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TOWARDS COMPREHENSIVE SOCIAL POLICY FOR EQUALITY AND THE MILLENNIUM DEVELOPMENT GOALS

12-0200

Preface

The present paper is the fifth of a working paper series produced by the Social Development Division of the United Nations Economic and Social Commission of Western Asia (ESCWA). The research presented in this paper was conducted as part of the ongoing efforts of the Social Policy Section to build a knowledge base and enhanced expertise towards comprehensive social policy for equality and the Millennium Development Goals.

The Millennium Development Goals provide a framework to improve the situation of the world's poorest by making significant strides against poverty, hunger and disease. Reducing inequality not only helps achieve those objectives but promotes a socially just world in which individuals have the opportunity to participate in their own development. Social policy can ensure equitable distribution of economic growth and development. In the Arab region, not all groups benefit equally from the basic social services provided by their Governments. The provision of basic social services in the region is often underfunded, inefficient or limited in reach. Social protection in the region is hindered by the lack of information, capacity and infrastructure to implement more effective systems.

This working paper calls for an adoption of comprehensive social policy to tackle inequality and drive development in the region. Investing in people and social protection measures can have a multiplier effect on income generation, health and education of a population and lead to a virtuous cycle of social and economic development. An initiative such as the social protection floor allows for equal opportunities and prevents existing inequalities from becoming wider by guaranteeing a minimum set of basic social services and social protection. While the countries of the Arab region are characterized by varying social and economic challenges that require unique solutions, they share a common priority: comprehensive social policy including the provision of basic social services and social protection for all.

The working paper was written by Ms. Loris Elqura, under the guidance of Ms. Gisela Nauk (Chief of the Social Policy Section) and Mr. Frederico Neto (Director of the Social Development Division). It builds on extensive research conducted with the support of Ms. Christine Rouhana (Research Assistant). The paper benefited from the helpful comments and reviews of other members of the Social Policy Team, namely Ms. Dina Tannir, Ms. Tanja Sejersen, Mr. Elias Attiyeh and Ms. Nathalie Grand.

CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF BOXES

ACRONYMS

ALMP	Active Labour Market Policy
GCC	Gulf Cooperation Council
GDP	Gross domestic product
ILO	International Labour Organization
IMF	International Monetary Fund
LDC	Least Developed Country
MDG	Millennium Development Goal
MSME	Micro, small and medium enterprise
NGO	Non-governmental organization
OECD	Organisation for Economic Cooperation and Development
PES	Public Employment Services
TIMSS	Trends in International Mathematics and Science Study
UNDP	United Nations Development Programme
WHO	World Health Organization
WHO-EMRO	World Health Organization Regional Office for the Eastern Mediterranean

Introduction

The Millennium Declaration documents the commitment of United Nations Member States to uphold the principles of human dignity, equality and equity on national and global levels. The eight Millennium Development Goals (MDGs) contain a clear and measurable framework for progress across policy fields which range from halving extreme poverty to halting the spread of HIV/AIDS and providing universal primary education.

With just a few years left until the 2015 deadline, the international community is focused on accelerating progress towards achieving MDGs and their targets. According to the 2011 MDG Report, although significant strides have been made and the world is on track to reach many MDG targets, there is a need for greater efforts to reach the world's poorest and most disadvantaged populations, which have not benefited equally from the achievements thus far.[1] Hence, there is a need to put equality back at the forefront of the development agenda not only to meet the targets but to set a course towards sustainable and inclusive development.

THE 8 MILLENNIUM DEVELOPMENT GOALS

Eradicate Extreme Poverty and Hunger

Achieve Universal Primary Education

Promote Gender Equality and Empower Women

Reduce Child Mortality

Improve Maternal Health

Combat HIV/AIDS, Malaria and other Diseases

Ensure Environmental Sustainability

Develop a Global Partnership for Development

Addressing inequality follows a human rights-based and pro-poor approach to development because equal societies allow individuals to participate in their own development. In addition, inequality is economically inefficient. Inequality in power and wealth results in institutions that perpetuate inequality and contribute to intergenerational poverty or "inequality traps". Increasing equality leads to better institutions and better use of resources. Equality is also central to the discourse on development as evidence shows that countries marked by high inequality have slower economic growth, poorer health, greater social problems and more political instability,[2] all of which could impede development.

While many countries have pushed for economic reform and focused on enhancing economic growth as a mechanism for development, especially in the light of the economic crisis, the role of inclusive social policy should not be overlooked. Inclusive social policy levels the playing field, giving individuals equal opportunities for health and education and the ability to participate in their own development and well-being. This is not to say that economic development is unimportant. Social policy is inextricably linked to economic development and plays an integral role in supporting and enhancing economic growth. A healthy, educated, skilled and productive workforce can lead to a more efficient and productive economy.

A recent progress report demonstrated that many countries in the Arab region have significant barriers to overcome if they are to reach MDGs by 2015.[3] The barriers may be even greater than indicated by reports, because MDG indicators are based on national aggregated data, which may have the effect of masking

[1] United Nations (2011), p. 4.

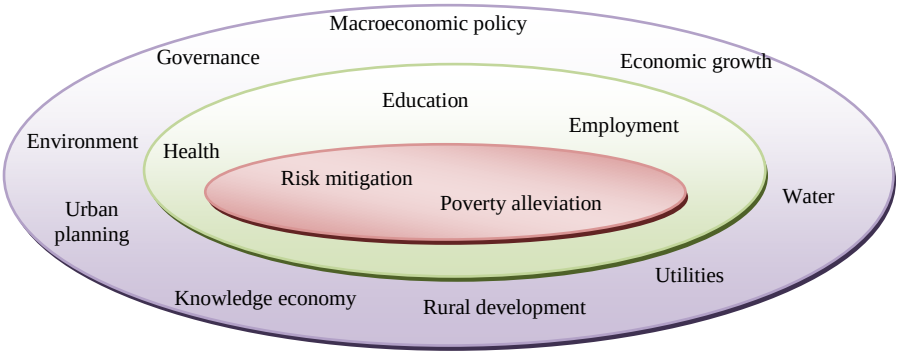
[2] UNICEF (2011), pp. 23-28.

[3] United Nations and the League of Arab States (2010), p. xxii. The report included all ESCWA member countries in addition to Algeria, the Comoros, Djibouti and Mauritania.

inequalities within countries. The uprisings sweeping the region provided some evidence of inequality, manifested by unbalanced power, corruption and disproportionate burdens of unemployment. That reality highlights the need to examine the social policies which have contributed both to progress towards MDGs and shortcomings in achieving them. By examining the policies that impact MDGs and support development, priorities and avenues for intervention can be identified. Furthermore, in-country disparities with regard to MDG targets emphasize the need to examine the capacity of current efforts to reach vulnerable and marginalized groups in order to reduce gaps between populations. The exclusion of groups from social development puts vulnerable populations at an additional risk of poverty and increases inequality and its negative effects on society. Social inclusion is critical for achieving MDGs, yet many countries lack comprehensive social policies and where they do exist, they tend to be fragmented and fail to reach large segments of the population.[4]

Social policies that focus on investing in people through the provision of quality, accessible and affordable social services (such as health, education and labour) and social protection (such as social insurance) play a significant role in improving development, reducing inequality and achieving MDGs at the country level. Figure I outlines the various dimensions of social policy, each of which addresses inequality. At the core of social policy is social protection. Social protection can be described as the policy interventions that aim to protect the most vulnerable people against "livelihood risks associated with sharp reductions in or interruption of their income or consumption."[5] The aim of social protection is to reduce the income equality gap and, if designed properly, it can prevent individuals and households from falling deeper into poverty. Social protection includes two types of measures: a) risk mitigation, such as social insurance measures and pension schemes; and b) poverty alleviation, such as cash or in-kind transfers and subsidies, which are sometimes referred to as safety nets. Social policies that focus on investing in people in terms of labour, health and education compose the next ring of the social policy framework. Those social policies promote equal access to services which in turn can lead to equal outcomes. In addition, "public investment in human capital can be an efficient way to reduce income inequality over the long run."[6] The outer ring of the framework includes other issues that broadly support social development such as macroeconomic policy, governance, access to water and environmental protection and demonstrates the influence of such policies on social development.

