

A. Demographic indicators**B. Nutrition****C. Health**

- C.18 Antenatal care**
 - C.19 Skilled attendant at delivery**
 - C.20 Maternal mortality**
 - C.21 Pregnant women with anaemia**
 - C.22 Contraception**
 - C.23 Female mutilation/cutting**
 - C.24 Immunization**
 - C.25 Acute Respiratory Infection (ARI)**
 - C.26 Neonatal tetanus deaths**
 - C.27 Diarrhoea**
 - C.28 Environmental conditions and Child Health**
 - C.29 Infant deaths**
 - C.30 Road traffic mortality**
 - C.31 Tobacco use, exposure and attitude**
 - C.32 HIV/AIDS**
 - C.33 Health resources**
-

D. Education**E. Economic indicators****F. Social indicators**

Antenatal care

C 18.1 - Antenatal care coverage by region (%), 1995 - 2003	Pg 178
C 18.2 - Antenatal care coverage (%), 1995 - 2003	Pg 179

Skilled attendant at delivery

C 19.1 - Trends in skilled care at delivery (as % of total), 1990 - 2000	Pg 180
C 19.2 - Skilled attendant at delivery (as % of total), 1995 - 2002	Pg 181

Maternal mortality

C 20.1 - Maternal mortality ratio by region (per 100,000 live births), 1985 - 2003	Pg 182
C 20.2 - Estimated number of maternal deaths, 2000	Pg 183
C 20.3 - Lifetime risk of dying in pregnancy or childbirth, 1995	Pg 184
C 20.4 - Estimates of maternal mortality ratio (per 100,000 live births), 2000	Pg 185

Pregnant women with anaemia

C 21 - Pregnant women with anaemia (as % of total), 1975 - 1991	Pg 186
---	--------

Contraception

C 22.1 - Contraceptive prevalence (%) among women (in union) aged 15-49, by region, 1990 and 2000	Pg 187
C 22.2 - Contraceptive prevalence (%), 1995 - 2003	Pg 188

Female mutilation/cutting

C 23 - Women aged 15 to 49 who have been mutilated/cut, 1998 - 2003	Pg 189
---	--------

Immunization

C 24.1 - Number of children not immunized with DPT3 by region, 2000	Pg 190
C 24.2 - Measles coverage by region (as % of total), 1990 and 2000	Pg 191
C 24.3 - Children under 1 fully immunized against polio (as % of total), by region, 2002	Pg 192
C 24.4 - Routine EPI vaccination financed by government (as % of total), 2003	Pg 193
C 24.5 - Percentage of 1-year-old children who have been immunized, 2003	Pg 194

Acute Respiratory Infection (ARI)

C 25.1 - Children with ARI taken to health provider (%), by residence, 2000	Pg 195
C 25.2 - Regional differences in seeking care for children with ARI (%), 2000	Pg 196
C 25.3 - Children under 5 with ARI (%), 1995 - 2000	Pg 197

Neonatal tetanus deaths

C 26 - Estimates of neonatal tetanus deaths, 1999	Pg 198
---	--------

Diarrhoea

C 27.1 - Children under 5 with diarrhoea in the two weeks prior to the survey (%), 1995 - 2000	Pg 199
C 27.2 - Children under 5 who received oral rehydration treatment (ORT) (%), 1994 - 2000	Pg 200

Environmental conditions and Child Health

C 28 - Environmental determinants to Child Health, 2000	Pg 201
---	--------

Infant deaths

C 29 - Most important cause of infant deaths, 1998 - 2002	Pg 202
---	--------

Road traffic mortality

C 30 - Mortality caused by road traffic accident by selected age groups and gender, 1992 - 2002	Pg 203
---	--------

Tobacco use, exposure and attitude

C 31 - Tobacco use, exposure and attitude, 2001 - 2003	Pg 204
--	--------

HIV/AIDS

C 32.1 - Children under 15 newly infected with HIV, by region, 2001	Pg 205
C 32.2 - Pregnant women with HIV by region, 2001	Pg 206
C 32.3 - People living with HIV/AIDS, 2001	Pg 207

Health resources

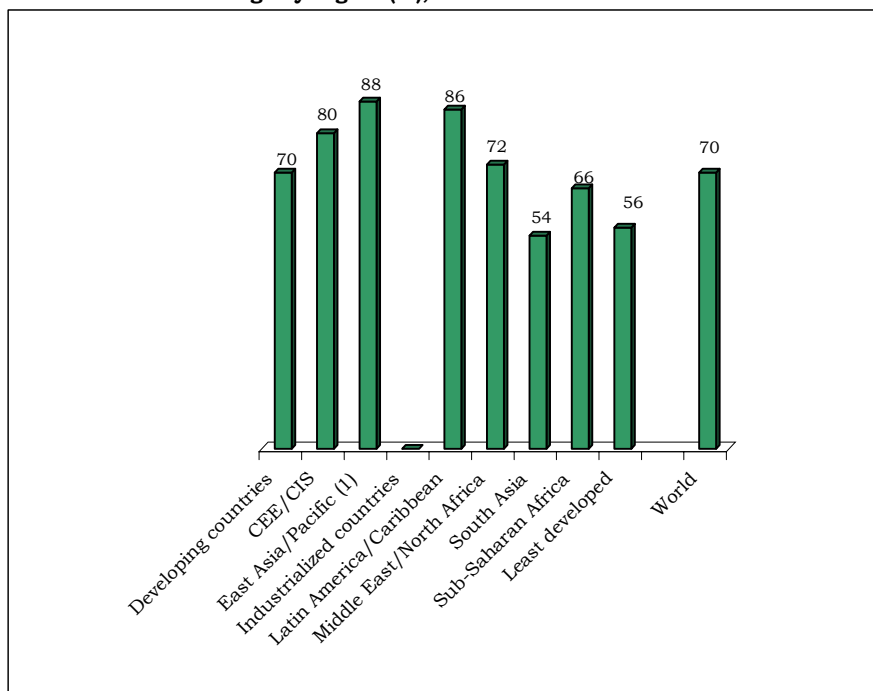
C 33.1 - Physicians per 100,000 people, 1995 - 2002	Pg 208
C 33.2 - Hospital beds (per 1,000 people) 1995 - 2002	Pg 209
C 33.3 - Per capita health expenditure (Intl. US\$), 2001	Pg 210
C 33.4 - Expenditure on health, 2001	Pg 211
C 33.5 - Out of Pocket Health expenditure (% of total expenditure on health), 2001	Pg 212

18.1 Antenatal care

In 2001, WHO published a new model of antenatal care that separates pregnant women into two groups: those likely to need only routine antenatal care (some 75% of the total population of pregnant women), and those with specific health conditions or risk factors that necessitate special care (25% of pregnant women). For the first group, a standard programme of four antenatal visits is recommended.

Virtually all pregnant women in the more developed countries receive antenatal care at least once during pregnancy from a doctor, nurse or midwife, compared with only 69% in developing countries. In the Middle East and North Africa, around 72% of pregnant women receive antenatal care — a level of coverage just above the average of 70% shown for developing countries.

Antenatal care coverage by region (%), 1995 - 2003



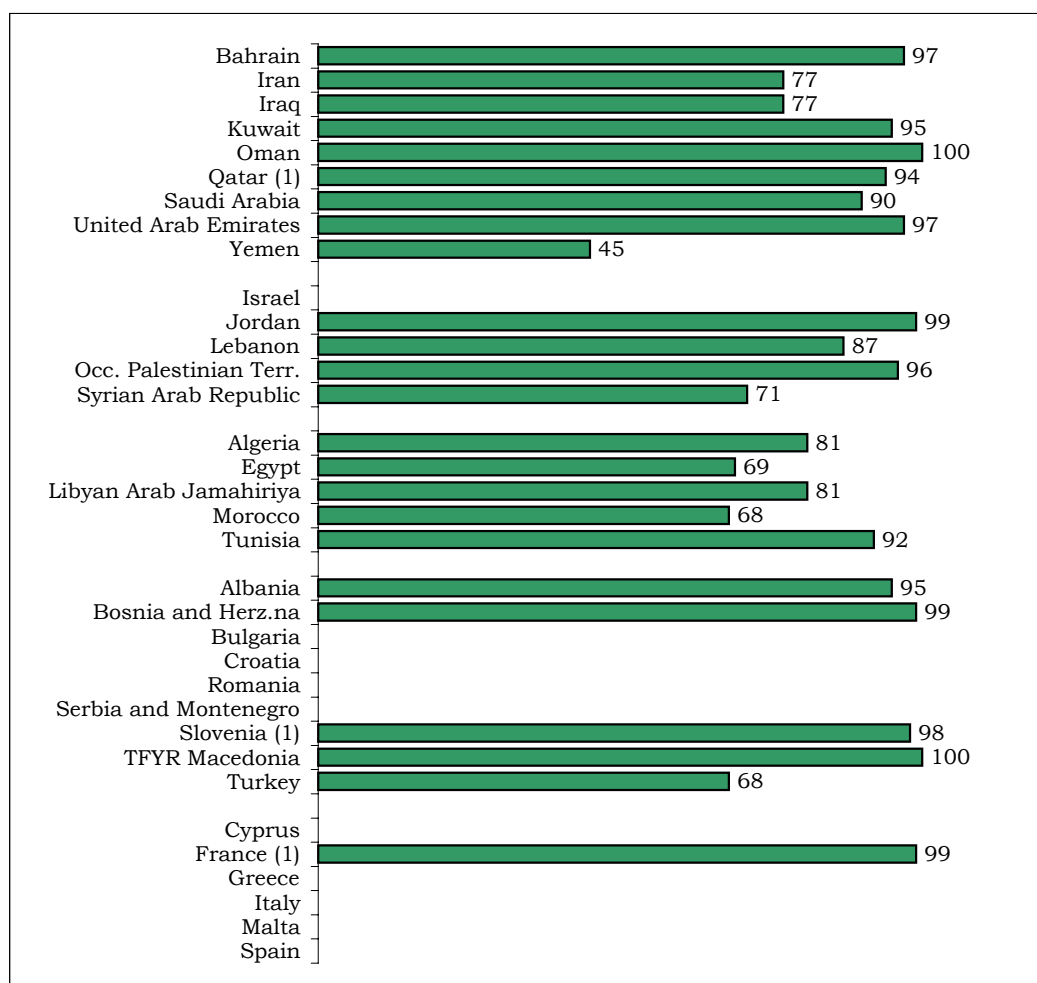
(1) East Asia/Pacific excluding China.

Source: *The State of the World's Children*, UNICEF, 2005

18.2 Antenatal care

Antenatal care, skilled assistance at delivery, and physical and economic accessibility to efficient emergency obstetric care 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 92% in Tunisia, 87% in Lebanon, around 77-81% in Algeria, Iran, Iraq, and Libya, and around 68-71% in Egypt, Morocco, Syria and Turkey. The lowest coverage is shown for Yemen (45%).

