pertussis and tetanus vaccine.

Source: WHO, UNICEF, 2001

20.2 Immunization

Vaccination against measles appears to be fairly widespread over most regions of the world. Coverage has reached more than 85% of children in North Africa and the Middle East over the last decade. It is only in South Asia and Sub-Saharan Africa that 50% of children are still not vaccinated against measles. Immunization against this exanthematic disease is widespread throughout Southwest Europe and its occurrence is normally benign, unlike the situation in developing countries, where the number of non-immunized children is considerably higher and the acutely epidemic nature of measles produces mortality rates of over 5%. The prognosis is also worsened by possible conditions of immunodeficiency, with mortality rates of about 40% registered for patients with AIDS. Over 90% of children are vaccinated against measles by the age of one year in most countries south of the Mediterranean, the exceptions being Algeria (83%) and Yemen (79%).

Measles coverage by region (as % of total), 1990 and 2000



Source: WHO, UNICEF, 2001

20.3 Poliomyelitis

Poliomyelitis was endemic in 125 countries throughout the world at the end of the 1980s. By 2000 it was present in only 20 countries. When the target of completely eradicating polio was set in 1988, there were some 35,000 reported cases and these were estimated as representing one-tenth of the actual number throughout the world. After 25 years of major immunization campaigns, the number of cases had fallen to 1,919 by 2002. The campaigns launched in the early 1990s, primarily through the joint efforts of UNICEF and WHO, have resulted in the vaccination of 2 billion children aged under five. In North Africa and the Middle East an average of 91% of children aged under one have been vaccinated against polio, which is an extremely significant figure by comparison with developing countries in other parts

Children under 1 fully immunized against polio* by region (as % of total), 1997-1999

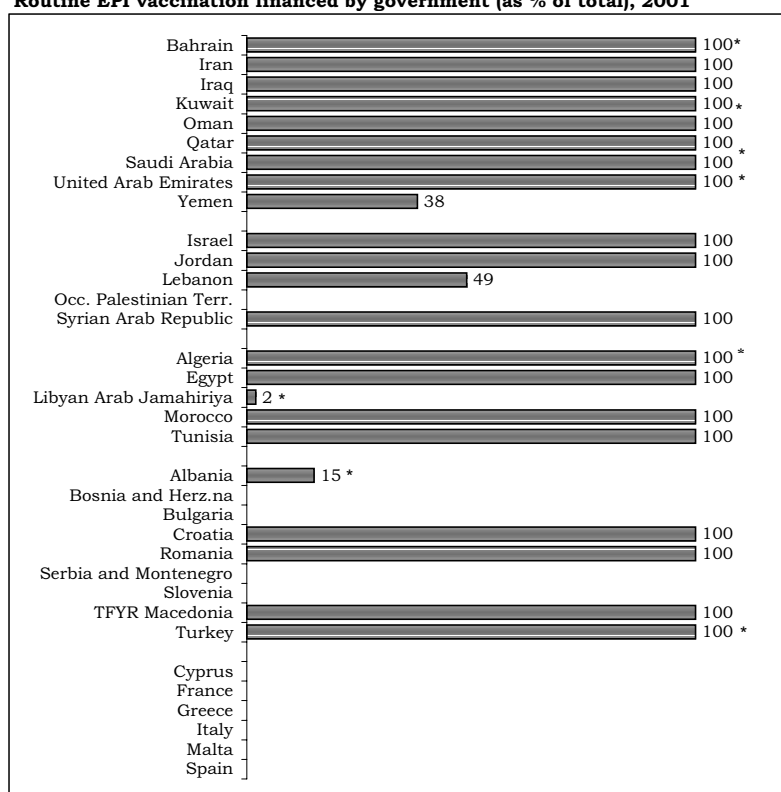
Region	% under-ones fully immunized against polio
	1997-1999
CEE/CIS	93
Latin America/Caribbean	91
Middle East/North Africa	91
East Asia	87
South Asia	67
Sub-Saharan Africa	50
World	76

Source: WHO, 2001

20.4 Immunization

The government-funded EPI (Extended Program on Immunization) has produced satisfactory results for most of the countries under consideration, the exceptions being Albania (15%), Libya (2%), Lebanon (49%) and Yemen (38%). The vaccination of children was an important target set at the 1990 World Conference on Children and the figures shown below demonstrate the great successes achieved in little over a decade. The under-five mortality rates are still high, however, and children of the poorest countries are the most frequent victims, not least due to the incomplete immunization of the infant population. The target of 90% protection set at the World Conference is still very distant in some cases and can only be obtained if funds are made available by national governments.

Routine EPI vaccination financed by government (as % of total), 2001



* Data refer to years or periods other than those specified in the column heading differ from the standard definition or refer to only part of a country

