

# INVESTING IN REPRODUCTIVE HEALTH TO ACHIEVE DEVELOPMENT GOALS

## The Middle East and North Africa

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Development experts increasingly see family planning and other reproductive health care as vital for improving well-being and achieving other social and development goals. The use of modern contraceptives, for example, helps couples avoid unintended pregnancies and protects both mothers' and children's health. Other reproductive health care helps women have healthy pregnancies and helps protect women and men against sexually transmitted diseases and HIV/AIDS. The linkages between reproductive health and development are particularly important in the Middle East and North Africa (MENA), where progress toward development goals is uneven.<sup>1</sup>

Investing in reproductive health, however, rarely ranks high on the list of national priorities, which usually emphasize creating jobs and raising incomes. This lack of attention is counterproductive. Prioritizing women's reproductive health at a national level would help accelerate progress toward achieving the Millennium Development Goals (MDGs)—a global development framework adopted by the United Nations (UN) for improving people's lives and combating poverty.

This policy brief examines how countries in the MENA region are progressing toward achieving the MDGs and highlights how these countries could benefit from greater attention to reproductive health. The region is moving in the right

direction on most MDG indicators, but priority attention is needed to increase gender equality, expand quality health services, and address freshwater scarcity.<sup>2</sup>

### The International Consensus

At the UN's Millennium Summit in 2000, world leaders agreed on a declaration that resulted in eight MDGs, which together form a policy framework for alleviating poverty and enhancing well-being. The goals are wide-ranging and complementary, including eradicating poverty, increasing education, promoting gender equality, improving health, and ensuring environmental sustainability.<sup>3</sup>

In September 2005, at the five-year anniversary of the summit, world leaders reaffirmed the MDGs and officially recognized that universal access to reproductive health is essential to achieve gender equality, combat HIV/AIDS, and reduce maternal and child mortality.<sup>4</sup> The connections between reproductive health and the MDGs have also been recognized repeatedly in reports by UN agencies; the World Bank; and task forces of the Millennium Project, which analyze efforts to achieve the MDGs.<sup>5</sup> (For more background, see Box 1, page 2.)

### Progress Toward the MDGs and Improved Reproductive Health

Overall, the MENA region is on track to achieve about one-half of the goals by their deadline of 2015, but the degree of progress on each goal varies from country to country.<sup>6</sup> National averages are also deceptive, as they can mask major disparities between advantaged and disadvantaged populations within countries. Having reliable and consistent data is essential for monitoring progress, but such data is not available for all countries and all indicators.

This section outlines how the region's countries have progressed toward each of the eight MDGs

Table 1

#### Trends in Poverty in the MENA Region

	Population Living Below US\$2 a Day	
	Percent	Number, in millions
1990	21	50
2002	23	70

**NOTE:** Countries and territories included in this table are Algeria, Djibouti, Egypt, Iran, Iraq, Jordan, Lebanon, Libya, Morocco, Oman, Saudi Arabia, Syria, Tunisia, Yemen, and the West Bank and Gaza.

**SOURCES:** The World Bank, *Millennium Development Goals: Middle East & North Africa* (2004); and United Nations, *World Population Prospects: The 2004 Revision, Population Database*, accessed at <http://esa.un.org>.

and examines how improvements in reproductive health could contribute to further progress.

### **Goal 1: Eradicate Extreme Poverty and Hunger**

The first MDG calls for countries to reduce by one-half from 1990 to 2015 the proportion of their people living in poverty and the proportion suffering from hunger. Although economic growth in the 1970s and 1980s increased prosperity in the MENA region, poverty in the region overall has not improved since 1990—the benchmark year against which progress toward the MDGs is measured.

The World Bank estimates that 23 percent of MENA's population in 2002 lived on less than the international poverty threshold of \$2 a day—a slight increase from 21 percent in 1990.<sup>7</sup> During the same period, the number of people living below that threshold in the region increased by 40 percent—from 50 million to 70 million—because of population growth (see Table 1, page 1).