Antenatal care coverage (%), 1995 - 2003



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

(1) 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.

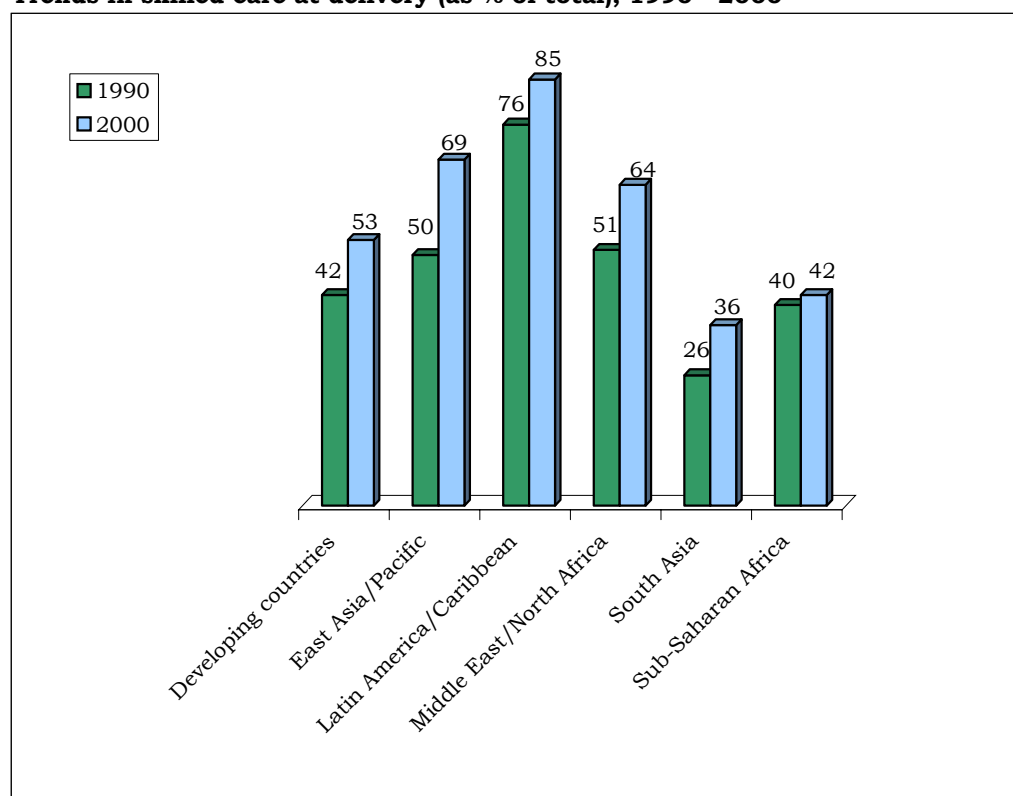
Source: *The State of the World's Children*, UNICEF, 2005

19.1 Skilled attendant at delivery

Most safe motherhood programmes currently stress ensuring access to emergency obstetric care and ensuring that all pregnant women benefit from proper care by qualified personnel during labour and delivery.

The number of deliveries attended by qualified personnel rose sharply all over the world between 1990 and 2000. However, around 58% of pregnant women living in developing countries still lack access to skilled attendant at delivery. The most dramatic situation in this respect is found in South Asia and Sub-Saharan Africa. In the Middle East and North Africa, the proportion of women receiving skilled assistance at the delivery increased from 51% in 1990 to 64% in 2000.

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

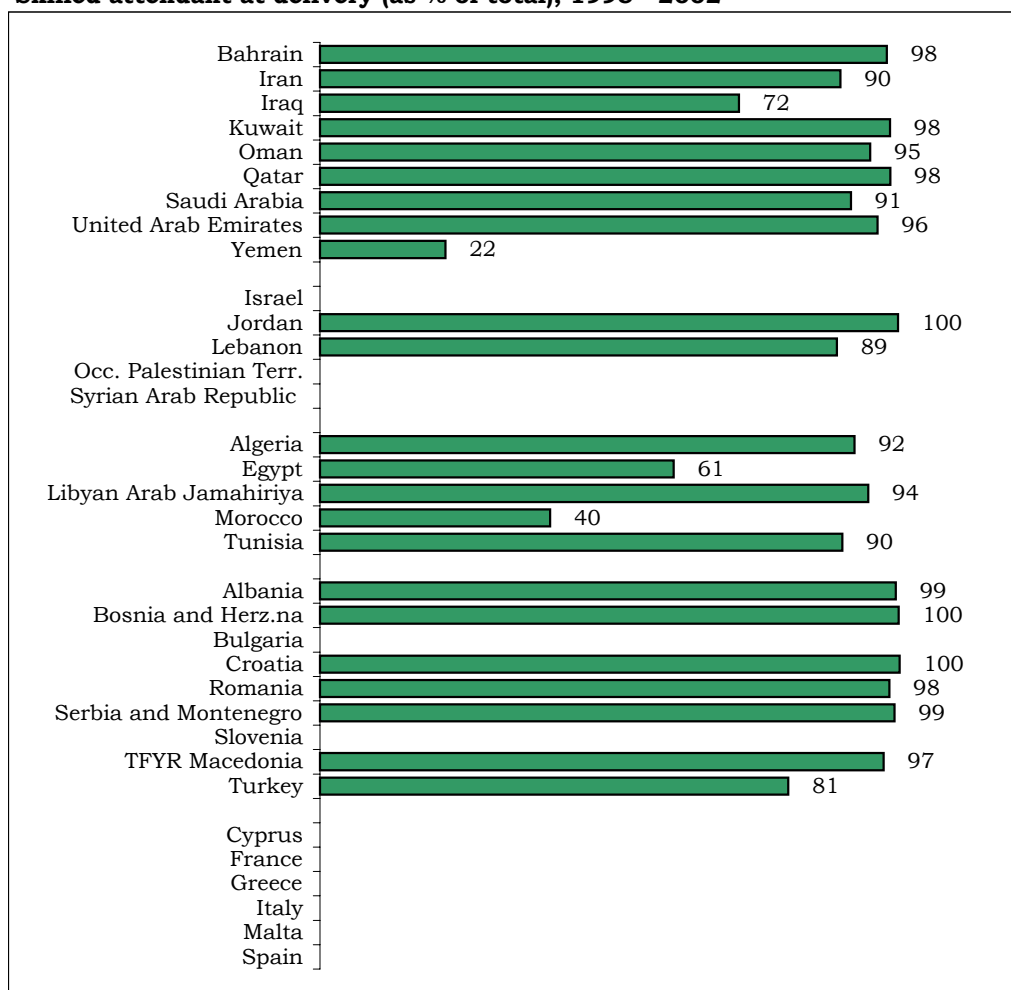


Source: UNICEF, 2001

19.2 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. The most striking difference observed is between the almost universal maternity care available in the oil-producing Gulf states 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 - 2002



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

Source: World Bank, World Development Report, 2004

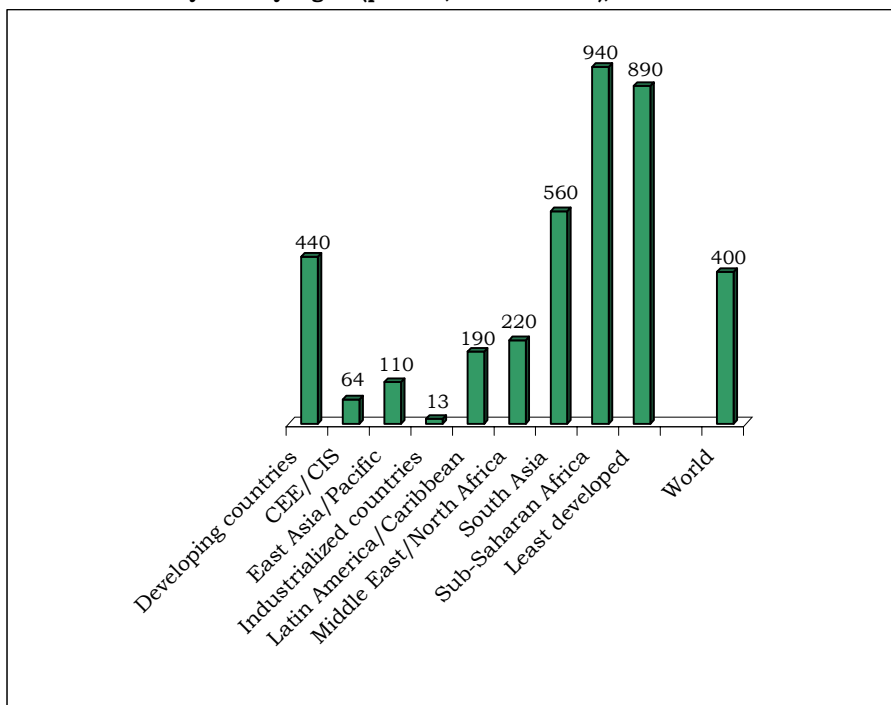
20.1 Maternal mortality

The direct causes of maternal deaths are haemorrhage, sepsis (infections on a massive scale), obstructed labour, hypertensive disorders of pregnancy, and complications of unsafe abortion. For every woman who dies from complications related to childbirth, approximately 30 more suffer injuries, infections and disabilities that are usually untreated and ignored.

Most of these complications cannot be predicted and prevented. All pregnant women are at risk and can develop complications at any time during pregnancy, delivery and after delivery. These complications, however, can be treated. Providing emergency obstetric care is the single most effective way to reduce maternal deaths.

The devastating effects of inadequate medical and health services can be seen in the high rates of maternal mortality recorded in certain parts 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 the Middle East and North Africa. 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), 1985 - 2003



Source: *The State of the World's Children*, UNICEF, 2005

20.2 Maternal mortality

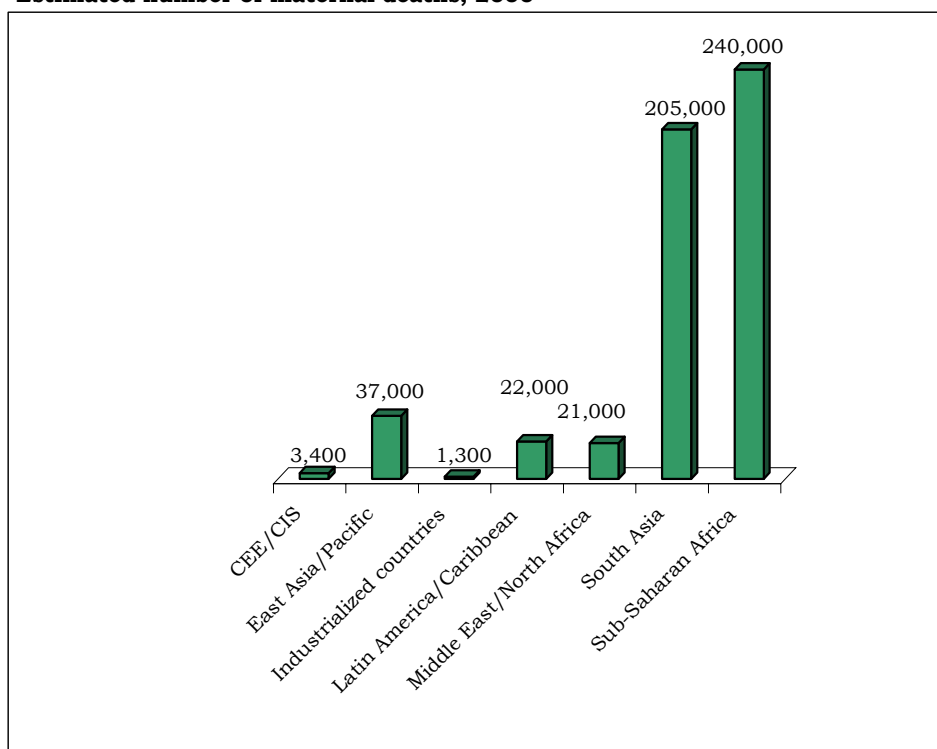
Over half a million women die every year in the world because of complications related to pregnancy and childbirth. Of these deaths, almost all (99%) occur in the developing world. Maternal mortality has by far the largest difference between poor and rich countries of any health indicator. For every women who dies from complications related to childbirth, at least 13 remain alive in a severely impaired state of health.