Source: UNICEF, 2003

20.5 Immunization

Children aged 1 vaccinated (as % of total), 2001

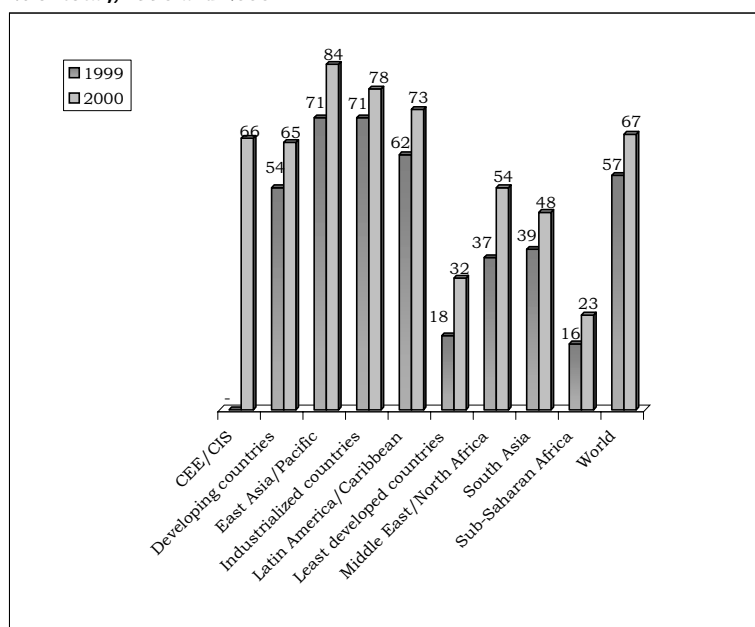
Country	TB	DPT3	polio3	measles	hep3
Bahrain	n.a.	97	97	98	97
Iran	93	95	95	96	94
Iraq	93	81	84	90	70
Kuwait	95	98	94	99	n.a.
Oman	98	99	99	99	99
Qatar	99	93	90	92	99
Saudi Arabia	94	97	97	94	95
United Arab Emirates	98	94	94	94	92
Yemen	73	76	76	79	21
Israel	n.a.	95	92	94	96
Jordan	n.a.	99	97	99	97
Lebanon	n.a.	93	93	94	70
Occ. Palestinian Terr.	n.a.	n.a.	n.a.	n.a.	n.a.
Syrian Arab Republic	99	92	92	93	89
Algeria	97	89	89	83	n.a.
Egypt	98	99	99	97	99
Libyan Arab Jamahiriya	99	94	94	93	93
Morocco	93	96	93	96	84
Tunisia	97	96	96	92	94
Albania	93	97	97	95	96
Bosnia and Herz.na	95	91	92	92	n.a.
Bulgaria	98	94	94	90	93
Croatia	97	94	94	94	98
Romania	99	99	99	98	98
Serbia and Montenegro	99	93	93	90	n.a.
Slovenia	96	92	93	98	n.a.
TFYR Macedonia	97	90	91	92	n.a.
Turkey	89	88	88	90	77
Cyprus	n.a.	n.a.	n.a.	n.a.	n.a.
France	84	98	97	84	n.a.
Greece	88	88	87	88	88
Italy	n.a.	95	96	70	95
Malta	n.a.	95	95	65	n.a.
Spain	n.a.	95	95	94	80
Developing countries	78	71	73	70	20
Industrialized countries	85	94	93	90	82
MENA	88	87	87	89	66
World	79	73	75	72	24

Source: UNICEF, 2003

21.1 Contraception

Significant improvements were recorded between 1990 and 2000 in the availability and accessibility of contraceptives and in the range of choice. This period saw a considerable increase in the number of women with access to methods of temporary contraception. While it is estimated that 78% of women aged 15-49 use contraceptives in the industrialized world, this figure drops to 54% for North Africa and the Middle East, which is even lower than the average of 65% shown for developing countries as a whole.

Contraceptive prevalence among women (in union) aged 15-49 by region (as % of total), 1990 and 2000

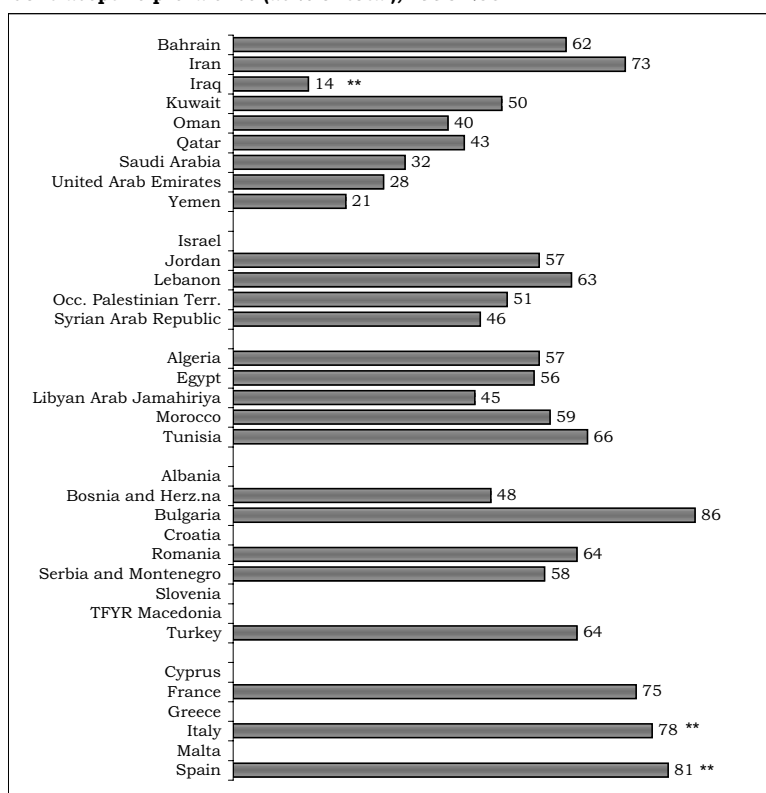


Source: UN, 2001

21.2 Contraception

The difference in fertility rates between rich and poor countries is reflected quite faithfully in the differing degrees of access, acceptance and use as regards family planning. The estimated contraceptive prevalence in Europe ranges from a peak of 86% in Bulgaria to 75% in France, 64% in Turkey and Romania, and 48% in Bosnia-Herzegovina, while in North Africa it ranges from 66% (Tunisia) to 45% (Libya). Similar figures are shown for the Middle East, ranging from 63% in Lebanon to 46% in Syria. Contraceptive prevalence varies considerably in the Arabian peninsula and the Gulf; decreasing from 73% in Iran to 14% in the neighbouring country of Iraq, from 62% in Bahrain to 32% in Saudi Arabia, and from 28% in the United Arab Emirates to 21% in Yemen. The great disparities registered in the region are the result of many different factors including not only economic conditions but also cultural and behavioral dimensions.