Figure I. Different dimensions of social policy



Social protection
Investing in people
Supporting social development

Source: ESCWA (2009a), p. 9.

Poverty alleviation includes measures such as price subsidies, cash or in-kind transfers and fee waivers.
Risk mitigation includes social insurance measures such as unemployment insurance and pension schemes.

[4] ESCWA (2010a), p. 2.

[5] ESCWA (2010b), p. 10.

[6] IMF (1998).

As governments bear the main responsibility of providing basic social services and social protection schemes, the paper will focus on the inner circles of the social policy framework, which correspond to MDGs one through six, and examine the breadth and reach of social policies. First, it will examine social policies which have contributed both to the progress towards and shortcomings in achieving MDGs, along with the levels of inequality in social policy areas of health, education, labour and employment and social protection. Then it will present a social policy framework and argue for social policy strategies which promote equality and drive development.

I. PROVISION OF BASIC SERVICES

A. HEALTH SERVICES AND HEALTH SYSTEMS

Health systems in the Arab region are beset by many challenges, namely: bureaucratic inefficiency; emphasis on curative rather than preventive care; relatively weak public health institutions; lack of capacity in policymaking and poor professional capability; and disproportional geographic distribution of health workers.[7] Those shortcomings result in disparities in health care provision and marginalize the poor and residents of rural areas.[8] In turn, those disparities create greater health inequality within a country's population which hinders development.

In addition, the health sector in the Arab region suffers from underfunding. Generally, health expenditure is positively correlated to good health outcomes.[9] In 2002, it was estimated that Middle Eastern countries spend an average of 4.8 per cent of GDP on health; more than Asia and the Pacific (4.4 per cent) but less than Latin America (7.0 per cent) and the average for countries of the Organisation for Economic Cooperation and Development (OECD) (9.7 per cent).[10] Figures from 2008, however, for Jordan, Lebanon[11] and Palestine[12] indicate expenditures of 8.5 per cent, 8.8 per cent, and 13.5 per cent respectively.[13] Furthermore, health expenditure per capita provides further evidence of Arab Governments' underfunding of health (figure II).

[7] UNDP (2009), pp. 145-154; and Regional Committee for the Eastern Mediterranean (2004), pp. 6-8.

[8] UNDP (2009), p. 151.

[9] Poullier, et al. (2002), p. 9.

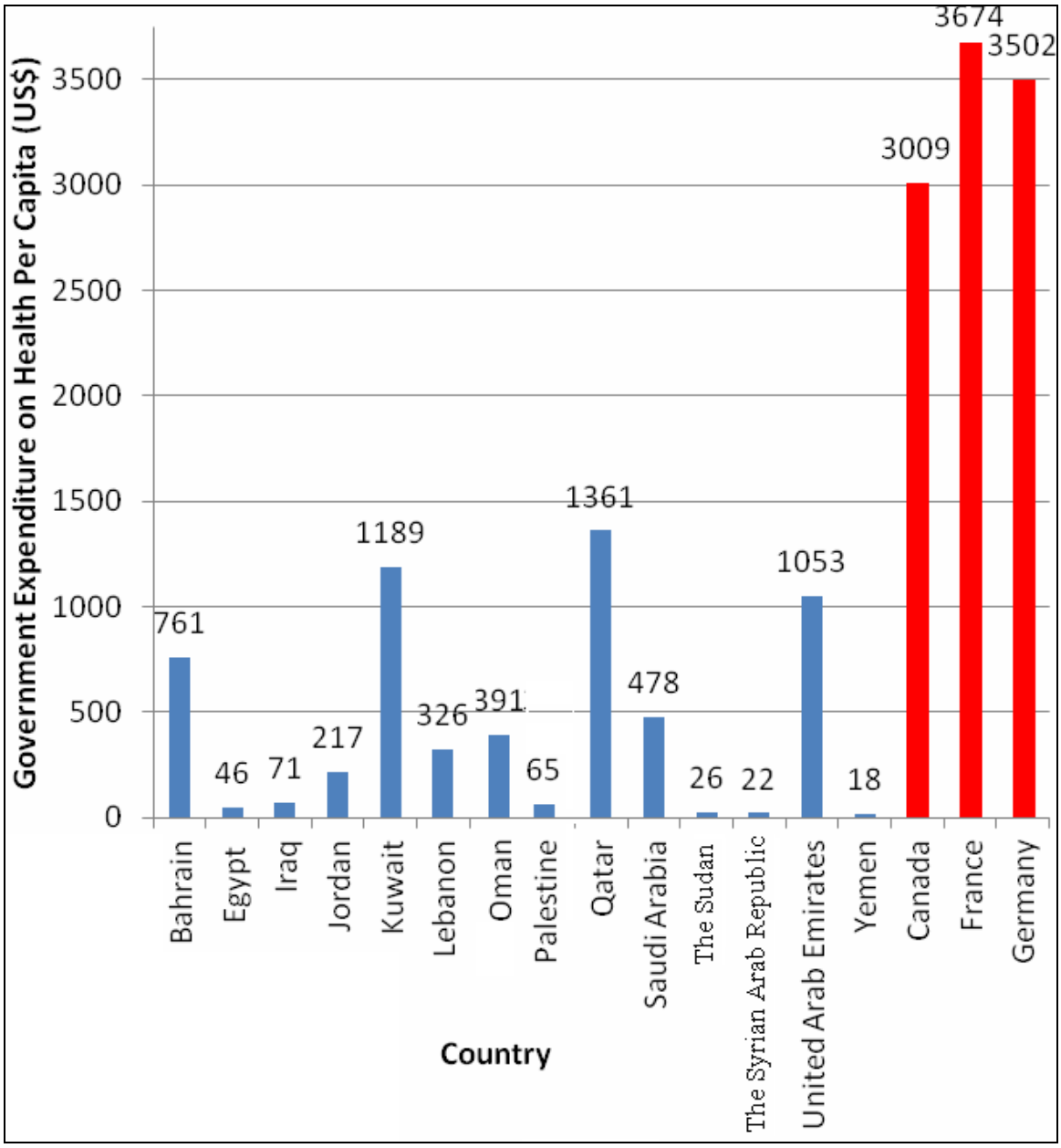
[10] Ibid., p. 6. The study included North African countries along with Pakistan and Afghanistan in its definition of the Middle East.