Maternal mortality is greatly reduced in countries that ensure that health facilities, within functioning health systems, are able to provide emergency obstetric care services.

Most maternal deaths (85%), occur in Sub-Saharan Africa and South Asia.

A comparison between the number of maternal deaths in 2000 in the Middle East and North Africa (21,000 deaths) and that in the industrialized countries (1,300 deaths), underscores the gap in terms of health prospects and health care coverage between the countries to the north and south of the Mediterranean.

Estimated number of maternal deaths, 2000



Source: WHO, UNICEF and UNFPA, 2001

20.3 Maternal mortality

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 haemorrhage 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 morbidity). Prompt intervention in cases of pregnancy-related emergency is not available in many parts of the world. The human toll can be expressed by comparing lifetime risk: one in 16 in Sub-Saharan Africa, and one in 100 in the Middle East and North Africa, will die in pregnancy and childbirth, while in the industrialized countries, only one in 4,000 will die.

Lifetime risk of dying in pregnancy or childbirth, 1995

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

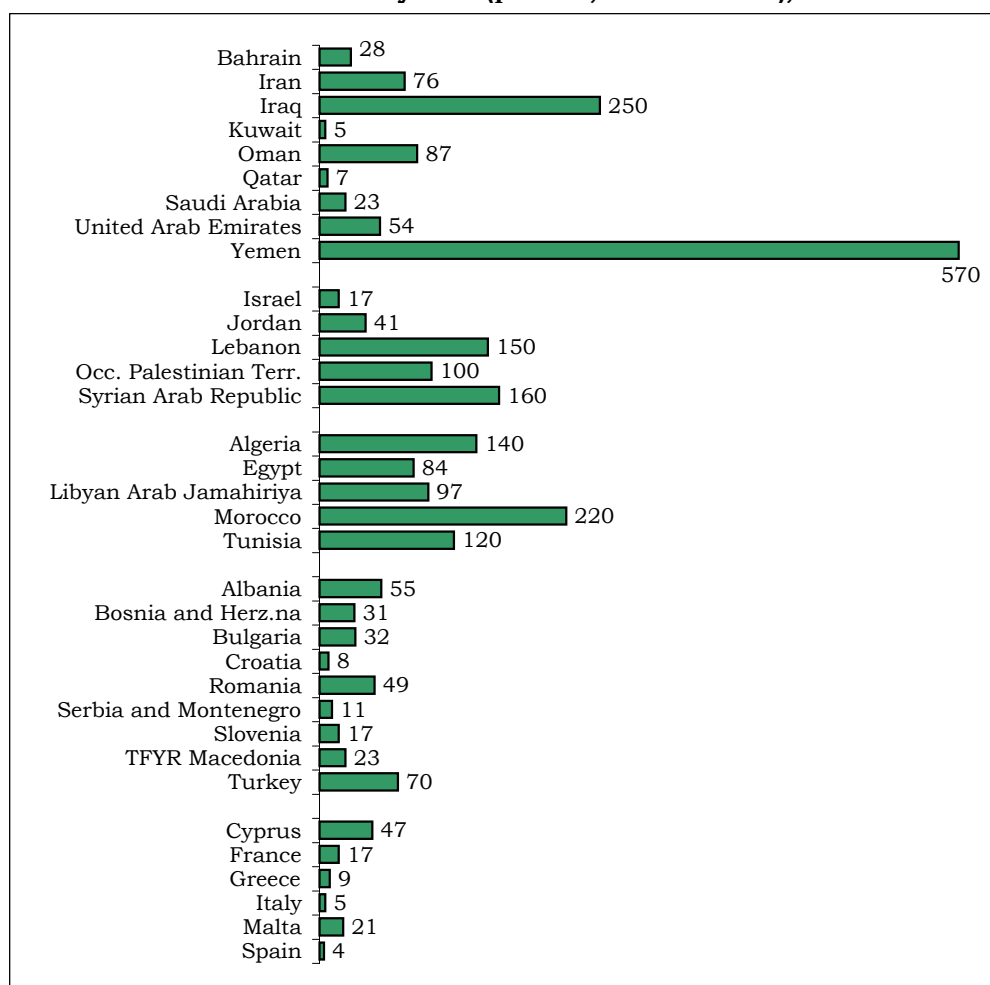
Affected not only by maternal mortality rates but also by the number of birth per woman.

Source: WHO, UNICEF and UNFPA, 2003

20.4 Maternal mortality

Recent estimates of maternal mortality ratios (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 – in Albania, Romania and especially Turkey. The most positive figures south of the Mediterranean are shown for Kuwait and Qatar. Higher rates of maternal mortality are shown for Iraq and Morocco, while the highest rate is found in Yemen.

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

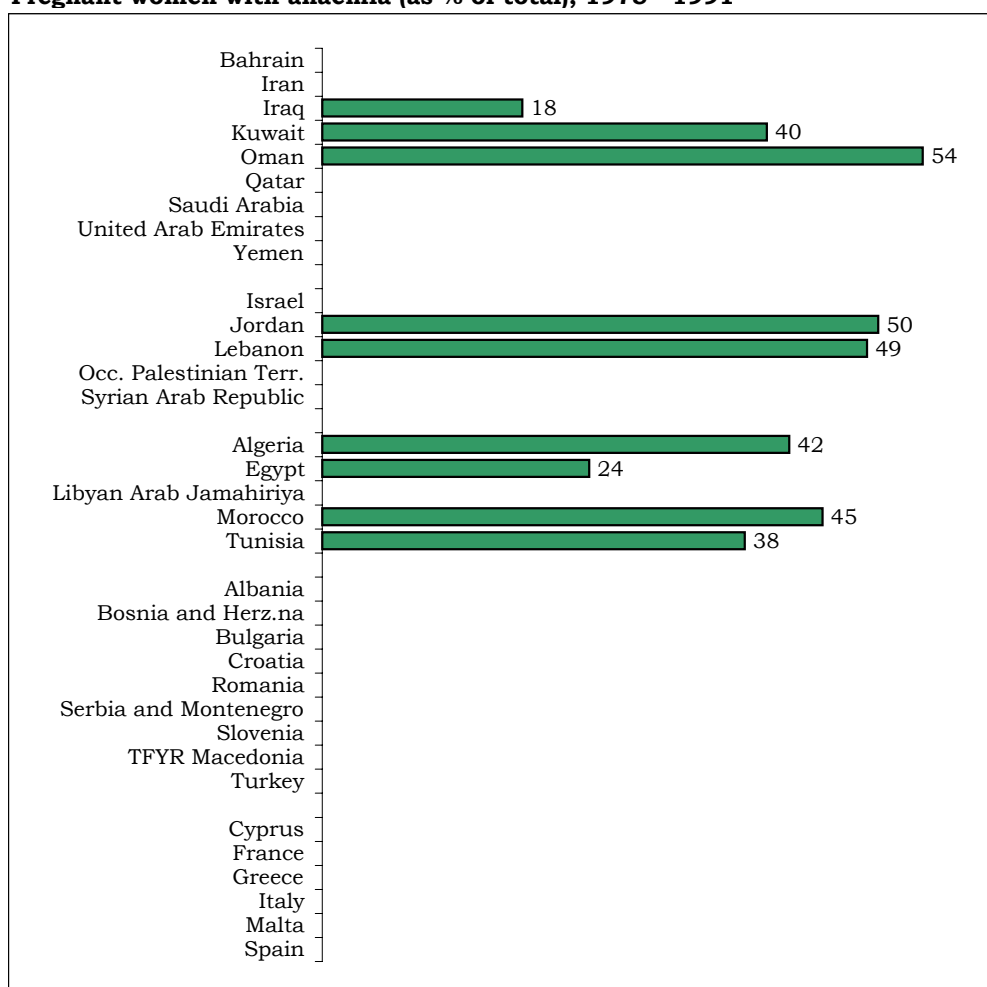


Source: WHO, UNICEF and UNFPA, 2003

21 Pregnant women with anaemia

Data on the prevalence of anaemia in pregnant women are scanty and fragmentary. An anaemic 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 anaemic 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. The problem 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 anaemic condition.

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



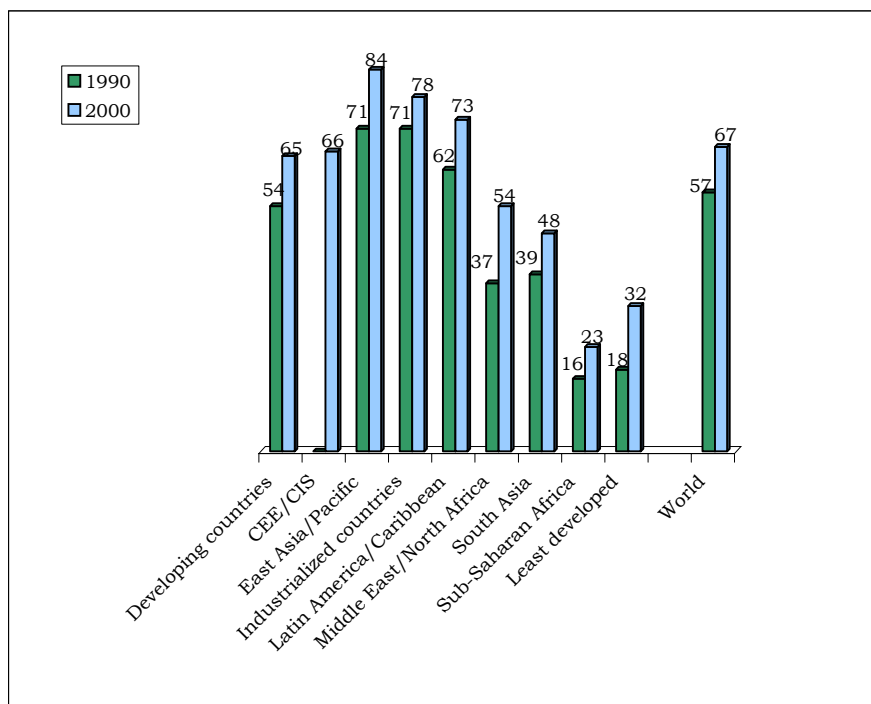
Data refer to the most recent year available during the period specified.

