

A COMPARATIVE ANALYSIS OF

GENDER DISPARITIES

IN ARAB COUNTRIES

A Study Based on Household Survey Data



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ABBREVIATIONS

AGFUND	Arab Gulf Program for United Nations Development Organizations
BPfA	Beijing Platform for Action
CAWTAR	Centre of Arab Women for Training and Research
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CVDs	Cardiovascular Diseases
DHS	Demographic and Health Surveys
DPT	Diphtheria Pertussis Tetanus
ESCWA	Economic and Social Commission for Western Asia
FAO	Food and Agriculture Organization
HBP	High Blood Pressure
ICPD	International Conference on Population and Development Program of Action
ILO	International Labor Organization
LDCs	Least Developed Countries
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
PAPFAM	Pan Arab Family Health Survey
UNDP	United Nations Development Program
UNESCO	United Nations Educational, Scientific and Cultural Organization

UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Development Fund for Women (now UN Women)
UN-WOMEN	United Nations Entity for Gender Equality and the Empowerment of Women
WHO	World Health Organization

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EXECUTIVE SUMMARY

The international community has widely recognized that gender equality is critical for achieving development objectives. While the Arab region has demonstrated commitment to gender equality through support for key international declarations, the commitment has not been matched by progress in the production of sex-disaggregated data to inform evidence-based policy interventions to promote gender equality in the region. The region lags behind in the production and dissemination of sex-disaggregated statistics which are considered the basis of gender equality measurement. Much of the existing analysis of sex-disaggregated data in the region is based on macro-level indicators, providing an incomplete picture of gender equality. Analysis of sex-disaggregated data which are further disaggregated by background variables using micro household survey data, expose inequalities that would have otherwise been masked by national-level indicators. Gaining a better understanding of the data allows policy makers and governments to better target interventions aimed at reducing gender disparities. To contribute to more comprehensive data analysis of gender equality in the region, ESCWA with funding from UN Women produced the following report to measure the gap between women and men nationally and disaggregated by socio-economic background in a multitude of areas of life, using micro-level data from household surveys from 11 Arab States (namely Algeria, Egypt, Iraq, Jordan, Lebanon, Morocco, Palestine, Sudan, Syria, Tunisia and Yemen).

Data for this report comes from three comparable household survey programs from recent years since a common source was not available for all the countries in the study. The three surveys are: (i) Demographic Health Surveys (DHS), (ii) Pan Arab Family Health Surveys (PAPFAM) and (iii) Multiple Indicators Cluster Surveys MICS/PAPCHILD.

The first part of the report presents descriptive statistics on the demographic profiles of the women and men populations of the countries included in the study. Next, the report presents a descriptive analysis of gender gaps in socio-economic and health conditions. Key indicators in these areas are further disaggregated by background variables, such as area of residence, wealth, and educational attainment. Lastly, the report presents data on the attitudes of men and women on family planning in order to measure women's involvement in decisions that affect their reproductive health.

The analysis presents a portrait of population trends which serve as a backdrop to the analysis of gender equality in socio-economic conditions and family planning. Data shows that the region is witnessing, though at different paces, demographic transitions which include a trend towards more urbanization in some countries, a relatively young population and an ageing population. In addition, higher rates of female-headed households are more present in urban areas than rural areas. The age of marriage is increasing but girls marry at younger ages than boys.

The report also shows that in some cases gender gaps in the areas of education, labor force participation and health are exacerbated by background variables. For example, the proportion of illiterate women is higher than that of men but gender gaps in rural areas are greater than those in urban areas. Other indicators demonstrate the gap exists between those in urban/rural residence or richest/poorest wealth quintiles regardless of gender such as in the case of childhood immunization rates. Analysis also shows that family planning methods are generally more accepted among wives than their husbands.

While the report does not identify the causes for gender gaps, it provides a descriptive analysis of gender gaps and identifies areas where data is lacking or needs improvement. Thus, the report also serves to advocate for greater resources to improve sex-disaggregated statistics. Improved sex-disaggregated data will allow for better monitoring of progress towards gender equality and is in line with the region's commitment to, and recognition of the importance of gender equality for development.

BACKGROUND

“Gender equality is a human right... and an indispensable tool for advancing development.”¹

1 United Nations Population Fund (UNFPA). <http://www.unfpa.org/gender/>

2 The United Nations Development Programme (UNDP) works to ensure that the empowerment of women and human rights are mainstreamed into all of the organization’s different programs. The United Nations Development Fund for Women (UNIFEM) – now UN Women – worked in advancing women’s empowerment and gender equality to face challenges that include feminized poverty, the spread of HIV/AIDS among women and violence against women. The United Nations Children’s Fund committed itself to promote health, education, equality and protection of girls. The Office of the High Commissioner for Human Rights, the Food and Agriculture Organization of the United Nations (FAO) and the United Nations Population Fund (UNFPA), to cite a few, concentrated their efforts on a human-rights based approach to improve women’s conditions (UNDP, 2005).

3 CAWTAR aims to help forge a new perspective on the Arab woman and change traditional views of the roles of the sexes in social development by raising the level of awareness among policy-makers, planners, interested and involved groups, and others about the current situation of Arab women and their actual and potential contribution to comprehensive and sustainable development (UNDP, 2006).

There have been important development efforts in the past century to advance gender equality worldwide. Women’s rights – be them civil, political, social, economic or cultural- have been increasingly recognized. Many United Nations agencies and regional organizations joined hands to support all aspects of women’s empowerment.² In point of fact, the United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), the Beijing Platform for Action (BPfA), the United Nations Security Council Resolutions 1325, 1820, 1888 and 1889, the Millennium Declaration, the 2005 World Summit, the 2008 Accra Agenda for Action and Doha Declaration and the International Labor Organization (ILO) Conventions on the rights of working women have all fully emphasized the commitment to fulfill the human rights of both women and girls (UNIFEM, 2010).

In the Arab region, many international Funds as well as regional funding institutions have been active in the area of women’s empowerment (UNDP, 2005). These include the Arab Fund for Economic and Social Development (AFESD), which supports the economic and social development of Arab countries, and the Arab Gulf Program for United Nations Development Organizations (AGFUND), whose initiative to fund projects aimed at the advancement of Arab mothers in the areas of health and education was launched in the 1980s. AGFUND collaborated with the United Nations Development Programme (UNDP) and the Government of Tunisia to establish the Centre of Arab Women for Training and Research (CAWTAR) in Tunis in 1993.³

Moreover, the commitment to gender equality in the Arab region has been demonstrated by the ratification of CEDAW by 19 out of 22 Arab States and by significant progress in the implementation of the BPfA (United Nations, 2010). Further, following the ten-year review of the Beijing Conference, the Arab States approved the Arab Women’s Beirut Declaration in 2004, which established a framework and an outline for the empowerment of women in the period of 2005-2015 (UNDP, 2006). In addition, adherence to the Millennium Declaration was confirmed through the Arab declaration on the pursuit of the implementation of the Millennium Development Goals (MDGs), which was approved by the League of Arab States in Cairo in 2005 (ESCWA, 2008).

The commitment to gender equality as a concept in the Arab world, has not however gone hand in hand with sufficient advances in the production and dissemination of sex-disaggregated statistics to support evidence-based policy interventions to promote gender equality. Although there has been prolific qualitative literature on both the situation and the progress of Arab women, much less has been dedicated to quantitative measurements. To date, data covering women’s rights are incomprehensive, vary widely in quality, and have been pieced

4 The lack of sex-disaggregated data and gender sensitive indicators was highlighted in the UNDP Arab Human Development Report 2004 and 2005.

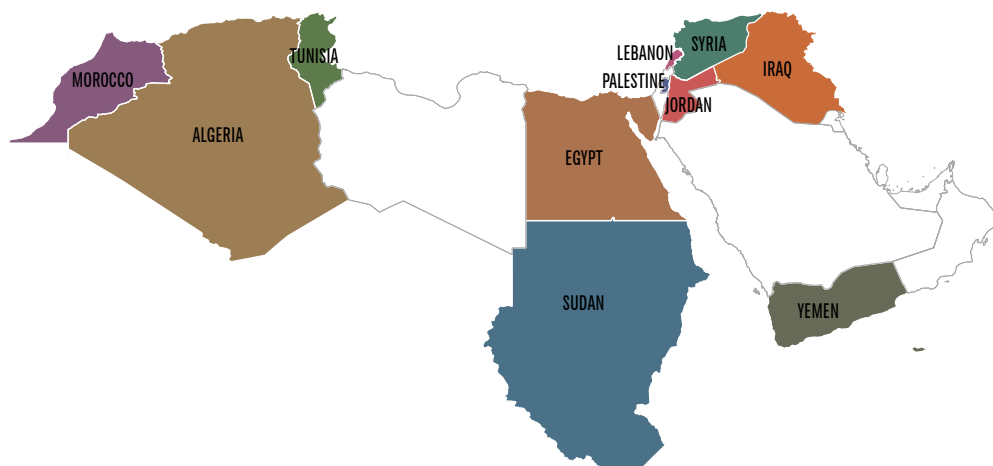
together from many, often disparate sources (such as administrative bodies, national statistics offices, and international organizations).⁴

The variation in data availability -within and among countries- acts as a constraint on any comparative endeavor. Previous analyses of sex-disaggregated data in the region relied heavily on readily available macro-level indicators, without further disaggregation by other background variables, such as area of residence or socio-economic status. While such macro-level data provides a snapshot of key indicators for a particular country, data that are not further disaggregated by background variables can mask inequalities within and between countries. For example, data to measure progress towards the MDGs is based on national aggregated data. Although significant strides have been made and the world is on track to reach many of the targets according to the 2011 MDG Report, many of the world's poorest and most vulnerable have not benefited equally from the achievements thus far (United Nations, 2011). Being poor and female, for instance, can serve as a double disadvantage. Comprehensive micro-level data provides a more complete picture and a better understanding of the context in which women are disproportionately carrying the burden of development challenges. Sex-disaggregated data that are further disaggregated by background variables can identify influential factors in development, avenues for intervention and serve as a foundation for evidence-based policy making.

ESCWA, in collaboration with specialized United Nations agencies and other partners, has taken a handful of initiatives to gender mainstream statistics in the Arab region. This report, a product of a cooperation between ESCWA and UN Women, intends to measure the gap between women and men in a multitude of areas of life, using micro-level data from household surveys from 11 Arab States (**Figure 1**):

- | | |
|------------|--------------|
| 1. Algeria | 7. Palestine |
| 2. Egypt | 8. Sudan |
| 3. Iraq | 9. Syria |
| 4. Jordan | 10. Tunisia |
| 5. Lebanon | 11. Yemen |
| 6. Morocco | |

FIGURE 1. Geographic distribution of the Arab countries included in the study



“Generate and disseminate gender-disaggregated data and information for planning and evaluation.” (UN, 1996)

⁵ The Global Gender Gap Index was first introduced in the World’s Economic Forum’s Global Gender Gap Report 2006. It is designed to rank countries on gender gaps and not on their actual development level. It examines the gap between men and women in four fundamental categories: economic participation and opportunity, educational attainment, health and survival and political empowerment.

Arab countries benefit from a number of similarities, including rich histories spanning thousands of years, a common language, strong cultural traditions and increasingly educated workforces (UNDP, 2010). However, the Arab region is characterized by many differences. Apart from vast demographic, geographic, political and socio-economic diversity, Arab countries also fare differently in terms of gender equality. Not only does the degree of gender inequality vary amongst Arab countries, but also the type of inequality.

The Global Gender Gap Index⁵ was used to assign scores and ranks to 135 countries in 2011. Amongst the countries included in this report, they were all ranked in the bottom 20 per cent with Tunisia ranked highest (108) and Yemen was ranked number 135, the last on the list (World Economic Forum, 2011).

This report provides a statistical description of gender inequalities in the region based on the latest available household survey data. Apart from cross-country analysis, it will seek to expose variations vis-à-vis area of residence, socio-economic status and, when relevant, educational attainment which are often missing from reports on gender inequalities. The descriptive analysis serves to not only present gender inequalities but also provides an indirect assessment of where data gaps exist and need improvement.

METHODS

6 DHS are nationally-representative household surveys that provide data for a wide range of monitoring and impact evaluation indicators in the areas of population, health, and nutrition. Funded by the United States Agency for International Development (USAID), the project has provided technical assistance for household surveys in over 90 countries and 260 surveys. Standard DHS Surveys have large sample sizes (usually between 5,000 and 30,000 households) and typically are conducted every 5 years, to allow comparisons over time. **PAPFAM** is a data collection project which aims to provide information on Arab family health. It obtains information on health status measures of the Arabic mothers and children and their underlying determinants. It is administered by the League of Arab States. **MICS / PAPCHILD** is administered by UNICEF to collect and produce statistically sound, internationally comparable data across a range of indicators, including health, education, child protection and HIV/AIDS. **PAPCHILD** is supported by the League of Arab States and United Nations Population Fund (UNFPA) to collect data on women and children's health.

7 Age at first marriage in the DHS data was obtained from the household listing data file.

The study relied on three different sources of data: (i) Demographic Health Surveys (DHS), (ii) Pan Arab Family Health Surveys (PAPFAM) and (iii) Multiple Indicators Cluster Surveys MICS/PAPCHILD since no common data source for all the countries of interest was available.⁶

DHS was used to obtain data on Egypt (2000, 2008), Jordan (2002, 2007) and Morocco (2004). PAPFAM was used to obtain data on Algeria (2002), Lebanon (2004), Syria (2001), Tunisia (2001) and Yemen (2003). MICS/PAPCHILD was used to obtain data on Algeria (2006), Iraq (2006), Morocco (2006), Palestine (2006), Sudan (2006), Syria (2006), Tunisia (2006) and Yemen (2006).

Demographic and household composition indicators, in addition to the main background variables, such as age, education (literacy rate, school enrollment, school attendance and educational attainment), area of residence (urban vs. rural) and wealth index, were obtained from the household listing data file of every data source. Marital status, employment and labor force data, in addition to health related indicators, such as chronic diseases and disability, were also extracted from the primary household roster data file.

Indicators pertaining to age at first marriage of women, fertility preference, and attitude towards use of contraception were analyzed using the women's survey data file from every data source.⁷

Indicators pertaining to child health care, vaccination, birth history, birth spacing and child mortality were analyzed using the child data files for DHS and MICS surveys and women's data files for PAPFAM surveys.

Table 1 summarized the source of every indicator analyzed and presented in this report.

Table 1. Summary of indicators by data source

	DHS				MICS				PAPFAM		
	HH	HL	Wom	CH	HH	HL	Wom	CH	HL	Wom	BH
Household headship	X				X				X		
Population distribution		X				X			X		
Age		X				X			X		
Wealth index		X				X			X		
Area of residence		X				X			X		
Educational attainment		X				X			X		
School attendance		X				X			X		
Illiteracy rate		-				X			X		
Employment status		-				X			X		
Labor force participation		-				X			X		
Marital status		X				X			X		
Age at first marriage		X					X			X	X
Attitude towards use of contraception			X			-				X	X
Chronic diseases		-				-			X		
Disability		-				-			X		
Woman's autonomy			X				-			-	-
Infant and child mortality				X				X			X
Child health care				X				X		X	
Vaccination				X				X		X	

HH: Household headship; HL: Household Listing; Wom: Women's questionnaire; CH: Child health questionnaire; BH: Birth history

The survey used for each country, the corresponding year, sample size and response rate is presented in **Table 2** below.

Table 2. Survey sample size and response rates

	YEAR	NUMBER OF HOUSEHOLDS INTERVIEWED	RESPONSE RATE
Algeria MICS	2006	29476	98.4%
Egypt DHS	2008	18968	99.1%
Iraq MICS	2006	18136	98.6%
Jordan DHS	2007	14564	98.8%
Lebanon PAPFAM	2004	5532	85.0%
Morocco MICS	2006	7931	98.0%
Palestine MICS	2006	11661	99.6%
Sudan MICS	2006	24046	98.1%
Syria MICS	2006	19019	95.7%
Tunisia MICS	2006	9106	95.4%
Yemen MICS	2006	3979	90.3%

MEASURES AND VARIABLES

Household headship was extracted from the variable *relationship to head of household*. Age was categorized into groups of five years starting from 0–4 years. Type of area of residence was used to designate whether the individual resides in an urban or rural area, with the exception of Palestine where a third area of residence – refugee camp – was added. The variable wealth index (divided into 5 equal quintiles) was used to identify the wealth category to which the individual and his/her family belong; these categories ranged from poorest to richest.

Educational attainment and illiteracy rates were calculated using the variable *highest educational level attained*, which included categories ranging from *illiterate* to *higher/post-secondary*. School attendance was calculated using the variable *currently attending school during this school year*.

Chronic disease was analyzed based upon whether a respondent reported being diagnosed by a health care provider with one or more of the following chronic diseases: cardiovascular diseases, hypertension and asthma.

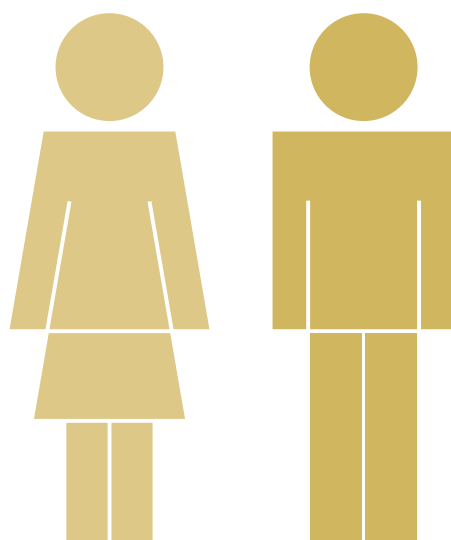
Disability was analyzed based upon whether a respondent reported having any of the following: limited vision, limited hearing, limited understanding, limited movement, limited self-caring, or other limitations concerning communication with others. These measurements, however, were only available for PAFAM surveys.

Labor force participation and employment status were analyzed using the *employment activity* variable. The variable assessed the current employment activity of all household members. Unemployment was then calculated based on individuals who are part of the labor force and are current job seekers. Labor force was comprised of all individuals who are either currently working or currently unemployed but seeking a job.

Attitude towards use of family planning methods was assessed in the women questionnaires using the following questions: “*Would you say that in general you approve or disapprove of couples using a method to avoid pregnancy?*” and “*Do you think that in general your husband approves or disapproves of couples using a method to avoid pregnancy?*” Answers to these questions were: Approves, conditionally approves, disapproves, and unsure; conditionally approve and disapprove were merged into one category.

DATA LIMITATIONS

The major data limitations stem from the fact the data come from multiple sources. As such, question and variable coding differed from between countries and required the development separate analysis syntaxes for every country. With the exception of the DHS data which were standardized across the two countries (Egypt and Jordan), similar variables were differently coded differently for each country. Furthermore, the limited availability of some of the survey questionnaires made the identification and analysis of variables more challenging.



WOMEN AND MEN POPULATIONS

⁸ The drop in fertility has been witnessed throughout the Arab region over the last 20 years but the timing and intensity of the decline were uneven. Fertility exceeded 6 children per woman in 1975 and decreased slightly to 5.7 children in the early 80's, before falling to 4.2 in the start on the 90's and reaching 3.1 around 2002 (Tabutin and Schoumaker, 2005).

The combined population of the Arab countries rose from 172 million in 1980 to 300 million in 2002 (UN, 2007) and was estimated to reach 360 million in 2010 (United Nations, 2009). The average exponential growth rate, estimated at 2.6 per cent per annum in the period 1980-2002, is expected to drop to 1.9 per cent per annum in 2002-2015 (United Nations, 2007). A contributing factor to the demographic shift is the drop in fertility rates in all Arab states⁸ (excluding Somalia) reaching below five births per woman in the period 2010-2015 (ESCWA, 2008).

In addition to drops in fertility, transition in mortality in the Arab region is also witnessed. The shift from high mortality rates to relatively lower ones began somewhat later than elsewhere in the world but was swift thereafter (Tabutin and Schoumaker, 2005). Life expectancy generally increased for both men and women from 51 years in 1970 to almost 70 in 2010, the greatest gain of any region in the world, while infant mortality rates plummeted from 98 deaths per 1,000 live births in 1970 to 38 in 2008, below the current world average of 44 per 1,000 (UNDP, 2010).

As a result, a major shift in the age structure of the population which was previously characterized by a wide-bottomed population pyramid is occurring. The once dominant first band (0-14) is shrinking, the second band (15-65) is expanding and the highest age group band (65+) is growing modestly (ESCWA, 2008).

The main purpose of the following section is to present a broad description of the demographic profiles of the women and men populations of the countries included in the study. It acts as a prelude to the subsequent sections and intends to highlight some of the demographic characteristics of the countries under scrutiny using age, sex, area of residence, marital status and household headship data.

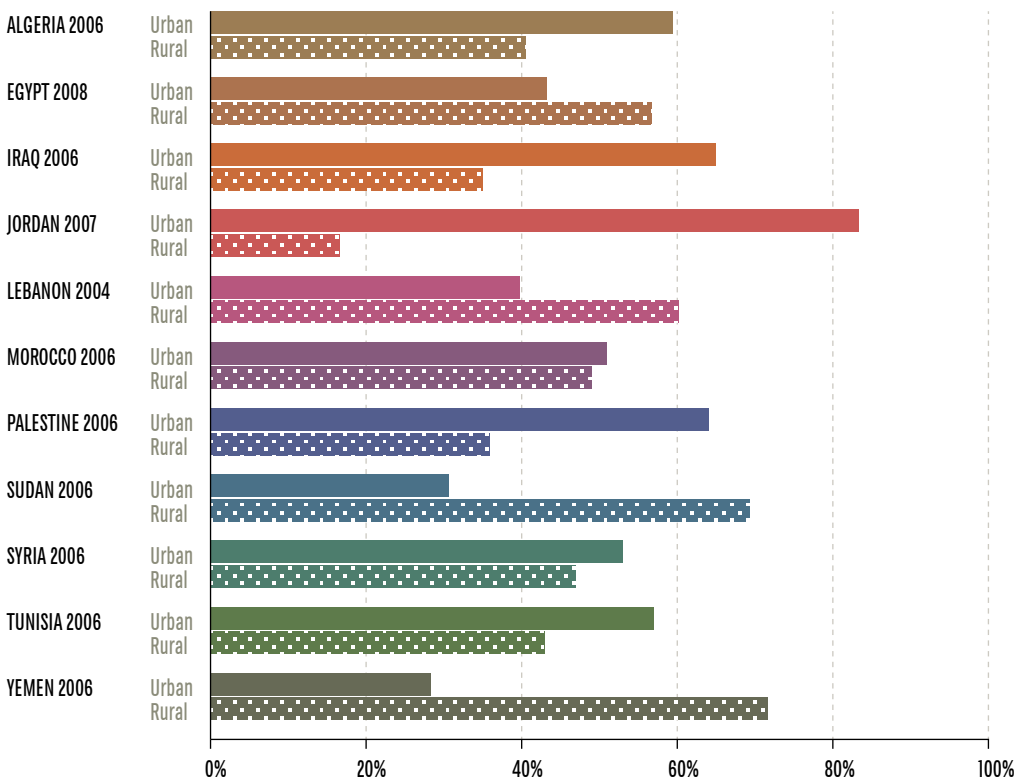
URBAN/RURAL DISTRIBUTION

⁹ Figure refers to the population not living in refugee camps.

As in many parts of the globe, one of the major demographic changes to occur in the Arab World during the second half of the twentieth century was the rapid urbanization of its population (Tabutin and Schoumaker, 2005) and growth of large cities, namely Algiers, Amman, Baghdad, Cairo, Damascus, Jeddah and Riyadh (UNDP, 2010). Urban growth was mainly due to the natural increase in the urban population, rural-urban migration and the reclassification of rural localities as urban localities.

The urban/rural distributions of the countries included in the study are depicted in **Figure 2**. It shows that a relatively high proportion of the population lives in the urban regions of Iraq (65%), Jordan (83%), Palestine (64%)⁹, Algeria (59%) and Tunisia (57%). Rural populations were dominant in Yemen (72%), Sudan (69%) and, to a lesser extent, Egypt (57%).

FIGURE 2. Urban/rural distributions (per cent of population)



SEX DISTRIBUTION

¹⁰ Sex-ratio represents the number of males to females in a population. A sex-ratio greater than 1 indicates there are more males than females while a sex-ratio less than one indicates a greater number of females than males.

Figure 3 shows the per cent of females in the countries included in this report. In 3 out of 4 countries of the Maghreb that are included in this study, namely Tunisia, Morocco and Egypt, the female population is larger than that of males. The sex distribution is the least uniform in Morocco (48% males and 52 % females). Male and female populations also differ in size in Syria, where a predominance of males (52%) is observed.