[11] WHO (2008). In Lebanon, individual households account for the majority of health care spending due to a highly privatized health care system. The result is not necessarily better access to health for the poor.

[12] Such external sources as international donors and the United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) provide the majority of health care financing in Palestine (WHO Regional Health Systems Observatory (2006), p. 18).

[13] Data for 2008. Source: WHO Regional Office for the Eastern Mediterranean (EMRO), Country Profiles of Jordan, Lebanon, Palestine.

Figure II. Government expenditure on health per capita in US$ (2009)



Source: WHO Global Health Observatory Data Repository, available from http://apps.who.int/gho/data/.

* For Palestine, data is from 2008.

Most health services in the Arab region are under the purview of the Government through the ministries of health. The exception is Lebanon, where more than 80 per cent of health services are provided by the private sector.[14] Thus, government-run health schemes are the primary mechanism through which quality, equitable and accessible health care are ensured to the population. Data suggest that coverage rates through health schemes are relatively high. For example, in Egypt, Libya and Yemen, 100 per cent of the population are reported to be entitled to subsidized or free governmental health services or insurance, while Lebanon and Tunisia have enrolled high percentages of the population in social health insurance (52 per cent and 78 per cent) (table 1).

[14] WHO (2008).

TABLE 1. ESTIMATED COVERAGE BY HEALTH FINANCING SCHEME IN SELECTED ARAB COUNTRIES, 2008
(*Percentage*)

Country	Population enrolled in social health insurance	Population enrolled in private health insurance	Population Uninsured	Population entitled to subsidized or free governmental health services or insurance
Egypt	45.0	<1	55.0	100.0
Lebanon	52.0	15.0	>48.0	23.0
Libya	-	-	-	100.0
Palestine	48.5	10.2*	22.4	18.9**
Tunisia	78.0	-	14.8	7.2
Yemen	-	-	-	100.0

Source: World Bank (2010), p. 5.

* Includes military, private and Israeli insurance schemes.
** Covered by the United Nations Relief and Works Agency (UNRWA).

However, despite the presence of subsidies and reported coverage rates, the use of health care services is low in many countries.[15] Low use implies that the accessibility or quality of health services provided through government-run health schemes are limited and inadequate. High out-of-pocket expenditures in the majority of Arab countries provide further evidence that access to care and quality of services are deficient. This is a cause of concern on the individual level because high out-of-pocket costs can drive vulnerable households further into poverty and increase their vulnerability as health care costs rise. In essence, out-of-pocket expenses can significantly widen the income inequality gap and in many countries health care can constitute the single largest household expense after food.[16] Households may forgo health care because of the cost, resulting in illnesses that could have been prevented or other detrimental health consequences. On the national level, high out-of-pocket expenditures, despite reported coverage and access to health services, are correlated to poor health outcomes (table 2). For example, the least developed countries (LDCs) tend to have the worst health outcomes in the region and the highest out-of-pocket expenditures. By contrast, in the Gulf Cooperation Council (GCC) countries, the average out-of-pocket expenditure is the lowest in the region and GCC countries enjoy good health outcomes owing in part to access to quality services.[17] The countries of the Arab Mashreq on average spend more on health than the other subregions, but high out-of-pocket expenditures indicate that government-provided health services are inaccessible, weak and inadequate.

[15] WHO Regional Committee for the Eastern Mediterranean (2004), p. 7.

[16] World Bank (2010), pp. 1, 7 and 17-18.

[17] WHO-EMRO Country Profiles.

TABLE 2. HEALTH EXPENDITURE AND HEALTH INDICATORS IN SELECTED ARAB COUNTRIES

	Country	Expenditure on health as a percentage of GDP	Out-of-pocket as a percentage of total health care expenditure	Percentage of population with access to local health services total/urban/rural	Infant mortality per 1 000 live births	Under 5 mortality per 1 000 live births	Maternal mortality per 10 000 live births
GCC	Bahrain	3.6	19.7	100/100/100 (2009)	7.5	9.4	18
	Kuwait	2.0	21.3	100/100/100 (2007)	9.1	10.5	13
	Oman	2.4	17	100/100/100 (2009)	9.0	11.7	17
	Qatar	3.3	26.5	28/15/50 (2004)	7.1 (2009)	8.8 (2009)	22 (2009)
	Saudi Arabia	3.3	16.3	-	17.4	21.1	14
	United Arab Emirates	2.4	22.1	100/100/100 (2007)	7.6	9.8	1.5
LDC	Comoros	2.7 (2003)	45.9 (2003)	-	52.0 (2004)	70 (2004)	480 (2000)
	Djibouti	8.5	23.6	98/100/95	67.0 (2006)	94 (2006)	-
	Mauritania	4.2 (2003)	23.2 (2003)	-	78.0 (2004)	125 (2004)	1000 (2000)
	Somalia	-	-	95/100/90 (2006)	86.0 (2006)	135 (2006)	1044 (2006)
	The Sudan	3.6	63.4	95 (total) (2006)	81.0 (2006)	112 (2006)	1107 (2006)
	Yemen	5.6 (2009)	66.3 (2009)	50/80/25 (2003)	68.5 (2006	78.2 (2006)	-
Maghreb	Algeria	4.1 (2003)	18.3 (2003)	-	35 (2004)	40 (2004)	140 (2000)
	Libya	3.5 (2009)	16 (2009)	98/100/95	14.0	20.0	23.0
	Morocco	5.3	56.1	96/100/92	32.2 (2004)	37.9 (2004)	227 (2004)
	Tunisia	6.0	42.5	-	18.4	22 (2006)	36 (2009)
	Egypt	6.4	58.7	88/90/82 (2009)	17.0	21.8	55
	Iraq	2.7	18.8	100 (urban)	24 (2009)	29.5 (2009)	84 (2009)
	Jordan	8.5	33.4	-	23.0	28	19
	Lebanon	8.8	39.9	70/66/77 (2004)	18.6	19.1	23
	Palestine	13.5	34.5	-	25.0 (2009)	28 (2009)	38 (2009)
	Syrian Arab Republic	3.2	54.9	100/100/100	15.5 (2006)	22 (2006)	58 (2006)

Source: WHO-EMRO Country Profiles.

Note: Data are for 2008 except as noted.