According to national poverty measures, poverty dropped in some MENA countries but not all. In Morocco, for instance, the proportion of people living below the national poverty line increased from 13 percent in 1991 to 19 percent in 1999. In other countries, such as Egypt (see

Box 2, page 5), Jordan, and Tunisia, poverty rates declined during the 1990s. In Jordan, the proportion living below the national poverty line declined from 15 percent in 1991 to 12 percent in 1997, and in Tunisia it dropped from 7 percent in 1990 to 4 percent in 2000.<sup>8</sup>

As in other parts of the world, poverty in MENA is generally higher among rural populations. In Algeria and Morocco, poverty rates in rural areas are more than double those in urban areas (see Figure 1). In Egypt, 54 percent of those living below the national poverty line are from Upper Egypt, a rural region where only 27 percent of the country's population lives.<sup>9</sup> In rural, impoverished areas, progress toward other MDGs also typically lags urban areas.

The poor tend to have larger families than the rich, suffer disproportionately from illnesses, and make less use of health services, including modern contraception and care during pregnancy (see Table 2). But reproductive health care can enhance poor people's health and help families escape the "poverty trap" that can result from large numbers of children, poor health, and few resources. Universal access to quality family planning information and services would enable cou-

#### *Box 1*

### **UN Agreements Recognize Connections Between Reproductive Health and Development**

The links between women's status, reproductive health, and social and economic development were first recognized at the landmark International Conference on Population and Development, a UN meeting held in Cairo in 1994. The Programme of Action adopted at the conference (referred to here as the Cairo program) spelled out a comprehensive plan for empowering women and making family planning universally available as part of a package of reproductive health care.

The Cairo program broke new ground in developing a common understanding of reproductive health, which it defined as *a state of complete physical, mental and social well-being in all matters related to reproduction, including sexual health*. Consistent

with this broad definition, reproductive health care was defined to include family planning information and services; safe pregnancy and delivery services; post-abortion care in general and abortion where legal; prevention and treatment of sexually transmitted infections (including HIV/AIDS); information and counseling on sexuality; and elimination of harmful practices against women, such as genital cutting and forced marriage. The program also called for greater attention to men as partners in reproductive health.

The emphasis on reproductive health in the Cairo program was built on the notion that enhancing individual health and rights would enable governments to achieve their population goals—such as preventing unplanned pregnancies and slowing population growth—and provide the necessary conditions for economic and social development.

Combating poverty—the first and overarching goal of the Millennium

Declaration—is one of the basic principles of the Cairo program. Reducing infant mortality, reducing maternal mortality, and achieving universal access to primary education are also common goals with specific targets to achieve by 2015.

The Cairo program and Millennium Declaration also share several basic principles—that development, security, and human rights go hand-in-hand, and that implementation is the sovereign right of each country, consistent with its culture, religion, national laws, and development priorities.

**REFERENCES:** Stan Bernstein and Emily White, "The Relevance of the ICPD Programme of Action for the Achievement of the Millennium Development Goals—And Vice-Versa: Shared Visions and Common Goals" (New York: UN, 2005), accessed online at [www.un.org](http://www.un.org), on Nov. 15, 2005; and United Nations, *Programme of Action of the International Conference on Population and Development* (New York: UN, 1994): section 7.2.

ples to decide freely the number and timing of their children and thereby avoid unintended pregnancies.

Reducing unintended pregnancies leads to slower national population growth and lower economic dependency as the proportion of working-age people increases relative to children in the population. This reduced economic dependency can open a “demographic window of opportunity” for economic growth that can reduce poverty.<sup>10</sup> Reducing ill health is central for enhancing individual security and capabilities, which in turn improve productivity, national income, and development prospects.

### Goal 2: Achieve Universal Primary Education

An average of 85 percent of children in the MENA region are enrolled in primary school.<sup>11</sup> If current enrollment trends continue, the region as a whole is not expected to achieve universal primary education by 2015. However, progress toward achieving the goal is on track in countries such as Algeria, Jordan, Qatar, and Tunisia.<sup>12</sup>

Education contributes directly to growth in national income by improving the productive capacity of workers. But literacy rates remain low in some MENA countries, especially for poor

women. Illiteracy and poverty go hand in hand: Illiterates are disproportionately poor, and children of poor families are less likely to attend school. For example, one-half of women ages 15 to 49 in Morocco have had no formal education, but there is much variation in literacy rates there according to household wealth. Eighty-six percent of women in the poorest one-fifth of Morocco’s population have no education, compared with only 19 percent of women in the richest one-fifth (see Figure 2, page 4).