Contraceptive prevalence (as % of total), 1995-2001*



* Data refer to the most recent year available during the period specified in the column heading

** Data refer to years or periods other than those specified in the column heading differ from the standard definition or refer to only part of a country

Source: UNICEF, 2003

22.1 HIV/AIDS

There are over 3 million children aged under 15 living with HIV/AIDS in the world, and 800,000 new children contracted the disease in 2001 (12,000 of whom in the Middle East and North Africa). There are also an estimated 2.5 million pregnant women with this virus (40,000 in the MENA region). The virus is most widespread among young people in Sub-Saharan Africa, with females accounting for the majority of its victims. It is difficult to estimate the children under 15 affected by the virus in many different countries in Europe, North Africa and the Middle East. Worrying figures are registered for Romania, where it is estimated the 4,000 children under 15 have the disease as against 1,300 in Spain and 1,000 in France. National estimates are not available for North Africa and the Middle East, but estimates suggest an overall total of 35,000 children under 15 living with HIV/AIDS.

Children under 15 newly infected with HIV by region (a.v.), 2001

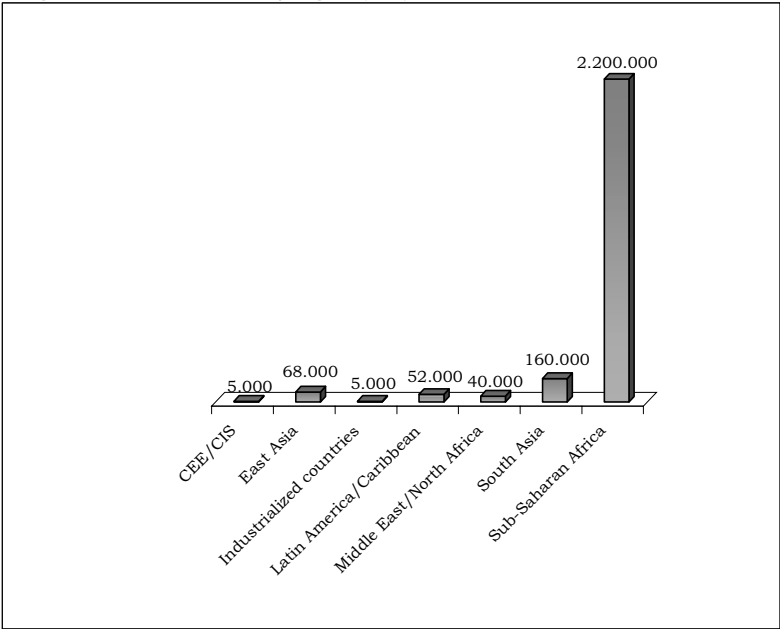
Region	Rounded estimates of children infected	Rounded estimates of pregnant women with HIV
CEE/CIS	1.000	5.000
East Asia	3.000	68.000
Industrialized countries	<1,000	5.000
Latin America/Caribbean	17.000	52.000
Middle East/North Africa	12.000	40.000
South Asia	60.000	160.000
Sub-Saharan Africa	700.000	2.200.000
World	800.000	2.500.000

Source: UNICEF, 2001

22.2 HIV/AIDS

Estimates suggest that there are 40,000 pregnant women with HIV living in North Africa and the Middle East. While the spread of this virus in Sub-Saharan Africa has reached appalling levels far in excess of any other geographical region in the world, the figures for HIV prevalence among pregnant women in the Arab region of the Mediterranean do not differ substantially from those for Latin-America and Southeast Asia. The table below shows that around 97% of women of childbearing age and of children under 15 years of age who contacted HIV/AIDS are in the developing countries. Further, the number of women of childbearing age who have been infected gives an indication of the size of the problems associated with HIV/AIDS that could affect future generations of children.

Pregnant women with HIV by region (a.v.), 2001



Source: UNICEF, 2001

22.3 HIV/AIDS

People living with HIV/AIDS (a.v.), 2001*

Country	Women (age 15-49)	Children (age 0-14)
Bahrain	150	n.a.
Iran	5.000	<200
Iraq	n.a.	n.a.
Kuwait	n.a.	n.a.
Oman	200	n.a.
Qatar	n.a.	n.a.
Saudi Arabia	n.a.	n.a.
United Arab Emirates	n.a.	n.a.
Yemen	1.500	n.a.
Israel	n.a.	n.a.
Jordan	150	n.a.
Lebanon	n.a.	n.a.
Occ. Palestinian Terr.	n.a.	n.a.
Syrian Arab Republic	n.a.	n.a.
Algeria	n.a.	n.a.
Egypt	780	n.a.
Libyan Arab Jamahiriya	1.100	n.a.
Morocco	2.000	n.a.
Tunisia	n.a.	n.a.
Albania	n.a.	n.a.
Bosnia and Herz. na	n.a.	n.a.
Bulgaria	n.a.	n.a.
Croatia	<100	<10
Romania	n.a.	4.000
Serbia and Montenegro	n.a.	n.a.
Slovenia	<100	<100
TFYR Macedonia	<100	<100
Turkey	n.a.	n.a.
Cyprus	150	n.a.
France	27.000	1.000
Greece	1.800	<100
Italy	33.000	770
Malta	n.a.	n.a.
Spain	26.000	1.300
Developing countries	18.000.000	2.900.000
Industrialized countries	360.000	19.000
MENA	250.000	35.000
World	18.500.000	3.000.000