Examining health outcomes in the Arab region, particularly in Egypt, Jordan, Morocco, the Sudan, Tunisia and Yemen, sheds light on the factors that contribute to health inequities. Those factors are primarily income level, mother's education level and place of residence:[18] Arab children in families with higher income levels or who have mothers with higher education levels enjoy health care and health levels that are three to four times better than the level of children in low-income families with less-educated mothers.[19] That testifies to the interlinked relationship between poverty, education and health and gives important insight into the channels of the intergenerational transmission of poverty. Strategies aimed to raise income and female education levels are expected to have a positive ripple effect on health. The stark health disparities between urban and rural populations within countries can be attributed to the fact that such resources as hospitals, skilled personnel and health care technology and equipment tend to be concentrated in urban areas.[20] In addition, Governments spend a disproportionate amount of resources on treatment services and hospitals, which also tend to be concentrated in urban areas.[21]

Given that the main challenges for most countries include limited access to affordable and quality care, priority areas for interventions should focus on improving the quality of health services while ensuring equal access to care for all populations. A strong health system would also lay the foundation for targeted, pro-poor interventions and social protection measures for all to improve health opportunities for the most vulnerable. Interventions linked to improving income or education can also magnify improvements in health given the links between those factors. For countries that are marked by low public expenditure on health, financing should be fair and adequate to ensure coverage and quality of services. Fair and adequate financing means that insurance schemes are well-funded and structured to overcome gaps in coverage and services are more balanced between preventive and treatment-based care. Investing in prevention can be more cost-effective and result in better health outcomes. In countries in which non-governmental organizations (NGOs) provide a large share of health services, such as the Sudan and Lebanon, it is recommended that ministries of health develop contractual agreements for health service delivery with NGOs to regulate and oversee the standardization and quality of services.[22]

To certify that rural and poor populations benefit from improvements in the health system, policies should ensure an appropriate balance of resources. For countries which are characterized by large rural populations and disparities in health access by geography, a basic set of health services at the district level should be provided. In addition, countries should focus on interventions to develop and retain a more skilled and balanced human resource base in the health sector. Many middle-income countries, specifically Egypt, Iraq, Jordan, Lebanon, Libya, Morocco, Palestine, the Syrian Arab Republic and Tunisia have a poorly skilled health workforce. To balance the distribution of human resources, countries can encourage skilled health professionals to serve rural areas by providing incentives. A programme by the Ministry of Health in Morocco is one example of a successful intervention to address the distribution of the workforce (box 1). In GCC countries, the reliance on an expatriate workforce presents a different human resource challenge, and those countries should maximize the use of the available national health workforce. Though each country faces different challenges, a common step to correcting those deficiencies is improved coordination between relevant ministries, donors and stakeholders. Furthermore, increasing the availability, accessibility and use of information can allow ministries of health and other health service providers to identify priority health areas and cost effective interventions.[23]

[18] UNDP (2009), p. 151.

[19] Ibid.

[20] Abdullatif (2006), p. 14.

[21] UNDP (2009), pp. 156-157.

[22] WHO Regional Committee for the Eastern Mediterranean (2004), pp. 6-8, 11-12.

[23] Ibid., p. 6.

Box 1. Closing the health inequality gap by improving health systems: The case of Morocco

Supported by the Ministry of Health of Morocco and the World Bank, the Social Priorities Programme Basic Health Project addressed the health disparities between urban and rural populations by strengthening health systems in 14 rural and disadvantaged provinces. Health facilities in rural areas were neither easily accessible nor fully staffed. By decentralizing the delivery of health services to the rural areas, improving the physical infrastructure and strengthening human resources and technical capacity to deliver quality health services at the provincial level, significant achievements were gained. Activities included providing lodging for health personnel, increasing the capacity of community health workers, and improving pharmaceutical supply management in rural health facilities. Results included improvements in medically-assisted deliveries (from 18.5 per cent to 47 per cent) in a period of 5 years. The programme serves as an example of positive results of a targeted health policy intervention.

Source: World Bank (2004), pp. 2, 6 and 15.

B. EDUCATION

Most countries in the Arab region provide primary education for nationals and, with the exception of Lebanon, education is largely publicly financed.[24] At the time of independence, in response to a growing youth population and low education rates, countries in the Arab region focused on establishing expansive education systems and improving the educational status of the population. Over the past 40 years, Arab countries invested about 5 per cent of GDP and 20 per cent of public budgets in education, significantly more than the average 3 per cent spending of some Latin American and East Asian countries.[25] As a result of significant investment in education in Arab countries, most have nearly achieved full primary education enrolment, made significant gains in gender parity and reduced illiteracy by half over the past 20 years.[26] Specifically, the net primary enrolment rate in the Arab region increased from 61.8 per cent in 1970 to 84.7 per cent in 2003.[27] In 2005, Arab countries achieved an average 69 per cent adult literacy rate, which ranged from a low of 51 per cent in Mauritania to a high of 93 per cent in Kuwait.[28] These rates are slightly above those of Southern Asia (62 per cent) and sub-Saharan Africa (63 per cent) but well below the global rate of 83 per cent.[29] In addition, over a period of 40 years between 1960 and 2000, the average years of schooling increased from 1.1 years to 4.8 years in several countries (Algeria, Bahrain, Egypt, Jordan, Kuwait, the Sudan, the Syrian Arab Republic and Tunisia).[30]

While those significant improvements should be applauded, it is important to note that the starting points for those indicators were very low and education levels are still comparatively low. For example, the youth literacy rate in the Arab region, which is an indicator for MDG 2, ranks below the regions of Latin America and the Caribbean and East Asia and the Pacific (figure III). In addition, it is important to highlight that the disparity between male and female youth literacy rates in the Arab region is greater than in the other regions.

[24] World Bank (1998), p. 8.

[25] UNDP and the League of Arab States (2009), p. 26. The average for Arab countries included Algeria, Comoros, Djibouti and Mauritania and all ESCWA member countries except Iraq and Palestine.

[26] World Bank (2008a).

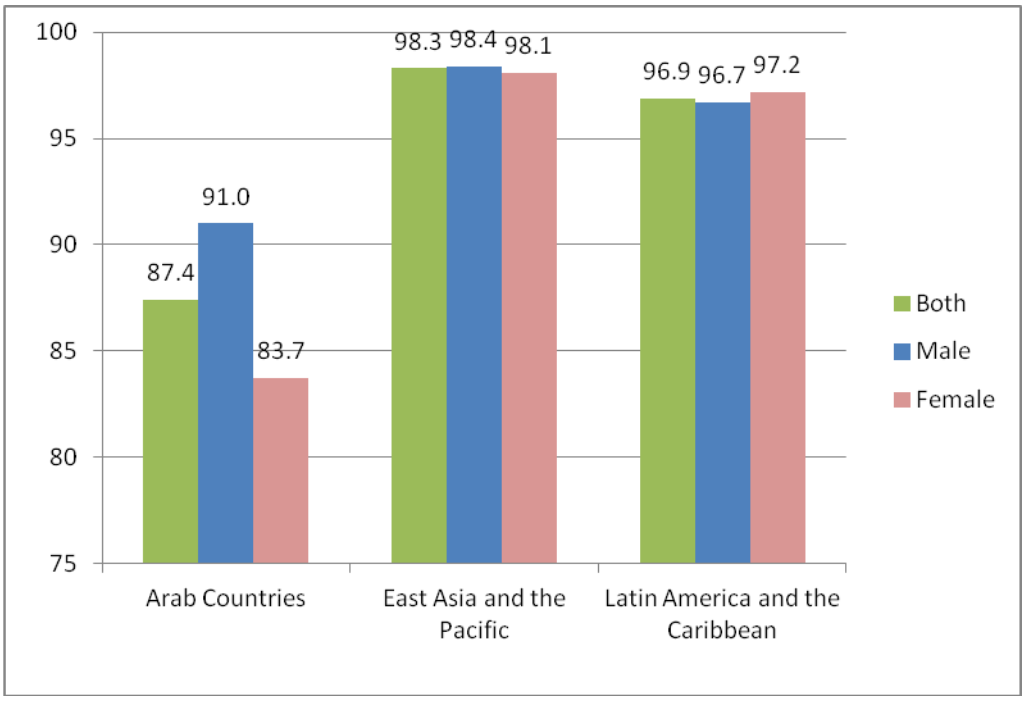
[27] World Bank (2008b), p. 13.