FIGURE 3. Per cent of females in population

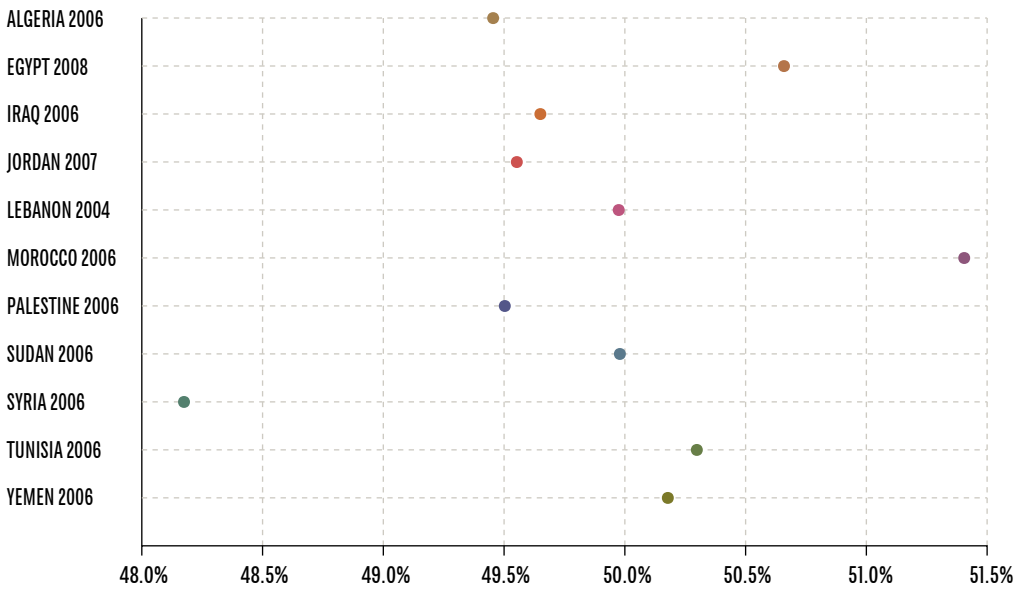


Figure 4 and **Figure 5** display sex ratios¹⁰ by 5-year age groups. While the ratio is consistently close to that of most North African countries, strong irregularities in the sex ratio are present in Sudan. These irregularities may be attributed to data quality issues or they may reflect legitimate variation in the sex structure of the population. The male-to-female ratio is less than one in the 20 to 39 age group, rises above one in the 40 to 49 age group and drops sharply again in the 50 to 54 age group. In the older age groups, however, men are consistently more numerous than women in Sudan (**Figure 4**). In Egypt and Morocco, sex ratios drop below one in the 20 to 49 age group. In Tunisia, female numbers are higher in two age groups: 35 to 39 and 55 to 59.

In the countries of the Mashreq, Yemen and Syria show more irregularities in the sex ratio pattern as compared to their neighboring countries (**Figure 5**). Again, data quality may be a contributing factor. In Yemen, the sex ratio exceeds 1.5 in the 60 to 64 age group and rises to nearly 2 in the 70 to 74 age group. In Syria, the sex ratio rises above 1.2 in the older age groups.

FIGURE 4. Sex ratio by 5-year age group (North Africa)

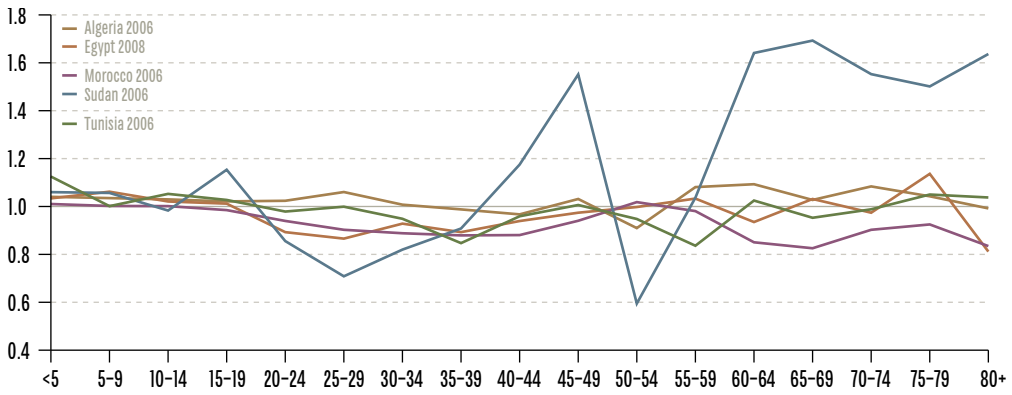
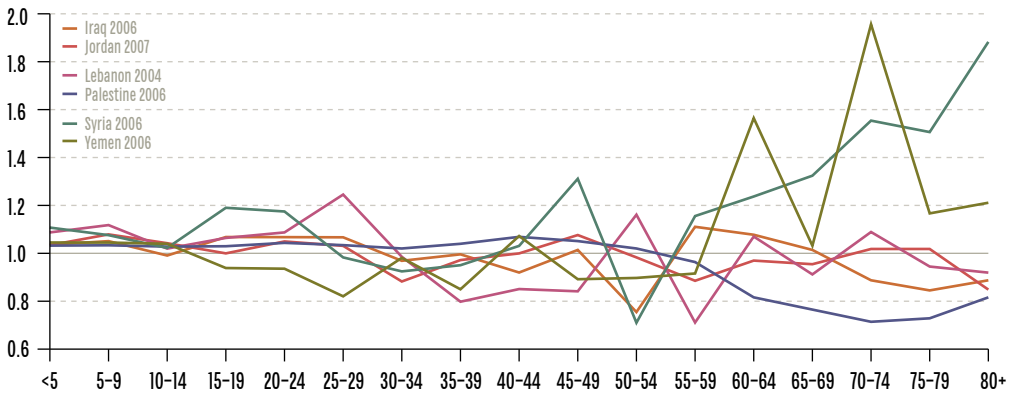


FIGURE 5. Sex ratio by 5-year age group (West Asia)



AGE-SEX DISTRIBUTION

As mentioned before, demographic transition is occurring in the Arab countries at different paces. The transition in both fertility and mortality has altered the age structure of their population (ESCWA, 2007). The region has witnessed dramatic declines in fertility as a result of delayed marriage, wider acceptance of and access to family planning services, and increased education of girls and young women (Roudi-Fahimi, 2008). According to UNDP (2010a), the sharpest decline in fertility was experienced by Algeria, followed by Bahrain, Egypt, Iraq, Jordan, Kuwait, Lebanon, Morocco, Qatar, Saudi Arabia, Syria, Tunisia and the United Arab Emirates. In some of the latter countries, though, the pace of fertility decline has slowed. In three countries, namely Egypt, Syria and Jordan, fertility remains at three or more children per woman. Also, not all countries in the region have seen sharp declines in fertility; in 8 out of 22 Arab countries (including Palestine, Somalia, Oman and Yemen) fertility exceeds 4 children per woman.

Furthermore, better hygiene, improved nutrition and scientifically-based medical practices in addition to economic growth and improvements in education in addition to lower fertility rates resulted in major decreases in mortality levels. More than half of the Arab countries met the International Conference on Population and Development (ICPD) Program of Action goal: to reach a life expectancy at birth higher than 70 years in 2005-2010. However, seven countries (Iraq, Sudan and Yemen, among others) fell short of reaching the target (UNDP, 2010a).

Despite the decreases in fertility and mortality, the population of the Arab region is still young with children under 15 accounting for a third of the population and young individuals aged 15 to 24 years accounting for nearly a fifth of the population. The youngest countries are Palestine and Somalia which are closely followed by Yemen (UNDP, 2010a).

At the other end of the age spectrum and as a byproduct of the demographic transition, a new phenomenon has emerged: the ageing of the population. According to UNDP (2010a), the proportion of the population aged 60 years and above increased to 7% in the Arab region compared to 9% for all developing countries. Lebanon and Tunisia have the largest proportions of older people.

The age-sex distributions of the 11 countries in this study are shown in **Figure 6 – Figure 16** and demonstrate any disparities in light of the demographic trends.

FIGURE 6. Age-sex distribution, Algeria 2006

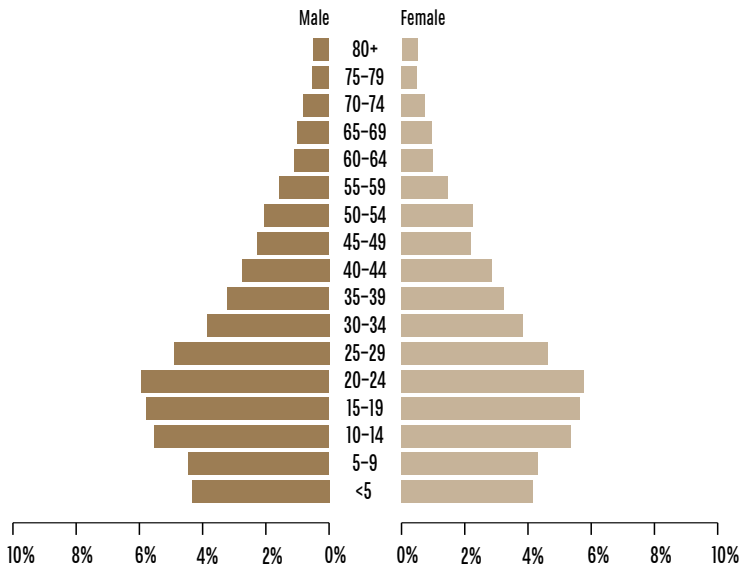
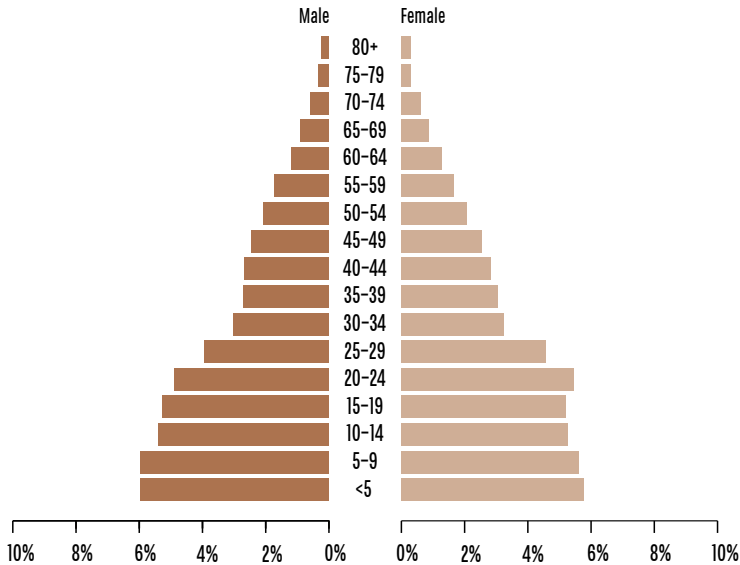


Figure 6 shows the age-sex distribution of the population in Algeria. The country has experienced a very sharp decline in its fertility rate as seen in the narrowing of the base and a parallel decrease in mortality, indicated by a broader top.

FIGURE 7. Age-sex distribution, Egypt 2008



The population pyramid of Egypt shown in Figure 7 has more or less the shape of a stationary population, where the width of the base is similar in width to the population in the reproductive age groups. Some asymmetries in the shape are present in the below 5 and 5 to 9 age groups where males outnumber females and in the 20-29 age group where females outnumber males.

FIGURE 8. Age-sex distribution, Iraq 2006

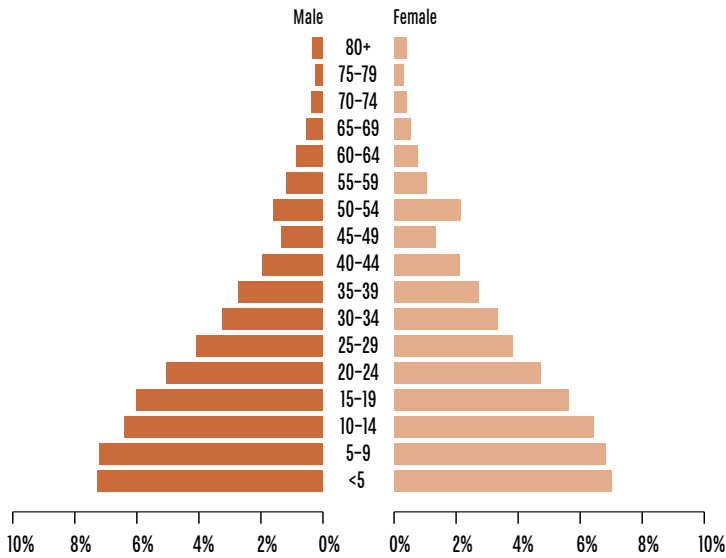
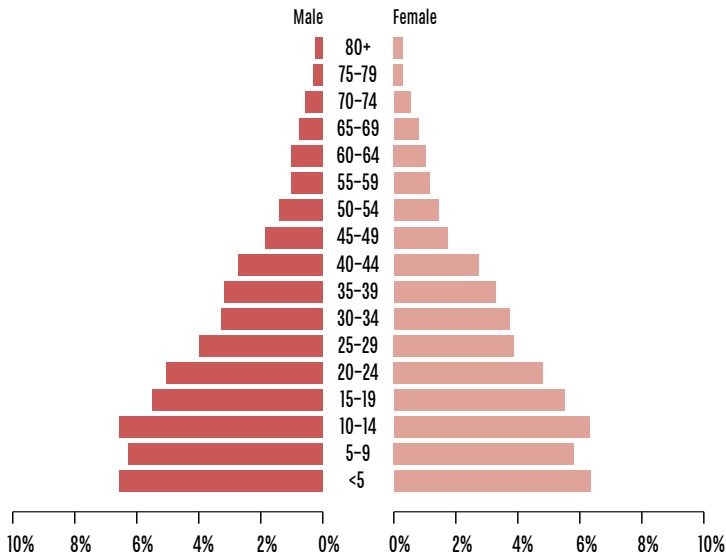


Figure 8 displays the population pyramid of Iraq, which has a classic triangular shape. The broad base suggests a high birth rate whereas the small top shows a high death rate. The asymmetry in the 50 to 54 age group is probably indicative of the female widowhood that was caused by the war.

FIGURE 9. Age-sex distribution, Jordan 2007



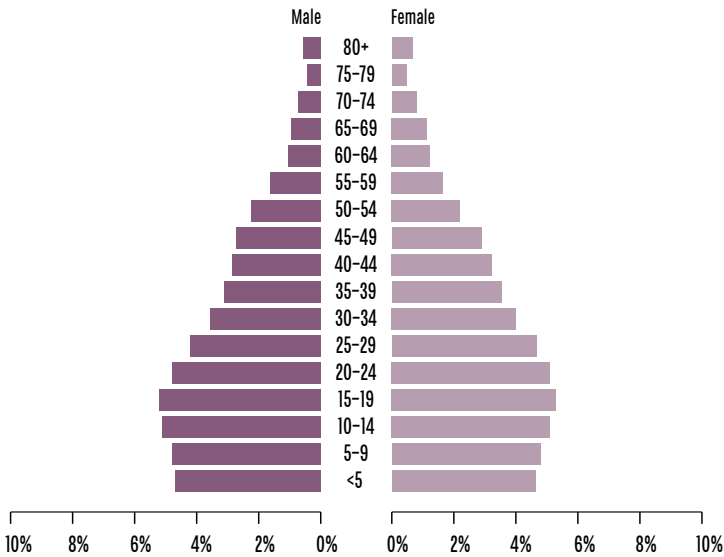
The age-sex distribution of Jordan is shown in Figure 9. Again, the classic shape of the pyramid is indicative of high birth and high death rates.

FIGURE 10. Age-sex distribution, Lebanon 2004



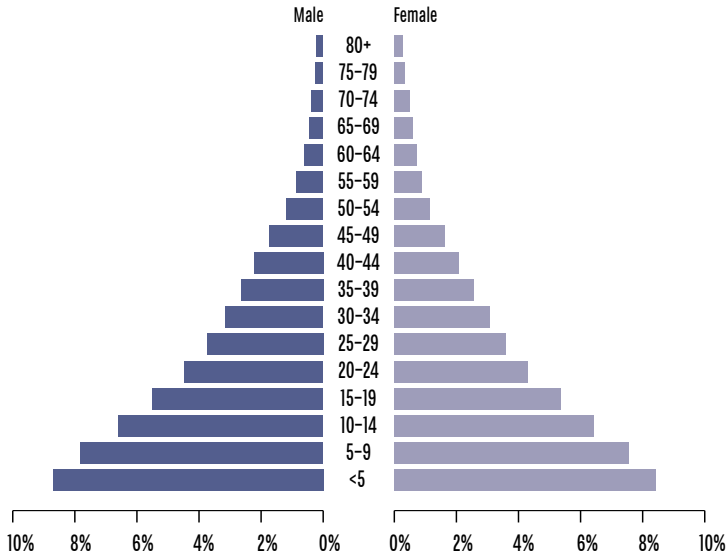
The population pyramid of Lebanon is shown in **Figure 10**. The narrow base indicates a drop in the fertility rate and a broadening of the top reflects a decreased mortality rate. Obvious asymmetries in the shape of the pyramid are present in the 15 to 29 age group where males outnumber females and in the 35 to 49 age group, where the reverse is true.

FIGURE 11. Age-sex distribution, Morocco 2006



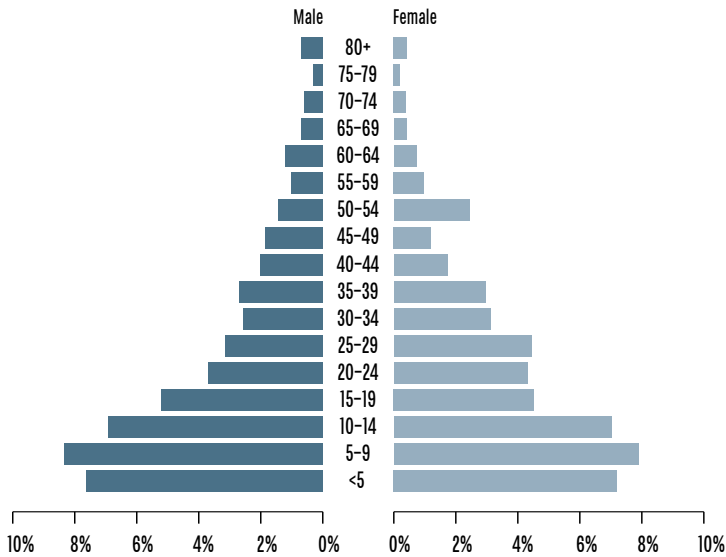
Fertility and mortality rates are also on the decline in Morocco as seen in **Figure 11**.

FIGURE 12. Age-sex distribution, Palestine 2006



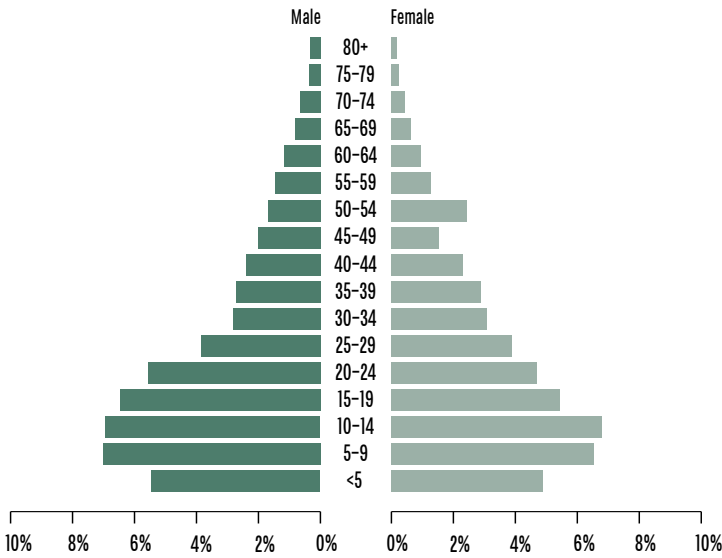
The age-sex distribution of Palestine (including refugee camps) portrayed in Figure 12 depicts high fertility and mortality rates.

FIGURE 13. Age-sex distribution, Sudan 2006



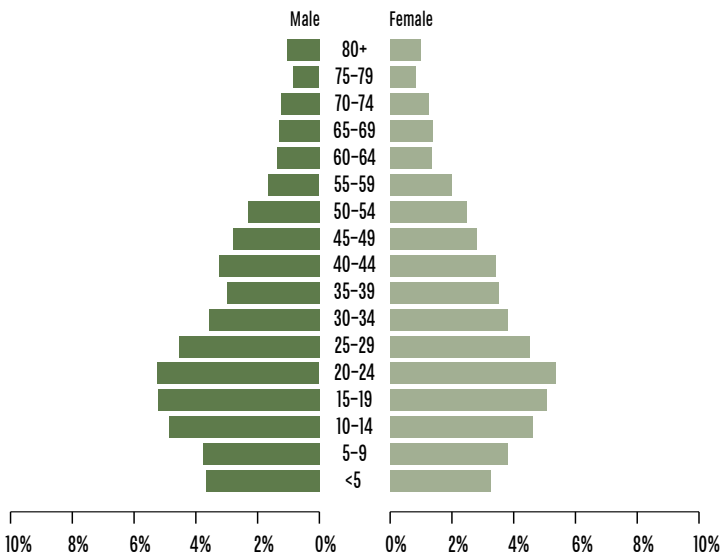
A small decline in fertility is shown in the case of Sudan, whose age-sex pyramid is pictured in Figure 13. Many asymmetries across the age groups are seen, especially in the 50 to 54 age group, which makes up 3.9% of the female population and only 1.9% of the male population.

FIGURE 14. Age-sex distribution, Syria 2006



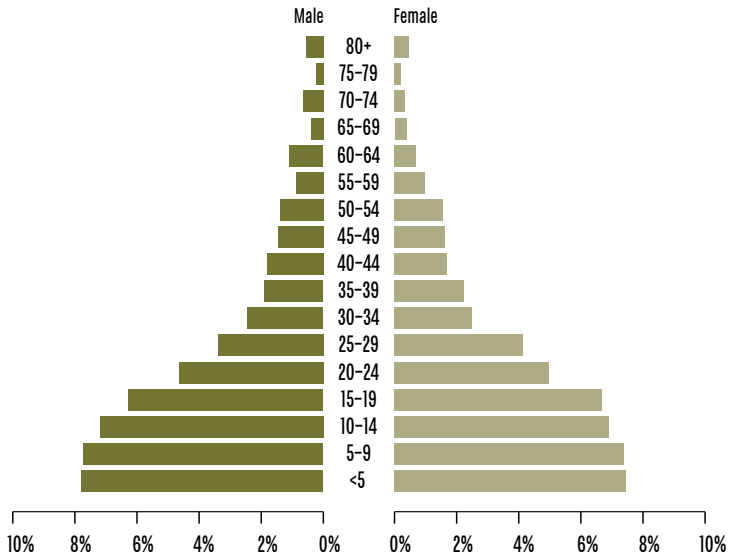
Likewise, a decline in fertility is being witnessed in Syria, as shown by the narrowing in the base of the age-sex pyramid in **Figure 14**. Also noteworthy is the fact that the top of the pyramid shows unexpected differences in sex proportions; men outnumber women in the older age groups.

FIGURE 15. Age-sex distribution, Tunisia 2006



The population pyramid of Tunisia displayed in **Figure 15** shows a contracting population. Apart from a drop in fertility, there is a broadening of the older age groups for both women and men.

FIGURE 16. Age-sex distribution, Yemen 2006



The Yemen population pyramid shown in **Figure 16** indicates high fertility and mortality rates.

FEMALE HEADSHIP

Increased recognition of an eminent proportion of households with female heads is being noted in the literature in the Arab region. One out of every ten households in Arab countries is headed by a woman (Rashad and Osman, 2000). The profile of a female head differs from one Arab country to another due to differences in the contexts surrounding the phenomenon. However, available data on female headships do not provide a complete and detailed picture of the profile and needs of this group. Furthermore, the sparse available research and data on this issue are built on the use of the heavily criticized criterion of self-definition or acknowledgement of household members. Such a definition underestimates the prevalence of these households and does not capture the real situation of female headship.

The proportions of female-headed households in the countries included in this analysis are shown in **Figure 17**. The percentage of female-headed households ranged from 8% in Syria and Palestine to 18% in Sudan.

Figure 18 shows the per cent of female-headed households by type of residence across all countries. The per cent of female-headed households is higher in urban locales than rural ones in most of the countries included in the study. This is the case in Algeria (12% vs. 7%), Egypt (13% vs. 11%), Iraq (12% vs. 9%), Lebanon (16% vs. 14%), Morocco (20% vs. 10%) and Tunisia (14% vs. 10%). Only Sudan, and to a lesser extent Jordan and Palestine, have a higher per cent of female-headed households in rural areas than urban ones.

