



Population Situation Analysis

Egypt 2016

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Executive Summary

The report presents a new analysis for the current population situation in Egypt. The new analysis is needed given the changes in the political, economic, and social eco-system in the last few years.

Thus, the report will serve as:

- A baseline for monitoring the implementation of the National Population Strategy,
- A source for technical input and recommendations to UNFPA's 10th Country Program, and,
- The main UNFPA resource for technical input and recommendations to the forthcoming UNDAF.

An overview of the population status in Egypt indicate that political instability between 2011 and 2014 had its impact on health services delivery including reproductive health and family planning and had a significant impact on economic growth, job creation and poverty. The lack of advocacy activities supporting the two-child policy and spacing between births coupled with a conservative mindset contributed to turning the stalled fertility levels between 1995 and 2005 to an increase in total fertility from 3 to 3.5 child per women in 2014. The reproductive role of women was competing with their productive role in a society that witnessed a setback in women empowerment and gender equality.

The recent population projections of the UN Population Division suggest that the population of Egypt might reach, based on the medium scenario, 151 million by 2050. Such increase will have its significant impact on natural resources, especially water and energy, and might have serious implications on food security, poverty and social stability. It also implies that the country is not likely to benefit from a demographic dividend if fertility levels does not come down in the coming few years.

For such challenges, policy matters and Egypt has adopted a set of policies and strategies including the population and development strategy 2015-2030 and Egypt vision 2030. The review shows that targets adopted in the planning phases were not achieved due to lack of resources, weak coordination, lack of continuity in institutional framework, centralization, and absence of monitoring and evaluation.

Issues related to inequality are pertinent when addressing population dynamics. In Egypt, significant disparities in population and health outcomes can be explained by poverty level

and place of residence (urban vs. rural and upper Egypt vs lower Egypt). This can be illustrated in Figures 1, 2 and 3, it is evident that poverty and living in rural upper Egypt are highly associated with large families and/or low contraceptive prevalence and fertility level. The implications is not only reflected in a higher fertility level, but also manifested in internal and illegal migration, in increasing unemployment and in risk of political unrest. This is mainly hurting the youth and is creating a vicious circle that will become harder to break. Securing reproductive health and family planning services especially in deprived areas and among marginalized sub-populations should get the highest priority. Programs need to be specific to the local context and different approaches need to be considered especially in rural upper Egypt.