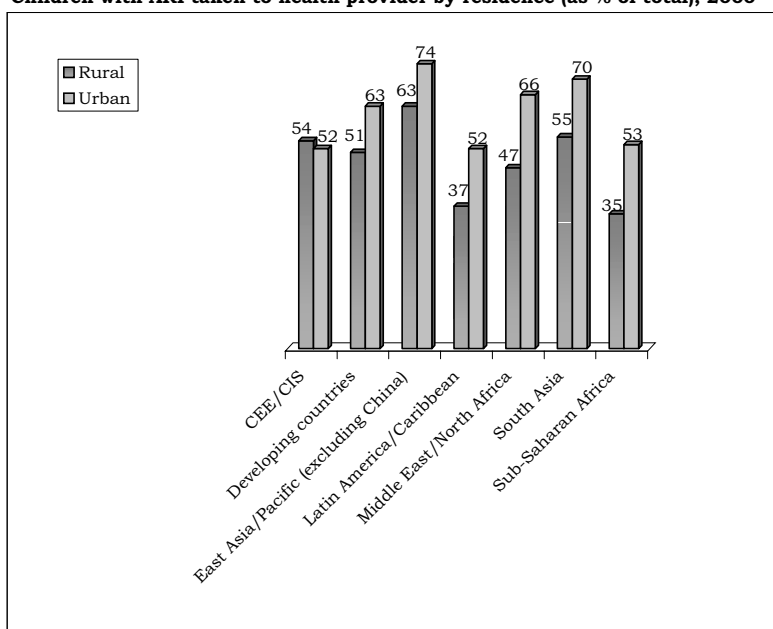
* Data refer to the end of 2001. Aggregate are rounded estimates; regional totals may not sum to the world total.

Source: UNAIDS, WHO, 2002

23.1 Acute Respiratory Infection (ARI)

Acute respiratory infection (ARI) is still a leading cause of death among children all over the world. UNICEF estimates suggest that about 2 million children aged under five died of ARI in 2000. Viral or bacterial infections of this type can involve mild disorders or potentially deadly diseases such as pneumonia requiring suitable treatment with antibiotics, which is often not available or incorrectly administered in many developing countries. It is estimated that 60% of the deaths caused by ARI could have been avoided by prompt diagnosis and appropriate treatment with antibiotics. The number of children examined by a health provider is much lower in rural than in urban areas except in Europe, where basic health services are widely available in both sectors.

Children with ARI taken to health provider by residence (as % of total), 2000

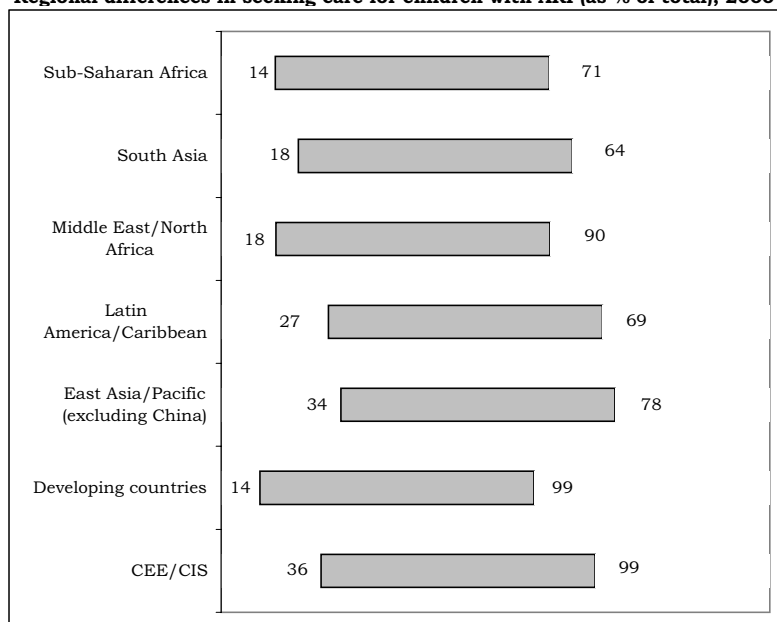


Source: UNICEF, 2001

23.2 Acute Respiratory Infection (ARI)

Health facilities vary greatly between rural and urban areas and from one country to another. There are considerable differences in the Euro-Mediterranean area with regard to care seeking behaviour. Data show that around 97% of the children under five years of age who had acute respiratory infections, in the two weeks preceding the survey, were taken to a health facility or provider for advice on treatment in Serbia and Montenegro. The likelihood of seeking medical advice ranged from 80% to 90% in Albania, Bosnia-Herzegovina, and five of the six Arab Gulf States, and it was lowest in Turkey (37%) and Yemen (32%).

Regional differences in seeking care for children with ARI (as % of total), 2000*



* The two figures shown for each region refer to the highest and the lowest country rates recorded for taking children with ARI symptoms to a health care provider.

Source: UNICEF, 2001

23.3 Acute Respiratory Infection (ARI)

Children under 5 with ARI (as % of total), 1995-2000

Country	% of children under 5 with ARI in the two weeks prior to the survey*	% with ARI taken to a health provider	Year of survey
Bahrain	8,3	77,8**	1995
Iran	n.a.	n.a.	n.a.
Iraq	n.a.	n.a.	n.a.
Kuwait	9,9	89,5**	1996
Oman	6,2	83,2**	1995
Qatar	7,8	85,6**	1998
Saudi Arabia	8,8	85,6**	1996
United Arab Emirates	6,2	86,9	1995
Yemen	23,4	32,2	1997
Israel	n.a.	n.a.	n.a.
Jordan	10,2	76,3	1997
Lebanon	3,5	73,6	2000
Occ. Palestinian Terr.	n.a.	n.a.	n.a.
Syrian Arab Republic	n.a.	n.a.	n.a.
Algeria	n.a.	n.a.	n.a.
Egypt	n.a.	67,3	1997
Libyan Arab Jamahiriya	n.a.	n.a.	n.a.
Morocco	15,3	18,1	1992
Tunisia	21,0	59,0	1995
Albania	1,4	83,0	2000
Bosnia and Herz.na	1,5	80,0	2000
Bulgaria	n.a.	n.a.	n.a.
Croatia	n.a.	n.a.	n.a.
Romania	n.a.	n.a.	n.a.
Serbia and Montenegro	2,7	96,7	2000
Slovenia	n.a.	n.a.	n.a.
TFYR Macedonia	n.a.	n.a.	n.a.
Turkey	12,4	37,3	1993
Cyprus	n.a.	n.a.	n.a.
France	n.a.	n.a.	n.a.
Greece	n.a.	n.a.	n.a.
Italy	n.a.	n.a.	n.a.
Malta	n.a.	n.a.	n.a.
Spain	n.a.	n.a.	n.a.
Developing countries	n.a.	n.a.	n.a.
Industrialized countries	n.a.	n.a.	n.a.
MENA	n.a.	n.a.	n.a.
World	n.a.	n.a.	n.a.