[28] UNDP and the League of Arab States (2009), p. 12. See footnote 25 on the scope of the estimate.

[29] UNESCO Institute for Statistics (2010a).

[30] UNDP and the League of Arab States (2009), p. 26.

Figure III. Youth literacy by region
(*Percentage*)



Source: UNESCO Institute for Statistics (2010b), pp. 220-227.

Note: All ESCWA member countries along with Algeria, Djibouti and Mauritania are included in the average.

Despite significant progress in educational enrolment, the returns on public investment in education are less than what would be expected, especially with regards to equality and quality. Not all groups within a country have equal access to education. The poor and those residing in rural areas are at a particular disadvantage. An estimated 30 per cent of rural children in Arab countries are out of school compared to 18 per cent of children residing in cities and towns.[31] As a result, rural populations have not experienced the same dramatic increases in literacy as their urban counterparts. "Literacy increases more rapidly in urban areas, [thus] countries with significant rural populations (Egypt, Morocco and Yemen) also have lower adult literacy rates."[32] In addition, being female in the Arab region increases the likelihood of being illiterate. According to data for the Arab region from 2005-2008, the literacy among adult women was 63.1 per cent, and 81.2 per cent among adult men.[33] While enrolment of males and females has reached parity in several Arab countries, many have not yet achieved that goal and girls compose more than 60 per cent of out-of-school children in the Arab region.[34] Part of the remaining gender gap can be explained by social factors because the enrolment of boys has been historically favoured over that of girls.[35] Countries in conflict and LDCs face additional challenges, such as enrolment and retention of students. Iraq, Palestine, the Sudan and Yemen are characterized by a large out-of-school population[36] which draws attention to the impact of conflict and poverty on educational attainment.

[31] United Nations and League of Arab States (2010), p. 23. Estimate includes all ESCWA member countries in addition to Algeria, the Comoros, Djibouti and Mauritania.

[32] World Bank (1998), p. 10.

[33] UNESCO Institute for Statistics (2010b), p. 227. See figure III note for countries included in the estimate.

[34] United Nations and the League of Arab States (2010), pp. 23-25.

[35] UNDP (2009), p. 137.

[36] United Nations and the League of Arab States (2010), p. xiv.

It is notable that the quality of education in the Arab region, as measured by international test results, specifically Trends in International Mathematics and Science Study (TIMSS), has not improved in the past several years.[37] Scores of Arab students on the 2003 round of TIMSS averaged 394 in math and 417 in science, which rank below the international average scores of 467 in math and 474 in science.[38] Despite national financial investments in the education sector, the approach to expanding education in the Middle East and North Africa may have contributed to the low quality of education. In some countries, the expansion was not progressive, meaning that efforts to expand secondary and tertiary education took place before universal primary education was reached.[39] This was the case in Egypt, where the Government concurrently expanded all levels of education even though full enrolment at the primary level had not yet been attained. Expansion at all levels concurrently, though ambitious, compromised the level and quality of education provided. By contrast, Latin America and Asia took a progressive approach to expanding education and as a result have achieved higher average levels of education.[40]

Countries should focus on achieving full primary education enrolment and ensuring quality in order to level the playing field. A more educated population can spur the achievement of other development objectives such as child health, given the strong link between educational levels of mothers and health, as discussed above. Increasing enrolment, especially among poor and marginalized populations, requires policies that overcome the costs and barriers to education. For example, transportation and supply costs can be a significant barrier to education for a poor family residing in a rural area. Opportunity costs, such as child labour, can be a barrier to primary education and must be reduced. Families may not see the value of enrolling their children in school when there are additional direct costs, the quality is low and children can otherwise generate income or, in the case of girls, see to household chores and other responsibilities.

There is a need to improve the quality of education, which requires investments in the physical infrastructure, school administration, improved training of teachers and adequate monitoring and evaluation of the performance of schools and teachers.[41] Because many countries have neither national standards for achievements in learning nor tests to measure achievement, there is little accountability. Countries should focus on developing standards and appropriate monitoring systems to identify areas for interventions that can positively influence educational policy.[42]

C. LABOUR AND EMPLOYMENT

As labour income is often the main and only source of income for poor individuals in the Arab region, employment is critical to the discourse on poverty alleviation (MDG1) and equality. Several challenges characterize the labour market in the Arab region, but high unemployment and high levels of informal employment stand out as particularly significant obstacles to development.

Unemployment is neither a new trend nor a direct result of the global economic crisis for Arab countries.[43] The level of unemployment within the region varies dramatically: in GCC countries, unemployment rates range from 0.5 percent in Qatar and 1.8 per cent Kuwait, while unemployment has reached 15.3 per cent in Iraq and 23.7 per cent in Palestine.[44] In 2010, unemployment rates in Egypt, Jordan, and the Syrian Arab Republic ranged from 8.6 per cent to 12.5 per cent.[45]

[37] World Bank (2009), p. 1.

[38] UNDP and the League of Arab States (2009), p. 28.

[39] World Bank (2008b), p. 14.

[40] Ibid.

[41] World Bank (2009), pp. 2-3.

[42] Ibid.

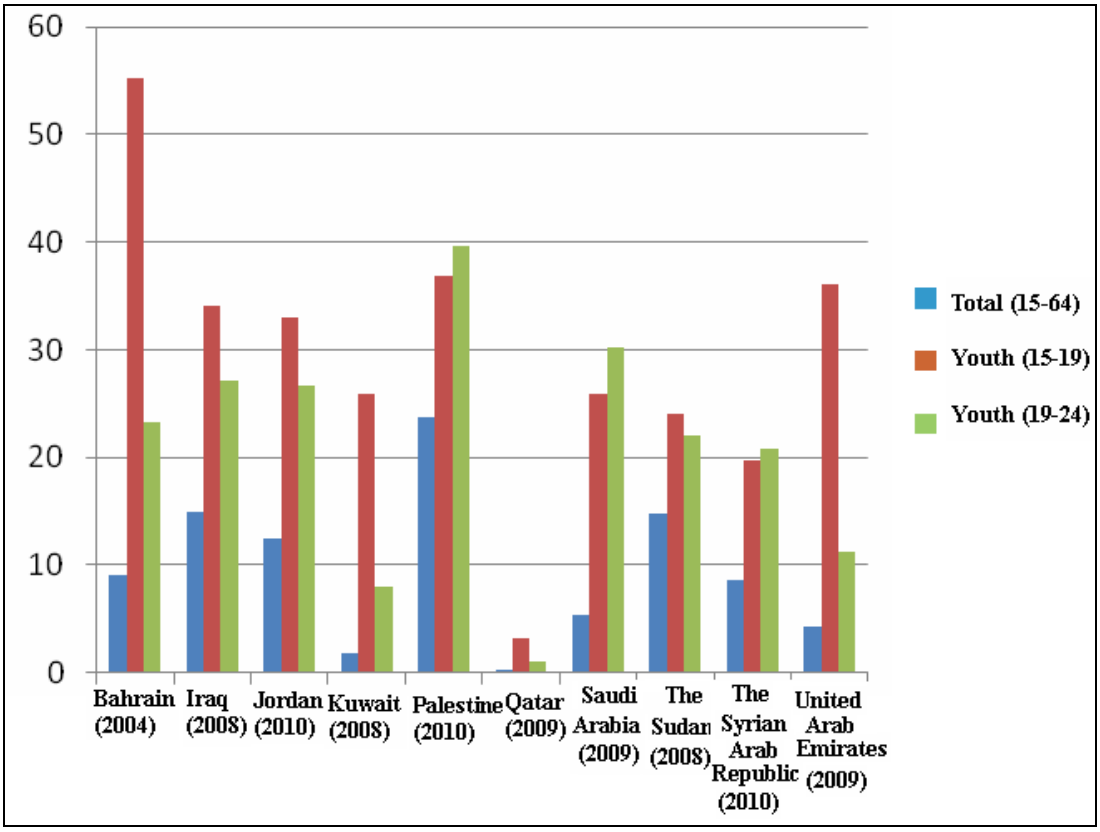
[43] IMF (2011), p. 39.