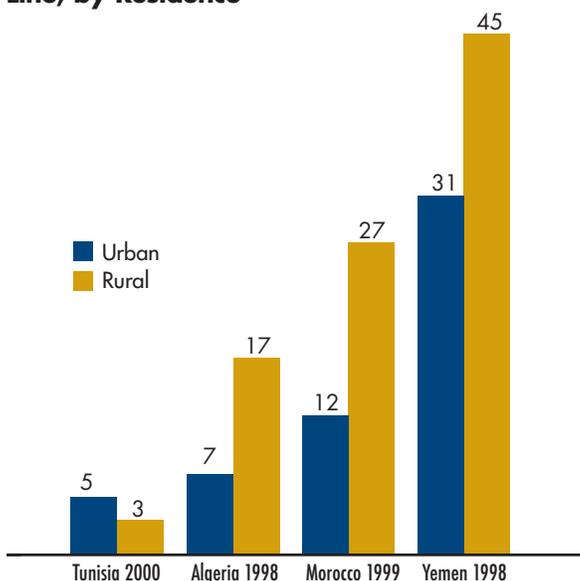
Education and family planning programs are mutually reinforcing investments. Educated women generally have healthier children, want smaller families, and make better use of family planning information and services to achieve their desired family size. Girls of smaller families are also less likely to drop out of school.<sup>13</sup> And smaller family sizes mean more family and national resources are available for each child.

### Goal 3: Promote Gender Equality and Women’s Empowerment

Ensuring women’s equal rights, opportunities, and participation in society and in the family is fundamental to ensuring human rights and also con-

Figure 1

#### Percent of Population in Selected MENA Countries Living Below the National Poverty Line, by Residence



SOURCES: UN Statistics Divisions, “Millennium Indicators, Goal 1: Eradicate Extreme Poverty and Hunger,” accessed at <http://millenniumindicators.un.org>; and UNDP, “Tunisia National Report on the Millennium Development Goals, May 2004,” accessed at [www.undg.org](http://www.undg.org).

Table 2

#### Linkages Between Wealth and Health in Egypt, Jordan, Morocco, and Yemen

	Country	Poorest fifth	Middle fifth	Richest fifth
Child mortality rate (Under-5 mortality per 1,000 live births)	Egypt	98	71	34
	Jordan	42	34	25
	Morocco	78	47	26
	Yemen	163	112	73
Total fertility rate (lifetime births per woman)	Egypt	4.0	3.3	2.9
	Jordan	5.2	4.3	3.1
	Morocco	3.3	2.5	1.9
	Yemen	7.3	7.3	4.7
Percent of births attended by medically trained personnel	Egypt	31	61	94
	Jordan	91	98	99
	Morocco	30	70	95
	Yemen	7	16	50

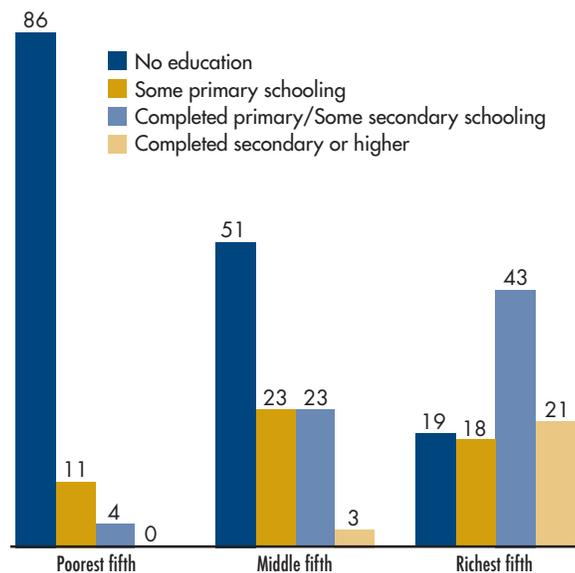
NOTE: Egypt survey data is from 2000; Jordan and Yemen data are from 1997; and Morocco data is from 2003–04. Wealth quintiles (five groups of equal size) were created using an index of household assets in each country. Data for the first (or lowest), third, and fifth (or highest) quintiles are shown here. Because a separate wealth index was created for each country, caution should be used comparing data across countries.