FIGURE 17. Proportion of female-headed households

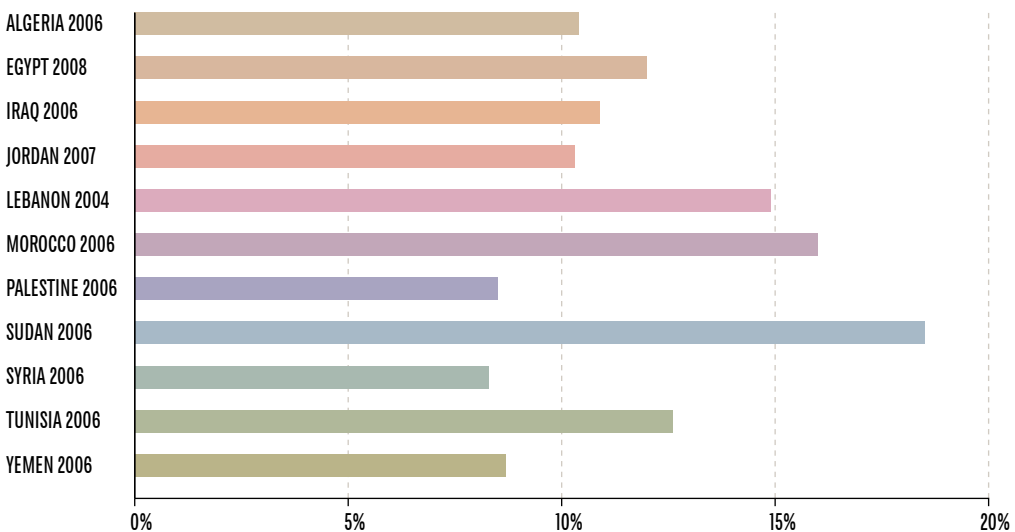
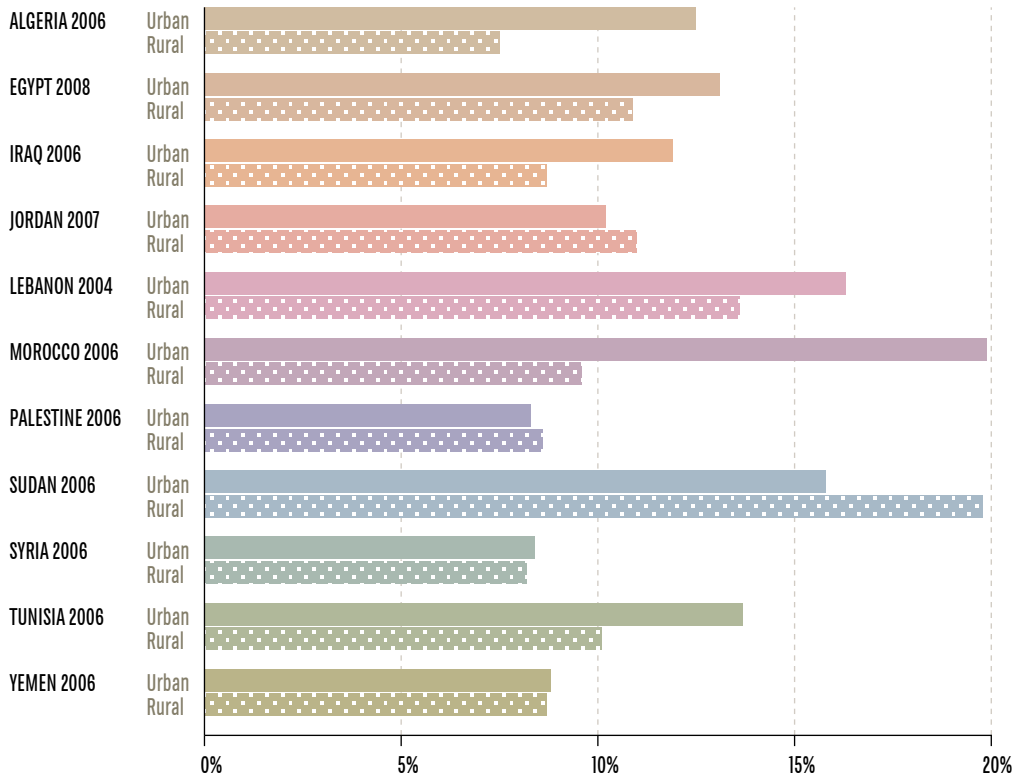


FIGURE 18. Proportion of female-headed households by area of residence

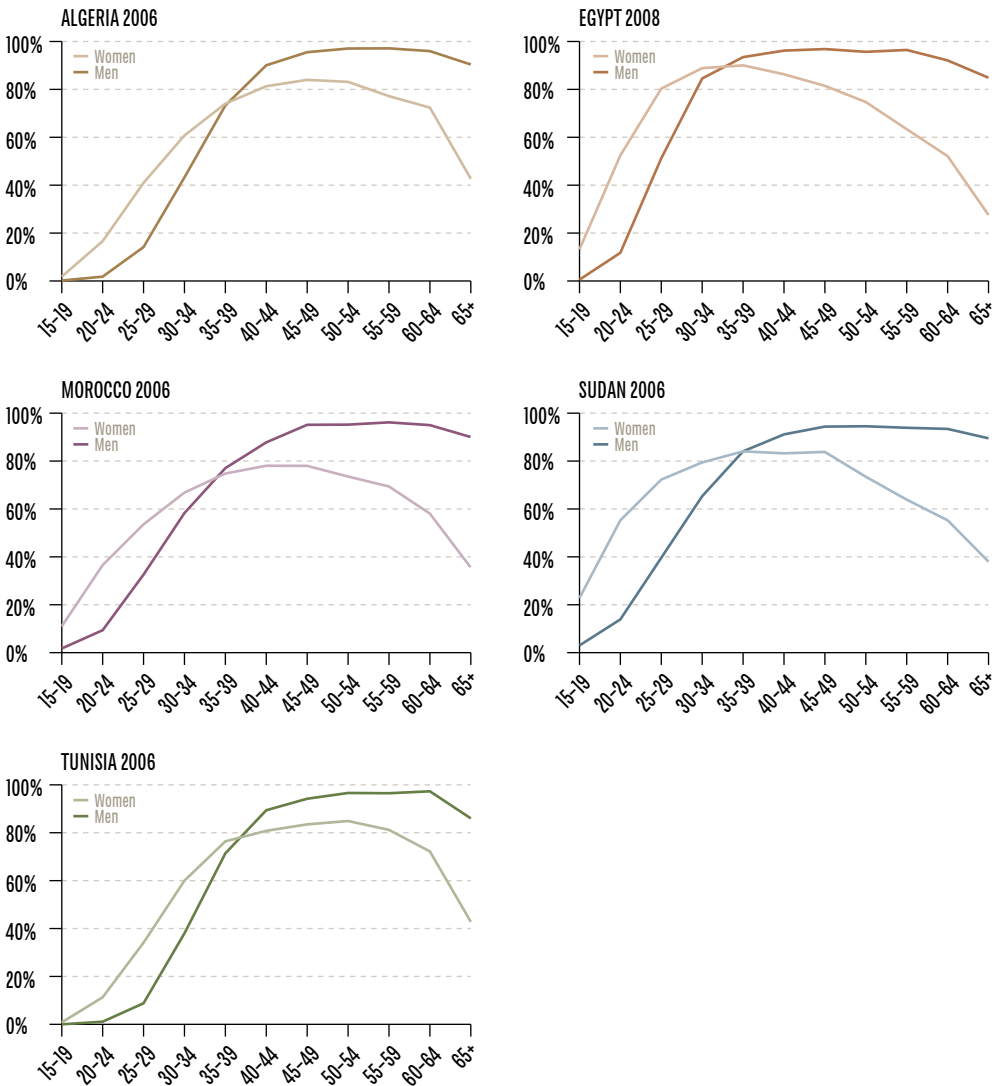


MARITAL STATUS

Families in the Arab region are experiencing significant changes in the face of new patterns of marriage and family formation. Early marriage is no longer as common and the average age at marriage for both women and men is increasing (Rashad et al., 2005).

Girls marry at a younger age than boys in the Arab countries included in this report, as shown in **Figure 19** and **Figure 20**. In North Africa, Sudan holds the largest proportion of currently married women in the 15 to 19 age group (23%), followed by Egypt (13%). Tunisia holds the lowest (1%) (**Figure 19**).

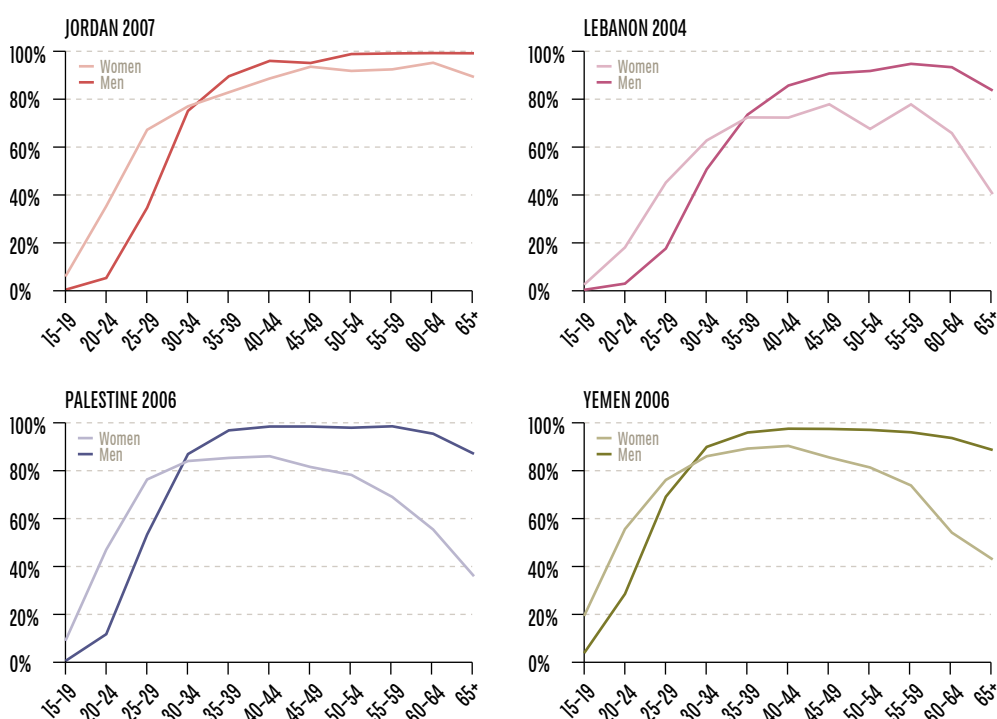
FIGURE 19. Proportion of currently married men and women in the population aged 15 years and above by age (North Africa)



Of the Western Asia countries in this study, Yemen holds the high-est percentage of currently married women in the 15 to 19 age group (19%), whereas Lebanon holds the lowest (3%) (**Figure 20**).

The proportion of women who are currently married falls below that of men in all countries, starting with the 40 to 44 age group (**Figure 19** and **Figure 20**). The pattern is likely a result of two factors: higher rates of widowhood amongst women and higher rates of remarriage following divorce or death of spouse amongst men.

FIGURE 20. Proportion of currently married men and women in the population aged 15 years and above by age (West Asia)



The proportions of divorced in the population aged 15 years and above by sex and age are shown in **Figure 21** and **Figure 22**. Morocco holds the highest proportion of divorced women (3.6%) of the countries under review. Divorce appears to be more common amongst women aged 15 years and above than it is amongst men in the same age groups. Morocco (3.6%) and Sudan (2.6%) hold higher percentages of divorced women than the other countries in this report.

The proportion of never married is shown in **Figure 23**. The data show that only 80% of women in Sudan are never married in the 15 to 19 age group. In contrast, nearly 100% of women in Algeria in the 15 to 19 age group are ever married. In all countries, the most significant decrease in the proportion of never married women happens before age 25.

FIGURE 21. Proportion divorced in the population aged 15 years and above by sex and age (North Africa)

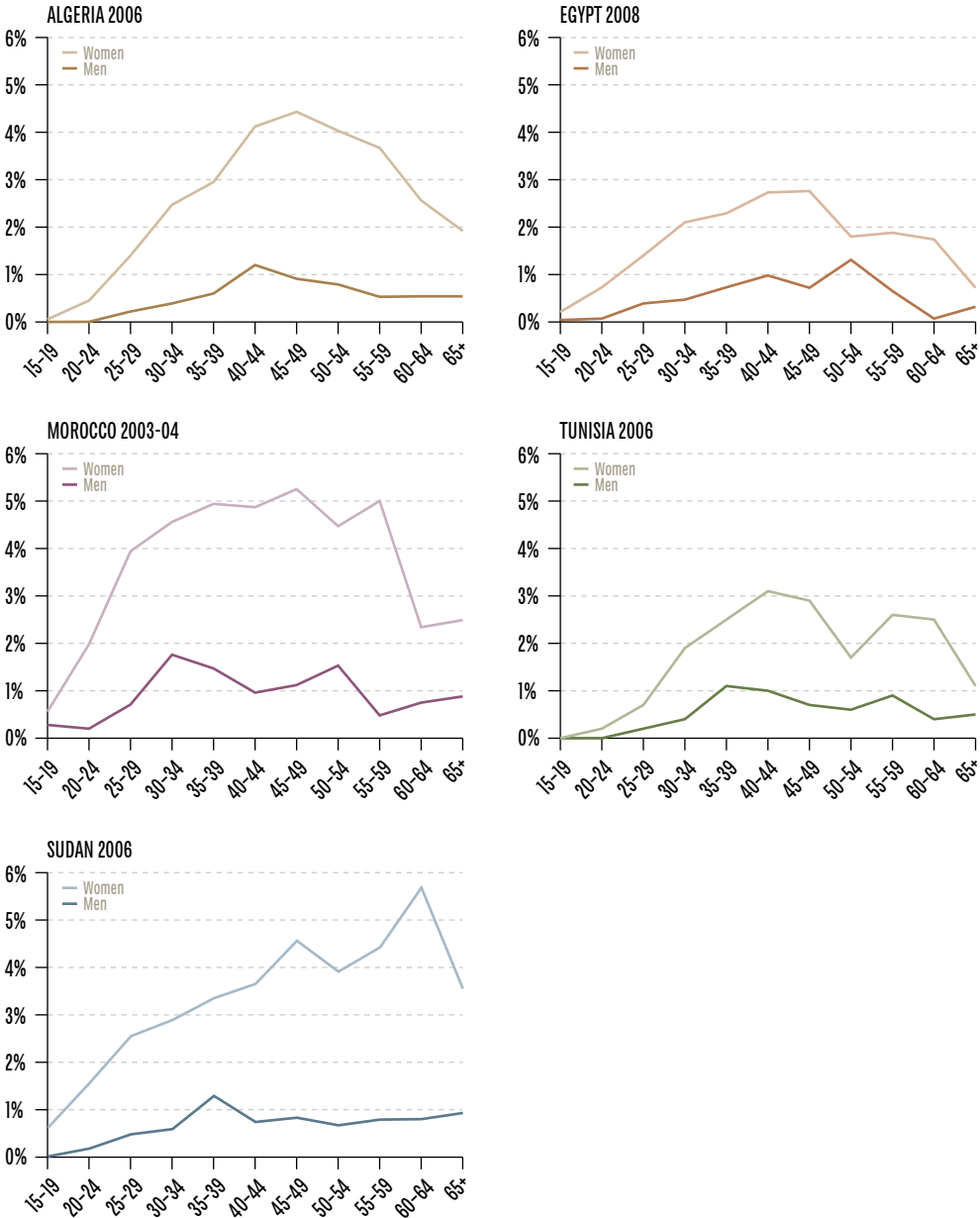


FIGURE 22. Proportion divorced in the population aged 15 years and above by sex and age (West Asia)

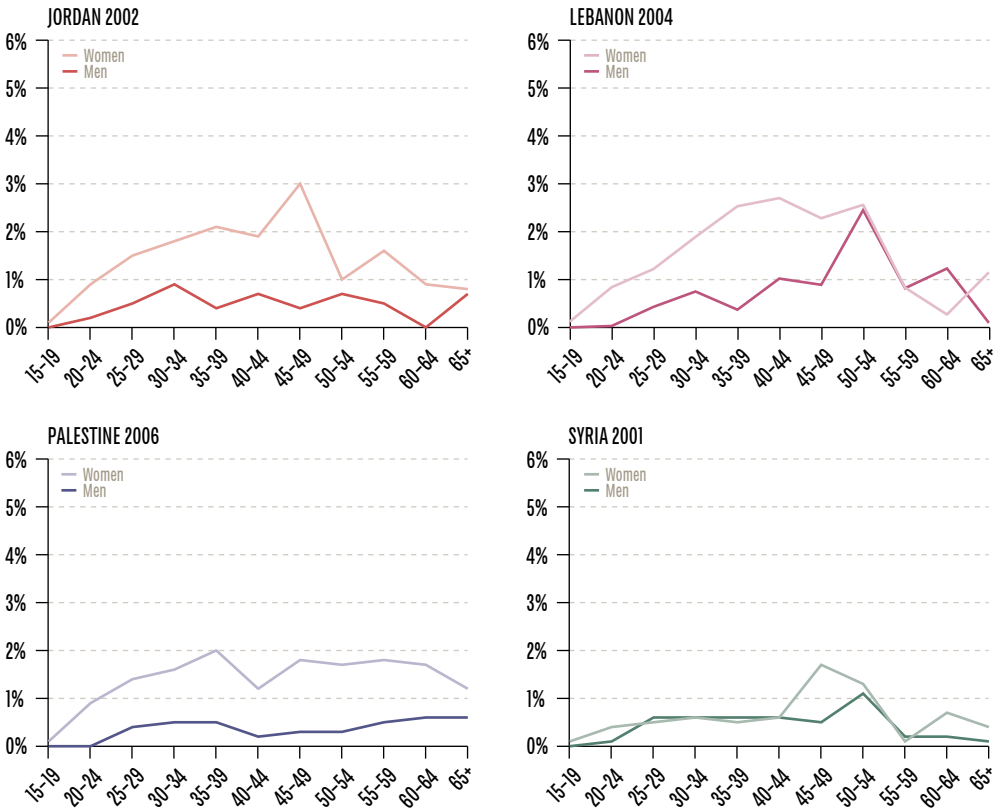
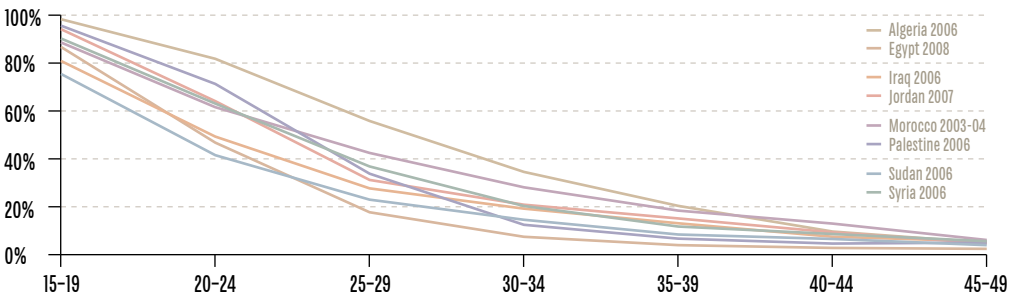
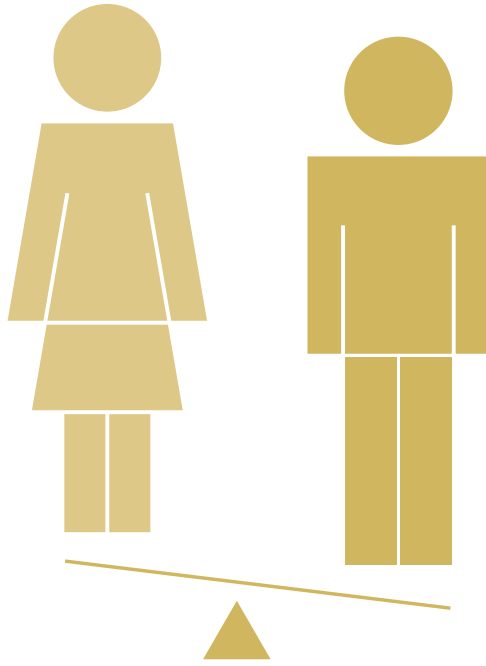


Figure 23. Proportion of never married women in the population aged 15 years and above by age





**GENDER INEQUITY IN SOCIO-
ECONOMIC CONDITIONS**

EDUCATION

11 ESCWA, Gender Statistics Program website available at www.escwa.org.lb/gsp

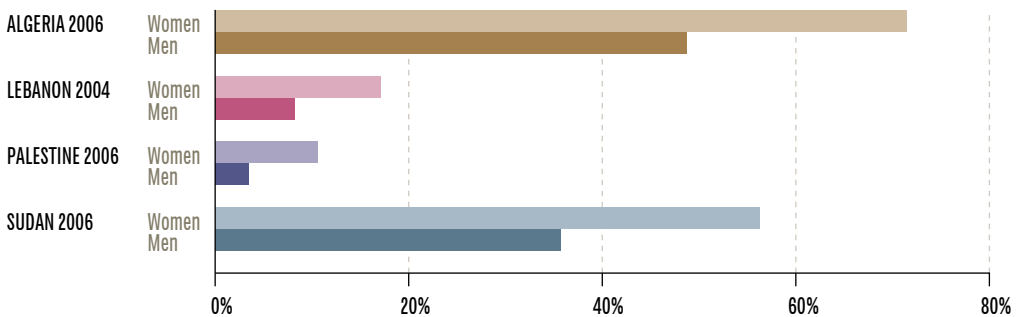
Education is one of the most valuable assets for gender empowerment and is important link for improved health and employment. In spite of widespread girls' education in Arab countries, women, more than men, continue to suffer from a lack of opportunities to acquire knowledge (UNDP, 2006). The adult literacy rate of Arab women equaled 51% compared to 73 % of Arab men in 2003.¹¹ According to the 2005-2009 data from the United Nations Educational, Scientific and Cultural Organization (UNESCO), literacy among adult women in the Arab region is at 63.1 per cent compared to 81.2 per cent of adult Arab men between 2005-2008 (UNESCO, 2010). However, while there has been an increase in the females' access to primary education, gender gaps in educational opportunities still exist (UNDP, 2006b).

This section will present and compare some basic information about the educational status of females and males across all the countries comprised in the analysis.

I. Illiteracy

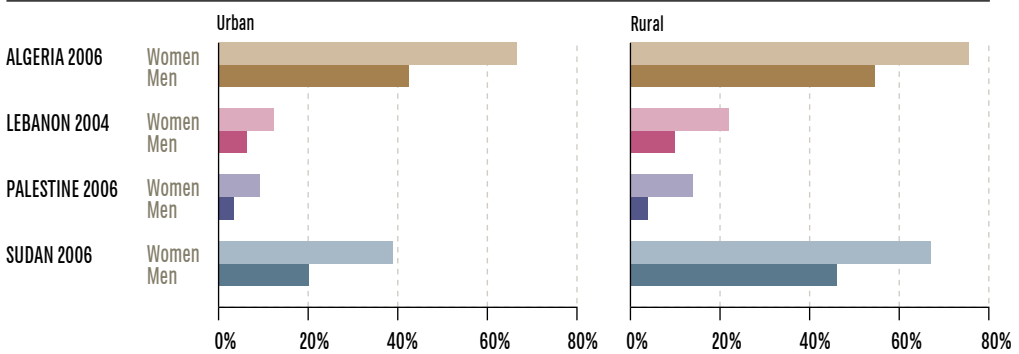
The Arab Region holds one of the highest rates of female illiteracy in the world (1 out of 2 women as compared to 1 out of 3 men are reported to be illiterate) (UNDP, 2006). The present study shows that illiteracy rate – in the four countries where recent data was available – increases with age for both men and women (**Figure 24**).

FIGURE 24. Illiteracy rate for household members aged 15 years and over by sex



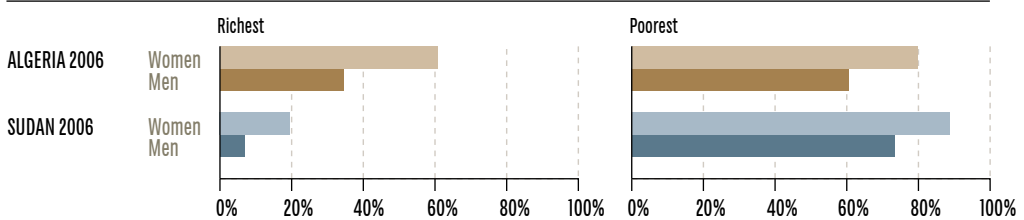
As seen in **Figure 25**, the percentage of illiterate women is greater than that of men across all countries in both urban and rural areas. The largest disparity between male and female rates exists in Algeria, where men lead women by 22.6 percentage points in urban areas and by 20.6 percentage points in rural areas. Illiteracy rates are most similar for men and women in Palestine; 5.8 and 10 percentage point gaps exist between men and women in urban and rural areas, respectively.

FIGURE 25. Illiteracy rate for household members aged 15 years and over by sex and area of residence



Illiteracy is also more pronounced among both women and men in the poorest quintile compared to their counterparts in the richest quintile (**Figure 26**). Recent wealth-disaggregated survey data were only available for two countries: Algeria and Sudan.