[44] Unemployment rates for nationals of Gulf countries are expected to be higher. Foreign workers, who by definition, must be employed, are included in the quoted rates. ESCWA (2012a), p. 11.

[45] Ibid.

Though there are multiple factors for high structural unemployment, one explanation can be limited opportunities for decent work. Digging deeper into the reasons behind limited decent work uncovers a multitude of explanations. One reason is the direction of economic diversification in the region, which moved towards low value added trades, such as the construction sector, and resulted in a weak demand of highly skilled labour.[46] Thus, of the few jobs created in recent years, the majority are low skill, low pay, low quality and were mostly filled by migrant labourers.[47] In parallel, the segmentation between the public and private sector only adds to the issue of limited decent work. The public sector is the largest employer in the region, with nearly one third of the employed population working in this sector, according to 2004 data.[48] Wages, benefits and work conditions of the highly preferred public sector rarely match those of the private sector. With reforms to downsize the public sector in many countries and a growing youth population, incorporating youth into the limited formal labour market poses a challenge. As a result, most educated youth prefer to be unemployed and wait for a government job rather than take a position in the private sector.[49] Youth in the Arab region are disproportionately affected by unemployment. Their rates of unemployment are among the highest in the world[50] and are significantly higher than overall unemployment rates (figure IV).

Figure IV. Total versus youth unemployment rates in selected Arab countries
(*Percentage*)



Source: ESCWA (2012a), pp. 91-92.

[46] Ibid., p. 74.

[47] ILO (2011), p. 6.

[48] ILO International Labour Office (2009a), p. 8. The data pertain to ESCWA member countries in addition to Algeria, Comoros, Djibouti Mauritania and Somalia.

[49] Chaaban (2010), p.17.

[50] Tzannatos (2009), p. 22.

As the formal sector is struggling to incorporate a growing labour force, the informal sector is expanding, likely owing to spillover effects. It is estimated that informal employment in most Arab countries accounts for 35-50 per cent of all non-agricultural employment.[51] Limited data show that informal employment accounts for approximately 40-50 per cent of total employment in Algeria, Egypt, Morocco and Tunisia and 20 per cent in the Syrian Arab Republic.[52] In comparison, OECD countries have 18 per cent informality on average[53] while selected transitioning countries have 24 per cent informality.[54] Informal jobs are a cause of concern as they are often characterized by bad working conditions, low wages, little chance of mobility from the informal to the formal sector and no social protection. Even more disconcerting is that workers in the informal sector are typically the most vulnerable in society as the sector includes disproportionally large percentages of women, youth, older persons and persons with disabilities. Without access to social protection measures, individuals who are informally employed are extremely vulnerable to economic shocks. One country is taking action to include those previously not covered by social protection measures. In 2008, the Government of Jordan began a project to extend social security to small enterprises (those with less than 5 employees) in order to reach those who are informally employed or self-employed. The pilot project was carried out in one town and successfully extended coverage to 85 per cent of its small enterprises.[55] Jordan's efforts provide an example of extending social security coverage to the most vulnerable despite limited fiscal space.

To respond to labour-market challenges, help absorb the economic shocks of unemployment and prevent households from falling into or delving deeper into the cycle of poverty, governments can implement labour policies aimed at employment generation, promotion of decent work and support to jobseekers. In the Arab region, however, many of those measures are weak and exclude large segments of the population.

A review of active labour market policies (ALMPs), such as public employment services (PES), employment subsidies, training programmes, public works programmes and micro, small, and medium enterprise (MSME) development programmes in several Arab countries, demonstrates that the policies provide limited services and coverage.[56] In particular, PES are very limited and characterized by low levels of activities, inadequate funding and infrastructure which result in low coverage rates.[57] Some countries have responded to the weakness of PES by creating nationalization agencies which provide integrated services (as is the case in GCC countries) and by regulating private employment agencies (as is the case in Jordan).[58] Training programmes are the largest components of labour polices in the Arab region. However, the fact that they are abundant does not mean that the coverage is equitable. Women, for example, have inequitable access to such programmes, which does little to remedy their high unemployment rates. Rural populations are also marginalized as training programmes tend to be in urban areas. Furthermore, the effectiveness of such training programmes is poor due to the mismatch between the skills provided and labour-market needs, poor quality control and poor coordination and regulation of private training providers. In summary, Arab countries face several challenges related to coverage, policy integration and coordination for ensuring employment for their population.

Employment protection and a mandated minimum wage are mechanisms aimed to help absorb economic shocks, especially for the most vulnerable. In the Arab region, labour regulation serves as the primary way to protect worker's rights since collective bargaining is not very prevalent.[59] Nevertheless,

[51] Bardak, et al. (2006) p. 14.

[52] UNDP (2009), p. 111.

[53] Schneider (2002).

[54] Jütting and de Laiglesia (2009), p. 61. The selected countries were Kyrgystan, Moldova, Romania and Russia.

[55] ILO International Institute for Labour Studies (2009), pp. 29-30.

[56] ESCWA (2012b).

[57] Bardak (2005), pp. 18-19.

[58] ESCWA (2012b).

[59] Angel-Urdinola and Kuddo (2010), p. 4.

labour-market regulations in Arab countries are often poorly enforced and are very limited in terms of their coverage, resulting in little benefit to employees. Most of the time, agricultural workers, domestic workers and foreigners are ineligible, limiting the coverage of labour market regulations. Furthermore, historically, minimum wages in Arab countries were either insufficient or poorly regulated.[60] Recently, however, several countries have instituted or improved minimum wages in response to the social uprisings. Among those countries are Bahrain, Oman, Saudi Arabia, the Syrian Arab Republic, the United Arab Emirates and Yemen. While Arab countries have quality and impact limitations with respect to labour policies, the reach of these measures is also limited. Typically, labour policies only apply to those employed in the formal sector and completely exclude those working in the informal sector, such as workers in family enterprises, migrants and refugee populations.

To address challenges of unemployment and informal employment, labour policies must be developed in coordination with other policies to enhance coverage, effectiveness and quality. International experience shows that combined services, such as PES and trainings for the unemployed, can be beneficial and provide comprehensive approaches to improving unemployment. In addition, because there is no generic solution to adjusting labour-market policies, it is advised that each country determine the right mix of policies and regulations to fit its needs. Because training comprises the majority of ALMPs in the ESCWA region, there is a need to coordinate non-State actors, including donors, NGOs and the private sector, since they are very involved in the provision of training. Improved capacity at the government level and improved coordination among all stakeholders involved would result in more efficient and complementary ALMPs.[61] Special care needs to be taken to ensure that those in the informal sector are included. As there are very few sources of data on the characteristics of the informally employed, identifying and targeting those individuals proves to be challenging.