SOURCES: The World Bank, *Round 11 Country Reports on Health, Nutrition and Population Conditions Among the Poor and Better Off in 56 Countries* (2004); and Ministry of Health (Morocco), ORC Macro, and League of Arab States, *Enquête sur la Population et Santé Familiale 2003–04* (2005).

Figure 2

### Education Among the Rich and Poor in Morocco, 2003–04

Distribution (in percent) of women ages 15–49 by educational level in three wealth quintiles\*



\* Wealth quintiles (five groups of equal size) were created using an index of household assets.

SOURCE: Ministry of Health (Morocco), ORC Macro, and League of Arab States, *Enquête sur la Population et Santé Familiale 2003–04* (2005).

tributes to achieving other MDGs. A key strategy for advancing women's rights is to close the gender gap in education. Differences between boys' and girls' schooling have been narrowing at all educational levels and throughout the MENA region, putting the region on track for achieving this goal.

The gap between male and female literacy among 15-to-24-year-olds has closed in Jordan, the Palestinian Territory, and Oman, where 97 percent or more of young women can read and write.<sup>14</sup> But Yemen, Morocco, and Egypt have had difficulty closing the gender gap in literacy. For instance, while 84 percent of Yemeni men ages 15 to 24 can read, only 51 percent of Yemeni women can. In these three countries together, there are nearly 5 million illiterate women ages 15 to 24—more than the total populations of Lebanon and Bahrain combined.<sup>15</sup>

Beyond education, the 2005 UN summit recognized that empowering women depends on universal access to reproductive health, equal rights to own and inherit property, equal access to labor markets, increased representation in government, and an end to discrimination and violence against

women. New indicators will be developed to monitor progress in these areas.

Having easy access to affordable and quality reproductive health information and services is fundamental to achieving Goal 3 of the MDGs. Ensuring women's ability to choose the number and timing of their births is a matter of human rights and key to empowering women as individuals, mothers, and citizens.

### Goal 4: Reduce Child Mortality

According to UNICEF estimates, child mortality has declined in all MENA countries except Iraq since 1990.<sup>16</sup> Most MENA countries are on track to reach this goal, which is to reduce by 2015 the under-5 mortality rate (deaths to children under age 5) by two-thirds from 1990 levels.

Egypt and Libya have seen the fastest declines. The under-5 mortality rate in Egypt declined from 104 deaths per 1,000 live births in 1990 to 39 per 1,000 live births in 2003; in Libya, it dropped from 42 per 1,000 to 16 per 1,000. Kuwait and the United Arab Emirates have already achieved child mortality rates similar to those of developed countries (fewer than 10 deaths per 1,000 live births).

But some MENA countries still face large challenges: Iraq and Yemen have recorded "triple-digit" mortality rates—over 100 deaths per 1,000 live births, or more than one in every 10 children dying before their fifth birthday. Most deaths among children under age 5 occur during the first year, and most of these occur during the first month of life—underscoring the importance of mothers' health for newborns.

Reproductive health care has been and continues to be critical for attaining this goal, because improving the health of mothers is a first step toward reducing child mortality. Family planning helps women avoid pregnancies that pose a high risk for the health of mothers and their babies. Research has long shown the links between the health of mothers and their infants: Babies born to mothers under age 20 and over age 35 face greater health risks, and those born to mothers who die in childbirth are less likely to survive. Also, siblings born three to five years apart are 2.5 times more likely to survive than those born less than two years apart.<sup>17</sup> Other reproductive health services help women receive adequate care during pregnancy, delivery, and the postpartum period, ensuring healthier outcomes for their newborns.

## Goal 5: Improve Maternal Health

Maternal health has improved to some degree in the MENA region, but it remains a key challenge in terms of health and in terms of data collection. Goal 5 calls for reducing the maternal mortality ratio (the number of deaths due to pregnancy and related causes per 100,000 live births) by three-fourths from 1990 levels. However, data on maternal deaths has not been reliable and consistent enough to determine whether the goal is likely to be met in all countries in the MENA region.