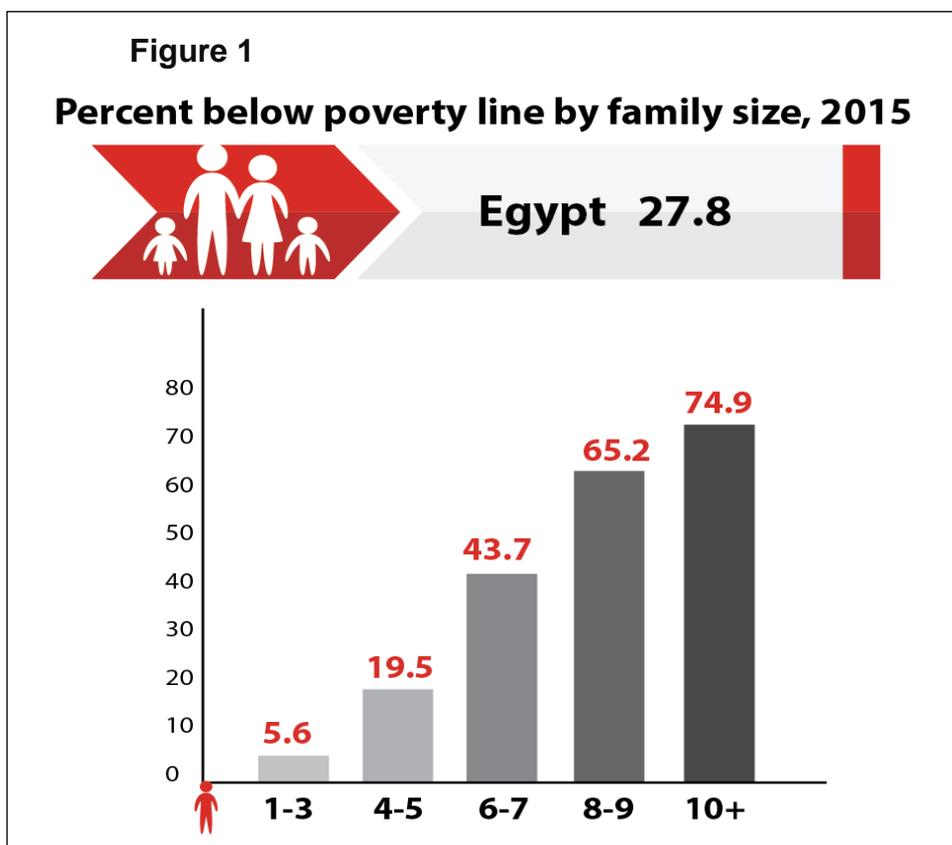


Figure 2
Contraceptive use (among currently married), 2014

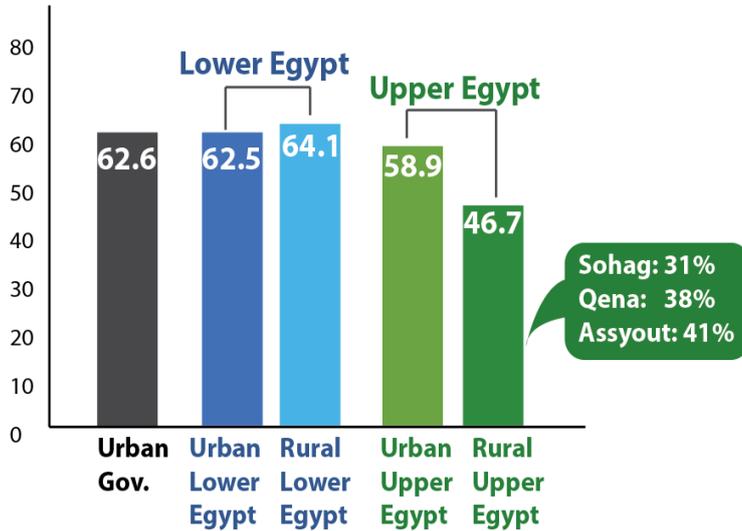
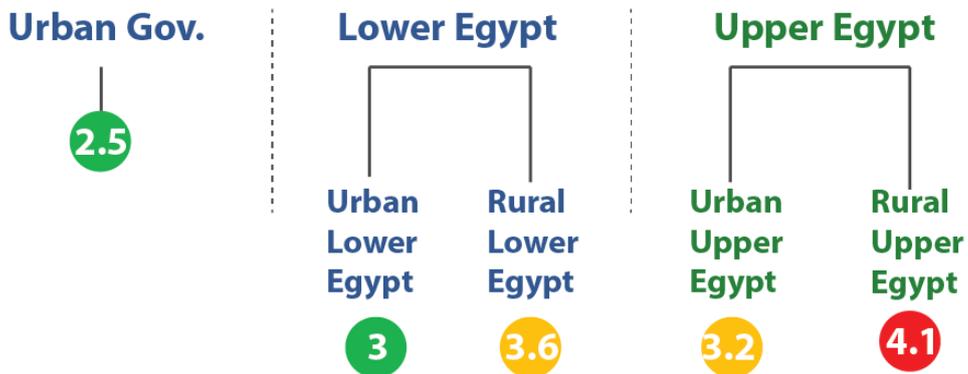
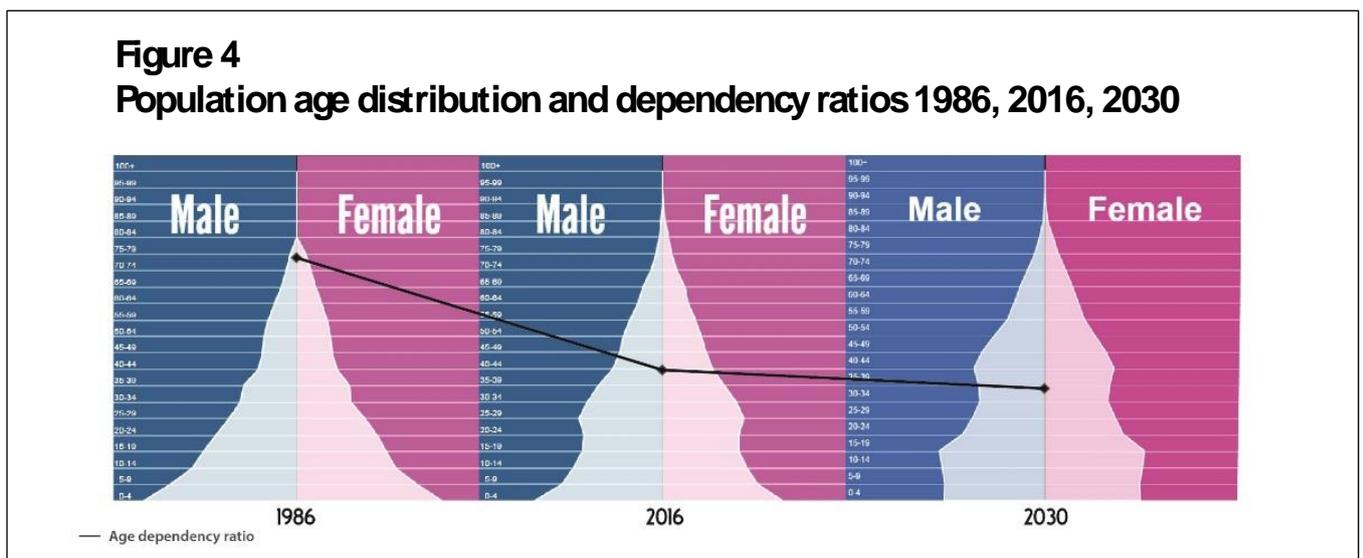