* The prevalence of ARI often varies by season. Country surveys were administered at different times, rendering the ARI prevalence data incomparable between countries

** Pharmacies are included in the definition of health provider.

24. Neonatal tetanus deaths

The lack of figures for most of the countries rules out a complete analysis of the incidence of tetanus with respect to neonatal mortality. The highest values are registered for Yemen, where the death rate for tetanus (as shown in the following datasheet) is 2.9 for every thousand live births.

Estimated neonatal tetanus deaths (a.v.), 1999

Country	Estimated cases	Estimated deaths	Estimated mortality rate (per 1,000 live births)
Bahrain	n.a.	n.a.	n.a.
Iran	n.a.	n.a.	n.a.
Iraq	870	522	0,66
Kuwait	n.a.	n.a.	n.a.
Oman	n.a.	n.a.	n.a.
Qatar	n.a.	n.a.	n.a.
Saudi Arabia	n.a.	n.a.	n.a.
United Arab Emirates	n.a.	n.a.	n.a.
Yemen	3.012	2.339	2,90
Israel	n.a.	n.a.	n.a.
Jordan	n.a.	n.a.	n.a.
Lebanon	n.a.	n.a.	n.a.
Occ. Palestinian Terr.	n.a.	n.a.	n.a.
Syrian Arab Republic	n.a.	n.a.	n.a.
Algeria	n.a.	n.a.	n.a.
Egypt	1.570	628	0,37
Libyan Arab Jamahiriya	n.a.	n.a.	n.a.
Morocco	n.a.	n.a.	n.a.
Tunisia	n.a.	n.a.	n.a.
Albania	n.a.	n.a.	n.a.
Bosnia and Herz.na	n.a.	n.a.	n.a.
Bulgaria	n.a.	n.a.	n.a.
Croatia	n.a.	n.a.	n.a.
Romania	n.a.	n.a.	n.a.
Serbia and Montenegro	n.a.	n.a.	n.a.
Slovenia	n.a.	n.a.	n.a.
TFYR Macedonia	n.a.	n.a.	n.a.
Turkey	231	139	0,10
Cyprus	n.a.	n.a.	n.a.
France	n.a.	n.a.	n.a.
Greece	n.a.	n.a.	n.a.
Italy	n.a.	n.a.	n.a.
Malta	n.a.	n.a.	n.a.
Spain	n.a.	n.a.	n.a.
Developing countries	n.a.	n.a.	n.a.
Industrialized countries	n.a.	n.a.	n.a.
MENA	n.a.	n.a.	n.a.
World	n.a.	n.a.	n.a.

Source: WHO, 1999

25.1 Diarrhoea

Children under 5 with diarrhoea in the two weeks prior to the survey (as % of total), 1995-2000**

Country	under 5 with diarrhoea in the two weeks prior to the survey*	% with diarrhoea that received ORT (1)	% with diarrhoea that received increased fluids plus continued feeding	Year of survey
Bahrain	8,4	39,3	40,1	1995
Iran	11,3	n.a.	n.a.	1995
Iraq	27,8	n.a.	37,4	1996
Kuwait	10,2	32,6	26,1	1996
Oman	6,7	60,8	88,0	1996
Qatar	8,8	23,9	22,3	1998
Saudi Arabia	9,1	53,1	20,2	1996
United Arab Emirates	8,8	42,1	23,4	1995
Yemen	27,5	35,3	n.a.	1997
Israel	n.a.	n.a.	n.a.	n.a.
Jordan	18,0	n.a.	n.a.	1997
Lebanon	19,3	n.a.	29,8	2000
Occ. Palestinian Terr.	n.a.	n.a.	n.a.	n.a.
Syrian Arab Republic	8,6	37,0	n.a.	1993
Algeria	19,8	n.a.	24,0	2000
Egypt	7,1	37,1	n.a.	2000
Libyan Arab Jamahiriya	16,9	n.a.	n.a.	1995
Morocco	10,4	n.a.	n.a.	1995
Tunisia	5,8	n.a.	n.a.	2000
Albania	7,3	n.a.	48,2	2000
Bosnia and Herz. na	8,9	n.a.	11,1	2000
Bulgaria	n.a.	n.a.	n.a.	n.a.
Croatia	11,3	n.a.	n.a.	1996
Romania	n.a.	n.a.	n.a.	n.a.
Serbia and Montenegro	8,6	n.a.	n.a.	2000
Slovenia	n.a.	n.a.	n.a.	n.a.
TFYR Macedonia	n.a.	n.a.	41,3	1996
Turkey	29,7	26,9	15,2	1998
Cyprus	n.a.	n.a.	n.a.	n.a.
France	n.a.	n.a.	n.a.	n.a.
Greece	n.a.	n.a.	n.a.	n.a.
Italy	n.a.	n.a.	n.a.	n.a.
Malta	n.a.	n.a.	n.a.	n.a.
Spain	n.a.	n.a.	n.a.	n.a.
Developing countries	n.a.	n.a.	n.a.	n.a.
Industrialized countries	n.a.	n.a.	n.a.	n.a.
MENA	n.a.	n.a.	n.a.	n.a.
World	n.a.	n.a.	n.a.	n.a.