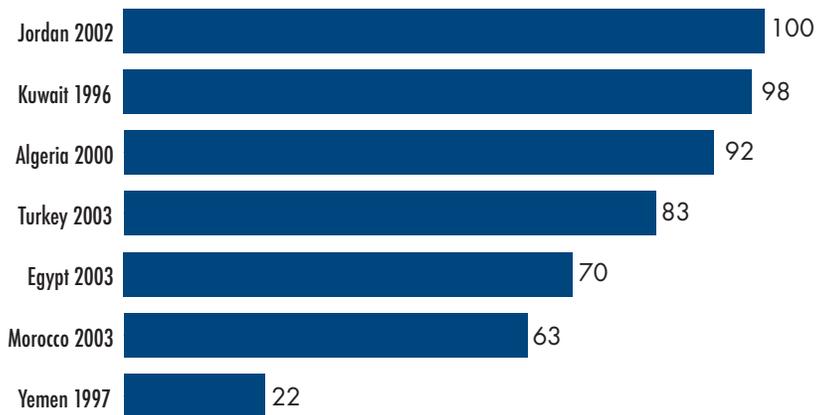
Estimates of maternal deaths range from a high of 570 per 100,000 live births in Yemen to a low of 5 per 100,000 births in Kuwait—the latter a level similar to those of more developed countries. In Egypt, where reliable trend data are available, maternal deaths have dropped from 174 per 100,000 births in 1992 to 84 per 100,000 births in 2000. For Egypt to meet Goal 5, maternal deaths would need to continue to decline at the same rate as they did during the 1990s.<sup>18</sup>

A key intervention for reducing maternal deaths is ensuring that skilled health personnel assist during labor and delivery to manage life-threatening complications if they arise. Yemen—the least developed country in the region—stands far behind other countries in skilled attendance at birth (see Figure 3). The low rate of skilled birth attendance in Yemen and parts of other MENA countries can be attributed to both low availability of health services and a lack of knowledge and awareness among families about safe delivery.

Figure 3

### Skilled Attendance at Childbirth in the MENA Countries

Percent of births assisted by skilled health personnel\*



\* "Skilled health personnel" are defined as a doctor, nurse, or midwife. Traditional birth attendants, even if trained, are not included.

SOURCE: WHO, *Skilled Attendant at Birth: 2005 Estimates* (2005).

In two countries where trend data are available—Egypt and Morocco—assistance during delivery increased in occurrence substantially from the mid-1990s to 2003, from fewer than one-half of births to about two-thirds of births. In Turkey, the proportion of births with skilled assistance remained virtually unchanged during the same period at 83 percent.

Family planning is also a first line of defense in protecting against maternal ill health. Each pregnan-

#### Box 2

### Population Dynamics and Poverty Trends in Egypt

Recent data from Egypt highlight both the plight of the poor in the MENA region as a whole as well as the linkages between population dynamics, health, and poverty. According to the Egyptian Ministry of Planning, Egypt's poverty rates declined during the 1990s—from 24 percent living below the national poverty line in 1990 to 17 percent in 2000. But the number of people living in poverty declined less sharply—from 13.4 million to 10.7 million—because of the higher rate of population growth among Egypt's lower-income

population. In addition, a 2003 report by the UN Development Programme (UNDP) suggests that the percentage of Egyptians living in poverty has increased since 2000.

The 2003 UNDP report also estimates that the number of Egyptians who are not able to meet their basic needs (defined by a minimum daily calorie intake) stands at 13 million, or over 20 percent of the country's total population. Confirming previous studies, rural parts of Upper Egypt were found to be worse off, with 35 percent of people not being able to meet their needs. In addition, the report shows that female-headed Egyptian households are usually poorer than male-headed households there;

larger Egyptian families (three or more children) are more vulnerable to poverty; and the least-educated Egyptians usually have the lowest incomes. Finally, the report found that 32 percent of Egyptians perceived themselves as poor, living below the income level they believed necessary to meet their daily requirements.