Figure 3
Total fertility rate, 2014



Political commitment and legislative framework offer a unique opportunity to reduce population growth and to improve population characteristics which will improve overtime quality of life and opportunities. The 2014 Egyptian Constitution, the new Vision for 2030, the population strategy and the Sustainable Development Goals provide a comprehensive approach to integrate population and development. However, the institutional framework needs to be enhanced to address challenges that go beyond high fertility level. The root causes need to be addressed in a participatory and harmonized approach and should not be limited to governmental organizations.

A comprehensive approach to population issues should take into consideration the benefits that can result from having a demographic dividend through a significant and continuing decline in fertility. Demographic dividend is the economic growth potential that can result from shifts in a population’s age structure when fertility levels decrease due to a larger share of the working-age population than the non-working-age share of the population.



Egypt can harness its demographic dividend through investments that would improve health, education, economic policy, and governance, and ultimately slow population growth. Economic growth can occur if younger population have access to high quality education, adequate nutrition and health including sexual and reproductive health.

These efforts are needed to break the vicious cycle of poverty, low education, early childbearing, and high fertility that has trapped a large segment of the Egyptian society. Demographic dividend can be addressed within the context of the sustainable development goals. The triple E's, namely, Educate, Empower and Employ can serve as a framework for not missing the demographic dividend.

Empowerment can be achieved through the access of all people to essential health care services especially women and girls who must have the rights and freedom to define their lives which require protecting them from harmful practices, child marriage and from all forms of violence. Women in Egypt continue to endure multiple forms of social, cultural, economic and political exclusion caused mainly by two important factors: First, the failure of public policies to bridge the gender gap which is ever-expanding on several levels. Second, the persistence and severity of social norms hindering economic and legal empowerment. No demographic dividend can take place without youth empowerment. In addition to accessibility to quality education, youth political and civic participation is an essential part of building a sustainable future. Comprehensive sexuality education needs to be more accessible. In addition, sexual and reproductive health for youths should be integrated in the health system to prevent them from risks.