Source: Arab Human Development Report, UNDP 2002

22.1 Contraception

Family planning is an integral part of reproductive health. It allows couples and individuals to realize the basic right of deciding freely and responsibly the number, spacing and timing of their children, a right reaffirmed at the International Conference on Population and Development held in Cairo in 1994. Indeed, it has been widely shown that both woman's and children's health are at high risk if women have pregnancies too soon, too late, too often or too close to each other. Significant improvements were achieved during the 1990s in the availability and accessibility of contraceptives and in the range of choice. In the industrialized countries, around 78% of women aged 15-49 use contraceptives. In the Middle East and North Africa, contraceptive prevalence drops to 54% — a level lower than the average of 65% shown for developing countries as a whole.

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

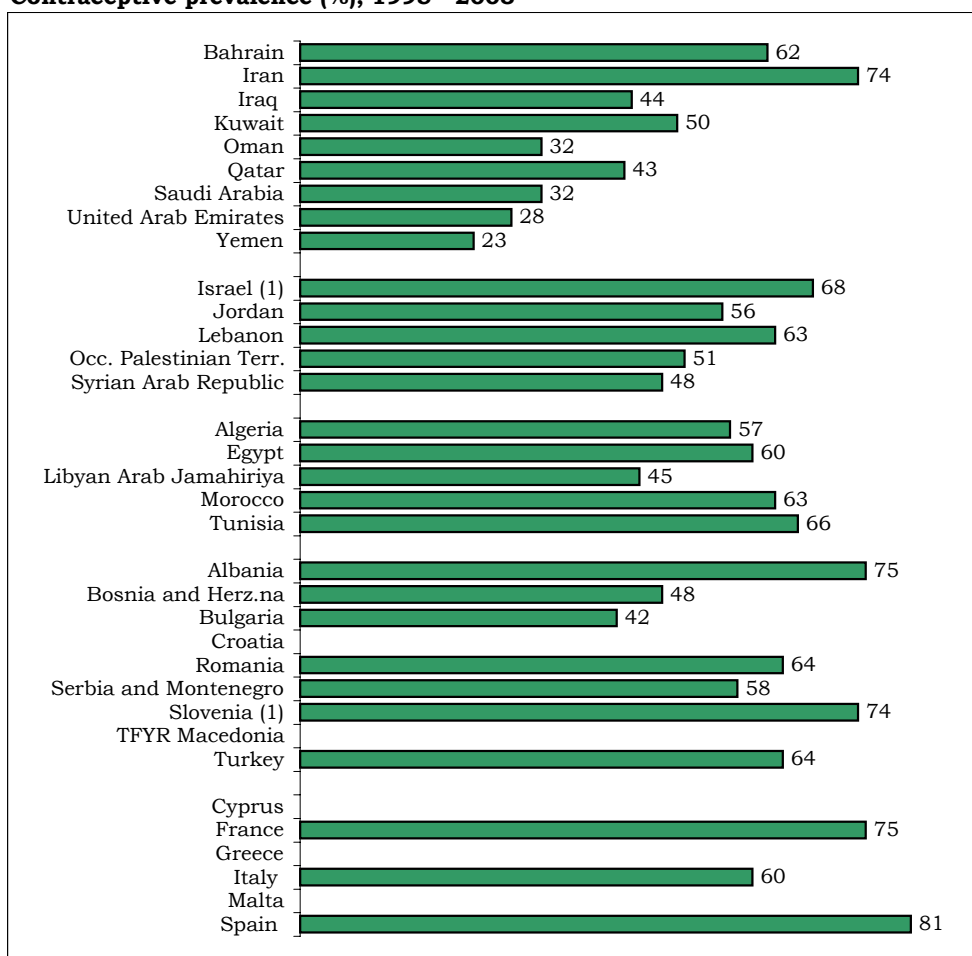


Source: UN, 2001

22.2 Contraception

The differences in fertility levels between the more developed and developing countries are associated with differing levels of access to, and acceptance and use of family planning. In southern Europe, contraceptive prevalence ranges from a peak of 81% in Spain, to around 75% in Albania, France and Slovenia, 64% in Turkey and Romania, and 42% in Bulgaria, while in North Africa it ranges from 66% in Tunisia to 45% in Libya. Similar figures are shown for the Middle East, ranging from 63% in Lebanon to 48% in Syria. Contraceptive prevalence varies considerably in the Arabian peninsula and the Gulf, decreasing from 74% in Iran to 44% in neighbouring Iraq; from 62% in Bahrain to 32% in Oman and Saudi Arabia; and from 28% in the United Arab Emirates to 23% in Yemen. This wide variation in contraceptive prevalence among countries south of the Mediterranean is related to many different factors, including economic and socio-cultural conditions.

Contraceptive prevalence (%), 1995 - 2003



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

(1) 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: *The State of the World's Children*, UNICEF, 2005

23 Female mutilation/cutting

Female Genital Mutilation/Cutting, also known as female circumcision (FC), is a traditional practice performed on girls and women, consisting in the partial or total removal of the external female genitalia, which, in many cases, results in serious health problems. The practice of FGM/C has no basis in any religion, even though FGM/C is practiced by many (Muslims and Christians) in the mistaken belief that it is a religious requirement.

The practice of female circumcision, even though it is officially banned, is virtually universal among girls and women in Egypt and, to a much lesser extent, in Yemen. In Egypt, the Ministry of Health and Population, in collaboration with UNICEF, have developed a Plan of Action to combat female circumcision with activities in all governorates.

In order to ensure that progressive changes take hold and that the ban on female genital cutting is successfully implemented, there is a continuing need to provide women and girls with empowering educational opportunities that help transform attitudes and cultural norms.

Women aged 15 to 49 who have been mutilated/cut, 1998 - 2003

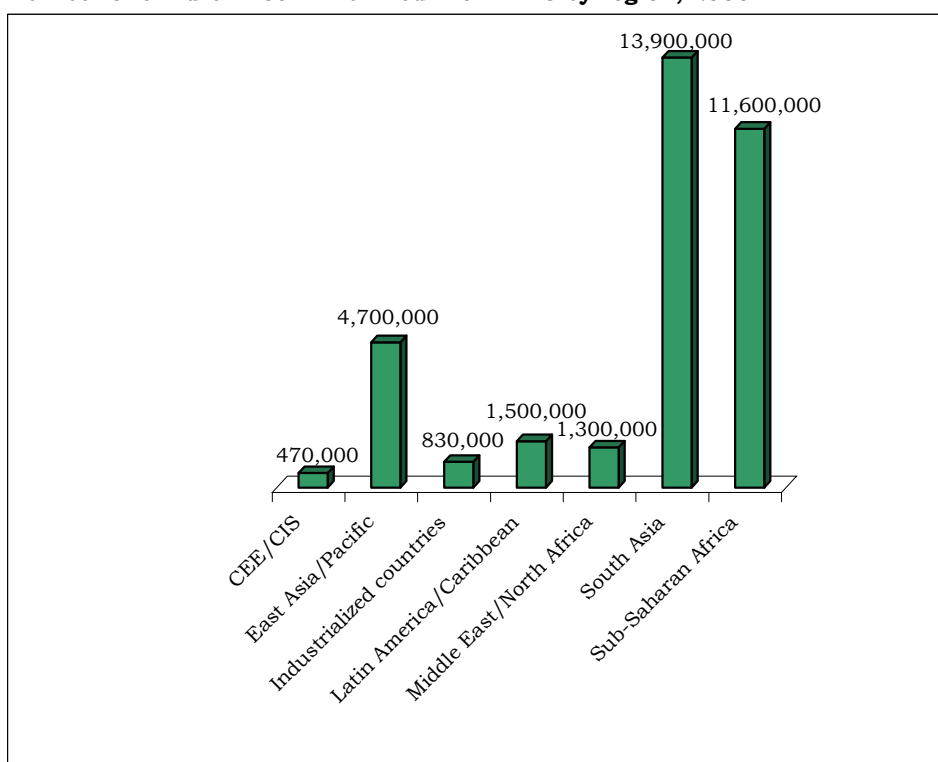
Country	Percentage			Women aged 15 to 49 with at least one mutilated/cut daughter
	Urban	Rural	Total	
Yemen	26	22	23	20
Egypt	95	99	97	50

24.1 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 health systems, 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, around 87%, compared to the average of 71% for developing countries.

Number of children not immunized with DPT3 by region, 2000



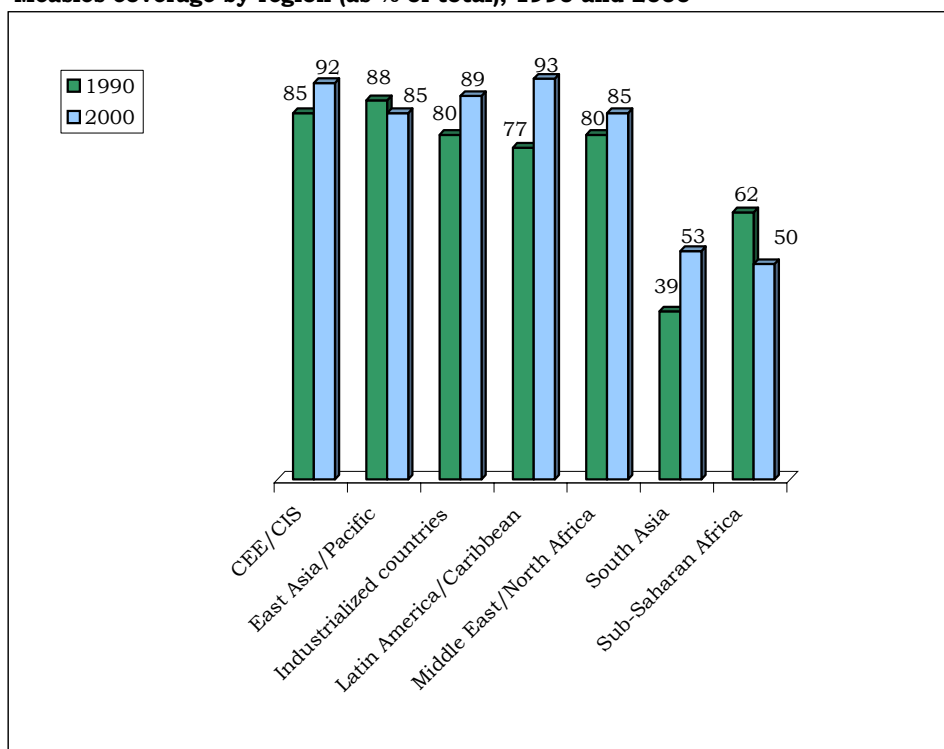
DPT refers to the combined diphtheria, pertussis and tetanus vaccine.