REFERENCES: Egyptian Ministry of Planning and UN, *Egypt 2004 Millennium Development Goals, Second Country Report* (Cairo: Public Administration Research & Consultation Centre, 2005): tables 1 and 2; and United Nations Development Programme (UNDP), "New Report Confirms Egypt's Need to Reverse Poverty: Study Reveals Fatalistic Streak in Egyptian Society" (June 2003 press release), accessed online at [www.undp.org.eg](http://www.undp.org.eg), on Aug. 3, 2005.

cy carries some risk of complications; thus, women's lifetime risk of maternal disability and death decreases as the average number of pregnancies decreases. Preventing unintended pregnancies would help reduce the incidence of unsafe abortion, which contributes to maternal disabilities and deaths.

In addition, family planning allows mothers more time to breastfeed between births and reduces mothers' risk of anemia. Anemia—common throughout the MENA region—lowers women's tolerance of blood loss and resistance to infection, contributing further to maternal illness and death.

But progress in making family planning available to all women who need it has been mixed among these countries. Contraceptive use in the region ranges from a low of 23 percent of married women in Yemen to a high of 74 percent in Iran. Additionally, many women report in surveys that, while they want to avoid a pregnancy, they are not using a family planning method. These women are referred to as having unmet need for family planning. Women with no education are less likely to use contraception and more

likely to have an unmet need than women who have completed secondary or higher education (see Figure 4).

### Goal 6: Combat HIV/AIDS, Malaria, and Other Diseases

The MENA region has the lowest rate of HIV infections among the world's major regions, with an HIV prevalence rate estimated at just 0.3 percent of all adults. However, the number of infections is growing in every MENA country (with about 50 percent of the new infections occurring among women), and there is potential for rapid spread in several countries. Algeria, for example, recorded twice as many new HIV cases in 2004 (266 diagnoses) as the year before.<sup>19</sup>

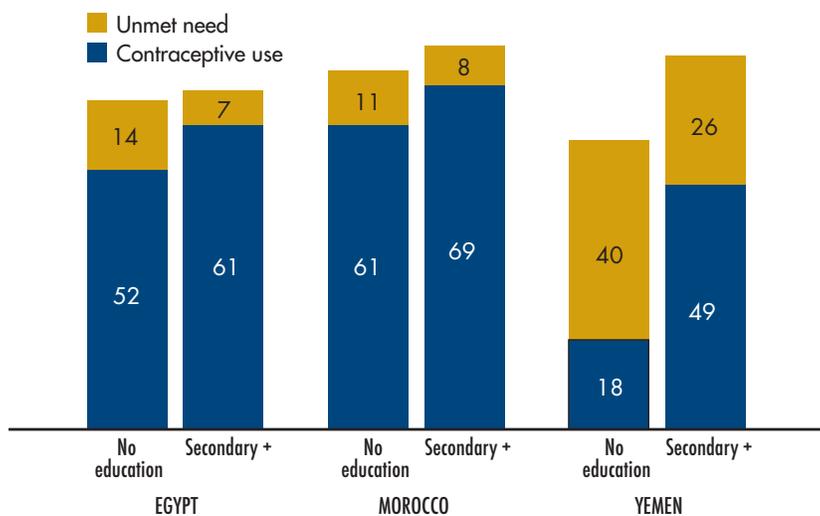
In the MENA region, paid sex, injecting drug use, and sex between men are the main sources of HIV infection. The social stigmas associated with these behaviors have meant that there are few programs and relatively little information to address the needs of high-risk groups, and any major outbreaks among these groups could be easily overlooked.<sup>20</sup> Injecting drug use accounts for most of the spread of HIV in Libya and Iran. When infected drug users have sexual relationships, they increase the potential for further spread of HIV to sex workers and the general public.