In addition to adopting the demographic dividend as a framework, the report outline a set of suggestions including:

- ✿ Provision of adequate and sustainable funding to ensure complete coverage of contraceptives especially in deprived areas,
- ✿ Building capacity to provide better quality reproductive health services to reduce unmet needs and dropouts,
- ✿ Advocating for adopting lower fertility norms, spacing between births, and avoiding early pregnancy,
- ✿ Empowering women through financial inclusion, legal support and skills development to decrease unemployment and to create opportunities,
- ✿ Empowering youths through knowledge, entrepreneurship, information and access to credit to create jobs and improve quality of life,
- ✿ Encouraging NGOs to play a larger role in providing services in remote areas and to marginalized sub-populations and in providing advocacy activities,
- ✿ Emphasizing population targets in conditional cash transfer programs as a vehicle to enhance social transformation and improve quality of life,
- ✿ Collaborating with the private sector in population activities through their corporate social responsibility programs,
- ✿ Using social media and innovative ideas to communicate with youths.

Introduction

Egypt witnessed several political changes during the last five years. These changes started when Egyptians went to street on January 25th, 2011 with specific requests “Bread, Freedom and Social Justice”. These requests reflected not only the needs of Egyptians but also a road map for a sustainable future. After a transition period, a presidential election was held in mid-2012. The nominee of the Muslim Brotherhood won the election and became the first president after the January 25th revolution. At the outset of his term, starting in June 2012, Morsi offered a package of promises, pledging to carry them out in the first 100 days of his rule. At the end of those 100 days, 78% of Egyptians approved Morsi’s performance. The high approval rating didn’t last long, and the decline began to set in right after the constitution amendment, a move that was largely perceived as a breach of existing constitutional provisions. The president’s approval rating continued to dip, reaching 32% in late June 2013, days before the June revolution. As a result of the MB failure to meet Egyptians’ expectations, Egyptians went to the streets demanding its ouster, and before long the army responded to Egyptians request and deposed Morsi from power. In June 2014, another presidential election was held and Abd El-Fatah El-Sisi won the elections and became Egypt’s president. Since then baseera polls show improvements in security and political stability as in August 2014 around 88% of the Egyptians stated that the security has been improved. This percentage continued at the same level in the following 2 years which led to a high approval rate for the president’s performance over the last 2 years.

The abovementioned political changes had severe impacts on the Egyptian population status. The indicators that were produced and published by different sources show deteriorations in different population and development indicators. Economic indicators developed by the Central Agency for Statistics and Public Mobilization (CAPMAS) showed an increase in the percentage below poverty line from 21.6% in 2009 to 27.8% in 2015. This percentage ranges between 25% and 40% in 6 governorates and exceeds 40% in 5 governorates. Indicators show also a drawback in the coverage and quality of different services.

As a response to the impact of the political changes on the Egyptian economy, Egypt is starting a set of mega projects that aim at improving the economic status and providing more opportunities for employment and geographic re-distribution.

The EDHS 2014 indicated a faster pace of population increase. The total fertility rate increased from 3 children per women in 2008 to 3.5 children per women in 2014. As a result the total number of births in Egypt increased from less than 2 million births to 2.7 million births in 2015.

These facts along with the emerge of new stakeholders with high impact on the population and the cultural changes suggest the need of a new analysis for the current situation in Egypt especially that Egypt launched in November 2014 a new strategy for population and development covering the period from 2015 to 2030. The strategy consisted of 4 main objectives:

- 1- Reducing the population growth rate
- 2- Improving the population characteristics
- 3- Achieving a balanced population distribution
- 4- Reducing the inequity among different demographic, social and economic groups.

Each objective was linked to a number of quantitative targets and a set of programs and activities. Different stakeholders participated in developing the strategy. The implementation of the strategy began in 2015 with a commitment from the different stakeholders to perform their roles and achieve the planned targets.

Monitoring and evaluation are important aspects in the implementation of the strategy to insure that the strategy will achieve its final goal by 2030. The “population situation analysis” report will serve as a baseline for monitoring the implementation of the National Population Strategy and help through monitoring the procedures and activities implemented by different stakeholders and evaluating the outcomes of these activities to clear whether they would achieve the targets or not.