FIGURE 26. Illiteracy rate for household members aged 15 years and over by sex and wealth



II. School enrolment

The majority of Arab States have made significant progress in the provision of education over the past ten years (UNESCO, 2011a). However, the quality of education remains poor, many children still leave primary education prematurely and illiteracy rates are relatively high, as observed in the UNESCO Education for All Global Monitoring Report 2011 (UNESCO, 2011b).

The UNESCO regional report for the Arab States finds that the primary school enrolment rate has increased by 17% from 1999-2008 (2011a). Yet six million primary school-aged children, the majority of whom are girls, remain out of school. Palestine, for instance, has witnessed a huge fall in primary school enrollment of 21%. Also, between 1999 and 2005, although Yemen saw a large increase in enrollment in 2008, it still had over one million children out-of-school, the highest number in the region. (UNESCO, 2011a)

School enrolment among girls and boys aged 6 to 14 years is shown in **Figure 27**. The highest proportion of enrolled children is observed in

Palestine (nearly 99% for boys and 98% girls). Tunisia has the least gender disparity (97% for boys and girls) while the greatest gender disparity is seen in Iraq (93% for boys and 85% for girls).

FIGURE 27. Proportion of girls and boys aged 6-14 who are currently enrolled in schools

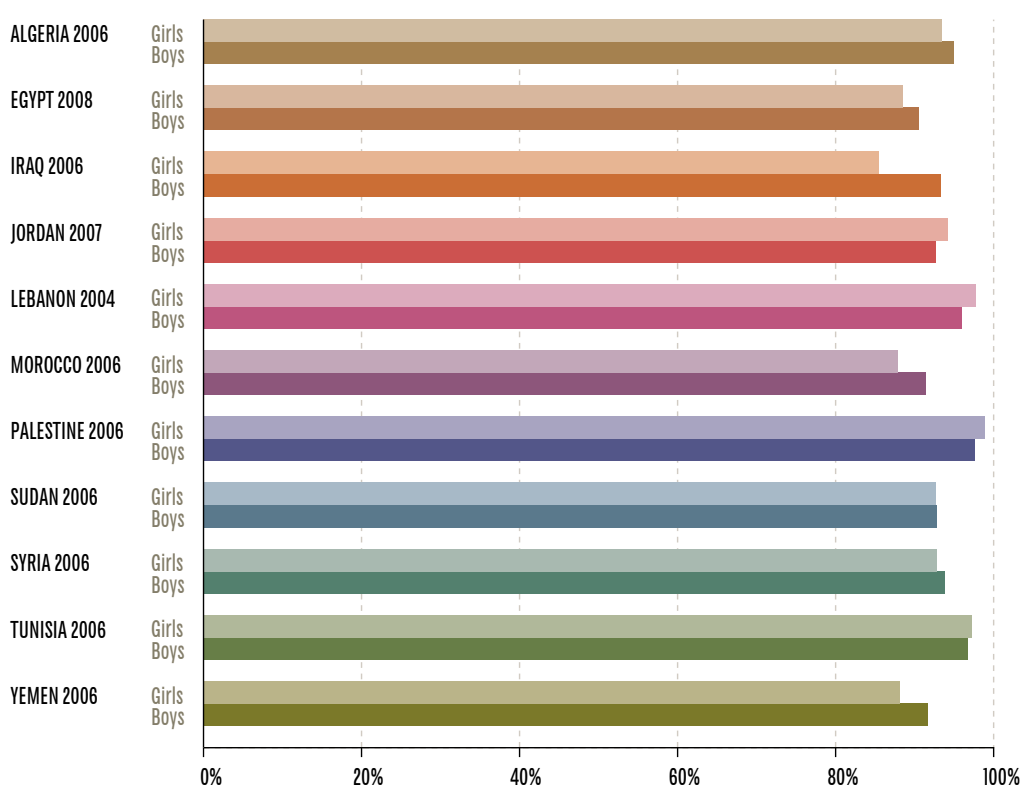
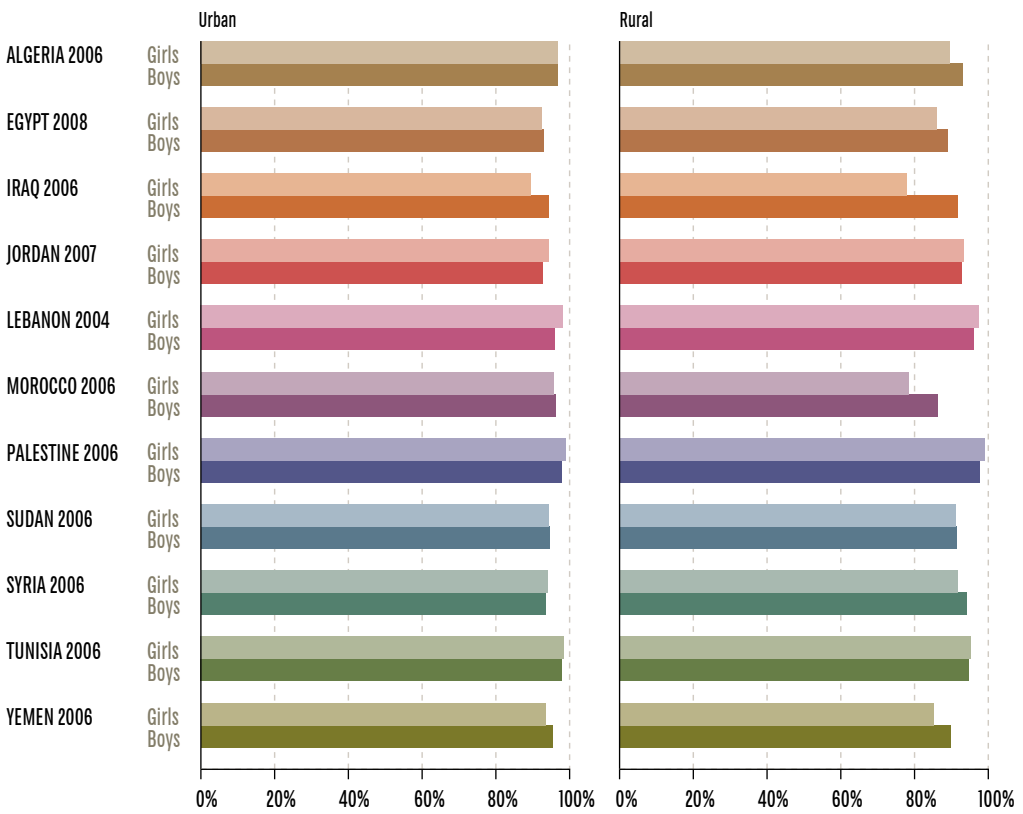


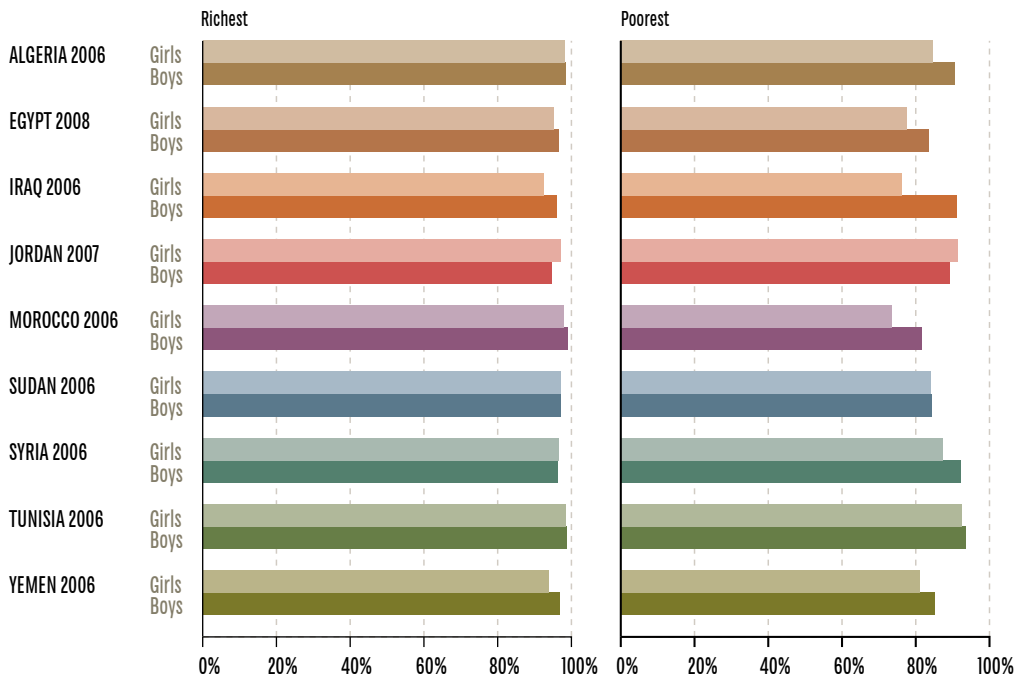
Figure 28 below shows school enrollment among girls and boys aged 6 to 14 years by area of residence. For both boys and girls, school enrollment is greater (if not the same as) for those that live in urban areas compared to those that live in rural areas. In some countries, the gender disparity between boys and girls is greater in rural areas than in urban areas. For example, in Iraq, girls in rural areas have a school enrolment rate of 78% compared to 89% in urban areas. In both areas, however, enrolment of girls is less than boys, who have an enrolment rates of 94% in urban areas and 92% in rural areas. Similarly, in Morocco, girls in rural areas have an enrolment rate of 79%, much lower than that of their urban boys and girls (96%) and even rural boys (86%).

FIGURE 28. School enrollment in the population aged between 6 to 14 years by area of residence



School enrollment of boys and girls by wealth is shown in **Figure 29** below. For both boys and girls, for all countries, enrolment rates are higher among the richest than among the poorest quintiles. Gender disparities are most apparent in the poorest wealth group, where the difference in enrolment rates between girls are much less than that of boys. In Iraq, there is a 16 percentage point difference between enrolment among girls in the poorest quintile (76%) versus their richest counterparts (92%). Gender gaps differences between the two wealth quintiles are seen in other countries as well.

FIGURE 29. School enrollment in the population aged between 6 to 14 years by wealth

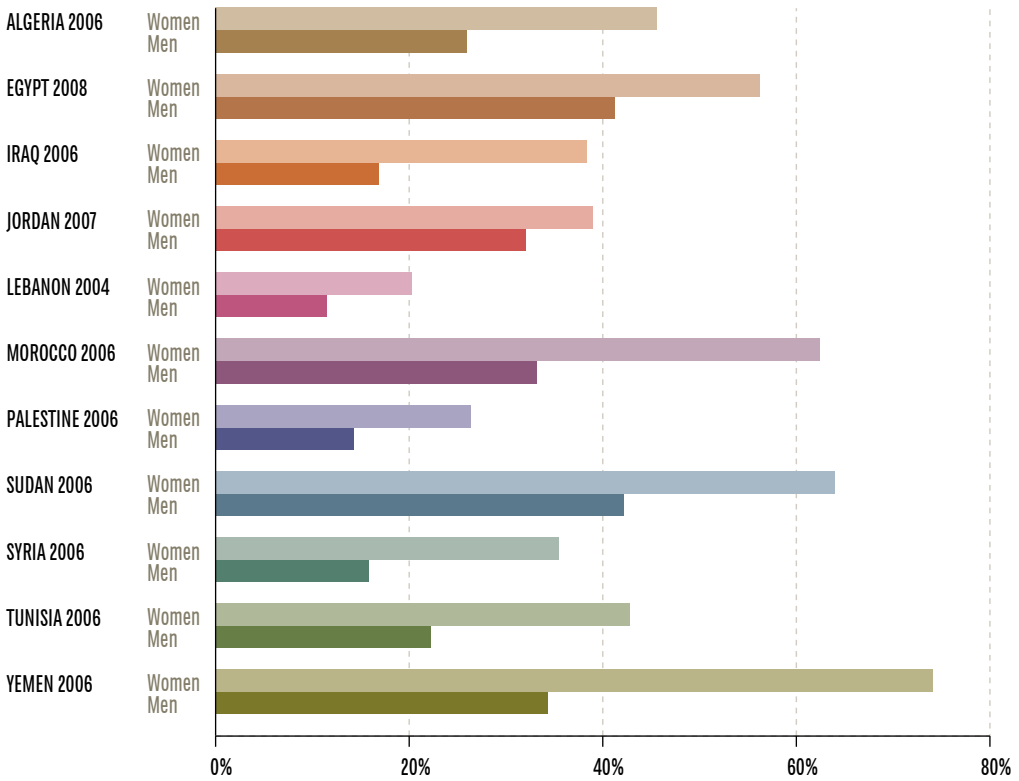


III. Educational attainment¹²

¹² Analysis was restricted to “No Education” (having completed primary education or less) and “Higher Education” categories due to differing definitions of education levels.

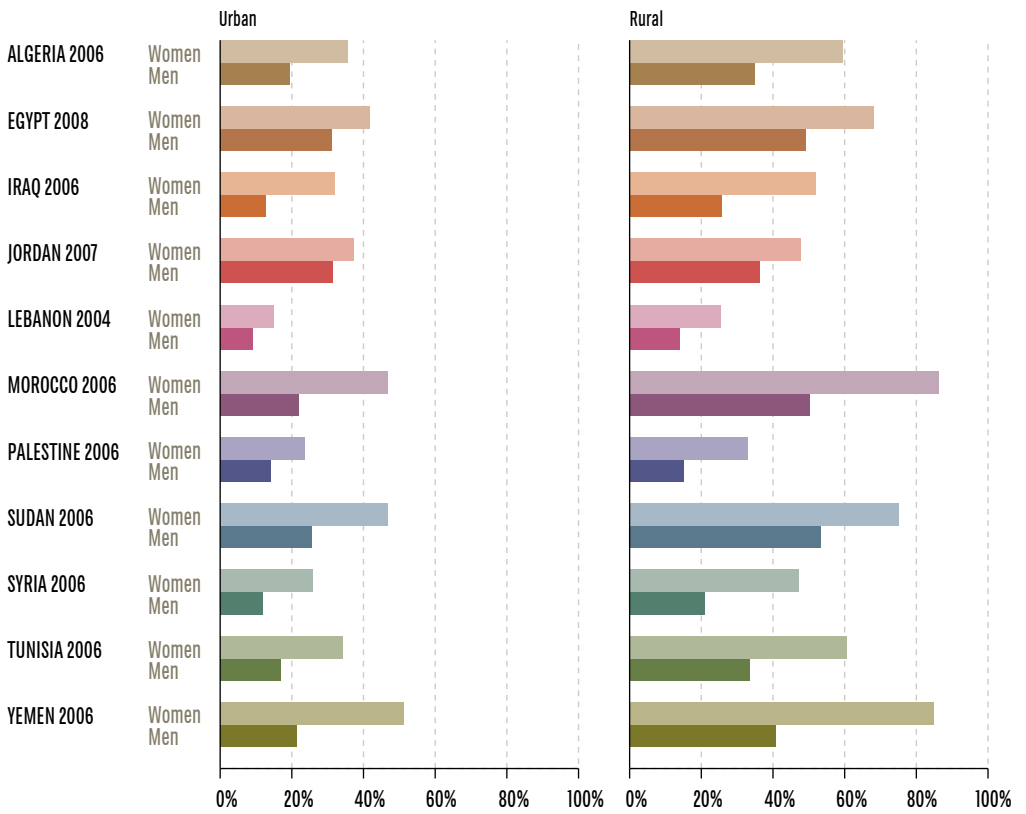
Figure 30 shows the percentage of women and men aged 25 years and more with no education (where no education is defined as having completed primary education or less) for all countries. By and large, a greater percentage of women compared to men have no education. However, the figure highlights clear variation across countries. Among women, the percentage of no education ranged from 20% in Lebanon to 74% in Yemen (almost three fourths the female population). Over half of the female population did not have any education in Egypt (56%), Morocco (62%), and Sudan (64%), and nearly half of women did not have any education in Algeria (46%) and Tunisia (43%). The percentage of men with no education is lowest (11%) in Lebanon and highest (42%) in Sudan. The highest gender gap is seen in Yemen (40 percentage point difference) and the lowest is seen in Jordan (7 percentage point difference).

FIGURE 30. Proportion of men and women aged 25 years and more with no education



Educational attainment, like illiteracy and school enrolment, appears to be highly associated with area of residence. Women and men aged 25 years and above living in cities are more likely to receive at least a basic level of education than their counterparts living in rural areas, as evidenced by smaller percentages of adults who had no education (**Figure 31**). The largest disparity between areas is seen in Morocco (40 percentage point difference for women and 28 percentage point difference for men).

FIGURE 31. Proportion of men and women aged 25 years and more with no education by area of residence



The “no education” status, as shown below in the graph, is far more common among the poorest wealth quintile (**Figure 32**). It is nearly universal (96%) in Yemen among women in the poorest category. The difference in the proportion of the household residents with no education between the poorest and the richest is more prominent among women than among men; gender disparity appears to drop with affluence. For instance, in Egypt, the gender gap in the proportion of the population with no education was 20 percentage points in the poorest quintile but only 5 percentage points in the richest quintile. Gender gap differences between the two wealth quintiles are seen in all other countries as well.

FIGURE 32. Proportion of men and women aged 25 years and more with no education by wealth

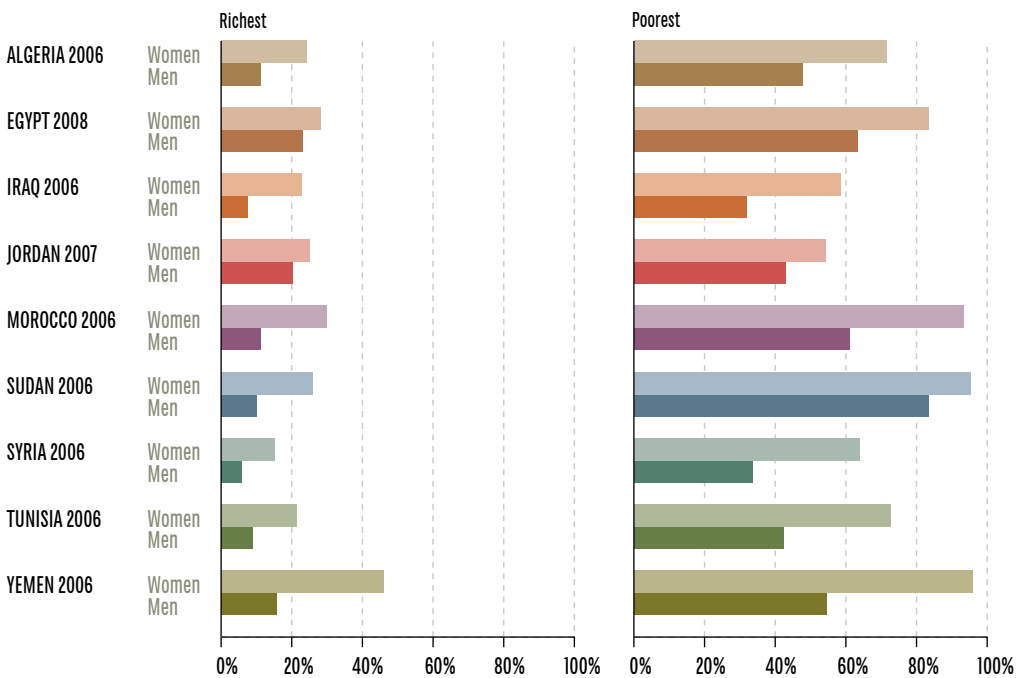
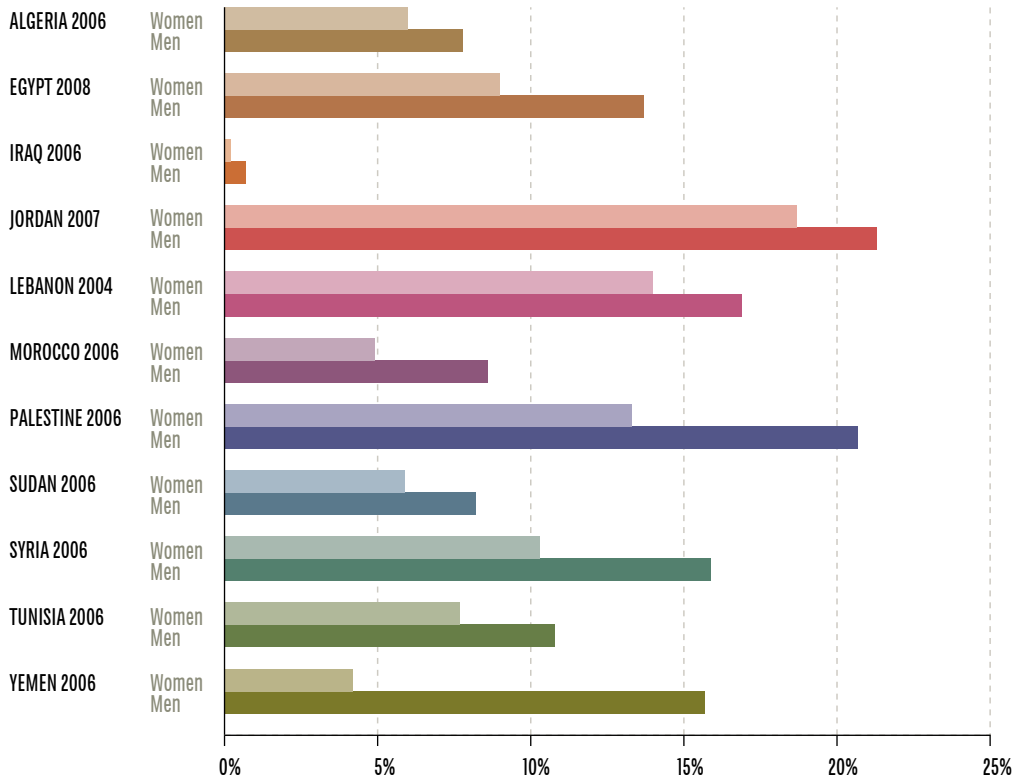


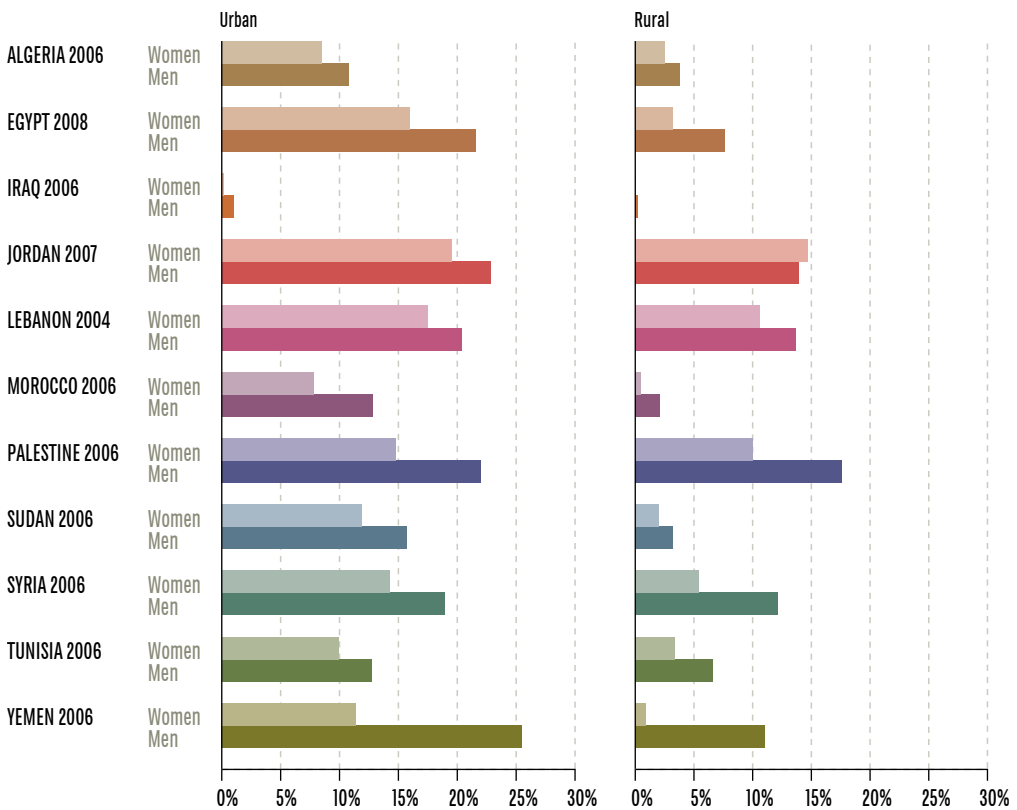
Figure 33 shows the percentage of women and men aged 25 years and more who received higher education. As expected, more men attain higher education than women in all countries. The countries of the Maghreb have lower proportions of household residents holding higher degrees than the countries of the Mashreq. In the latter region, however, Iraq shows strikingly low percentage of higher education for both sexes (0.2% for women and 0.7% for men). On the other hand, the highest percentage of higher education for women and men alike is seen in Jordan (19% and 21% respectively). The gender disparity in higher educational attainment is greatest in Yemen (11.5 percentage points), followed by Palestine (7 percentage points), Syria (6 percentage points) and Egypt (5 percentage points).