A study in Iran has revealed that one-half of injecting drug users there are married and that one-third have extramarital sex. Although Iran's national AIDS program distributes free condoms and has more active information campaigns on HIV/AIDS than do other countries in the region, sex workers in Iran still appear to be poorly equipped to protect themselves from HIV infection. While almost all of the sex workers who participated in a study in Kermanshah (a city in western Iran) knew about condoms, only 50 percent said that they had ever used condoms with their clients.<sup>21</sup>

With the epidemic still in its early stages in the region, MENA governments have the opportunity to stem the spread of HIV by adopting and implementing culturally sensitive policies and programs. Programs particularly need to target adolescents and young adults. Despite documentation of increasing premarital sex in the region and the known vulnerability of young people to HIV/AIDS, there is strikingly little information available to them in MENA countries about

Figure 4  
Contraceptive Use and Unmet Need in Egypt, Morocco, and Yemen, by Education

Percent of married women ages 15–49



NOTE: "Unmet need" refers to women who say that they prefer to avoid a pregnancy but are not using a method of contraception. "Secondary+" refers to those who have completed secondary school or a higher level of education.

SOURCES: ORC Macro, *Demographic and Health Surveys* (Egypt 2000 and Yemen 1997); and ORC Macro and Pan-Arab Project for Family Health (Morocco 2003–4).

sexuality and the risks of sexually transmitted infections, including HIV.<sup>24</sup>

Goal 6 recognizes the need for increasing the use of condoms, the only method that can prevent both pregnancy and the sexual transmission of HIV. Overall, with the exception of Iran and Turkey, condom use is negligible in the region, where the method is not yet culturally accepted. Comprehensive reproductive health services are critical, not only in making condoms available and acceptable, but in providing information and counseling on sexuality and health risks. These services can also test for and treat sexually transmitted infections, which increase the likelihood of HIV infection.

### **Goal 7: Ensure Environmental Sustainability**

In the MENA region—the most arid region in the world—freshwater scarcity tops the list of environmental concerns. The amount of renewable fresh water available has remained more or less constant over time, but as the populations of MENA countries have grown, the fresh water available per capita has declined.

The combined effects of population growth and modernization have increased the demand for fresh water. Improvements in technology can help expand availability to some extent by improving the efficiency of water use. Beyond that, helping couples avoid unintended pregnancies and promoting smaller family-size norms would slow population growth and lower population pressures on MENA's meager freshwater resources, thereby reducing potential political instability caused by conflicts over these resources.

### **Goal 8: Develop a Global Partnership for Development**

The Millennium Declaration and other UN agreements call on richer and more developed countries to help resource- and technology-poor countries progress toward their health and development goals. The region's oil-rich countries can support bilateral, multilateral, and regional programs that would help resource-poor countries of the region in achieving their development goals.

Such cooperation could share both knowledge and successful programs, including culturally sensitive programs to increase access to family planning and reproductive health care. Regional donor organizations such as the Arab Fund for Economic

and Social Development, which has played an important role in development in the region, need to increase their investments in women's empowerment and reproductive health.

## **Conclusion**

Women's reproductive health is closely linked to social and economic development and will therefore influence whether governments can achieve their poverty-reduction goals. Achieving universal access to family planning and related reproductive health services would help break the vicious cycle of poverty, poor health, and high fertility that prevails in parts of MENA countries today.

## **References**

- <sup>1</sup> The Middle East and North Africa region as defined here includes Algeria, Bahrain, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Qatar, Saudi Arabia, Syria, Turkey, the United Arab Emirates, the West Bank and Gaza, and Yemen.
- <sup>2</sup> Millennium Project, *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals* (New York: Millennium Project, 2005).
- <sup>3</sup> United Nations (UN), "UN Millennium Development Goals," accessed online at [www.un.org/millenniumgoals/](http://www.un.org/millenniumgoals/), on Nov. 18, 2005.
- <sup>4</sup> United Nations General Assembly, *2005 World Summit Outcome* (New York: UN, 2005).
- <sup>5</sup> Global Health Council, *Banking on Reproductive Health: The World Bank's Support for Population, the Cairo Agenda and the Millennium Development Goals* (Washington, DC: Global Health Council, 2004); United Nations Population Fund (UNFPA), *Achieving the Millennium Development Goals: Population and Reproductive Health as Critical Determinants* (New York: UNFPA, 2003); UNFPA, *Reducing Poverty and Achieving the Millennium Development Goals: Arguments for Investing in Reproductive Health & Rights* (New York: UNFPA, 2005); United Nations Development Programme (UNDP), *Millennium Project Report to the UN Secretary-General: Investing in Development: A Practical Plan to Achieve the Millennium Development Goals* (New York: UNDP, 2005); and World Health Organization (WHO), *En-Gendering the Millennium Development Goals (MDGs) on Health* (Geneva: WHO, 2003).
- <sup>6</sup> Farzaneh Roudi-Fahimi, *Progress Toward the Millennium Development Goals in the Middle East and North Africa* (Washington, DC: Population Reference Bureau, 2004).
- <sup>7</sup> World Bank, "Millennium Development Goals: Middle East and North Africa," accessed online at <http://ddp-ext.worldbank.org/ext/GMIS/gdmis.do?siteId=2&menuId=LNAV01REGSUB4>, on Aug. 2, 2005; and World Bank, *2005 World Development Indicators* (Washington, DC: World Bank, 2005): 2.
- <sup>8</sup> United Nations Statistics Division, "Millennium Indicators, Goal 1: Eradicate Extreme Poverty and Hunger" (table 1), accessed online at <http://millenniumindicators.un.org>, on Sept. 1, 2005; and United Nations Development Group, *Tunisia: National Report on the Millennium Development Goals*, accessed online at [www.undg.org](http://www.undg.org), on Sept. 14, 2005.