The report will present and discuss the changes in different issues related to population and development in Egypt, the programs, activities and actions taken to improve Egypt status and the actions needed to achieve the goals of the population and development strategy. Thus, the report will serve as:

- A baseline for monitoring the implementation of the National Population Strategy;
- A source for technical input and recommendations to UNFPA’s 10th Country Programme;

- The main UNFPA resource for technical input and recommendations to the forthcoming UNDAF.

To achieve these objectives, the report will include 9 chapters following this introduction. Each chapter provides an overview of the newest statistics related to the topics addressed in the chapter and analyzes the differences in the values of the indicators according to the main characteristics whenever possible. Each chapter presents a set of indicators that reflect Egypt status in the topics discussed in the chapter with focus on the indicators that was used to set the targets of the National Population and Development Strategy.

Chapter one presents an overview for the population status in Egypt including population growth, population dynamics, and population characteristics. The chapter sheds light on the population growth, marriage, fertility, mortality and population characteristics. The chapter ends with an analysis for Egyptians' perceptions regarding different population issues.

Chapter two discusses the different strategies that have been launched in Egypt during the past two years that aims to improve Egyptians' lives. The chapter discusses also the needed framework to implement the national strategy for population and development.

Chapter three sheds light on sexual and reproductive health and HIV and focus on adolescents and youths as a priority group.

Chapter four presents determinants of population growth including morbidity and mortality, marriage and family patterns and international migration.

Chapter five addresses the issue of inequality and vulnerable groups. Baseera team conducted a set of focus group discussions and in-depth interviews with Egyptians from different vulnerable groups to cover the shortage in information related to these groups.

Chapter six focus on women status and gender inequality and sheds light on different issues related to women empowerment and gender based violence.

Chapter seven focuses on adolescents youth access to sexual and reproductive health, early marriage and harmful practices against female adolescents.

To move forward towards achieving development goals chapter eight discusses the relationships between population, economic and poverty eradication, and environment. The

chapter highlights need for social protection and the link to age structure, and the universal social protection approach.

Finally, chapter nine summarizes the main challenges that face Egypt in different population and development issues and ends with a set of recommendations to accelerate the pace of achieving the population and development strategy.

Chapter 1

Population Status in Egypt

1-1- Introduction

Egypt population witnessed dramatic increases during the last decade. This increase require more resources to cover the population needs and achieve citizens' welfare. This depends to a great extent on the growth rate of the population, its characteristics and the citizens' perceptions regarding and knowledge about population growth and its consequences. The second section of this chapter presents population size and growth. Section three sheds light on population dynamics while section four presents the population characteristic. Section five presents the demographic transition in Egypt and discuss the demographic dividend in details, while section six discusses the knowledge of Egyptians about population size and the natural resources limitations.

1-2- Population Size and growth rate

The population of Egypt in November, 2016 was estimated at 9 million people by the Central Agency for Public Mobilization and Statistics (CAPMAS) compared to a total of 72 million people in November 2006. In absolute terms, the population of Egypt has increased by around than 20 million people in 10 years. This absolute addition to the population during the decade 2006-2016 is almost the size of the population of Belgium and Sweden together as well as Hungary and Czech Republic together. The total population of Egypt in 2016 is almost equal to three times the population of Malaysia, almost equal to the combined population of Morocco, Saudi Arabia and Yamen, and 2.5 the population of Canada.

The estimated global population in 2015 was 7,324.8 million. The population of Egypt accounts for almost 1.2% of the global population. The rank of Egypt is 15 in the World in 2014 according to info please (2015), as shown in Table 1.

The rank of Egypt was 20 in 1950 and kept the 15th rank since 1999. Egypt is the third populous country in Africa after Ethiopia which is ranked 13th with a population that exceeds 96.6 million and Nigeria which is ranked 7th with a population of 177 million.