* Data refer to the most recent year available during the period specified in the column heading

** Country surveys were administered at different times, rendering the diarrhoea prevalence data incomparable between countries.

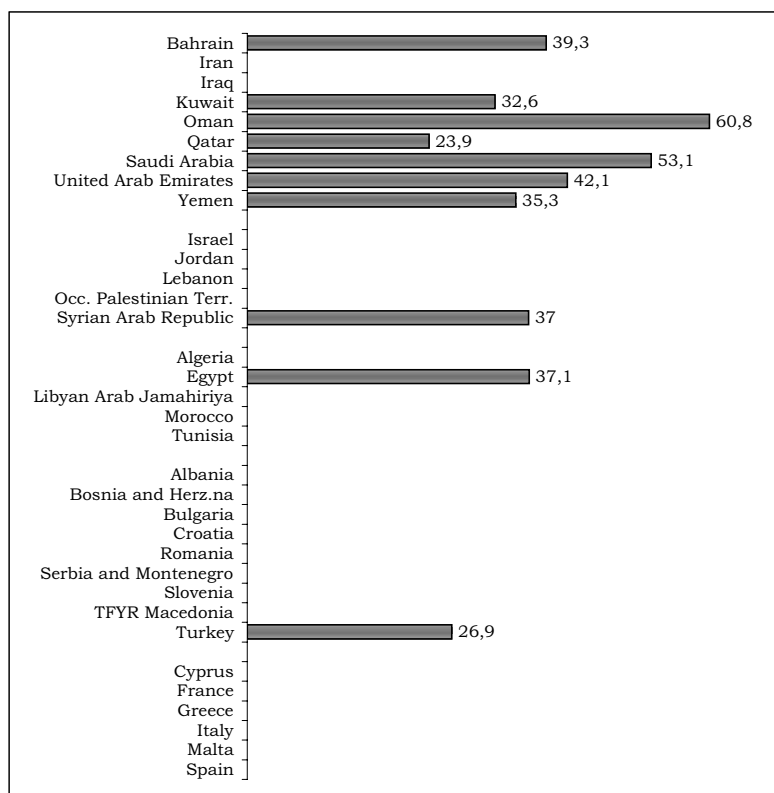
(1) ORT: Oral Rehydration Therapy

Source: DHS, MICS, Gulf Family Health Surveys 1995-1998

25.2 Diarrhoea

Diarrhoeal disease is a major contributory cause of pediatric morbidity; in many parts of the less developed countries, it is still the major cause of death for children under five due to the severe loss of fluids and mineral salts through dehydration. Oral rehydration therapy (ORT), which includes administration of a solution prepared from ORS packets, or a homemade sugar-salt-water solution, is an important modality for managing diarrhoea, particularly in young children. Data on children under five suffering from diarrhoea who received ORT are scarce for the Euro-Mediterranean area, being available only for 9 out of the 34 countries considered. Oman shows the highest proportion of children with diarrhoea receiving ORT (61%), followed by Saudi Arabia (53%), and six Arab countries with proportions ranging from 39% to 32%, while the lowest proportions are shown for Turkey (27%) and Qatar (24%).

Children under 5 who received oral rehydration treatment (as % of total), 1994-2000*



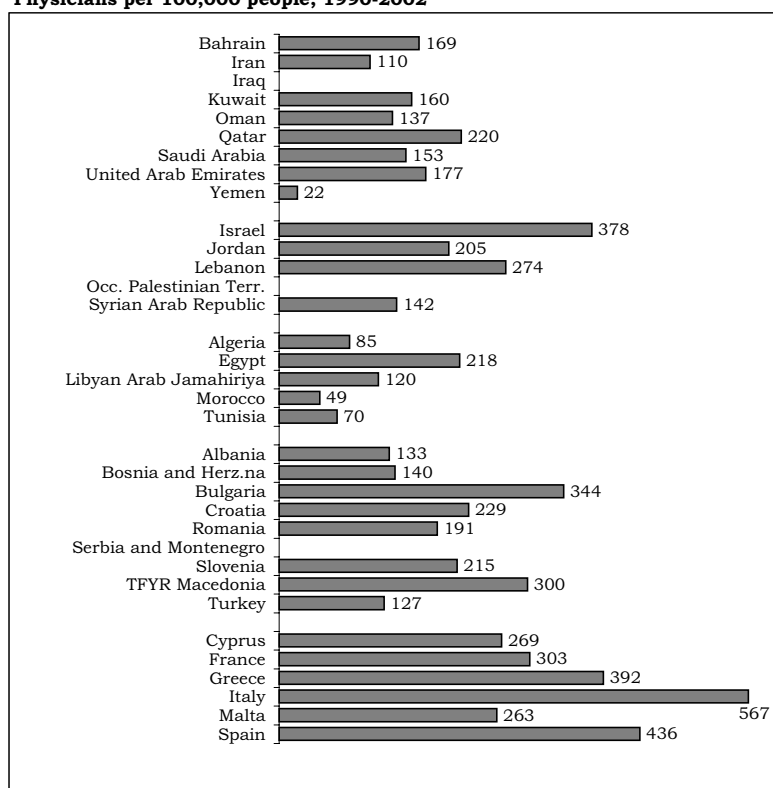
* Data refer to the most recent year available during the period specified in the column heading

Source: UNICEF, 2003

26.1 Health resources

The medical resources available differ considerably between and within the five regions examined. For example, the number of physicians per 100,000 inhabitants is consistently higher in South Europe than in other regions, with a high of 567 physicians per 100,000 persons recorded in Italy. This indicator of health resources is lowest in Yemen (22), Morocco (49) and Tunisia (70). It increases to 85 physicians per 100,000 persons in Algeria and 110 in Iran. It is worth pointing out that in Egypt, Lebanon and Jordan, the number of physicians per 100,000 persons is higher than in any of the other Arab countries considered.