D. SOCIAL PROTECTION

In the 1990s, the Arab region maintained reasonable investments in social protection.[62] The 2000s were marked by mixed experiences: in GCC countries, the rise of oil prices resulted in increased social spending while in some non-GCC countries such as Egypt, Jordan and the Syrian Arab Republic, the decline of public employment and growing populations resulted in reduced governmental spending on social protection.[63] Even with reduced spending, Egypt and Jordan, however, continued to spend a considerable share of national income on social protection.[64] While spending demonstrates a certain level of commitment by States, it does not provide any indication of the reach and effectiveness of social protection programmes in the region. For example, many social protection programmes in GCC countries do not include foreign workers who represent around 50 per cent of the population.[65] Adding to the uncertainty over the effectiveness of such programmes is the fact that Arab countries generally lack impact assessments, or transparent monitoring and evaluation mechanisms for social protection programmes.[66]

The current status of progress towards development indicators, such as MDG indicators, and the disparities that exist in populations of the Arab countries, demonstrate the need for better-coordinated, expanded and enhanced social protection measures. In Arab countries, social protection is heavily focused on price subsidies as a form of poverty alleviation. In its Regional Economic Outlook for the Middle East and Central Asia, the International Monetary Fund (IMF) noted that a majority of countries provided universal price subsidies on food and fuel.[67] While subsidies can be described as a blanket approach to mitigating

[60] Ibid., pp. 24-27.

[61] ESCWA (2012b).

[62] Jabbour et al. (2012), pp. 6-7.

[63] Ibid.

[64] Ibid.

[65] UNESCO (2011), p. 26.

[66] UNESCO (2011), p. 33.

[67] IMF (2011), pp. 5 and 44. The study covered the Middle East, North Africa, Afghanistan and Pakistan.

economic shocks and are administratively easy to implement, they are costly and have little impact on improving the conditions and opportunities of the most vulnerable, especially in the long term. Furthermore, IMF called for replacing price subsidies with social safety net programmes in the region because experience in other global regions has shown that conditional cash transfers are more cost-effective and reach the poorest and most vulnerable.[68] However, there are several barriers to phasing out subsidies and implementing social safety net programmes. First, many households rely on them and in the presence of weak public services, subsidies are seen as the only form of social support. Removing subsidies would likely cause social discontent. Second, conditional cash transfer programmes require the administrative capacity and infrastructure to identify those most in need. The level of poverty in Arab countries is unclear because few countries have data measuring the poverty line.[69] While all countries in the region provide social safety net programmes, they suffer from a lack of coordination and ad hoc funding, which leads to insecurity for recipients and administering institutions.[70] Ensuring an administratively and financially capable infrastructure is the first step in transitioning from price subsidies to social safety net programmes. Specifically, governments must have the capacity to identify target populations, determine the fiscal space and the costs and effectively implement the programme. Jordan has taken steps to reduce fuel subsidies along with other social protection measures (box 2).

Box 2. Transitioning from price subsidies to social safety nets: The case of Jordan

In Jordan, studies have demonstrated that higher income groups benefited more from subsidies than the poor: the poorest quintile received less than 10 per cent of the total fuel subsidies and the richest quintile received more than 40 per cent. As a result, between 2005 and 2008, Jordan phased out fuel price subsidies and instead used international fuel prices determined through a monthly automatic pricing system. Concurrently, other social protection measures were introduced. Those interventions included: increases in minimum and civil servant wages, cash transfers to low-income households, one-time bonuses for government employees and increased allocation to the Government's social assistance programme, the National Aid Fund. However, as a reaction to the Arab Spring, King Abdallah reinstated some subsidies.

Sources: IMF (2011), p. 47, and Achy (2010).

Social security schemes comprise the risk mitigation component of social protection measures. The presence of and restrictions on unemployment benefits vary across the Arab region. Overall, social security coverage is less than 40 per cent of the working population.[71] In Yemen, for example, coverage is as little as 8 per cent of the workforce.[72] Only five countries (Algeria, Egypt, Jordan, Libya and Tunisia) have coverage rates in the 55-80 per cent range, which is comparable to countries in other world regions with a similar per capita income.[73] In contrast, social security schemes in GCC countries cover only 5-30 per cent of the population, mostly because the labour market is saturated with expatriates who are not eligible for such social protection measures.[74] Those who are self-employed or work in the private sector may have a partial level of protection, if at all.[75] In addition, demographic and labour-market challenges undermine social security systems. An ageing population is presumably expected to require more care, yet the high youth unemployment rate and the large informal sector indicate that a large segment of the population is not contributing to current schemes. Bahrain, however, implemented an unemployment insurance scheme in

[68] Ibid., pp. 44-49.

[69] UNESCO (2011), p. 30.

[70] ILO International Labour Office (2009b), p. 6.

[71] Loewe (2009), p. 9. The study included all ESCWA member countries in addition to Algeria and Iran.

[72] Robalino (2005), p. 54.

[73] Loewe (2009), pp. 9-11.

[74] Ibid.

[75] ILO International Labour Office (2009b), p. 4.

2006 as part of an overall social reform to specifically increase contributions and support new entrants to the labour force (box 3).

Recently, Arab countries have implemented reform efforts to increase social security coverage and financed those reforms by increasing the retirement ages among other interventions.[76] In response to recent social uprisings, several countries have made reforms to their social security schemes. Oman, for example, increased the social insurance pension by 100 percent for all beneficiaries. Arab countries should take steps to extend coverage so that all are protected and then progressively increase the level of protection. Ultimately, moving towards universal social protection systems ensures that vulnerable groups are better able to cope with livelihood risks and contributes to greater social cohesion and stability. Universal approaches to social protection are therefore an integral component of comprehensive social policy and essential to achieving socially related MDGs and more equitable patterns of development.

Box 3. Protecting the unemployed: The case of Bahrain

With high unemployment rates and a growing population expected to put additional pressure on the labour market, the Ministry of Labour and Social Affairs developed the "Strategy for Employment and Integration of the National Workforce in the Labour Market in Bahrain". The strategy included social protection measures such as unemployment insurance. In Bahrain, the majority of the unemployed are recent graduates and without a record of regular employment. The scheme was then designed to offer income assistance to first time job seekers and the unemployed. The employee, employer and Government each contribute to the unemployment insurance scheme. Results have been overwhelmingly positive: unemployment was reduced to less than 4 per cent despite the global economic crisis. Bahrain's unemployment insurance scheme is a proactive and targeted response that matches the needs of its citizens. It is important to note that one of the key factors contributing to the success of the measure was the strong and effective social security system that was already in place, making the unemployment insurance scheme administratively manageable.

Source: ILO (2006), pp. 2 and 7.

II. THE WAY FORWARD: COMPREHENSIVE SOCIAL POLICY

The previous section demonstrated that social policy in the region is limited in reach, effectiveness and funding. Thus, Arab countries are not fully leveraging the role of social policy in achieving development objectives, increasing equality and promoting social cohesion. The most vulnerable are often left out of full participation in society. Investing in them is integral to reducing poverty and achieving MDGs (see box 4). Pro-poor measures can lead to higher revenues for contribution-based social protection measures and reinforce their sustainability.