Table 1-1: Population size of the most populated 15 countries in the World in 2014

Rank	Country	Population size
1.	World	7,174,611,584
2.	China	1,355,692,576
3.	India	1,236,344,631
4.	United States	318,892,103
5.	Indonesia	253,609,643
6.	Brazil	202,656,788
7.	Pakistan	196,174,380
8.	Nigeria	177,155,754
9.	Bangladesh	166,280,712
10.	Russia	142,470,272
11.	Japan	127,103,388
12.	Mexico	120,286,655
13.	Philippines	107,668,231
14.	Ethiopia	96,633,458
15.	Vietnam	93,421,835
16.	Egypt	86,895,099

Source: Info please, 2015

Egyptians live on one million square kilometer with a population density of around 89.2 per square kilometer in 2016. The rank of Egypt is 115 in population density. However, Egyptians only live on about 8% of the area. The inhabited area is concentrated around the strip along the Nile River from the south to the north. Given this extensive concentration of population on this narrow area, population density is exceedingly high if the inhabited areas only were considered. The population density of 2016 jumps to almost 1136.5 persons per square kilometer if inhabited areas were only accounted for. Accordingly, Egypt rank will jump from 115 to 14 among countries of the world. High population density could be related to low quality of life and low quality of services especially if the cities are not well-structured. This asserts the importance of addressing the population distribution issue in the national strategy for population and development.

The United Nations has estimated that the world population grew at an annual rate of 1.23% during the period 2000-2010. The average annual growth rate for selected countries and the World is shown in figure (1-1). China, which is the most populous country in the world, registered an annual growth rate of 0.53% during 2000-2010, India, which is the second populous country, grew at an annual rate of 1.64% during the same period. The growth rate of China is now third lowest among the ten most populous countries, after Russia and Japan and it is substantially lower than the USA (0.7%). Egypt is growing at a rate (2.3%) which is higher than many developing countries.

During the period 1897 to 2015, there has been over almost nine-fold increase in Egypt population; it first doubled during the first fifty years of the past century. However during the latter period from 1947-2015, population experienced a five-fold jump i.e. this surge started to gain pace in the early fifties of the past century.