Physicians per 100,000 people, 1990-2002*



* Data refer to the most recent year available during the period specified in the column heading

Source: Human Development Report, UNDP 2003

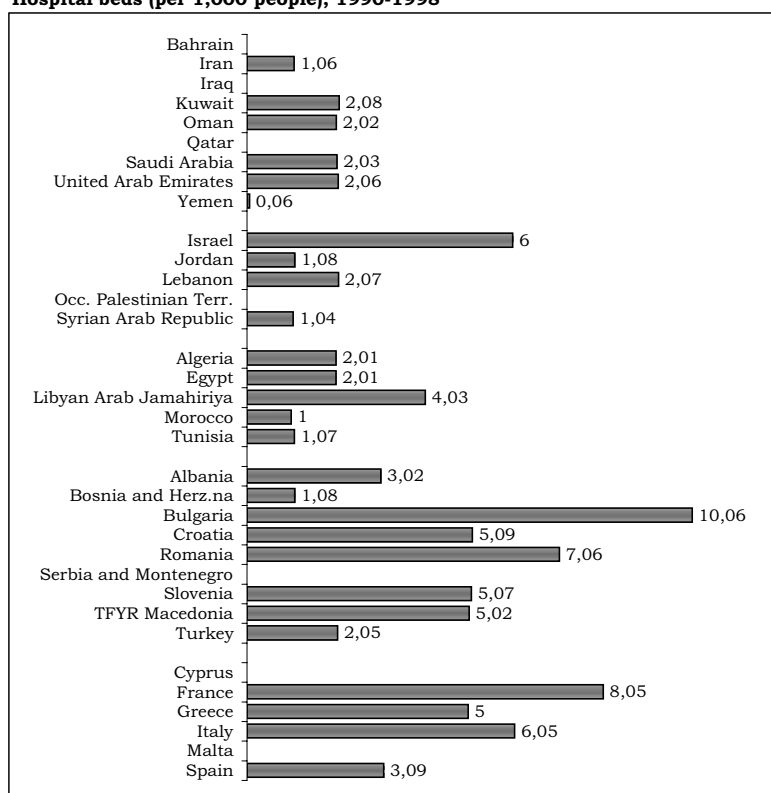
26.2 Health resources

The number of hospital beds in a country is an indicator of financial resources dedicated to health care. There are considerable differences in the Euro-Mediterranean area with regard to the availability of hospital beds. As may be seen, the average number of hospital beds per 1,000 people varies between 1 and 2 in most of the countries considered on the southern side of the Mediterranean, the exceptions being Yemen (with only 6 beds per 100,000 people), Libya (4 beds per 1,000 people), and Israel (with 6 beds per 1,000 people).

The availability of hospital beds also varies significantly from one country to another on the north shore of the Mediterranean, with Bosnia-Herzegovina showing the lowest average (1 bed per 1,000 people) and Bulgaria the highest (10 beds per 1,000 people).

It is interesting to note that some countries (i.e. Italy) have a higher number of physicians per capita than others (i.e. France), while the situation is reversed with regard to hospital beds.

Hospital beds (per 1,000 people), 1990-1998



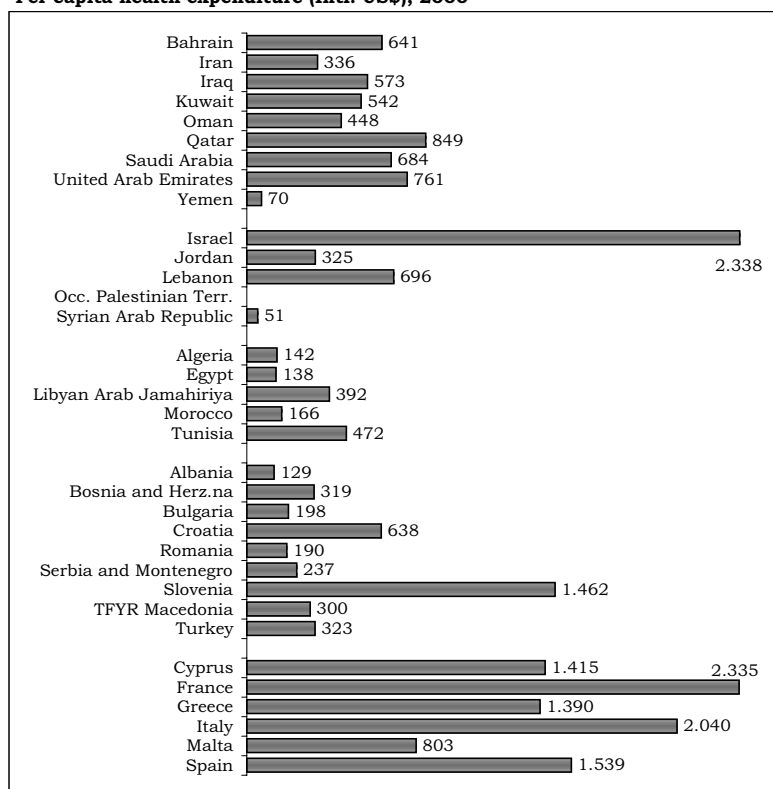
Source: World Development Indicators, 2001

26.3 Health resources

Information on the per capita health expenditure in the countries of the Mediterranean Arab region reveals a great deal of disparity in terms of both total and government expenditure on health. is lowest in the Syrian Arab Republic (\$51) and in Yemen (\$70); In North Africa, per capita total expenditure on health is around \$150, with the exceptions of Lybia (\$392) and Tunisia (472). The situation in the middle east is particularly diversified, with data ranging from \$51 of Syria to the \$2,338 of Israel. With the exception of Yemen on one extreme (\$70) and Qatar on the other (\$849), the situation of the Arabian Peninsula is slightly more homogeneous, with data ranging between \$336 and \$761.