FIGURE 33. Proportion of men and women aged 25 years and more with higher education



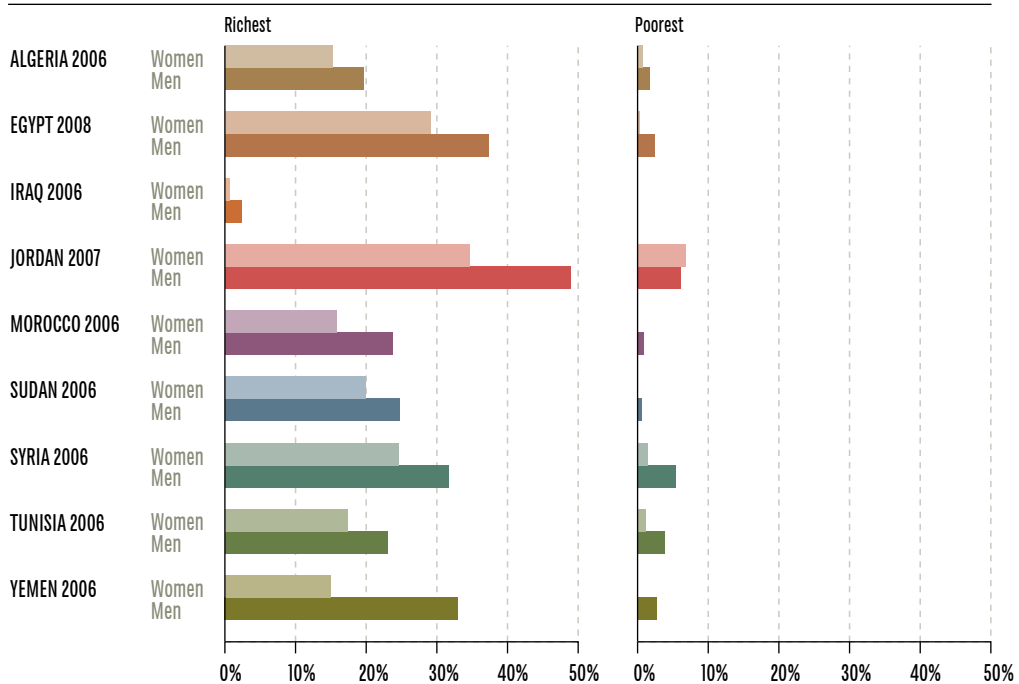
As seen in **Figure 34**, men and women are more likely to receive higher education in urban areas than they are in rural areas. The difference is most prominent in Egypt, Morocco, Sudan and Yemen. Gender gaps persist in both areas and are not considerably greater in one category than they are in the other. In Jordan, however, the gender difference is reversed (more women attain higher education) in rural locales.

FIGURE 34. Proportion of men and women aged 25 years and more with higher education among by area of residence



As apparent in **Figure 35**, for which data on 9 out of 11 countries were available, wealth and higher education are positively associated. As seen earlier, Jordan holds the highest proportion of individuals with higher education for men and for women in both poorest and the richest quintiles. Gender gaps persist in both quintiles, but are wider (in absolute terms) in the richest quintile. The widest are in Yemen (18 percentage point difference) and Jordan (14 percentage point difference).

FIGURE 35. Proportion of men and women aged 25 years and more with higher education by wealth



LABOR FORCE PARTICIPATION

According to the UNDP Arab Human Development Report 2005, the sluggish economic in the region has played a part in the low demand for female labor (UNDP, 2006). In many Arab countries, the majority of educated, employed women were working in the public sector, where they enjoyed better benefits and less discrimination than the private sector (ESCWA, 2012). However, with the down-sizing of the public sector and limited private sector, women have been disproportionately affected. In addition, the traditional view that the man is the sole breadwinner has contributed to a lower rate of labor force participation among women. Another factor is working conditions for women: *“women do not enjoy equality with men in job opportunities, conditions or wages let alone in promotion to decision-making positions.”* (UNDP, 2006) Additional reasons for Arab women’s low labor force participation rate are the laws designed for their “protection.” These laws restrict their freedom by requiring a father’s or husband’s permission to work, travel or borrow from financial institutions (UNDP, 2006).

In addition, starting from a low base, the Arab region made the largest strides in women’s share of economic activity than all other regions of the world: the increase for Arab women was 19 per cent compared to 3 per cent for the world as a whole during the period from 1990-2003 (UNDP, 2006). Nonetheless, Arab women’s economic participation remains the lowest in the world: not more than 33% of women fifteen years and older compared to 56% worldwide. Furthermore, in low-income Arab economies, women are inclined to find jobs in the services sector, which in the Arab world is characterized by low productivity and low remuneration.

I. Economically active population

The purpose of this section is to present and compare basic information on the economic activity of females and males across the seven countries where data were available. It should be noted that measurements of labor force do not strictly follow the ILO conventions in surveys used here.

Figure 36 shows the proportion of women and men participating in the labor market. The percentage of women who are economically active pales in comparison to that of men; men’s participation rate is approximately 4 to 5 times that of women in most countries.

FIGURE 36. Proportion of women and men aged 15 years and more that are economically active

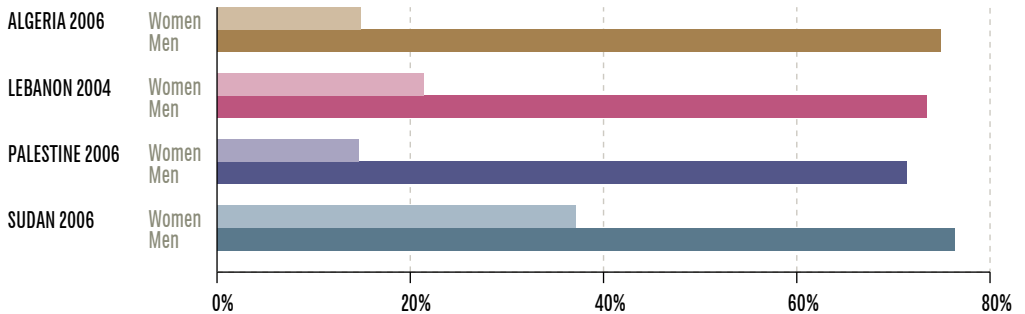


Figure 37 shows that the gender gap in economic activity tends to widen between the ages of 29 to 54. In Syria, the economic participation of women increases with age, peaking in the 35 to 39 age group (24%), but drops again in the older age groups. In Sudan, the economic participation of women peaks in the 25 to 29 age group, to decline in later years and then peak again in the 65+ age group.

Figure 38 shows the proportions of economically active men and women in urban and rural regions. In 2 out of the 4 available countries, women are more active in urban than rural localities: Algeria (19% versus 10%, respectively) and Lebanon (24% versus 19%, respectively). In Palestine and Sudan, however, women in rural regions tend to be more active than those in urban regions.

Figure 39 shows the proportions of economically active men and women in the poorest and richest wealth quintiles. In Algeria, wealth appears to be positively associated with labor force participation among women; the reverse is true among men. In Sudan, both men and women tend to be less active in the richest quintile (67% and 29%, respectively) than in the poorest (86% and 56%, respectively). Economic activity is not significantly affected by wealth in Palestine.

Figure 40 shows the proportions of men and women are economically active by marital status. Men are significantly more likely to be economically active than women across all categories of marital status for all available countries. For example, no more than 20% of married women are economically active compared to roughly 80% of married men (with the exception being Palestine where around 60% of men are economically active). Married and divorced men are much more likely to be economically active than single men for all countries. Married women on the other hand are much less likely to be economically active than their single or divorced counterparts.

FIGURE 37. Proportion of women and men aged 15 years and more that are economically active by age group and by country

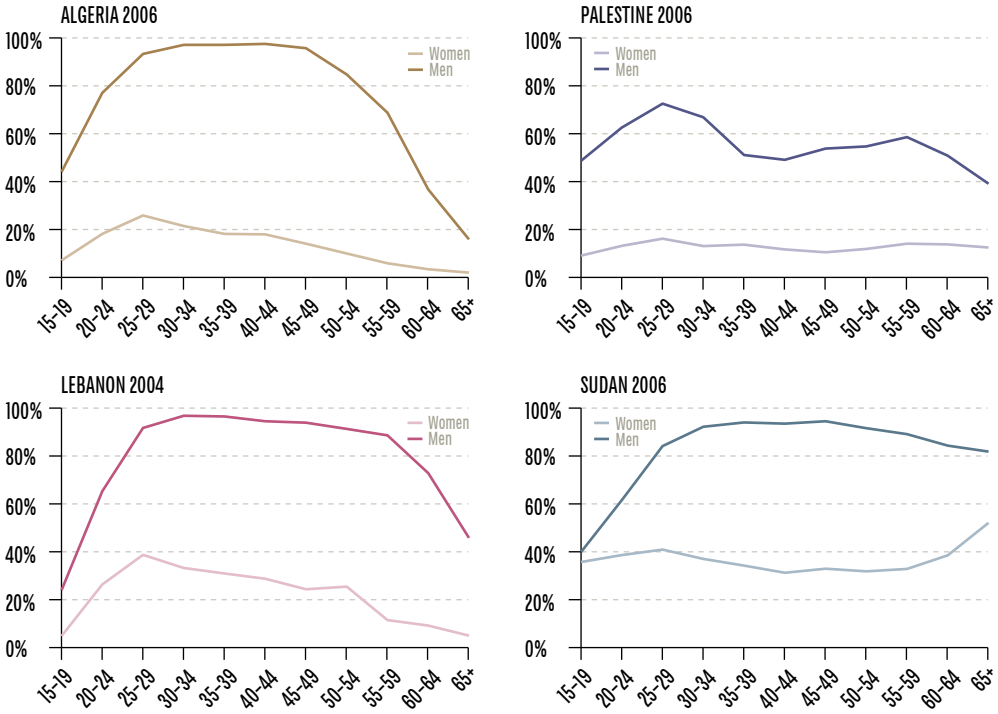


FIGURE 38. Proportion of men and women aged 15 years and more that are economically active by area of residence

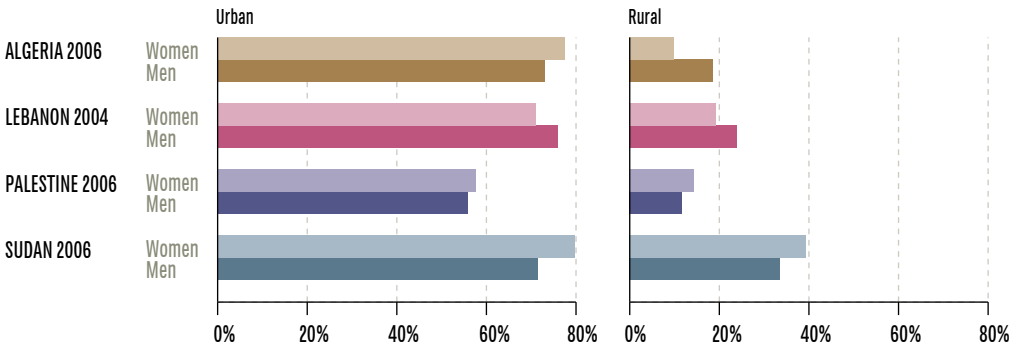


FIGURE 39. Proportion of men and women aged 15 years and more that are economically active by wealth

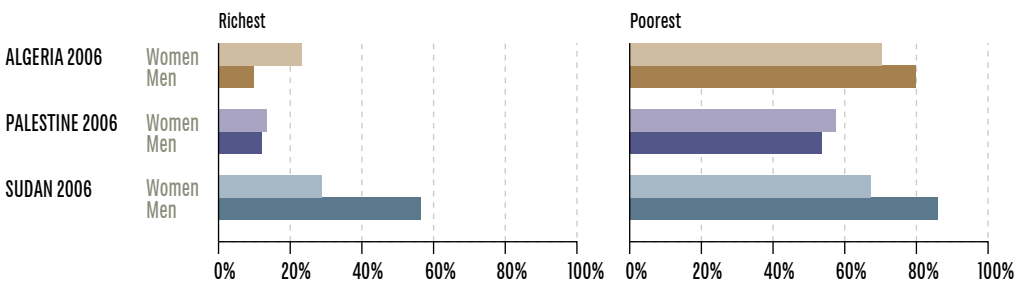
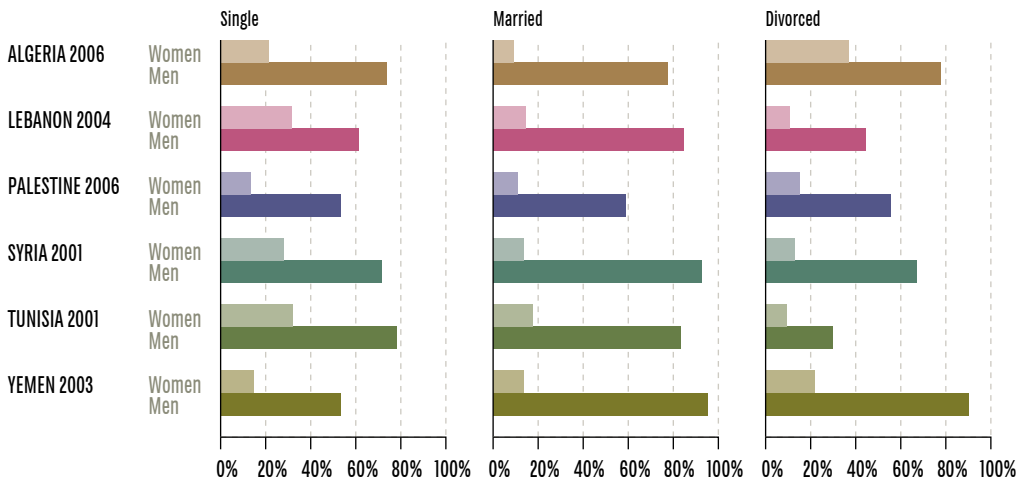


FIGURE 40. Proportion of men and women who are economically active by marital status



II. Employment status

Figure 41 shows the proportions of unemployed women and men in the four countries where recent data were available. A wide gender gap is seen in Sudan (33 percentage point difference) but no considerable gender differences are seen in Lebanon, Algeria or Palestine.

FIGURE 41. Proportion of unemployed men and women aged 15 years and more

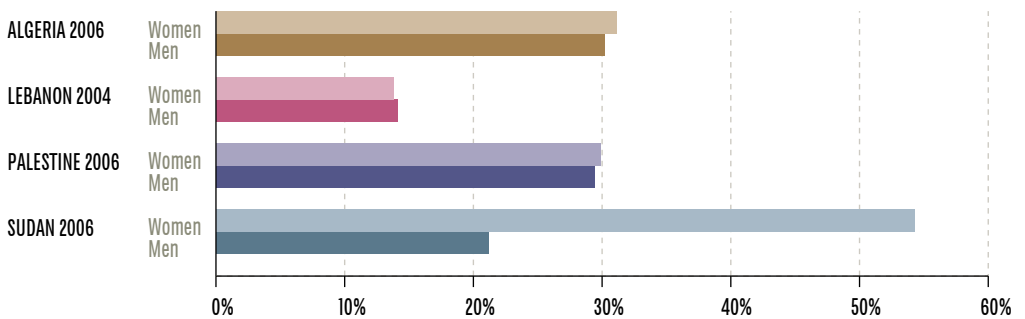


Figure 42 shows the unemployment rate by sex and five-year age group for each country where recent data is available. Unemployment is higher among youth for both men and women than it is in other age groups. For instance, in Algeria, 64% of economically active males and 60% of economically active females in the 15-19 age group are unemployed. The rate remains high, 50% for both males and females, in the 20 to 24 age group.

In general, unemployment also increases in older age groups for both sexes.

Unemployment among women is higher in rural regions than in urban ones, most notably in Sudan (57% versus 49%) (**Figure 43**).

FIGURE 42. Proportion of unemployed men and women aged 15 years and more by age group and by country (%)

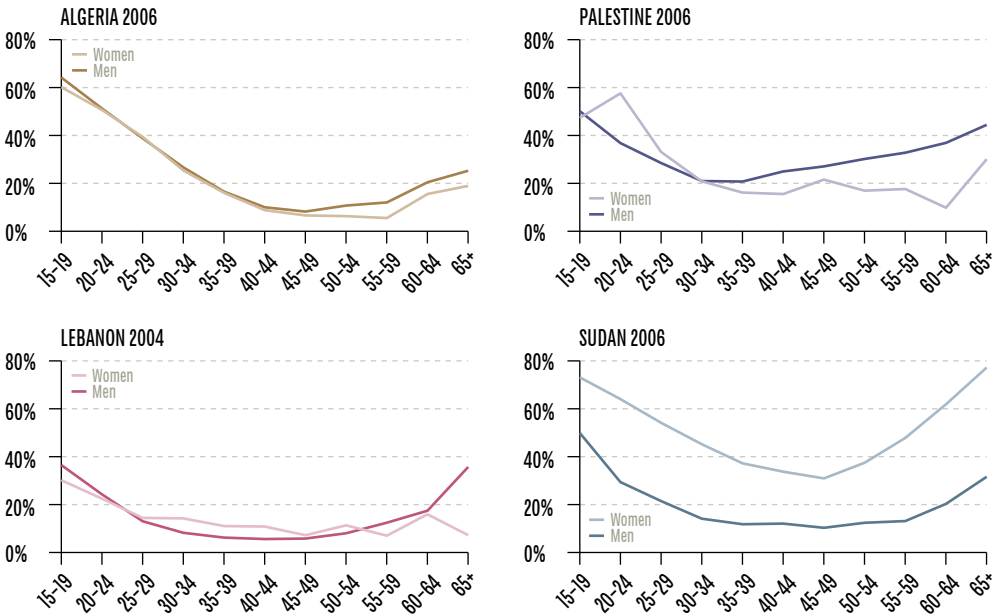
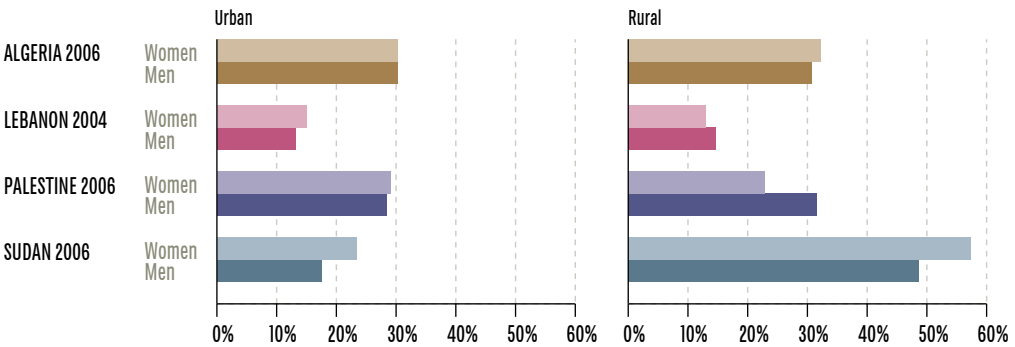


FIGURE 43. Proportion of unemployed men and women aged 15 years and more by area of residence (%)



As seen in **Figure 44**, there tend to be lower unemployment rates in the richest quintile than the poorest for both sexes in the three countries with recent data available. The exception is Palestinian women, whose unemployment rate was higher among the richest quintile.

Figure 45 shows the proportion of unemployed men and women by marital status. In almost all countries, married men and women have the lower unemployment rates compared to their single and divorced counterparts.

FIGURE 44. Proportion of unemployed women and men aged 15 years and more by wealth

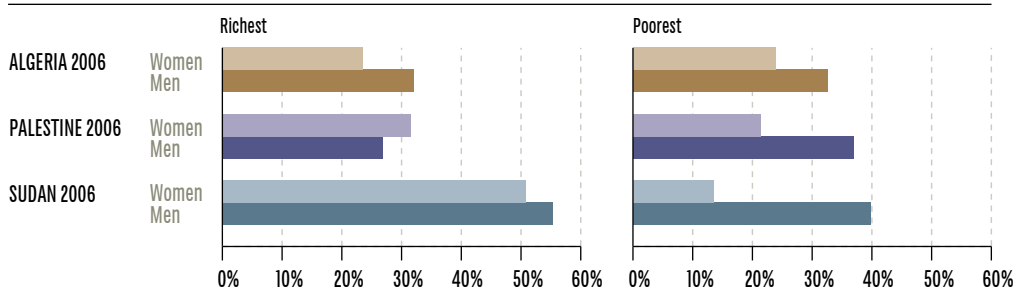
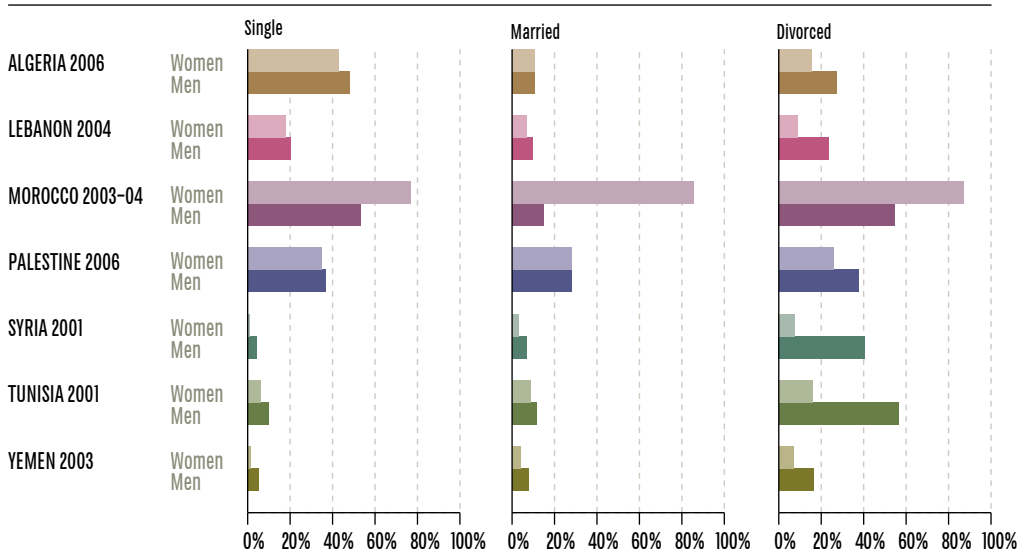


FIGURE 45. Proportion of unemployed women and men by marital status



Among single men and women, men have a slightly higher unemployment rate than women. The exception is Morocco where the reverse is true and there is a over a 20 percentage point difference between men and women.

Married men also have higher unemployment rates than married women in most countries. In Algeria and Palestine, unemployment rates for married men and women are nearly the same. The exception again is in Morocco, married women are significantly more likely than men to be unemployed.

Divorced men have a higher unemployment rate than women in all countries except Morocco. The gender gaps between men and women seems to be the greatest in this marital status category. The greatest disparities are seen in Syria where 7% of divorced women are unemployed compared to 40% unemployment among divorced men. In Morocco, divorced women experience a greater unemployment rate than divorced men.

HEALTH

13 WHO website available at:
<http://www.who.int/hhr/en/>

14 Malaria and Tuberculosis remain highly endemic in the Arab LDCs. Malaria is mainly prevalent in: North Sudan, Comoros and Mauritania. Tuberculosis remains a significant public health problem, and probably the leading cause of communicable disease deaths in adults in the Arab world (UNDP, 2010a).

The World Health Organization (WHO) constitution, it is stated that *“the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.”*¹³ Every country in the world is involved in at least one health-related human rights treaty. The United Nations Millennium Declaration, signed in September 2000 by 189 nations, is one of those treaties. Six out of the eight MDGs are linked to health: MDG 1 (reduce poverty), MDG 4 (reduce child mortality), MDG 5 (improve maternal health) and MDG 6 (combat HIV/AIDS, malaria and other diseases), MDG 7 (access to drinking water and basic sanitation) and MDG 8 (develop a global partnership for basic social services including primary health care).

In the Arab Region, where the monitoring of MDGs has been underway for many years now, the health situation is at best unclear (ESCWA, 2008). Thirteen countries in the Arab region met the ICPD’s goal of reaching a life expectancy at birth longer than 70 years in 2005–2010 (UNDP, 2010). Seven countries, nevertheless, failed to reach the target. Several factors add to these countries’ shorter life expectancy, including armed conflicts, dire economic climates and the resurgence of infectious diseases such as malaria, tuberculosis and cholera.¹⁴

Decreases in infant mortality rates in the Arab region have been the chief contributor to the overall rise of the life expectancy (UNDP, 2010). The infant mortality rate in the Arab world (44 deaths per 1,000 live births in 2005–2010) is considerably lower than that of other developing countries (52 deaths per 1,000 live births). Despite this overall decline, infant mortality rates are still high in some Arab countries, such as Yemen (59 deaths per 1,000 live births) and Sudan (69 deaths per 1,000 live births).