Source: WHO, UNICEF, 2001

24.2 Immunization

Vaccination against measles appears to be fairly widespread over most regions of the world. Coverage has reached more than 85% of children in the Middle East and North Africa over the last decade. It is only in South Asia and Sub-Saharan Africa that around 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 some 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% recorded among 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

24.3 Immunization

Poliomyelitis, or polio, was endemic in 125 countries throughout the world in the late 1980s. By end of 2003, it was present in only 6 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 reported cases in 2003 had fallen to 784. 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 the Middle East and North Africa, an average of 91% of children under one year of age have been vaccinated against polio, compared with an average of 73% for the developing countries.

Children under 1 fully immunized against polio (as % of total), by region, 2002

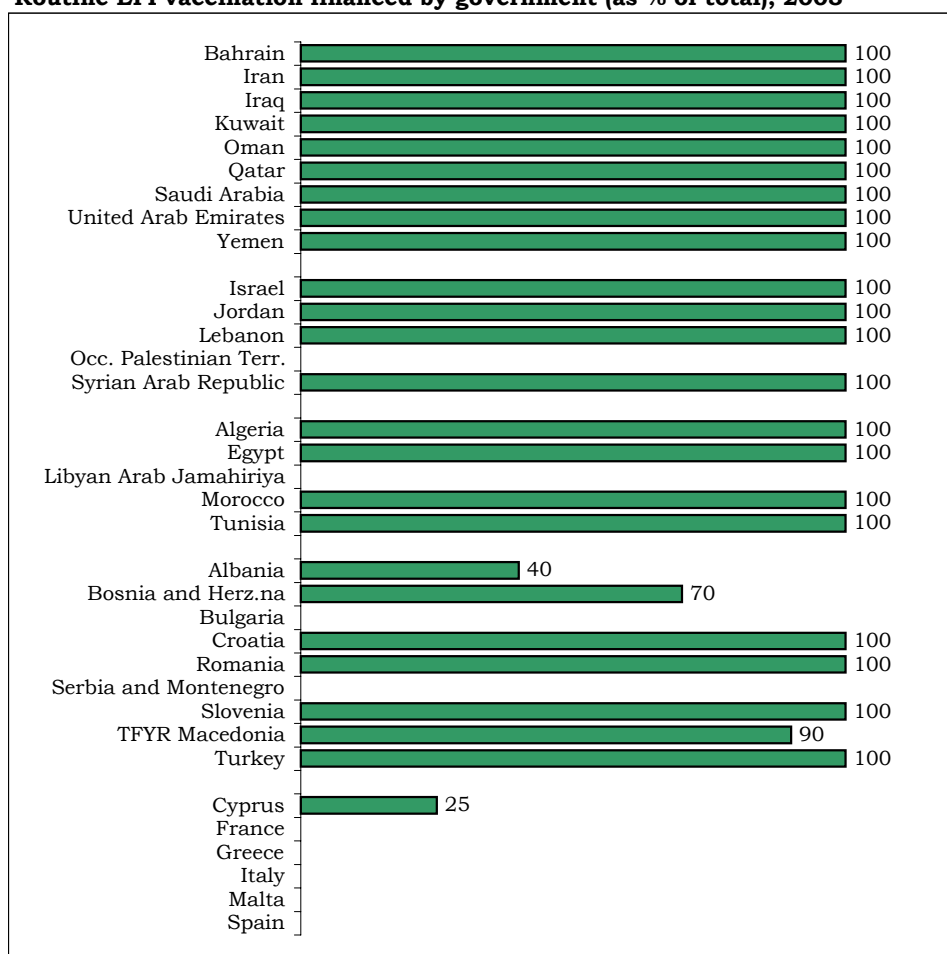
Region	% under one year of age fully immunized against polio
Developing countries	73
CEE/CIS	92
East Asia/Pacific	79
Industrialized countries	91
Latin America/Caribbean	89
Middle East/North Africa	86
South Asia	71
Sub-Saharan Africa	55
Least developed	63
World	75

Source: UNICEF, 2004

24.4 Immunization

Government-funded EPI (Expanded Program on Immunization) has produced satisfactory results for most of the countries under consideration, the exceptions being Cyprus (25%), and Albania (40%). 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), 2003



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: *The State of the World's Children, UNICEF, 2005*

24.5 Immunization

Percentage of 1-year-old children who have been immunized, 2003

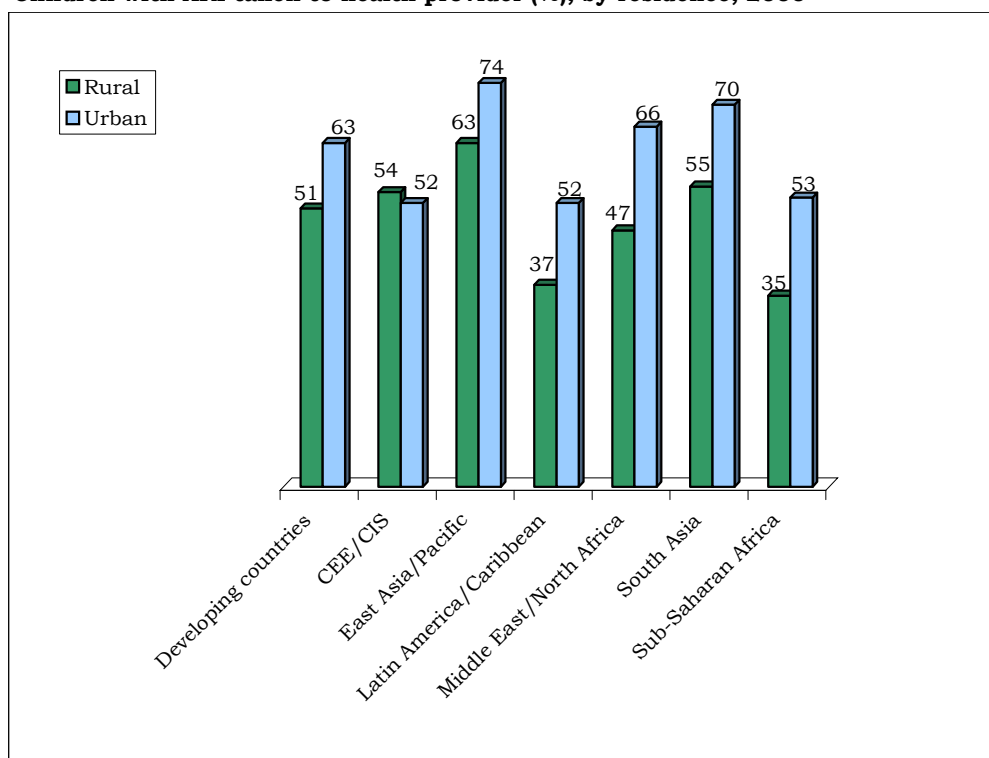
Country	TB	DPT3	polio3	measles	hepB3
Bahrain	n.a.	97	97	99	98
Iran	99	99	99	99	98
Iraq	93	81	84	90	70
Kuwait	n.a.	99	99	97	99
Oman	98	99	99	98	99
Qatar	99	92	93	93	98
Saudi Arabia	94	95	95	96	95
United Arab Emirates	98	94	94	94	92
Yemen	67	66	66	66	42
Israel	n.a.	97	93	95	98
Jordan	67	97	97	96	97
Lebanon	n.a.	92	92	96	88
Occ. Palestinian Terr.	99	98	98	99	98
Syrian Arab Republic	99	99	99	98	98
Algeria	98	87	87	84	n.a.
Egypt	98	98	98	98	98
Libyan Arab Jamahiriya	99	93	93	91	91
Morocco	92	91	91	90	90
Tunisia	93	95	95	90	92
Albania	95	97	97	93	97
Bosnia and Herz.na	94	87	86	84	n.a.
Bulgaria	98	96	96	96	96
Croatia	98	94	95	95	n.a.
Romania	99	97	97	97	98
Serbia and Montenegro	94	89	89	87	n.a.
Slovenia	98	92	93	94	n.a.
TFYR Macedonia	95	96	96	96	n.a.
Turkey	89	68	69	75	68
Cyprus	n.a.	98	98	86	88
France	85	97	97	86	29
Greece	88	88	87	88	88
Italy	n.a.	96	97	83	97
Malta	n.a.	94	94	90	70
Spain	n.a.	98	98	97	83
Developing countries	85	76	77	75	40
Industrialized countries	n.a.	95	93	92	62
MENA	88	87	87	88	71
World	85	78	79	77	42

Source: *The State of the World's Children, UNICEF, 2005*

25.1 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, 2000



Source: UNICEF, 2001

25.2 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 (%), 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.

(1) Excluding China

Source: UNICEF, 2001

25.3 Acute Respiratory Infection (ARI)

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

Country	% of children under 5 with ARI in the two weeks prior to the survey (1)	% with ARI taken to a health provider	Year of survey
Bahrain (2)	8.3	77.8	1995
Iran	n.a.	n.a.	n.a.
Iraq	n.a.	n.a.	n.a.
Kuwait (2)	9.9	89.5	1996
Oman (2)	6.2	83.2	1995
Qatar (2)	7.8	85.6	1998
Saudi Arabia (2)	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.

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

(2) Pharmacies are included in the definition of health provider.

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

26 Neonatal tetanus deaths

Neonatal tetanus is a preventable, often fatal condition resulting from unhygienic birth practices that expose the umbilical cord to tetanus bacteria. Pregnant women are also vulnerable to tetanus. It is most common in countries where access to basic health services is limited and hygiene conditions are poor. By 2000, 104 of 161 developing countries had achieved elimination of neonatal tetanus. Another 22 countries are close to eliminating it. Neonatal tetanus deaths decreased by more than half from 470,000 to 215,000 during the 1990s as a result of increased tetanus toxoid protection and clean delivery practices.

Maternal and neonatal tetanus (MNT) is still a public health problem in 57 developing countries. Immunizing all women of childbearing age with three doses of tetanus toxoid vaccine in high-risk areas protects women and their infants and is key to achieving elimination of MNT by 2005.

Estimates of neonatal tetanus deaths, 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

27.1 Diarrhoea

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

Region	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.