## PRB's Middle East and North Africa Program

The goal of the Population Reference Bureau's Middle East and North Africa (MENA) Program is to respond to regional needs for timely and objective information and analysis on population, socioeconomic, and reproductive health issues. The program raises awareness of these issues among decisionmakers in the region and in the international community in hopes of influencing policies and improving the lives of people living in the MENA region.

MENA program activities include: producing and disseminating both print and electronic publications on important population, reproductive health, environment, and development topics (many publications are translated into Arabic); working with journalists in the MENA region to enhance their knowledge and coverage of population and development issues; and working with researchers in the MENA region to improve their skills in communicating their research findings to policymakers and the media.

The Population Reference Bureau is the leader in providing timely and objective information on U.S. and international population trends and their implications.

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<sup>9</sup> UN and Egyptian Ministry of Planning, *Millennium Development Goals: Second Country Report, Egypt 2004* (Cairo: Public Administration Research and Consultation Centre, 2005): 12.

<sup>10</sup> Robert Eastwood and Michael Lipton, "Demographic Transition and Poverty: Effect via Economic Growth, Distribution, and Conversion," in *Population Matters: Demographic Change, Economic Growth, and Poverty in the Developing World*, ed. Nancy Birdsall, Allen C. Kelly, and Steven W. Sinding (New York: Oxford University Press, 2005); Stan Bernstein and Emily White, "The Relevance of the ICPD Programme of Action for the Achievement of the Millennium Development Goals—And Vice-Versa: Shared

Visions and Common Goals" (New York: UN, 2005), accessed online at [www.un.org](http://www.un.org), on Nov. 15, 2005; and Andrew Mason and Sang Hyop Lee, "The Demographic Dividend and Poverty Reduction," accessed online at [www.un.org](http://www.un.org), on Sept. 14, 2005.

<sup>11</sup> "Net enrollment ratio" is the percentage of children of the appropriate age for primary school who are enrolled.

<sup>12</sup> UNDP, *The Millennium Development Goals in Arab Countries, Towards 2015: Achievements and Aspirations* (New York: UNDP, 2003)

<sup>13</sup> Bernstein and White, "The Relevance of the ICPD Programme of Action."

<sup>14</sup> United Nations Population Division, "Millennium Development Goal Indicators Database," accessed online at <http://millenniumindicators.un.org>, on Sept. 10, 2005.

<sup>15</sup> Carl Haub, *2005 World Population Data Sheet* (Washington, DC: Population Reference Bureau, 2005).

<sup>16</sup> United Nations Statistics Division, "Millennium Indicators, Goal 4: Reduce Child Mortality," accessed online at <http://millenniumindicators.un.org>, on Oct. 31, 2005.

UNICEF figures for child mortality in Iraq have conflicted with other survey findings (Miho Tanaka, World Bank, personal communication, October 2005).

<sup>17</sup> Johns Hopkins University Center for Communication Programs, "Birth Spacing: Three to Five Saves Lives," accessed online at [www.infoforhealth.org](http://www.infoforhealth.org), on Sept. 1, 2005.

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