Similar developments have been reported for under-five mortality, brought about by improved access to primary health care, as well as better hygiene and infrastructure (UNDP, 2010). Also, a visible decrease in the maternal mortality ratio (MMR) was noted in the Arab states between 1990 and 2000 (UNDP, 2010).

I. Infant and child mortality

Figure 46 displays the infant mortality rate per thousand live births in eight Arab countries. The indicator ranges from 18 deaths per 1,000 live births in Syria to 81 deaths per 1,000 live births in Sudan. Gender gaps in favor of males are noted in Lebanon (24 male deaths versus 29 female deaths per 1,000 live births) and Sudan (78 male deaths versus 84 female deaths per 1,000 live births).

Child mortality rates are shown in **Figure 47**. Sudan again holds the highest rate of under-five mortality (34 deaths per 1,000 births) with a gender gap of 8 in favor of males. Gender gaps in favor of males are also noted in Jordan, Lebanon and Yemen.

FIGURE 46. Infant mortality rate (per thousand births) by sex

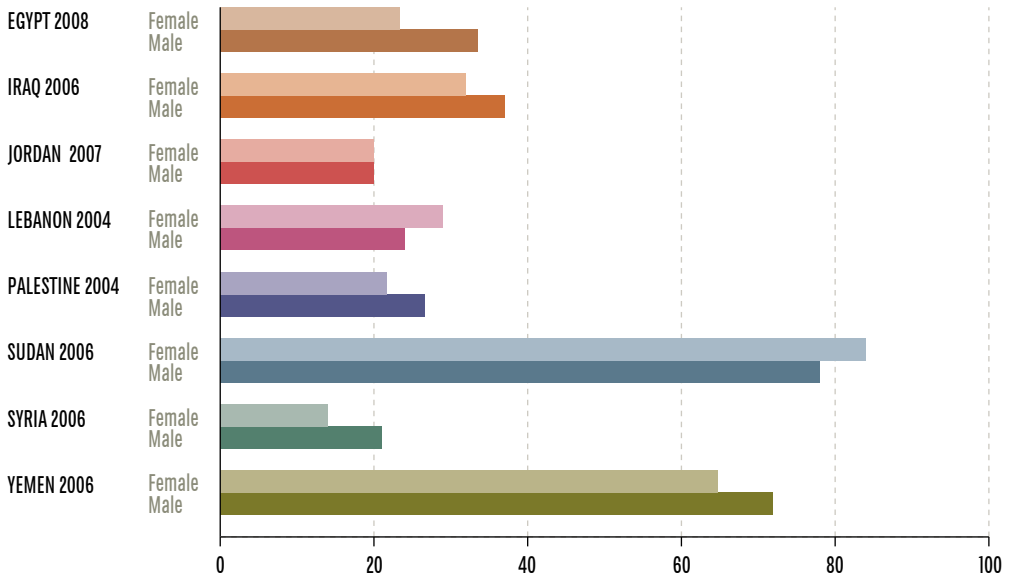
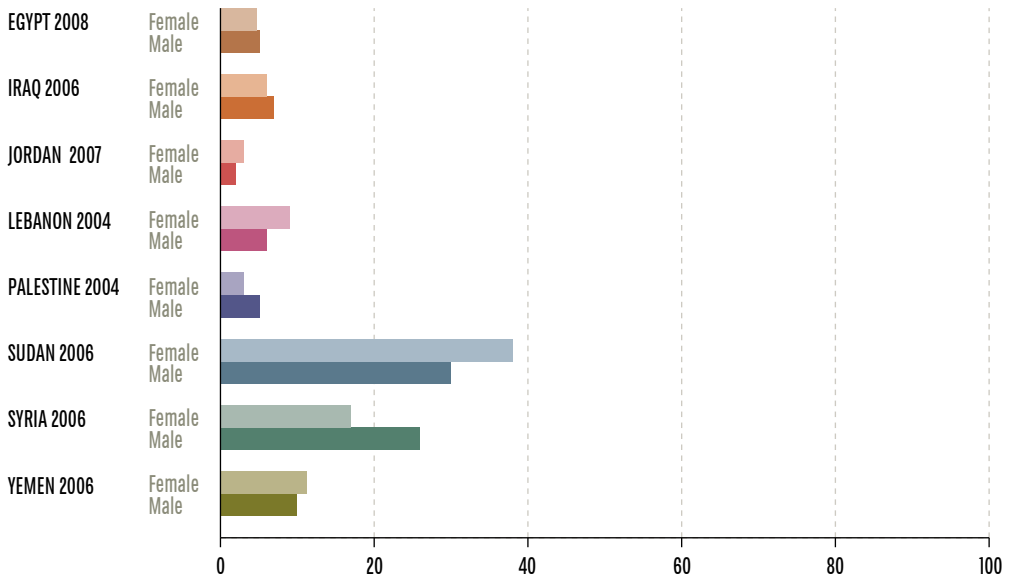


FIGURE 47. Under-5 child mortality rate (per thousand births) by sex

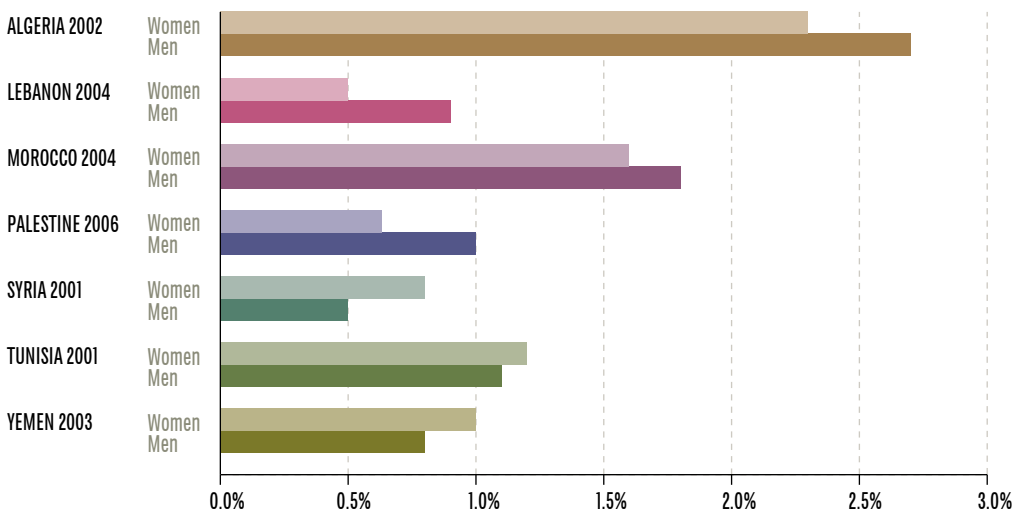


II. Chronic diseases and conditions

This section presents the prevalence of chronic diseases and health conditions, asthma, cardiovascular disease (CVD) and high blood pressure by sex and then further disaggregated by area, wealth and educational level. It is important to note that it is difficult to differentiate between disparities in diseases and conditions influenced by biological differences from those influenced by gender.

The prevalence of asthma by sex is shown in **Figure 48** below. Algeria has the highest rates of asthma with men having higher rates than women (2.7% vs. 2.3%, respectively). In addition to Algeria, in Lebanon, Morocco and Palestine there is a higher prevalence of asthma among men than women. In Syria, Tunisia and Yemen, the reverse is true. The gender disparities are quite minimal.

FIGURE 48. Prevalence of asthma by sex aged 45 and above



The prevalence of asthma disaggregated by sex and area of residence is shown in **Figure 49**. Asthma is only very slightly more prevalent in rural areas than urban areas in most countries. Between men and women in both urban areas and rural areas, any differences are minimal.

FIGURE 49. Prevalence of asthma by sex and area aged 45 and above

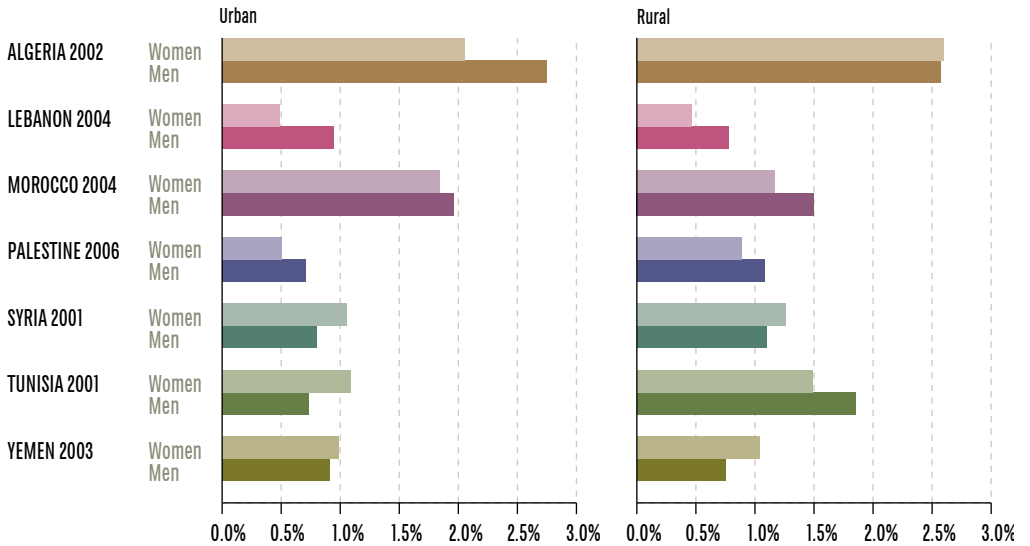


Figure 50 below shows the prevalence of asthma disaggregated by sex and wealth. The prevalence of asthma is slightly greater among women than men in the richest quintile for all countries except Algeria and Tunisia. Among the poorest quintiles, there is a higher prevalence rate among men than women in all countries, except Algeria, Syria and Yemen. The greatest disparity by gender and wealth is seen in Tunisia, where there is over a 2 percentage point difference between rich men and poor men and a nearly 2 percentage point difference between rich women and poorest women.

FIGURE 50. Prevalence of asthma by sex and wealth aged 45 and above

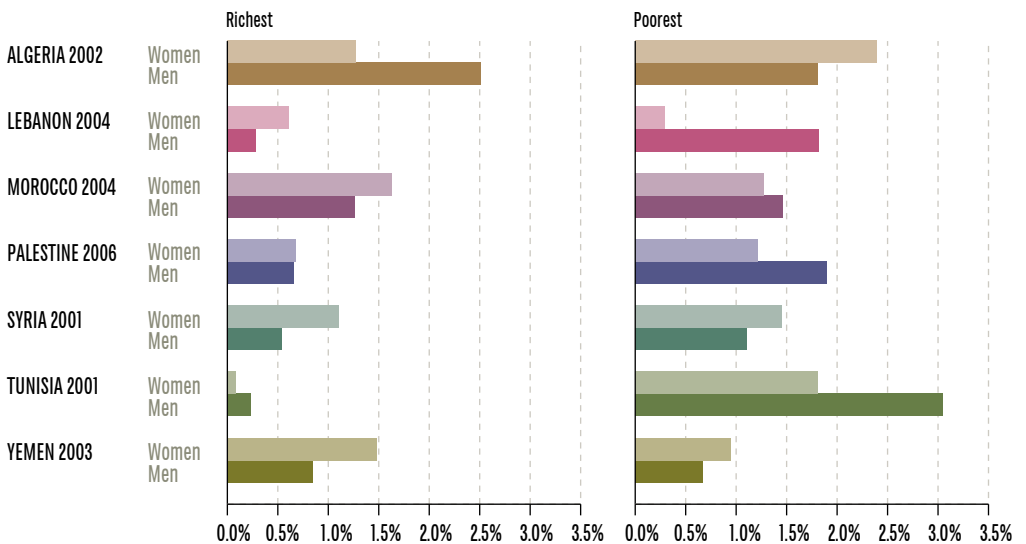


Figure 51 shows the prevalence of CVD by sex for respondents age 45 and over. The greatest gender disparity is seen in Lebanon with a CVD prevalence among men of 7.6% versus 4.7% among women. In all other countries, there is very little difference between men and women.

FIGURE 51. Prevalence of CVD by sex aged 45 and above

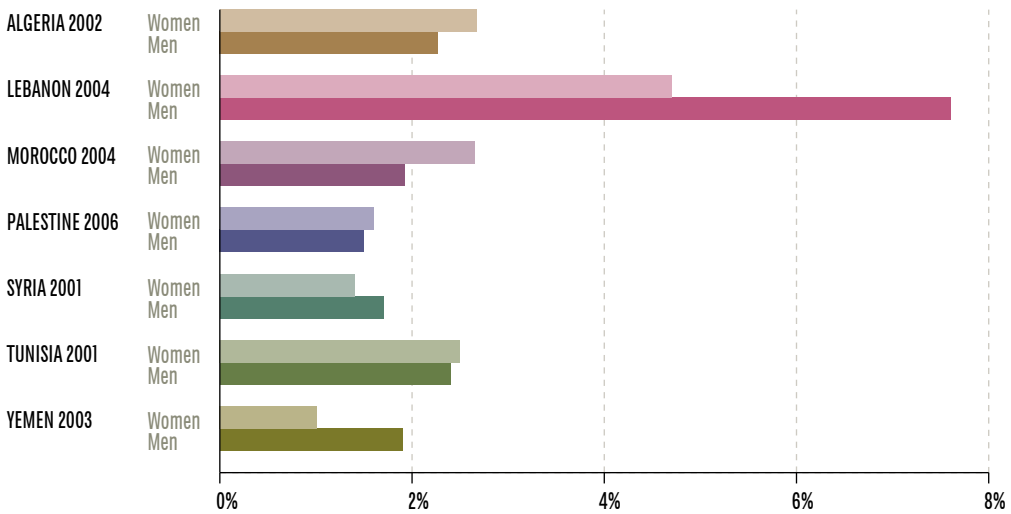
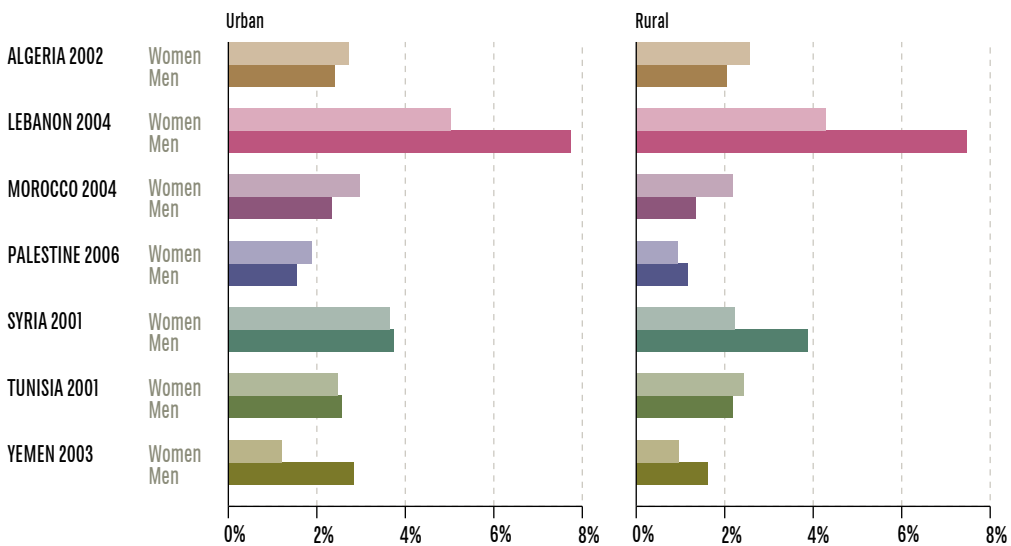


Figure 52 shows prevalence of CVD by sex and area. For most countries, for both men and women, there is not much difference in the prevalence rate between urban residents and rural residents. In Syria, however, there appears to be a gender disparity in rural areas but not in urban areas. The slight disparity in rural areas shows a higher prevalence of CVD among men.

FIGURE 52. Prevalence of CVD by sex and area aged 45 and above



The prevalence of CVD by sex and wealth is seen in **Figure 53** below. There is a higher prevalence of CVD among the richest men in most countries. Lebanon has the greatest disparity between men and women and this is seen among the richest quintile; men in the richest quintile have a prevalence rate of over 5% while women's prevalence rate is 2% in this wealth category.

FIGURE 53. Prevalence of CVD by sex and wealth aged 45 and above

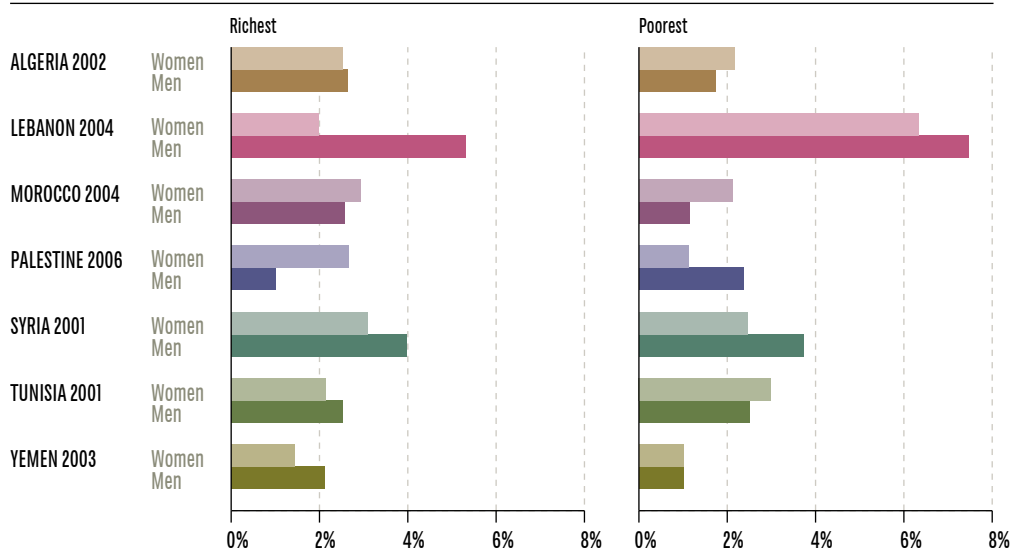


Figure 54 below shows the prevalence of CVD by sex and education attainment. For most countries, those with no education, regardless of sex have higher rates of CVD than their counterparts which have higher education. The greatest gender disparity is seen in Palestine among those with no education (with women having higher rates of CVD than men) and among those with higher education in Lebanon (with men having higher rates of CVD than men).

Prevalence of high blood pressure (HBP) among respondents aged 45 and over is presented in **Figure 55** and shows a clear gender disparity with women having higher rates of HBP than men in all countries. The greatest gender disparity is in Algeria where women have a HBP prevalence rate of 19% versus 7.6% for men. The least disparity is seen in Yemen where women have a HBP prevalence rate of 5.6% versus 3.7% for men.

FIGURE 54. Prevalence of CVD by sex and education attainment aged 45 and above

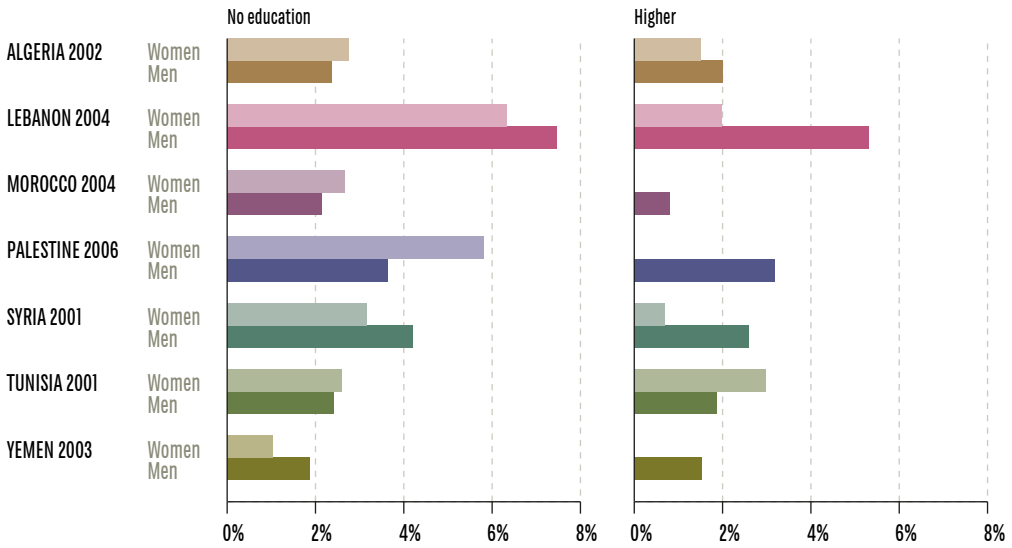
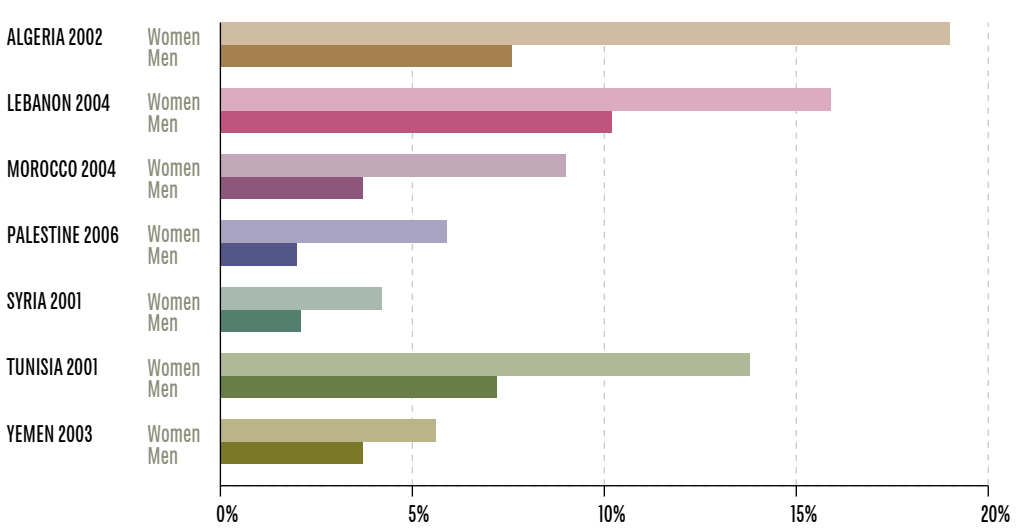


FIGURE 55. Prevalence of HBP by sex aged 45 and above



HBP is more prevalent among women than men in both urban and rural areas in all countries as seen in **Figure 56** below. The most significant gender disparity is seen in Syria where the disparity between men and women in urban areas with nearly a 6 percentage point difference versus a 3 percentage point difference in rural areas.

FIGURE 56. Prevalence of HBP by sex and area aged 45 and above

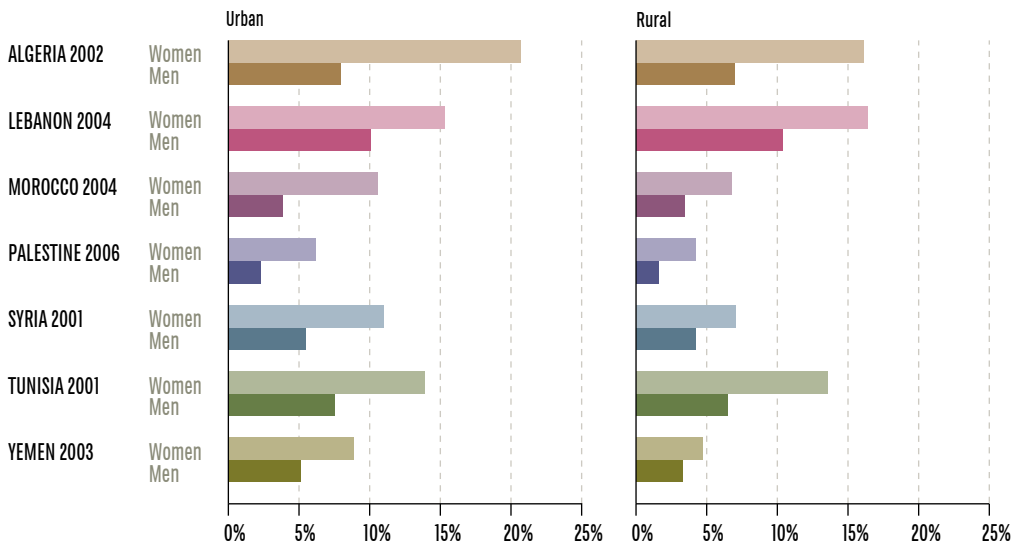
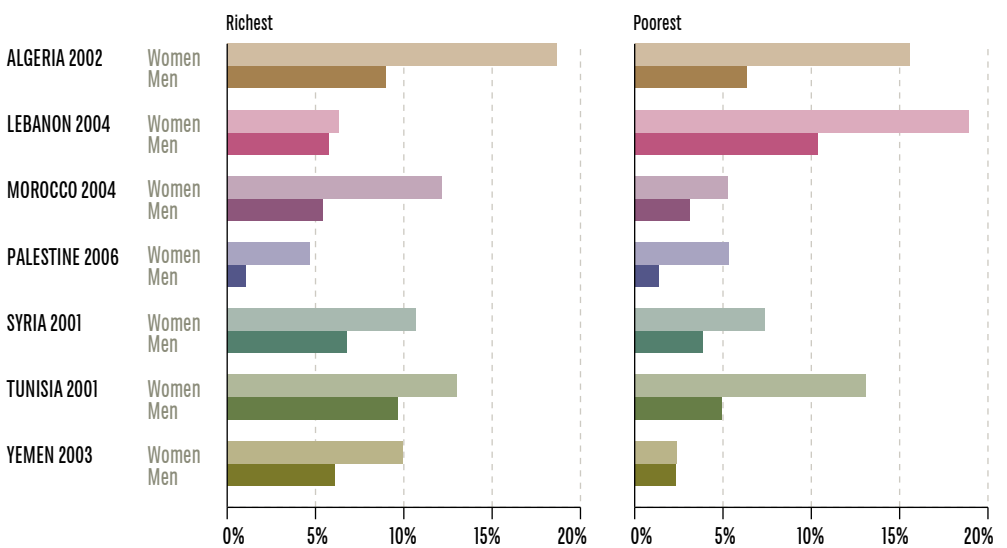


Figure 57 shows prevalence of HBP by sex and wealth. In almost all countries, among both richest and poorest quintiles, women have higher prevalence rates of HBP than men. The most significant gender disparities are seen among the richest quintiles in Morocco and the poorest quintiles in Lebanon and Tunisia.