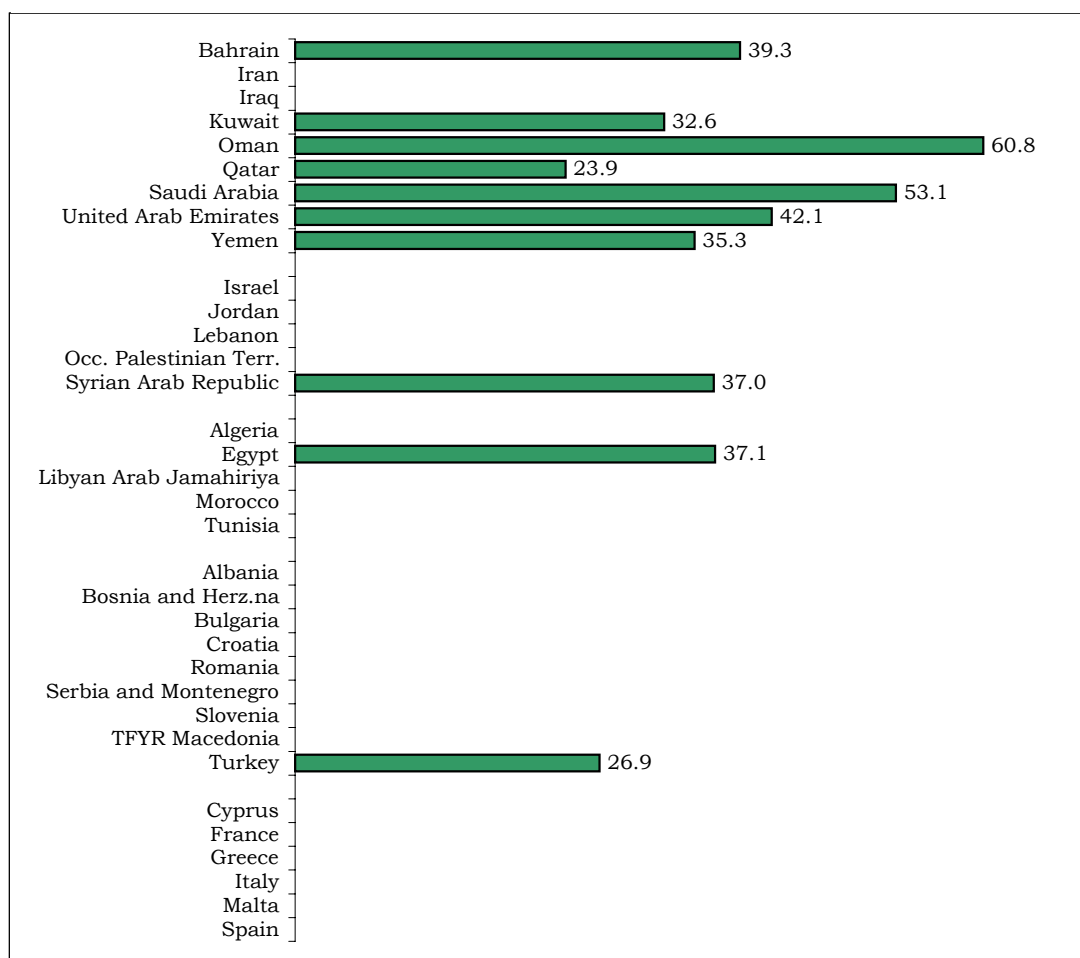
(1) ORT: Oral Rehydration Therapy

Source: UNICEF, 2003

27.2 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 10 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 (ORT) (%), 1994 - 2000



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.

Source: UNICEF, 2003

28 Environmental conditions and Child Health

Environmental determinants to Child Health, 2000

Country	Percentage of household using solid fuel for cooking	Dioxin and Furans: mean concentration of TEQ units in vegetation (pg/g)
Bahrain	<5	n.a.
Iran	2	n.a.
Iraq	2	n.a.
Kuwait	<5	n.a.
Oman	<5	n.a.
Qatar	<5	n.a.
Saudi Arabia	<5	n.a.
United Arab Emirates	<5	n.a.
Yemen	66	n.a.
Israel	<5	n.a.
Jordan	10	n.a.
Lebanon	<5	n.a.
Occ. Palestinian Terr.	n.a.	n.a.
Syrian Arab Republic	19	n.a.
Algeria	4	n.a.
Egypt	23	n.a.
Libyan Arab Jamahiriya	3	n.a.
Morocco	11	n.a.
Tunisia	29	n.a.
Albania	76	0.3
Bosnia and Herz. na	84	0.9
Bulgaria	31	0.8
Croatia	16	1.2
Romania	45	0.5
Serbia and Montenegro	70	0.6
Slovenia	<5	1.6
TFYR Macedonia	58	0.5
Turkey	11	0.1
Cyprus	24	0.0
France	<5	1.4
Greece	<5	1.0
Italy	<5	1.4
Malta	<5	0.0
Spain	<5	0.4

Source: Atlas of Children's Health and the Environment, World Health Organization (WHO), 2004

29 Infant deaths

Most important cause of infant deaths, 1998 - 2002

Country	1st cause	2nd cause	3rd cause	4th cause
Bahrain	Congenital anomalies	Certain condition originating in the perinatal period	Hypoxia and birth asphyxia	Congenital anomalies of heart and circulatory system
Iran	Congenital anomalies	Certain condition originating in the perinatal period	Hypoxia and birth asphyxia	Congenital anomalies of heart and circulatory system
Iraq				
Kuwait				
Oman	Certain condition originating in the perinatal period	Congenital anomalies	Signs, symptoms and ill-defined conditions	Hypoxia and birth asphyxia
Qatar				
Saudi Arabia				
United Arab Emirates				
Yemen				
Israel	Certain condition originating in the perinatal period	Diseases of the respiratory system	Pneumonia	Signs, symptoms and ill-defined conditions
Jordan				
Lebanon				
Occ. Palestinian Terr.				
Syrian Arab Republic				
Algeria				
Egypt				
Libyan Arab Jamahiriya				
Morocco				
Tunisia				
Albania	Certain condition originating in the perinatal period	Congenital anomalies	Diseases of the respiratory system	Pneumonia
Bosnia and Herz. na				
Bulgaria	Certain condition originating in the perinatal period	Congenital anomalies	Diseases of the respiratory system	Pneumonia
Croatia	Certain condition originating in the perinatal period	Hypoxia and birth asphyxia	Congenital anomalies	Signs, symptoms and ill-defined conditions
Romania	Diseases of the respiratory system	Pneumonia	Certain condition originating in the perinatal period	Congenital anomalies
Serbia and Montenegro	Certain condition originating in the perinatal period	Congenital anomalies	Congenital anomalies of heart and circulatory system	Hypoxia and birth asphyxia
Slovenia				
TFYR Macedonia	Certain condition originating in the perinatal period	Hypoxia and birth asphyxia	Congenital anomalies	Signs, symptoms and ill-defined conditions
Turkey	Certain condition originating in the perinatal period	Congenital anomalies	Signs, symptoms and ill-defined conditions	Hypoxia and birth asphyxia
Cyprus				
France				
Greece	Certain condition originating in the perinatal period	Congenital anomalies	Hypoxia and birth asphyxia	Congenital anomalies of heart and circulatory system
Italy	Certain condition originating in the perinatal period	Hypoxia and birth asphyxia	Congenital anomalies	Congenital anomalies of heart and circulatory system
Malta	Congenital anomalies	Certain condition originating in the perinatal period	Hypoxia and birth asphyxia	Congenital anomalies of heart and circulatory system
Spain	Certain condition originating in the perinatal period	Congenital anomalies	Hypoxia and birth asphyxia	Congenital anomalies of heart and circulatory system

Year of reference: 1998 Israel; 2000 Bahrain, TFYR Macedonia, France; 2001Albania, Greece, Italy, Spain; 2002 Kuwait, Bulgaria, Croatia, Romania, Slovenia, Malta.

Source: WHO, 2004

30 Road traffic mortality

Mortality caused by road traffic accident by selected age groups and gender, 1992 - 2002

Country	Males			Females		
	Age			Age		
	0 - 4	5 - 14	15 - 29	0 - 4	5 - 14	15 - 29
Bahrain	1	8	19	0	1	1
Iran	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Iraq	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Kuwait	11	14	113	7	8	13
Oman	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Qatar	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Saudi Arabia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
United Arab Emirates	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Yemen	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Israel	3	5	128	3	7	19
Jordan	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Lebanon	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Occ. Palestinian Terr.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Syrian Arab Republic	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Algeria	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Egypt	207	579	1,060	180	275	180
Libyan Arab Jamahiriya	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Morocco	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Tunisia	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Albania	7	12	72	5	8	14
Bosnia and Herz.na	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Bulgaria	7	15	164	4	11	48
Croatia	6	10	147	3	7	30
Romania	43	167	636	21	107	208
Serbia and Montenegro	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Slovenia	1	4	106	0	1	13
TFYR Macedonia	0	6	20	1	1	4
Turkey	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Cyprus	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
France	53	141	2,329	42	96	635
Greece	10	30	612	5	20	126
Italy	18	109	1,958	22	42	428
Malta	0	0	8	0	0	1
Spain	26	104	1,639	22	55	405

Source: World Report on Road Traffic Injury Prevention, WHO, 2004

31 Tobacco use, exposure and attitude

Tobacco use, exposure and attitude, 2001 - 2003

Country	Percentage			
	Students currently using any form of tobacco	Students currently smoking cigarettes	Students living in homes where others smoke in their presence	Students thinking smoking should be banned from public places
Bahrain	23	14	40	82
Iran	n.a.	n.a.	n.a.	n.a.
Iraq	n.a.	n.a.	n.a.	n.a.
Kuwait	27	15	45	81
Oman	18	9	22	86
Qatar	n.a.	n.a.	n.a.	n.a.
Saudi Arabia (2)	20	11	31	74
United Arab Emirates	22	9	32	71
Yemen (2)	21	7	49	78
Israel	n.a.	n.a.	n.a.	n.a.
Jordan	23	18	66 (1)	76
Lebanon	45	11	80 (1)	85
Occ. Palestinian Terr.	16	11	52 (1)	84
Syrian Arab Republic	21	7	54	78
Algeria	n.a.	n.a.	n.a.	n.a.
Egypt	20	4	29	87
Libyan Arab Jamahiriya	15	6	40	75
Morocco	14	4	28 (1)	77
Tunisia	18	14	63	86
Albania	17	12	85	93
Bosnia and Herz. na	16	14	98	85
Bulgaria	38	37	68	60
Croatia	17	17	94	77
Romania	24	23	89	83
Serbia and Montenegro (2a)	17 and 5	16 and 4	97 and 95	76 and 88
Slovenia	29	29	68	69
TFYR Macedonia	10	8	92	86
Turkey				
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.

Student definition may vary according to the country.

(1) Data refer to percentage of students living in homes where others smoke.

(2) For Saudi Arabia and Yemen data refers to the Capital city only.

(2a) The first figure refers to Serbia and the second to Montenegro.

Source: Global Youth Tobacco Survey

Tobacco use, exposure and attitude, 2001 - 2003

Smoking represents the most readily preventable risk factor for morbidity and mortality. More than 4,000 chemical compounds have been identified in tobacco smoke; many of these are toxic, mutagenic and carcinogenic, causing death via diseases ranging across the spectrum.