As next table shows, in nearly half of the 17 Arab States considered, government expenditure on health represents more than three-quarters of total expenditure on health. On the other hand, the share of government expenditure on health to the total expenditure on health is below 32% in Lebanon, Morocco and Yemen, and between 46-52% in Egypt, Jordan and Libyan Arab Jamahiriya. In these countries, the ability to supplement public resources is obviously restricted to the more affluent sections of society.

Per capita health expenditure (Intl. US\$), 2000



Source: Human Development Report, UNDP 2003

26.4 Health resources

Information on the per capita health expenditure in the countries of the Mediterranean Arab region reveals a great deal of disparity in terms of both total and government expenditure on health. Per capita total expenditure on health is lowest in the Syrian Arab Republic (\$51) and in Yemen (\$70), increasing to between \$138-\$166 in 3 countries in North Africa, and to between \$325-\$475 in 4 countries, and to more than \$640 in 5 countries, in the Middle East.

In nearly half of the 17 Arab States considered, government expenditure on health represents more than three-quarters of total expenditure on health. On the other hand, the share of government expenditure on health to the total expenditure on health is below 32% in Lebanon, Morocco and Yemen, and between 46-52% in Egypt, Jordan and Libyan Arab Jamahiriya. In these countries, the ability to supplement public resources is obviously restricted to the more affluent sections of society.

Total expenditure on health (as % of GDP), 2000

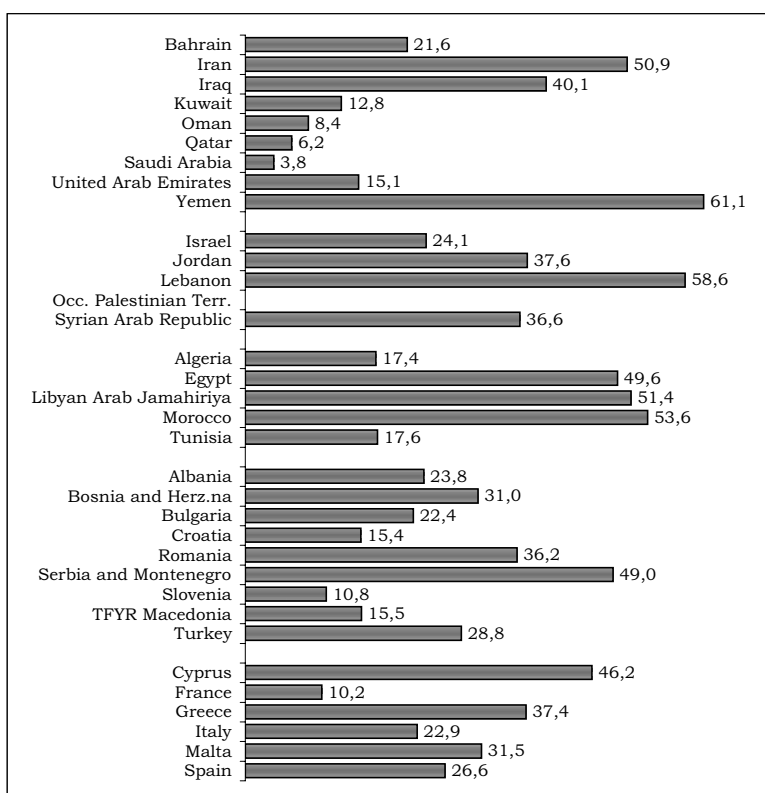
Country	Total expenditure on health		Private expenditure on Health	General Government expenditure on Health
	(as % of GDP)	(per capita, intl. \$)	(as % of total expenditure on health)	
Bahrain	4,1	641	30,9	69,1
Iran	5,5	336	53,7	46,3
Iraq	3,7	573	40,1	59,9
Kuwait	3,0	542	12,8	87,2
Oman	2,8	448	17,1	82,9
Qatar	3,2	849	22,5	77,5
Saudi Arabia	5,3	684	20,9	79,1
United Arab Emirates	3,2	761	22,3	77,7
Yemen	5,0	70	68,0	32,0
Israel	10,9	2338	24,1	75,9
Jordan	8,1	325	48,2	51,8
Lebanon	11,8	696	72,2	27,8
Occ. Palestinian Terr.	0,0	0	0,0	0,0
Syrian Arab Republic	2,5	51	36,6	63,4
Algeria	3,6	142	17,8	82,2
Egypt	3,8	138	53,9	46,1
Libyan Arab Jamahiriya	3,3	392	51,4	48,6
Morocco	4,5	166	70,4	29,6
Tunisia	7,0	472	21,8	78,2
Albania	3,4	129	37,9	62,1
Bosnia and Herz. na	4,5	319	31,0	69,0
Bulgaria	3,9	198	22,4	77,6
Croatia	8,6	638	15,4	84,6
Romania	2,9	190	36,2	63,8
Serbia and Montenegro	5,6	237	49,0	51,0
Slovenia	8,6	1462	21,1	78,9
TFYR Macedonia	6,0	300	15,5	84,5
Turkey	5,0	323	28,9	71,1
Cyprus	7,9	1415	46,2	53,8
France	9,5	2335	24,0	76,0
Greece	8,3	1390	44,5	55,5
Italy	8,1	2040	26,3	73,7
Malta	8,8	803	31,5	68,5
Spain	7,7	1539	30,1	69,9

Source: World Health Report, WHO 2002

26.5 Health resources

The amount of out-of-pocket expenditure involved in the provision of medical care and treatment varies from one country to another, depending on several factors, chief among them is the structure and scope of the national health service. Out-of-pocket expenditure on health accounts to as much as three-fifths of total expenditure on health in Yemen and Lebanon; about one half in Egypt, Libyan Arab Jamahiriya and Morocco; about one-fifth in Algeria, Bahrain and Tunisia; and below one-tenth in Oman, Qatar and Saudi Arabia

Out-of-pocket health expenditure (as % of total expenditure on health), 2000



Source: World Health Report, WHO 2002