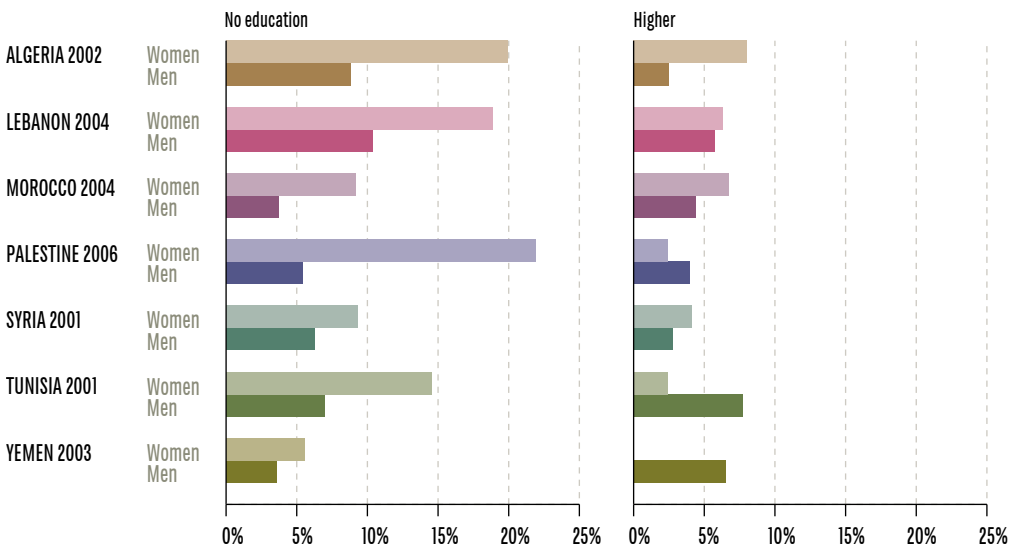
FIGURE 57. Prevalence of HBP by sex and wealth aged 45 and above



The prevalence of HBP by sex and education attainment shown in Figure 58 demonstrates that rates of HBP are not only higher among those with no education but there is a greater gender disparity in this education attain-

ment category. The most significant gender disparities are seen in Algeria, Lebanon, Palestine and Tunisia in the no education category. In Palestine for example, women with no education have a HBP prevalence rate of 22% while their male counterparts have a prevalence rate of 5%. More educated women in Palestine have an already low HPB prevalence rate of 2% which is slightly lower than that of their male counterparts (4%).

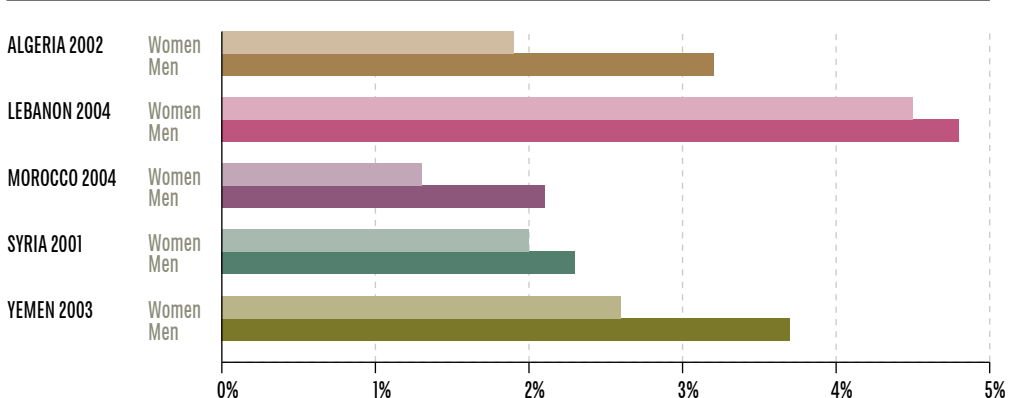
FIGURE 58. Prevalence of HBP by sex and education attainment aged 45 and above



III. Physical and mental disabilities

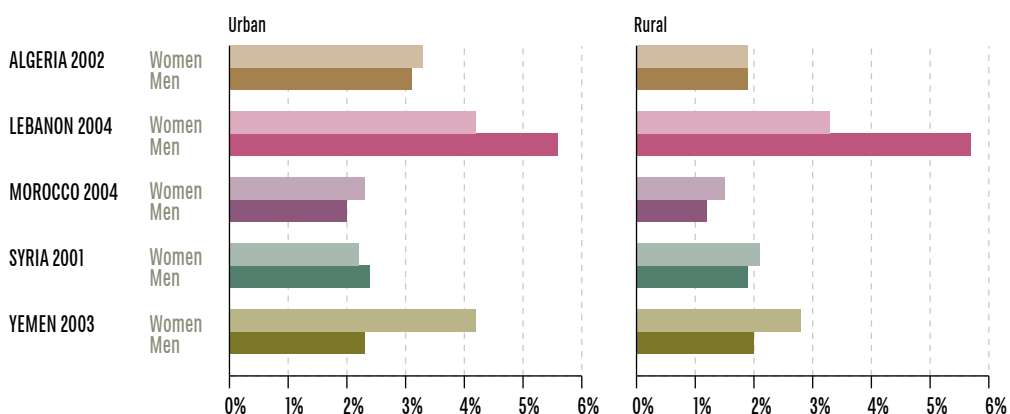
Prevalence of physical or mental disability in men and women 5 years and above is shown in **Figure 59**. Physical and mental disabilities appear to be more common among men than among women. The greatest disparities between men and women are seen in Algeria and Yemen. Disability is most prevalent in Lebanon, among both males and females.

FIGURE 59. Prevalence of physical and/or mental disability in the household population aged more than 5 years by sex



Prevalence of disability is shown in **Figure 60** below. In Algeria, Morocco and Syria, the prevalence of disability is approximately the same in the male and female population in both urban and rural regions. In Lebanon and Yemen, differences between areas are more apparent. In Lebanon, prevalence of disability appears higher in urban areas than in rural areas for both women and men. In Yemen, the opposite is true.

FIGURE 60. Prevalence of physical and/or mental disability in the household population aged 5 years and above by sex and by area of residence



The prevalence of disability is higher in the poorest quintile than it is in the richest quintile for both males and females as seen in **Figure 61**.

FIGURE 61. Prevalence of physical and/or mental disability in the household population aged more than 5 years by sex and wealth

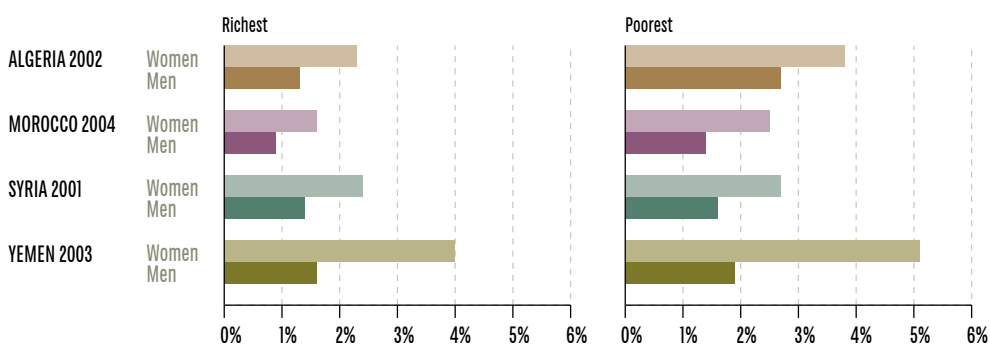
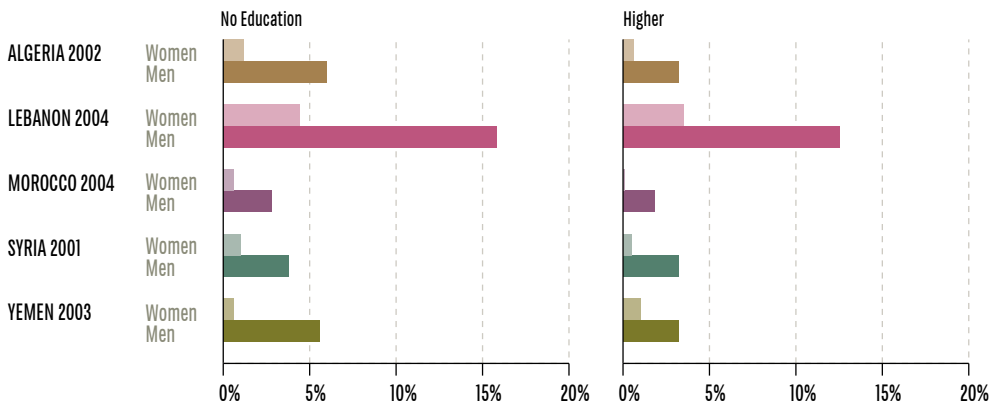


Figure 62 shows prevalence of physical and/or mental disability by educational attainment. Larger proportions of residents with physical and/or mental disability are found in the 'no education' category, most notably in Lebanon.

Figure 62. Prevalence of physical or mental disability in the household population aged more than 5 years by sex and by educational attainment

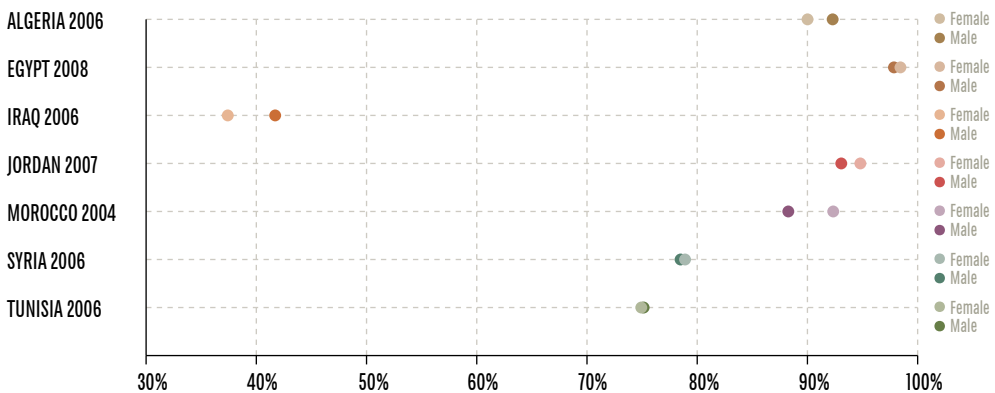


IV. Immunization

In this section, immunizations rates for key childhood immunizations, measles and DPT, are presented.

Measles immunization rates by sex are shown in **Figure 63**. Not surprisingly, the lowest rates are found in Iraq (42% among males and 33% among females). Iraq also presents the widest gender disparity. In all other countries, the immunization rate difference between males and females is not greater than 2 percentage points. The highest rates are seen in Egypt with 98% immunization rates for both sexes.

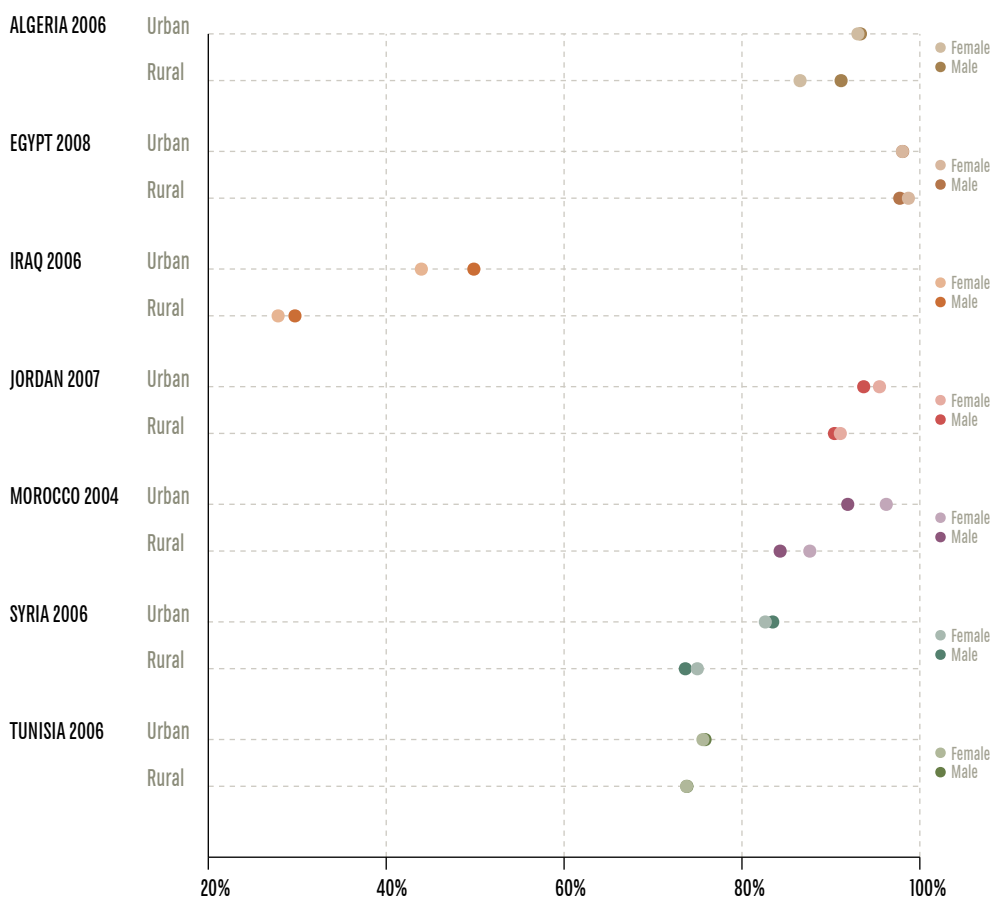
FIGURE 63. Measles immunization by sex



Measles immunization by gender and place of residence are shown in **Figure 64**. In Egypt and Tunisia, immunization rates are nearly identical for boys and girls and area of residence does not affect immunization rates. In Iraq and Syria, and to a lesser extent in Jordan and

Morocco, both boys and girls residing in rural areas are less likely to be immunized against measles compared to their urban counterparts. In Algeria, however, rural females in particular are at a greater disadvantage. Measles immunization rates among rural females are less likely to be immunized (87%) compared to rural males (91%) and both urban males and females (93%).

FIGURE 64. Measles immunization by area



In most countries, there appears to be a disparity by wealth with the poorest quintile being at a disadvantage as shown in **Figure 65**. In most countries, the disparity is greater by wealth than it is by gender. The greatest disparities by wealth appear to be in Iraq and Syria. There does not appear to be a clear trend of gender disparities, however. In Syria and Morocco, males in the poorest quintile are less likely to be immunized their female counterparts by about 5 percentage points in both countries. In Tunisia, poor females are less likely than poor males by about 4 percentage points. In all countries, except Iraq, the immunizations rates between richest males and richest females is nearly the same.

FIGURE 65. Measles immunization by wealth

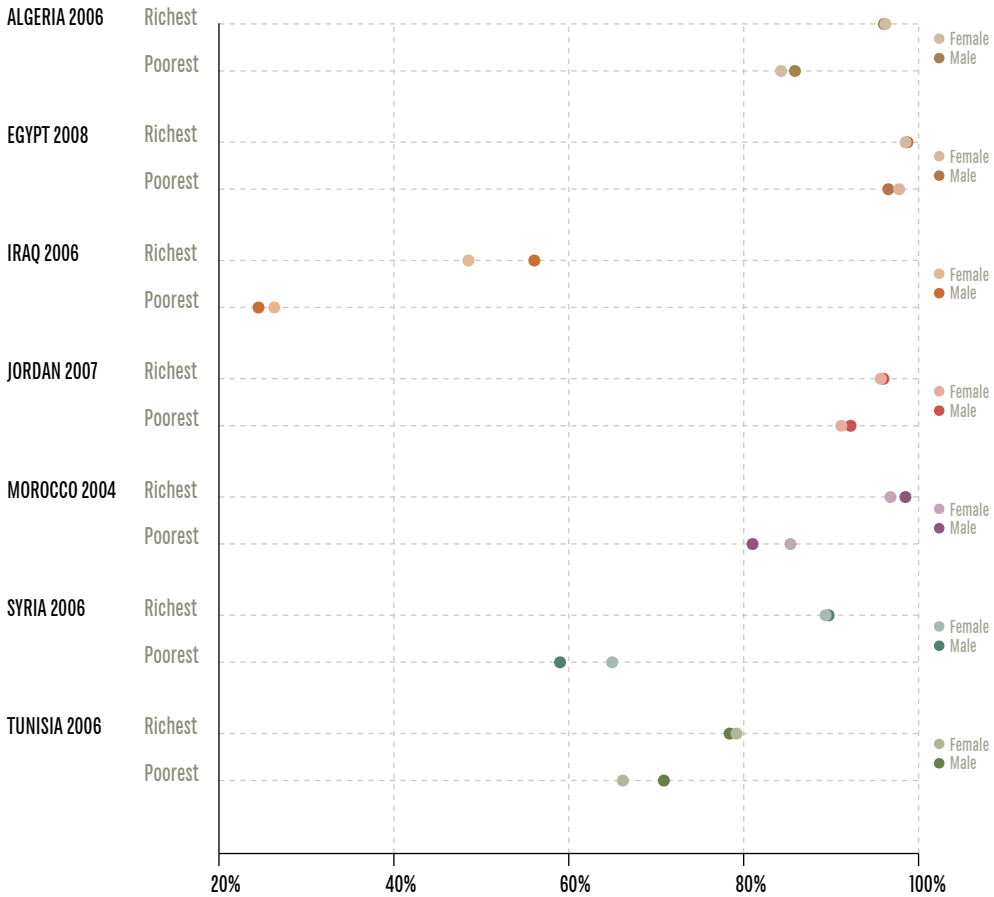
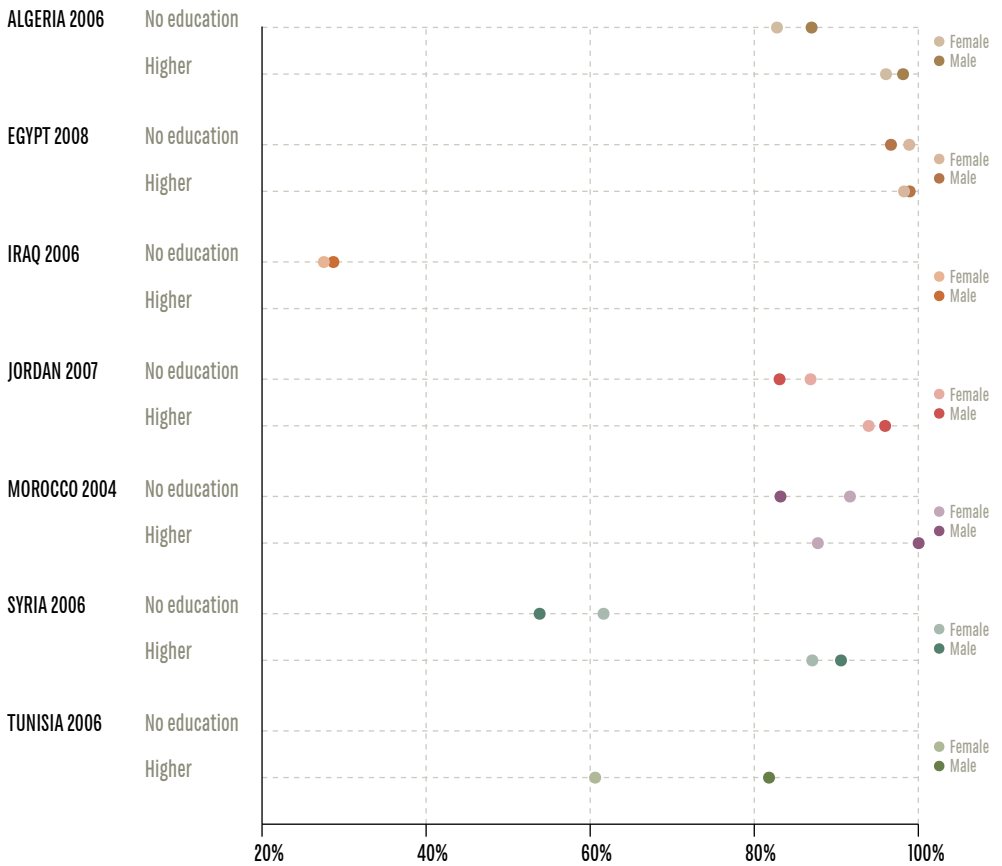


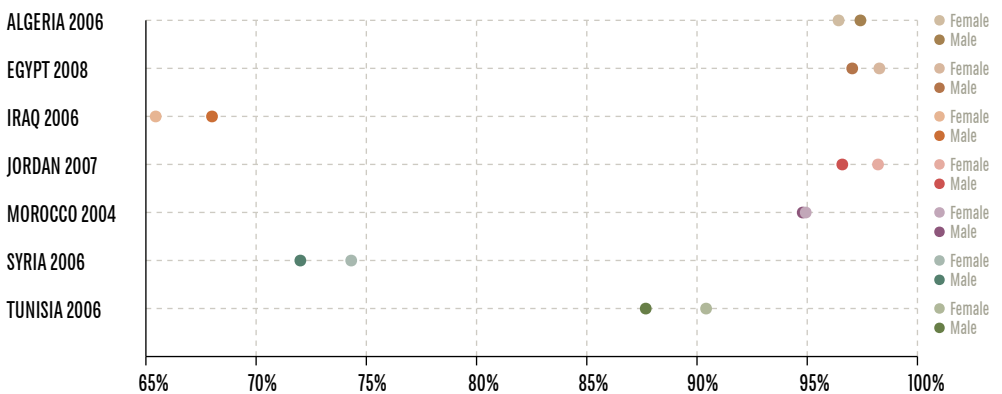
Figure 66 shows measles immunization rates by mother's educational level. In most countries, both boys and girls with mothers with no education have lower immunization rates than children with mother's with higher education. The exception is Morocco where females with mothers with higher education have immunization rates less than those of males with mothers with no education. Egypt, which boasts the highest immunization rates among all groups also demonstrates the least disparities by mother's education and sex. Data points for mothers with higher education for Iraq and data points for mothers with no education for Tunisia were not available.