Arab countries should direct efforts to providing a minimum level of protection. To do this, they can create a social protection floor, as developed by the World Commission on the Social Dimension of Globalization.[77] The concept of a social protection floor encompasses a set of essential services and social transfers to help realize human rights.[78] It calls for geographical and financial access to such essential services as water and sanitation, nutrition, health and education and a basic set of targeted essential social transfers, in cash and in kind, paid to the poor and vulnerable to provide a minimum income security.[79] In order to be successful, a social protection floor depends on such criteria as the efficacy of existing institutions, the level of economic development, the ability to raise more funds domestically and externally, and the political will for social and economic transformation.[80] Designing a social protection system involves

[76] Ibid.

[77] ILO (2004).

[78] ILO and WHO (2009), p. 2.

[79] Ibid.

[80] UNRISD (2010), p. v.

a review of existing structures and programmes to determine their capacity for administration and management, including identifying beneficiaries, setting up monitoring and evaluation systems and creating accountability systems. Furthermore, a successful design will investigate ways in which different activities could be better coordinated to increase efficiency and use resources.[81]

Box 4. The most vulnerable: Persons with disabilities

According to World Health Organization (WHO) estimates, 10 per cent of the world's population has some sort of disability (available from http://www.un.org/disabilities/default.asp?id=18). Applying this calculation to the Arab region results in estimates of over 30 million persons with disabilities. Furthermore, it is estimated that 20 per cent of the world's poor are living with a disability (Elwan (1999), p. v). As one of the most marginalized groups in society, persons with disabilities confront stigma, discrimination and other challenges hindering participation in their development. Therefore, ensuring that they have equal opportunities for development is critical to achieving MDGs.

The interconnectedness between disability, poverty and vulnerability calls for policy measures aimed at social integration and support for these often overlooked members of society. With regards to access to education and labour, persons with disabilities face extreme inequalities.

Education

In the Arab region, the educational systems do not accommodate disabled persons, thereby excluding as much as 95 per cent of disabled children at the primary level and nearly the entire disabled population at the university level (World Bank (2007), p. 29). In Jordan, for example, the illiteracy rate among persons with disabilities is 30.5 per cent, compared to a national average of 9.3 per cent and only 4.2 per cent of persons with disabilities have a university degree (ESCWA (2009b), pp. 29 and 33).

Labour

Disabled persons often face discrimination when seeking employment and many workplaces do not accommodate their disability. Those circumstances result in low labour force participation rates among persons with disabilities. For example, in Yemen, only 12 per cent of the working-age persons with disabilities were active in the labour force (ESCWA (2010c), p. 12). For those who are working, most of them find employment in the informal sector, which offers little or no social protection. Many countries in the Arab region have quota systems to counteract discrimination and other barriers to the employment of persons with disabilities, but it is unclear how well such regulations are monitored and enforced.

Social protection programmes that have multipronged approaches and address various sectors, such as health and education, require interministerial and intersectoral capacity-building in order to function efficiently.[82] The result is a minimum set of guarantees for all, allowing individuals to participate in their own development.

A key mantra of the social protection floor is that there is no one-size-fits-all approach. The Bolsa Familia (Brazil) and the Oportunidades (Mexico) conditional cash transfer programmes are often cited as successful social protection floor programmes. An impact assessment demonstrated that the programme in Brazil reduced the poverty gap by 12 per cent between 2001 and 2005 and contributed to a decline in income inequality.[83] In Mexico, the programme contributed to improvements in educational attainment in rural areas and maternal and child health indicators.[84] While those programmes were very successful, it is important to

[81] UNDP (2011), pp. 19-20.

[82] Ibid.

[83] Ibid., p. 16.

[84] Ibid.

note that much of their success comes from a design that was appropriately built upon existing administrative infrastructure, including a robust registry that allowed for the identification of poor families as in Brazil and strong interministerial coordination in Mexico. Thus, it is advisable for Arab countries to not simply replicate the successful programmes from Latin America but to assess how they can best leverage existing resources and mechanisms.

Financing a social protection floor can be perceived to be a barrier especially for countries with limited fiscal space. However, ILO has calculated the initial cost of a basic social protection package, excluding access to basic health care as it is assumed that access to basic health care is already financed. Their estimate revealed that basic social protection is relatively affordable and will cost 2.3-5.5 per cent of GDP for low income countries.[85] Table 3 shows the financial resources needed for low income countries to establish a social protection floor according to ILO estimates.

TABLE 3. ESTIMATED ANNUAL FUNDS REQUIRED TO ESTABLISH A SOCIAL PROTECTION FLOOR FOR LDCS IN THE ARAB REGION

Country Name	GDP 2009	2.2%-5.5% of GDP
Comoros	$535 million	$11-29 million
Djibouti	$1 billion	$23-58 million
Mauritania	$3 billion	$66-166 million
Morocco	$91 billion	$2-5 billion
Somalia	$917 million	$20-50 million
Yemen	$26 billion	$580 million-1.5 billon

Source: World Development Indicators database and author's calculations.

Using a progressive approach to financing a social protection floor is advised (see box 5). Countries that have more fiscal space can extend social protection beyond the minimum services.

Finally, if social protection mechanisms are to have their maximum impact, they must be complemented by broad social and economic policy initiatives which expand opportunities for all. The responsible institutions at the country level may need strengthening. Furthermore, although governments have the primary responsibility of the provision of services, it is recommended that they improve coordination with international donors and leverage support from the international community, NGOs and civil society.

Box 5. Checklist for financing a social protection floor

While each country has its own set of resources, challenges and policy environment, the ILO has proposed a checklist to guide countries in the construction of a social protection floor. It includes:

(a) Tax reforms to increase financial resources, raised and spent progressively;

(b) Gradual increases in social spending as a proportion of GDP as a proportion of total government spending;

(c) Redistribution between social policy areas to refocus spending on most urgent needs;

(d) Ensure revenue collection is progressive, and refocus spending within social sectors and policy areas to make it more progressive and more effective in combating poverty and vulnerability.

Source: ILO and WHO (2009), pp. 10-11.

[85] ILO and WHO (2009), p. 10.

III. CONCLUSION

In addition to providing a set of objectives for development, MDGs aim to prioritize development for the world's most poor and vulnerable. Thus, at their core, MDGs represent more than a deadline: they represent a focus on equal distribution of growth and opportunity. Social policy, which can serve to overcome inequality, becomes an effective approach to achieving MDGs and promoting development.

Current social policy in the Arab region is inadequate and inefficient. The result is unequal opportunities, poverty and inequality traps that hinder self-actualization on the individual level and development on the wider social level. A social protection floor, a basic set of social services and social protection systems, would help correct the current limitations in social policy in the Arab region. Developing a social protection floor involves identifying the gaps (both in reach and quality) and the available resources. Knowing the profile of the beneficiaries is as essential as having the capacity to reach them. Since each country faces different social and economic challenges, there is no standard solution. However, a successful comprehensive social policy for equality must be inclusive, realistic, based on evidence and the current capacity and complemented by other policies.

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