Youth in their late teens and early twenties are of particular interest as smoking is a habit acquired early, by young people with pressing concerns than thoughts of chronic debilitating disease or mortality risk in some distant future. They know the risks of smoking but the risks seem remote. Young smokers also postpone quitting, reassured by knowledge of the reduction in risk after quitting. Thus they become addicted; unaware of the detrimental effects of their dependency in future whatever their circumstances.

Among the 14 Arab states with data, the percentage of students who currently use any form of tobacco is in the range of 14-19% in 6 countries, and 20-27% in 7 countries, rising to a high of 45% in Lebanon. The prevalence of cigarette smoking among students is below 10% in 7 countries, and ranges from 10% to 18% in the remaining 7 Arab states.

The results indicate that the use of tobacco products other than cigarettes is about equal or higher than the use of cigarettes in 7 Arab countries. The use of tobacco products other than cigarettes among students in the Arab region takes the form of smoking tobacco in water pipes, and in the case of Yemen, of chewing 'qat.'

In the eight Balkan countries with data, the percentage of students who currently use any form of tobacco is below 20% in 5 countries, with a high of 38% in Bulgaria. Unlike the pattern shown for the Arab region, most of tobacco use in the Balkan region takes the form of cigarette smoking.

The harmful effects of smoking do not end with the smoker. Exposure to environmental tobacco smoke (ETS), or secondhand smoke, causes cancer of the lung in adult nonsmokers, and triggers, among other things, asthma attacks in children and causes infants to be hospitalized for lower respiratory tract infections. The percentage of students living in homes where others smoke in their presence ranges from 22% in Oman to 97% in Serbia. A large majority of students think smoking should be banned from public places.

32.1 HIV/AIDS

There are over 3 million children aged under 15 living with HIV/AIDS in the world, while 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. HIV/AIDS is now the fourth-biggest cause of death worldwide.

It is difficult to estimate the number of children under 15 affected by the virus in many different countries in Europe, the Middle East and North Africa. Alarming figures are shown for Romania, where it is estimated that 4,000 children under 15 have the disease, compared with 1,300 in Spain, and 1,000 in France. National estimates are not available for the Middle East and North Africa, 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, 2001

Region	Rounded estimates of children newly infected	Rounded estimates of pregnant women with HIV
CEE/CIS	1,000	5,000
East Asia/Pacific	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

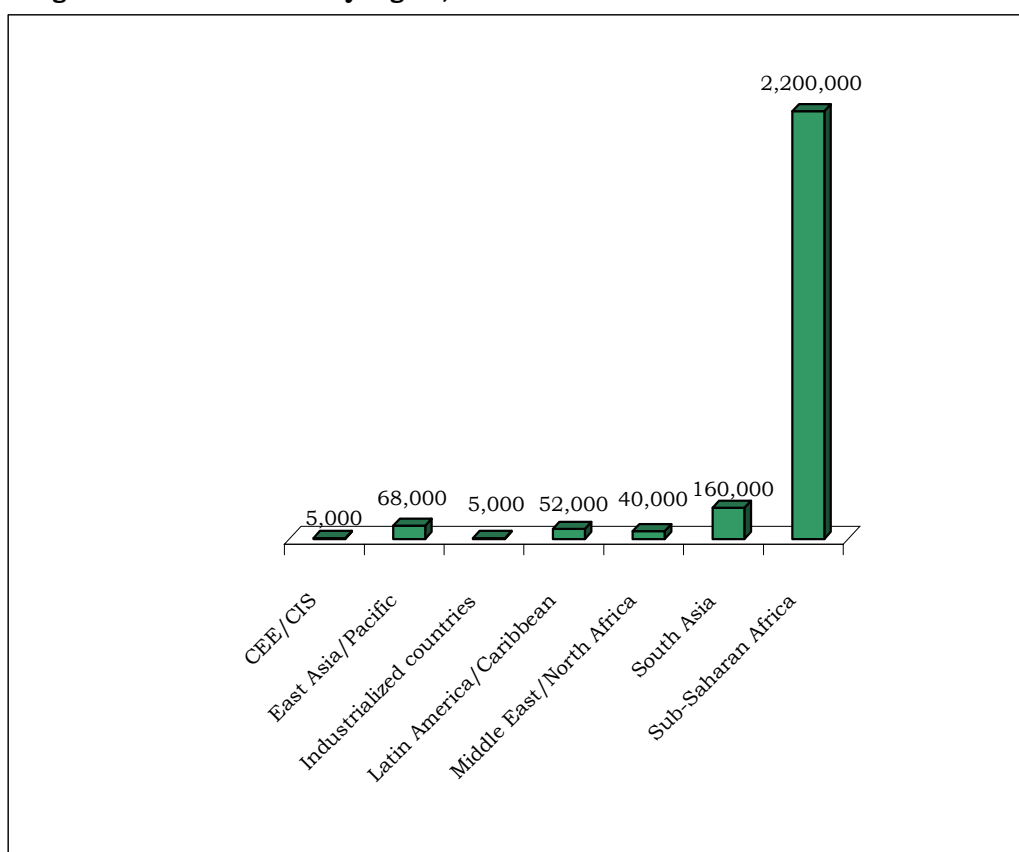
Source: UNICEF, 2001

32.2 HIV/AIDS

Estimates suggest that there are 40,000 pregnant women living with HIV in North Africa and the Middle East. Sub-Saharan Africa is by far the worst affected region in the world. The estimates for HIV prevalence among pregnant women in the Arab region do not differ substantially from those in Latin-America and Southeast Asia.

The table below suggests 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, 2001



Source: UNICEF, 2001

32.3 HIV/AIDS

People living with HIV/AIDS, 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

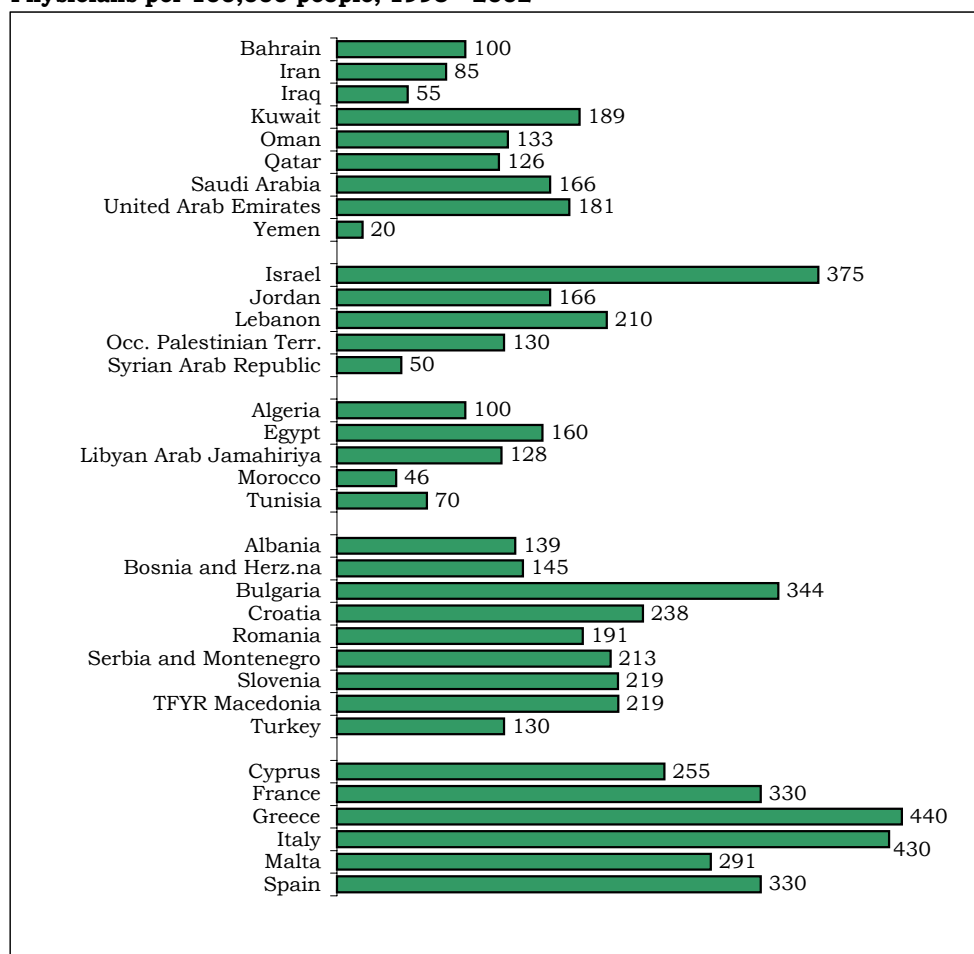
Data refer to the end of 2001. Aggregates are rounded estimates; regional totals may not sum to the world total.

Source: Human Development Report - UNDP, 2002

33.1 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 most countries in Southern Europe than in other regions, with a high of over 430 physicians per 100,000 persons recorded in Greece and Italy. This indicator of health resources is lowest in Yemen (20), Morocco (46), Syria (50), Iraq (55) and Tunisia (70). It increases to 100 physicians per 100,000 persons in Algeria, 110 in Iran, 130 in Turkey, 160 in Egypt, and 210 in Lebanon.