FIGURE 66. Measles immunization by mother's education



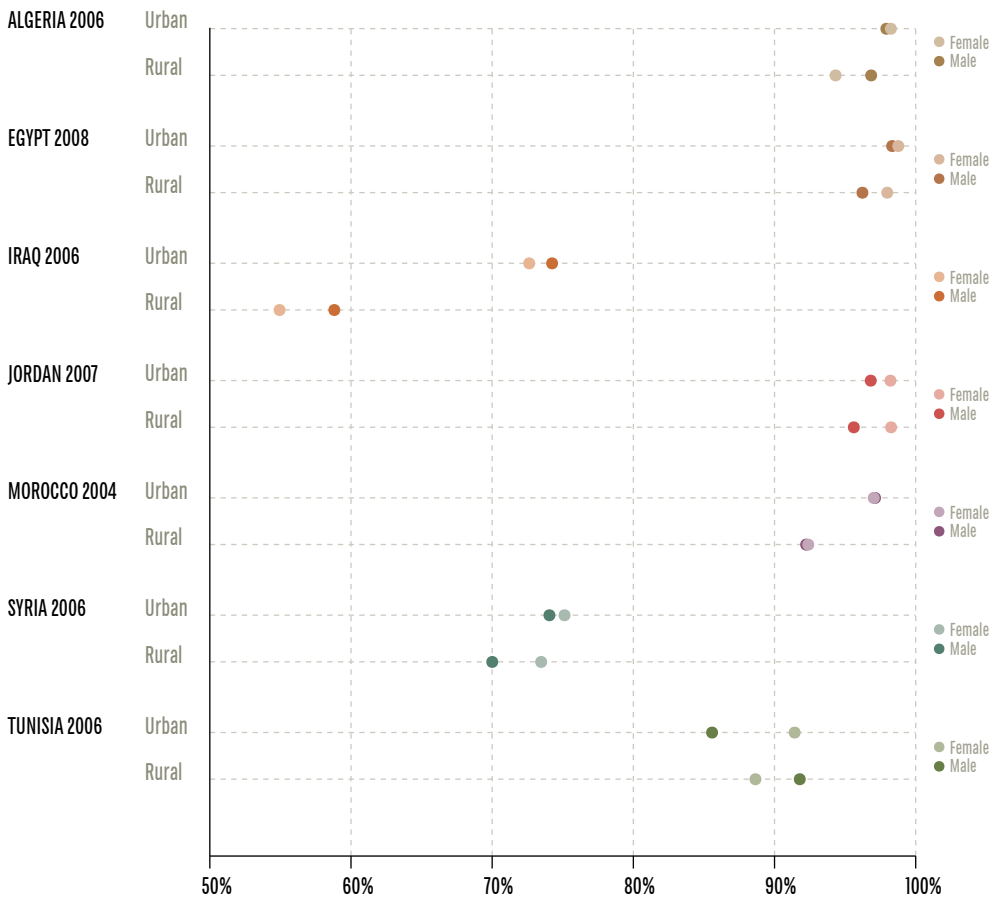
As shown in **Figure 67**, there does not appear to be a clear trend of gender disparities for DPT immunization rates. Males have lower immunization rates in Syria and Tunisia and to lesser extent in Egypt and Jordan. The contrary is true in Iraq and Algeria.

FIGURE 67. DPT immunization by sex



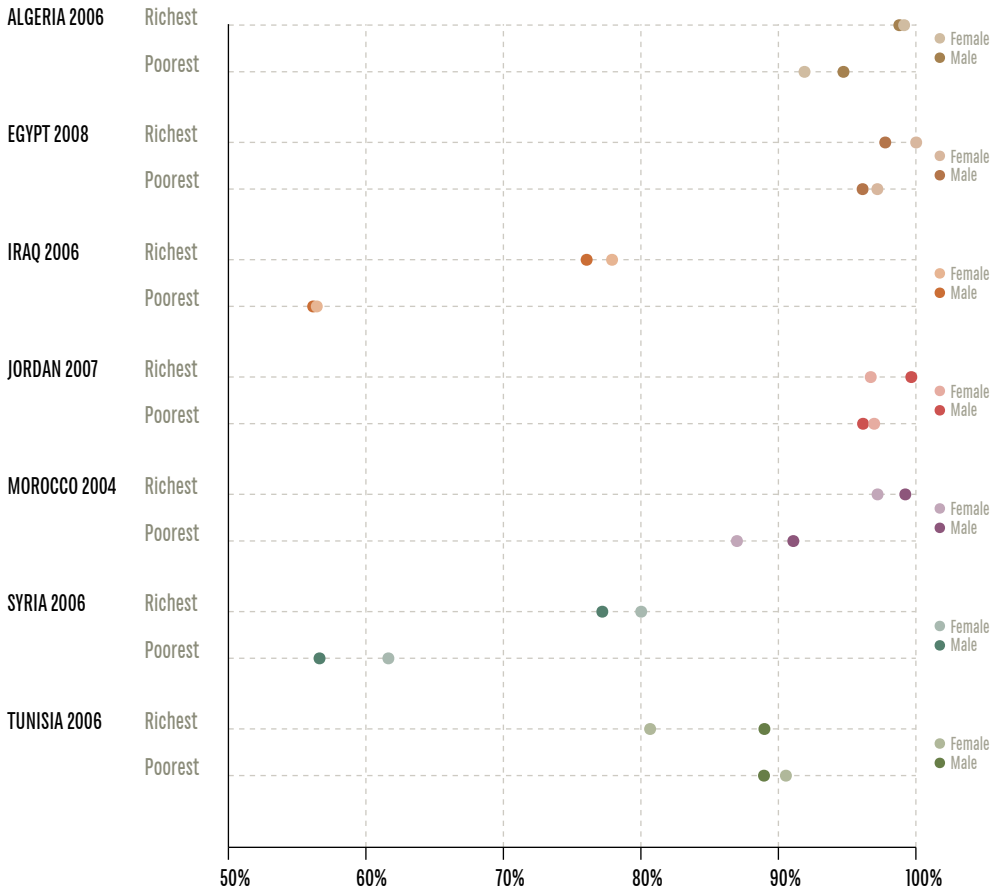
As shown in **Figure 68**, there does not appear to be a clear trend in disparities by area of residence nor gender. In Iraq, those living in rural areas are significantly less likely to have DPT immunizations compared to their urban counterparts. Furthermore, rates of female immunizations are less than those of male immunization rates in both areas of residence. In Morocco, the disparity also appears to be along area of residence but there does not appear to be a gender disparity.

FIGURE 68. DPT immunization by area



As shown in **Figure 69**, in Iraq, Syria, Morocco, Algeria and to a lesser extent, Jordan, poorest individuals are less likely to be immunized for DPT. There does not appear to be a clear trend of gender disparities. In Morocco and Syria for example, poor females are less likely to be immunized than poorest males and rich females are also less likely to be immunized than richest males, though the gender disparity is smaller among the richest than the poorest. In Algeria, there appears to be a disparity between poor females and poorest males, however, the disparity between males and females becomes almost minimal in the richest quintile.

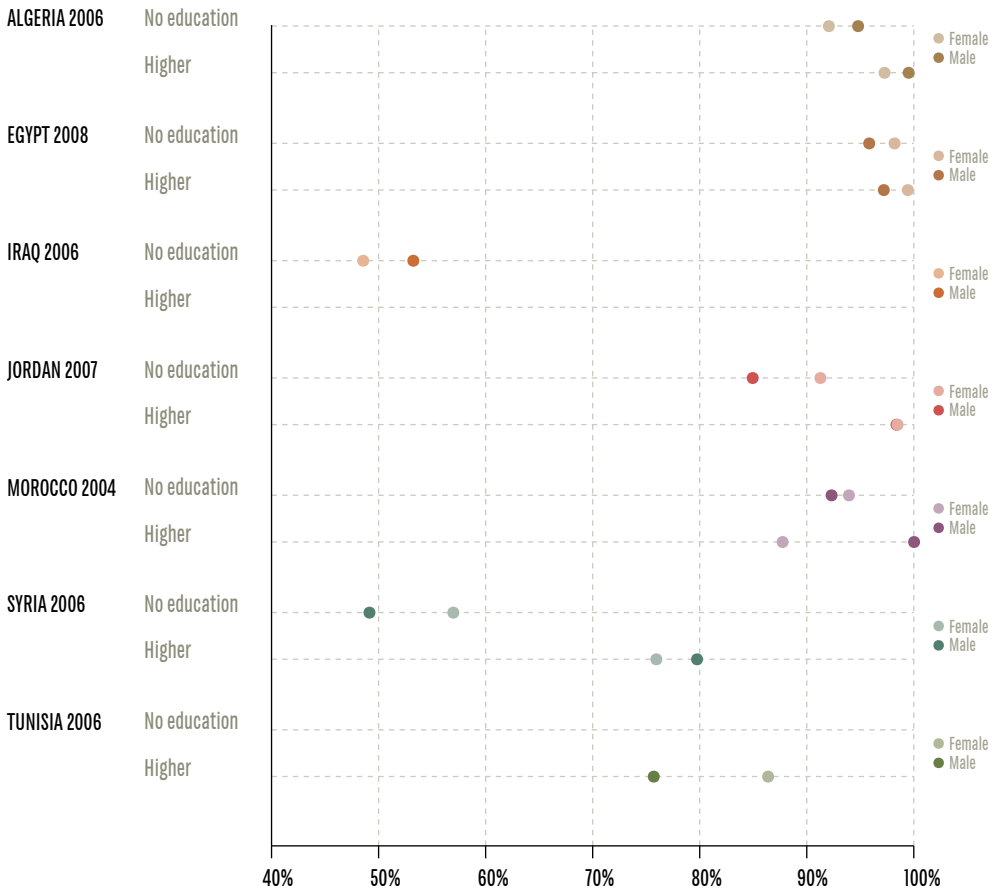
FIGURE 69. DPT immunization by wealth



DPT immunizations by mother’s education are shown in **Figure 70**. In Algeria, Jordan and Syria, children with mothers with no education are much less likely to be immunized against DPT than children with mothers with higher education. In Egypt, males are slightly less likely to be immunized than females, regardless of mother’s education level. In Morocco, there appears to be a greater gender disparity among children with mothers who have attained higher education. Females with mothers with higher education have immunization rates of 87% compared to their male counterparts (100%). For males and females with mothers with no education, the immunization rates are around 93% for both sexes.

Data points for mothers with higher education for Iraq and data points for mothers with no education for Tunisia were not available.

FIGURE 70. DPT immunization by mother's education



V. Family planning

¹⁵ Gender equality is strongly linked to men's and women's roles in different society, and informs the way they perceive their sexuality. Their access to – and perception of – reproductive health services are tied to gender equality as well. Females tend to have inferior access to financial resources, decision making power and perceived value in society as a whole. These affect the way men and women experience their sexuality and the control they have over their reproductive health (Yordi, 2007).

Reproductive health and rights are central in developing fulfilling, harmonious, and long-lasting relationships (UNFPA, 2005). Reproductive rights have been recognized in international agreements such as CEDAW and the ICPD. ICPD clearly defined the responsibilities of states to ensure equality between men's and women's access to reproductive health care (UNDP, 2010).

International agreements also stressed the importance of empowering women by ensuring they have complete control over decisions related to their fertility, which is integral to furthering development and eliminating poverty.¹⁵ Despite these agreements, however, gender discrimination continues to prevent many women in the world from exercising their reproductive rights, especially in the most impoverished countries (Yordi, 2007).

16 It has been shown that in some countries, such as Oman, women who have higher influence in decision making within the family are more likely to have their first child at an older age and to wait longer between births (WHO, 2007).

In many Arab countries, women continue to face tremendous challenges meeting their reproductive health needs due to poor quality of health services, ignorance about reproductive health issues and gender inequality (WHO, 2007). Women in the region have little involvement in decision making related to reproductive health and family planning.¹⁶

Some of the reasons given by women in the region for not using contraceptives are recent pregnancy, fear of side effects, opposition from husbands and relatives and failure of family planning providers to meet women’s reproductive health needs (Roudi-Fahimi, 2003).

Figure 71 shows the proportions of women of reproductive age and their husbands who approve of the use of family planning methods by area of residence. The acceptance rate of family planning is invariably higher among wives than husbands and is generally higher in urban areas than rural areas.

In the two countries of the Maghreb, family planning methods seem to be more accepted than in the three countries of the Mashreq. Lebanon, Syria, and Yemen show lower rates of acceptance in both urban and rural locales. The largest gender gap is seen in Yemen (17% difference for “urban” and 19% difference for “rural”).

FIGURE 71. Approval of family planning methods among married women of reproductive age (16-49) and their husbands

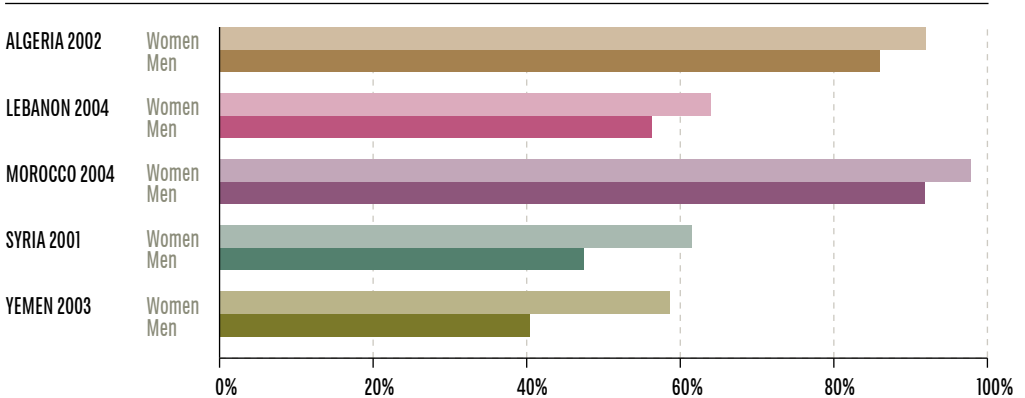


Figure 72 shows approval of family planning methods among married women and their husbands by area of residence. In all countries, women are more likely to approve family planning methods than men, in both urban and rural areas. In Algeria and Morocco, area of residence does not seem to affect approval rates among both men and women. In Lebanon, Syria and Yemen, approval rates among both men and women are greater in urban areas. Rural men in Yemen have the least approval rate (35%) compared to Moroccan women in urban areas with a nearly 100% approval rate.

FIGURE 72. Approval of family planning methods among married women of reproductive age (16-49) and their husbands by area of residence

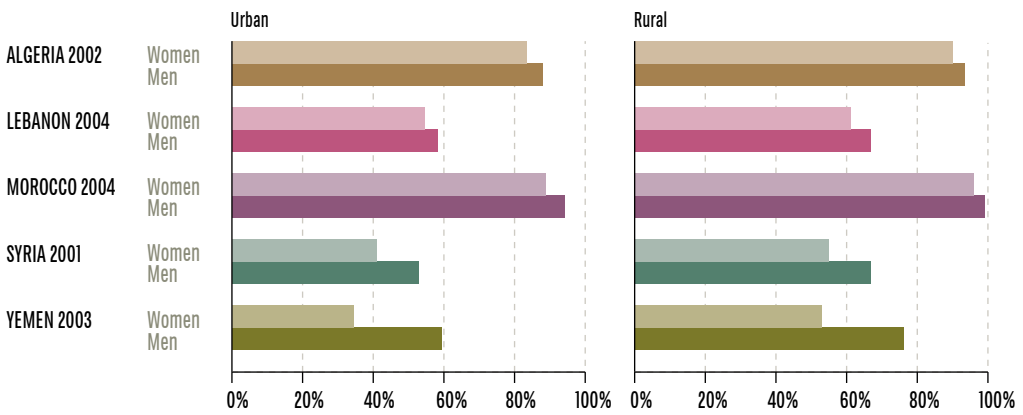
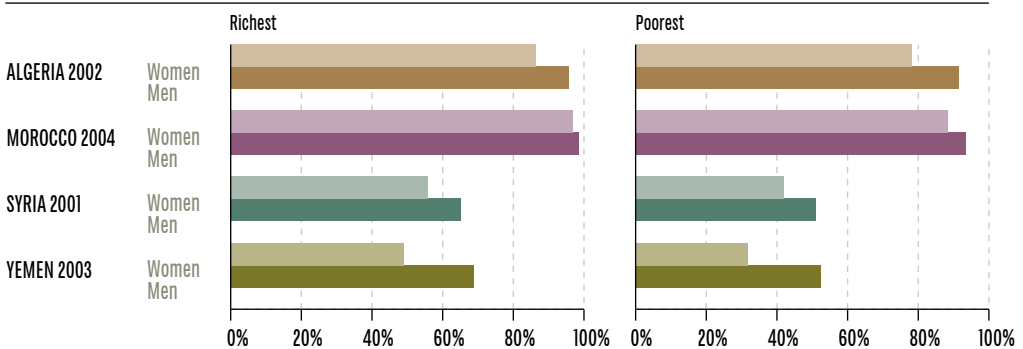


Figure 73 shows the proportions of wives of reproductive age and their husbands who approve of the use of family planning methods in the richest and the poorest socioeconomic groups. In the richest group, the percentage of acceptance ranged from 65% in Syria to 98% in Morocco among wives and from 51% in Syria to 94% in Morocco among husbands. In the poorest group, the percentage of acceptance ranged from 49% in Yemen to 97% in Morocco among wives and from 32% in Yemen to 89% in Morocco among husbands. The largest gender gap was seen in Yemen, in both the poorest (17 percentage point difference) and richest (15 percentage point difference) wealth quintiles.

FIGURE 73. Approval of family planning methods among married women of reproductive age (16-49) and their husbands by wealth



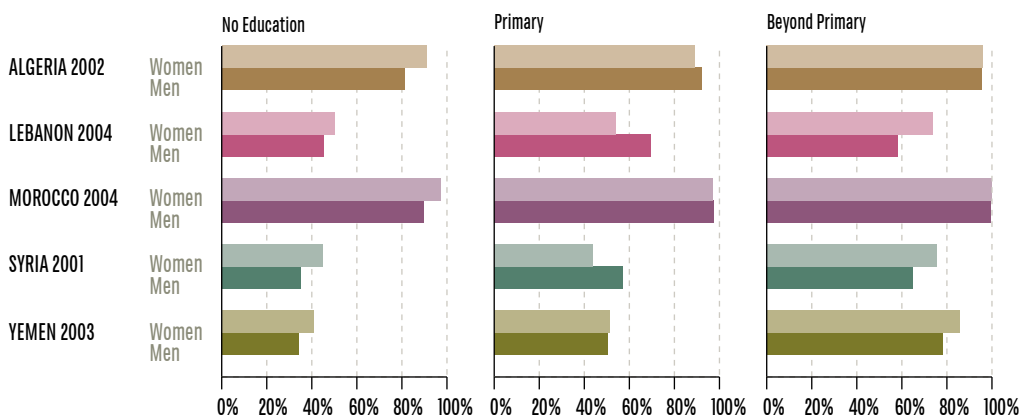
Approval of family planning methods by educational attainment is shown in **Figure 74**. In Algeria and Syria, a substantial difference is seen between approval rates in the no education and primary education categories for both sexes. In Morocco, the difference in approval among education attainment levels is minimal.

In Lebanon, the approval rates for the no education and primary education categories are similar, but rates are notably higher in the

beyond primary category for both sexes. The gender gap is consistent in all categories (approximately 8 percentage points).

Gender gaps in approval of family planning methods are larger for higher levels of educational attainment in the cases of Syria and Yemen. For instance, in Syria the gender gap is 11 percentage points in the no education category and 17 percentage points in the beyond primary category.

FIGURE 74. Approval of family planning methods among married women of reproductive age (16-49) and their husbands by educational attainment



CONCLUSIONS AND RECOMMENDATIONS

“There is now a shared understanding within the development community that development policies and actions that fail to take gender inequality into account and fail to address disparities between males and females will have limited effectiveness and serious cost implications.” World Bank (2003)

¹⁷ The interpretation of the report’s Gender Inequality Index (GII)—which measures gender gaps in reproductive health, empowerment and workforce participation in 138 countries—is the per cent loss of achievement of key dimensions due to gender inequality. The GII in the Arab states averages 70 percent, compared to the worldwide average GII of 56 percent. Gaps in education was cited as one of the main contributing factors. For example, only 32 percent of women in the region over the age of 25 have completed secondary education, compared to 45 percent for men. With a GII of 85 percent, Yemen suffered the largest overall HDI loss from gender inequality in the world. Among countries in the high human development category, Qatar is the furthest from gender equality.

¹⁸ <http://arabstates.undp.org/subpage.php?spid=10>

The 2010 Human Development Report entitled *The Real Wealth of Nations: Pathways to Human Development* (UNDP, 2010b) examined developments in health, income and education over the last four decades, based on the Human Development Index (HDI) for 135 countries. The report classified five Arab countries among the leaders in long-term development achievements: Algeria, Morocco, Oman, Saudi Arabia and Tunisia. However, the same report stated that gender inequality accounted for major setbacks in the achievement of key development dimensions in many Arab countries, most notably in Yemen, Iraq, Qatar and Saudi Arabia.¹⁷

The UNDP 2005 Arab Human Development Report, *Towards the Rise of Women in the Arab World*, also ascertained that gender inequality is one of the most crucial obstacles to human development in the Arab States. Despite legal guarantees for women’s rights to economic participation, stereotypical gender roles are deeply rooted, and limit women’s employment prospects, which are still among the lowest in the world. Furthermore, despite substantial efforts by Civil Society Organizations to advocate for women’s political rights, women still lag far behind men in terms of representation in the political arena.¹⁸

Many qualitative research endeavors on the situation and progress of Arab women have been undertaken, but fewer have advanced the production and dissemination of gender data. Sex-disaggregated data, are lacking in the Arab countries although crucial to the measurement of gender equality. Data in the region continues to be of varying quality, lack cohesion, and remain insufficient to cover the vast area of women’s human rights.

ESCWA, in collaboration with many United Nations agencies, national and international partners has taken many steps to engender data collection and dissemination in the Arab region. This report is another step taken by ESCWA, with funding from UN Women, to expose gender inequality in many areas of life, using data from comparable household surveys. It also serves as an indirect assessment of data availability at the national level, in hopes of increasing future financial and human resources needed for sustainable improvements in gender statistics and to produce sex-disaggregated MDG indicators.

The primary objectives of the report are to delineate some of the demographic characteristics of women and men populations and pinpoint gender inequality in socio-economic conditions and acceptance of family planning methods. Its main findings are enumerated below:

1. *Sex ratios indicate higher numbers of men than women in the 55 to 59 and older age groups in Sudan, Syria and Yemen. In Morocco and Palestine, the opposite is true.*
2. *The highest proportion of female-headed households is found in Sudan, followed by Morocco, Lebanon, Tunisia and Egypt. With the exception of Sudan, higher proportions of female-headed households are found in urban areas.*
3. *Girls marry at younger ages than boys. Yemen and Sudan hold the highest percentages of currently married women in the youngest age group (15 to 19).*
4. *The proportions of women who remain divorced are larger than those of men in every included country except Syria.*
5. *Illiteracy is more prevalent in older age groups for both men and women.*
6. *The proportion of illiterate women is substantially higher than that of men in all countries, in both urban and rural areas. Yemen holds the largest gender disparity, followed by Algeria.*
7. *Illiteracy is more prevalent in rural areas than urban areas for both genders. Gender gaps in rural areas tend to be larger than those in urban areas.*
8. *Illiteracy is more evident in the poorest wealth quintile than the richest wealth quintile for both sexes.*
9. *Gender differences in the proportion of girls and boys ages 6 to 14 years who are enrolled in school are minimal.*
10. *More girls than boys in the 6 to 14 age group are currently registered in schools in Jordan, Lebanon, Palestine and Tunisia. More girls and boys in the richest wealth quintile are enrolled in school than their counterparts in the poorest wealth quintile.*
11. *By and large, a greater percentage of women than men received no formal education. The largest gender gap is seen in Yemen.*
12. *Larger percentages of women received no formal education in rural areas than in urban areas.*
13. *Men attain higher education levels than women in all countries.*
14. *The percentage of women participating in the labor market is very low compared to that of men.*

19 ESCWA, 2001, Available at <http://www.escwa.un.org/gsp/about/regional.html>

15. *Gender gap in economic activity widens between the ages of 25 and 49 years.*

16. *Unemployment is drastically higher for women as than men in Sudan.*

17. *There is no clear trend of gender disparities for childhood immunization.*

18. *High blood pressure is more common among women than it is among men especially among those with no education.*

19. *In general, family planning methods are more accepted among wives than it is among their husbands.*

This report does not attempt to identify explanations or causes of existing gender gaps. Any meaningful discussion to that end would require additional, more in-depth information. As proposed in the ESCWA-Gender Statistics Program-Third Regional Report, which was based on a workshop held as part of the Development of National Gender Statistics Programs in the Arab countries,¹⁹ a handful of indicators related to many subjects should be taken into account when measuring gender inequality. Areas that deserve further in-depth investigation and data analysis and not covered in this report include the following:

- Women and poverty
- Violence against women
- Women, conflict and wars
- Women and public participation
- Institutional mechanisms to improve the status of women
- Women and human rights
- Women and the media
- Women and the environment

Moreover, data on attitudes related to gender roles, especially those that pertain to family and marriage are crucial to assessing the underlying issues that perpetuate the gaps between women and men.

In order to improve the quality and availability of relevant data, the following actions are proposed:

- Household survey designs should be revised to incorporate more variables that address the issues discussed above. Specialized modules on additional topics of interest should be designed and implemented.
- Data collection on additional topics should be harmonized to minimize discrepancies between various survey programs.

Concept and variable definitions, conventions and even the sequence of questions and the filtering process should be homogenized, in order to produce comparable, consistent data.

- Data file management is another concern. The structure of files should also be consistent.
- Variation in data quality should be addressed.
- More in-depth analysis of already available data should be performed.
- Micro data from regular household surveys and censuses, especially from the Gulf countries, should be released.

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