Physicians per 100,000 people, 1995 - 2002



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

Source: World Development Indicators, WB, 2004

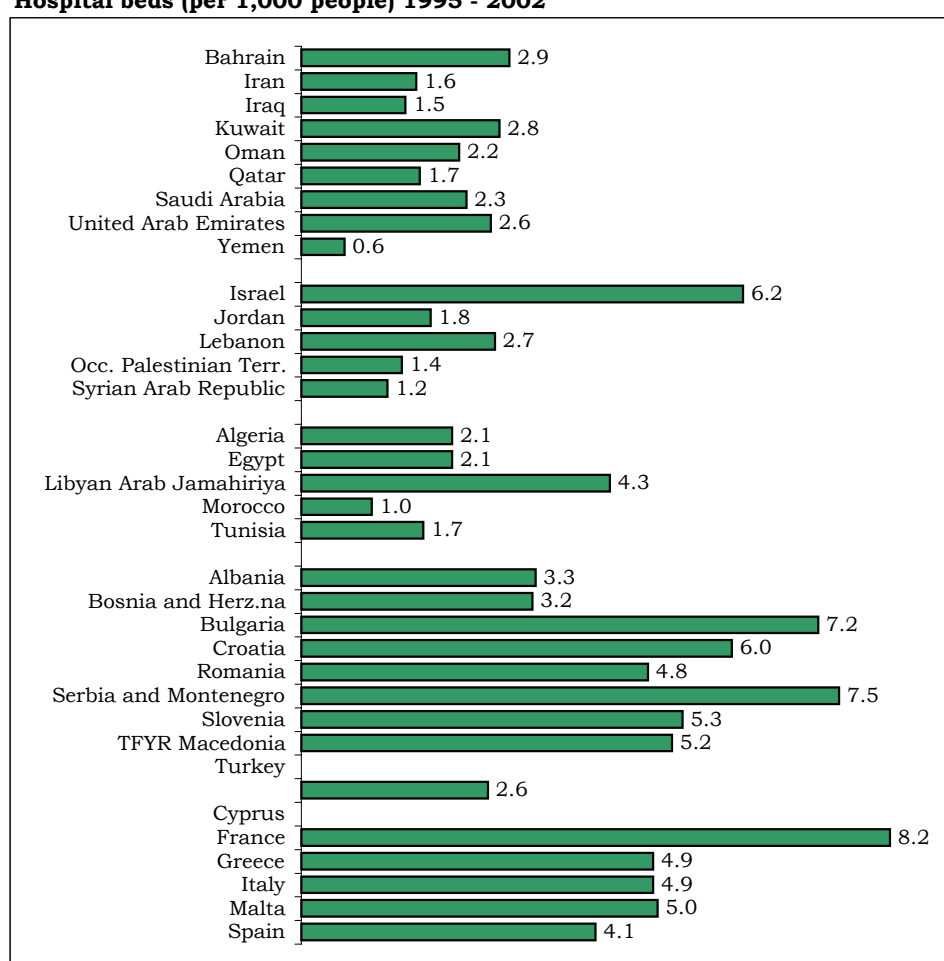
33.2 Health resources

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, at the lower end of the scale (with only 6 beds per 10,000 people), and Libya (4.3 beds per 1,000 people), and Israel (6.2 beds per 1,000 people), at the upper end.

The availability of hospital beds also varies significantly from one country to another on the northern shore of the Mediterranean, with Turkey Bosnia-Herzegovina showing the lowest average (2.6 bed per 1,000 people) and France the highest (8.2 beds per 1,000 people).

It is of interest 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) 1995 - 2002

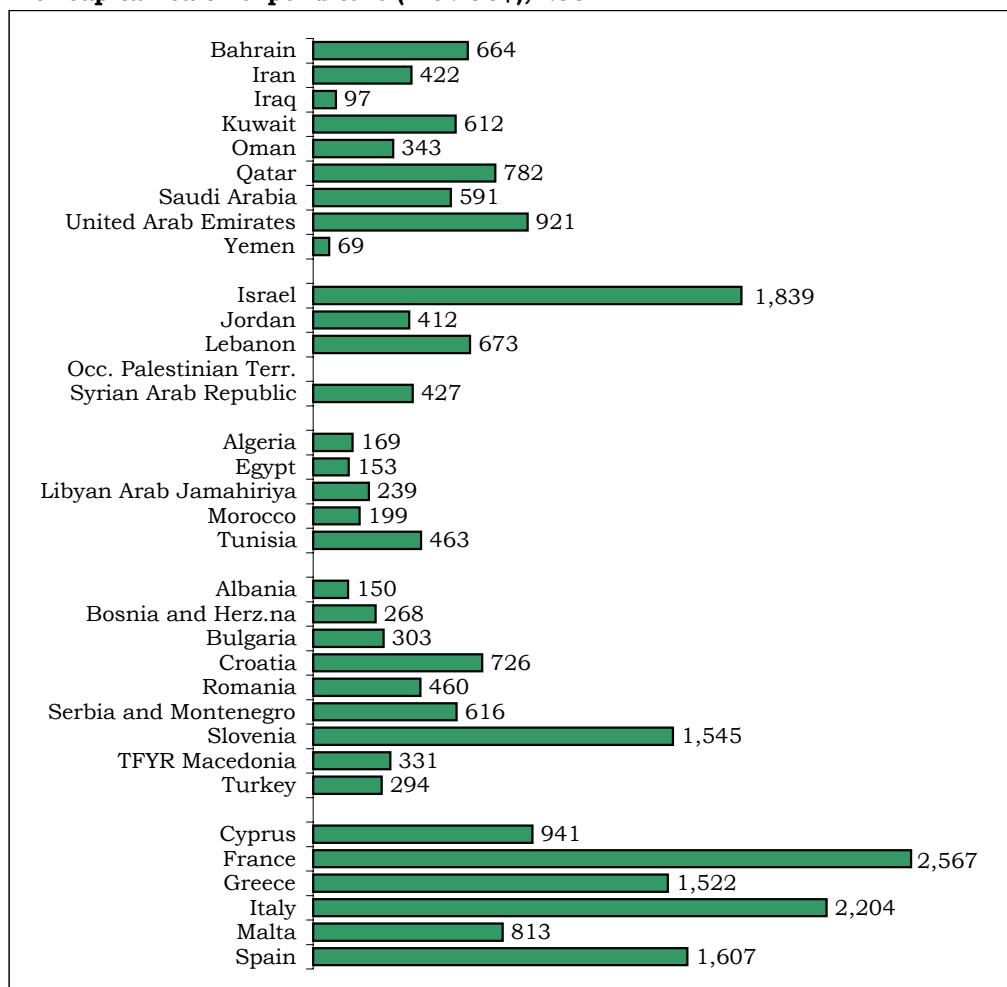


Source: World Development Report, WB, 2004

33.3 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. Per capita health expenditure is lowest in Yemen (\$69) and in Iraq (\$97); increasing to between \$150-\$200 in 3 of 5 countries in North Africa, between \$400-\$475 in 4 countries (Iran, Jordan, Syria and Tunisia), and to more than \$600 in 4 countries in the Gulf.

Per capita health expenditure (Intl. US\$), 2001



Source: Human Development Report, UNDP, 2004

33.4 Health resources

In seven 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 40% in Iraq, Lebanon, Morocco and Yemen, and between 40-55% in Egypt, Jordan, Libya and Syria. In these countries, the ability to supplement public resources is obviously restricted to the more affluent sections of society.

Expenditure on health, 2001

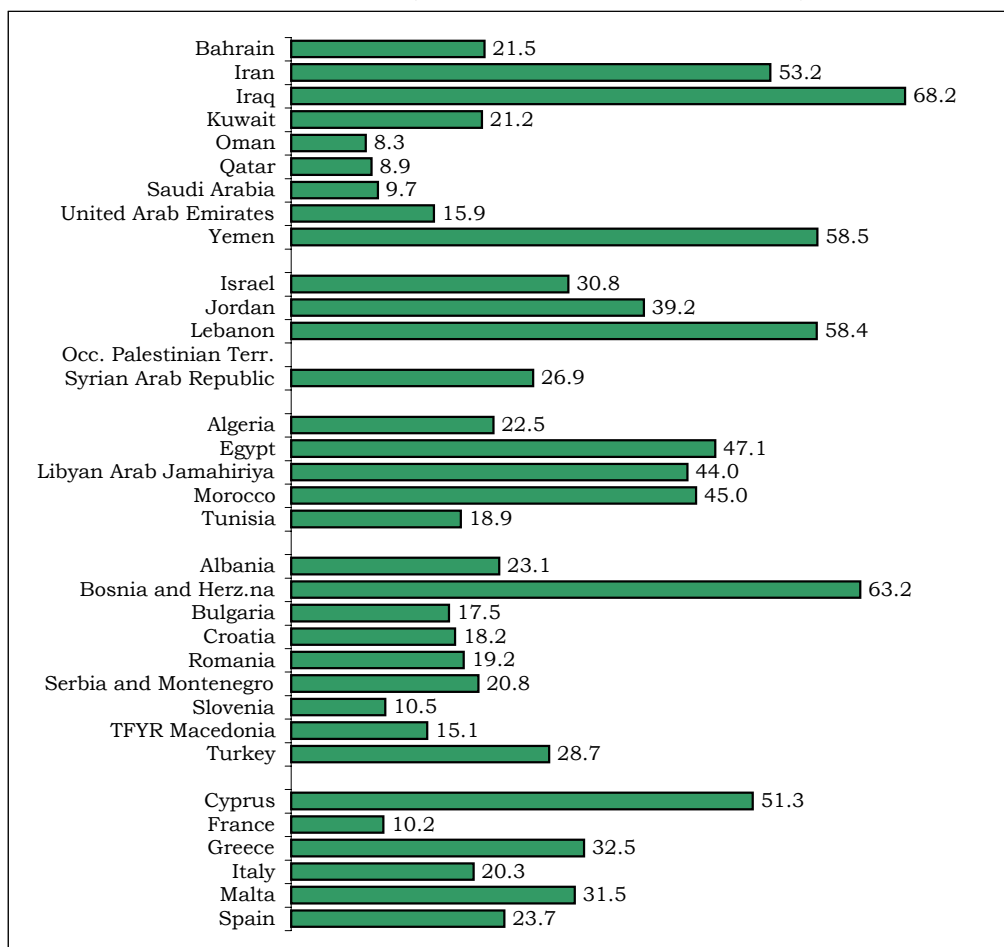
Country	Total expenditure on health		Private expenditure on health	General Government expenditure on health
	(As % of GDP)	(Per capita, intl. \$)	(As % of total expenditure on health)	
Bahrain	4.1	664	31.0	69.0
Iran	6.3	422	56.5	43.5
Iraq	3.2	97	68.2	31.8
Kuwait	3.9	612	21.2	78.8
Oman	3.0	343	19.3	80.7
Qatar	3.1	782	26.5	73.5
Saudi Arabia	4.6	591	25.4	74.6
United Arab Emirates	3.5	921	24.2	75.8
Yemen	4.5	69	65.9	34.1
Israel	8.7	1,839	30.8	69.2
Jordan	9.5	412	53.0	47.0
Lebanon	12.2	673	71.9	28.1
Occ. Palestinian Terr.	n.a.	n.a.	n.a.	n.a.
Syrian Arab Republic	3.4	427	46.9	53.1
Algeria	4.1	169	25.0	75.0
Egypt	3.9	153	51.1	48.9
Libyan Arab Jamahiriya	2.9	239	44.0	56.0
Morocco	5.1	199	60.7	39.3
Tunisia	6.4	463	24.3	75.7
Albania	3.7	150	35.4	64.6
Bosnia and Herz.na	7.5	268	63.2	36.8
Bulgaria	4.8	303	17.9	82.1
Croatia	9.0	726	18.2	81.8
Romania	6.5	460	20.8	79.2
Serbia and Montenegro	8.2	616	20.8	79.2
Slovenia	8.4	1,545	25.1	74.9
TFYR Macedonia	6.8	331	15.1	84.9
Turkey	5.0	294	29.0	71.0
Cyprus	8.1	941	52.3	47.7
France	9.6	2,567	24.0	76.0
Greece	9.4	1,522	44.0	56.0
Italy	8.4	2,204	24.7	75.3
Malta	8.8	813	31.5	68.5
Spain	7.5	1,607	28.6	71.4

Source: World Health Report, WHO, 2004

33.5 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 (% of total expenditure on health), 2001



Source: World Health Report, WHO, 2004