Figure 1-1: Population growth rates in selected countries

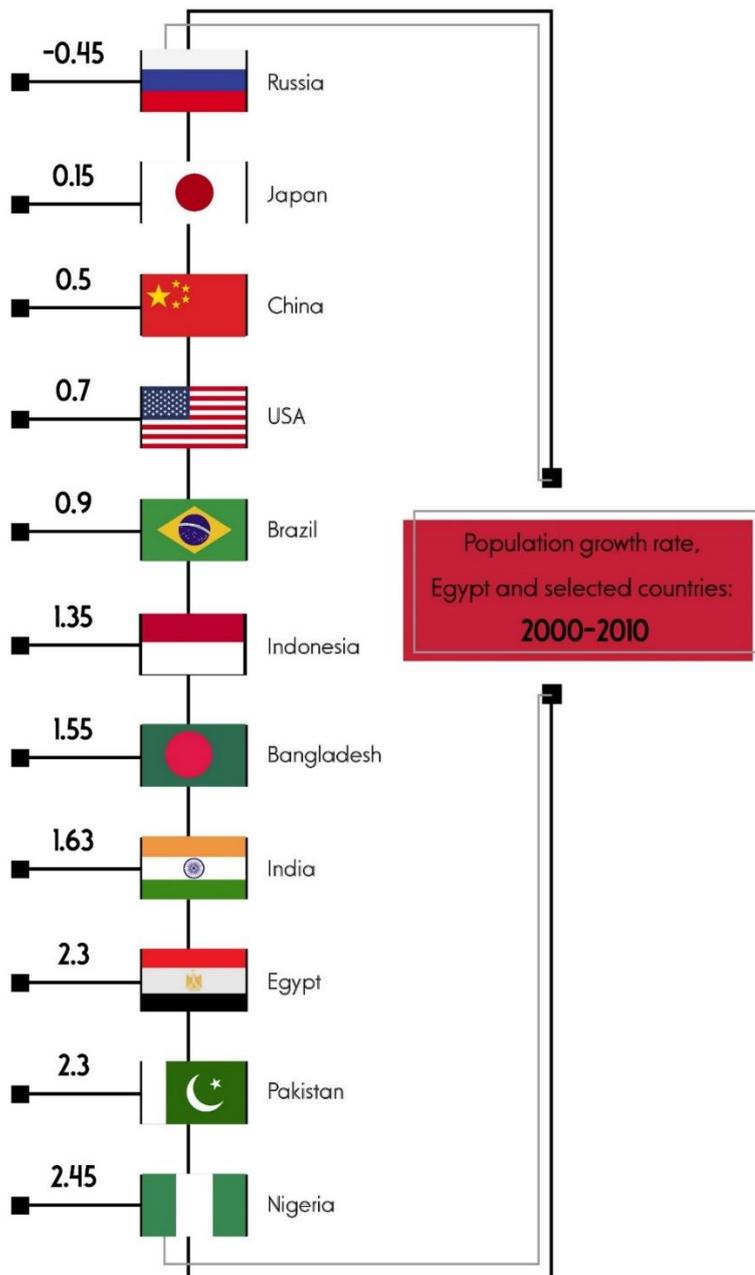


Table 1-2: Egypt population size and annual growth rate, 1987-2015

Census Year	Population Size (in millions)	Annual Growth Rate (%)	Index Number %
1897	9.7		100
1907	11.2	1.43	115.7
1917	12.7	1.31	131.5
1927	14.2	1.10	149.6
1937	15.9	1.15	164.7
1947	18.0	1.75	196.2
1960	26.0	2.30	268.7
1976	36.3	2.12	378.8
1986	48.2	2.86	499.1
1996	59.3	2.06	613.4
2006	72.8	2.05	752.9
2015	89.6	2.30	876.2

* Does not include Egyptians who were not in Egypt in the census reference night.

Source: Population censuses and statistics year book 2014, CAPMAS and CAPMAS site (<http://www.capmas.gov.eg/>) for 2015.

1-3- Population dynamics

1-3-1- Mortality Transition

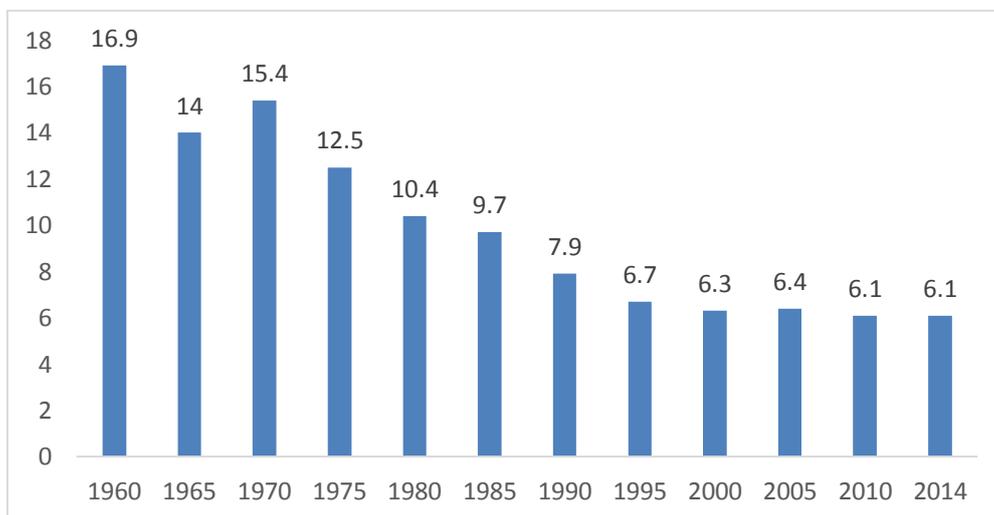
The period from the early 1960s until the early 1990s witnessed a remarkable fall in the death rate, as illustrated in figure (1-2).

It is noticed that this rate has been moving exceedingly slowly since the early 1970s until it reached 6.9 deaths per 1000 population in 1992.

In 2000, Egypt's crude death rate reached 6.3 deaths per 1000 population and decreased to 6.1 deaths per 1000 population in 2014. Male death accounted for about 55% of all deaths, while female deaths accounted for 45 % of them.

Deaths are more prevalent in urban areas (8.1 deaths per 1000 population) compared to rural areas (4.7 deaths per 1000 population). The highest death rates has been witnessed in Cairo (9 deaths per 1000 population) and Alexandria (8 deaths per 1000 population) while the least death rates are prevalent in the frontier governorates such as Al-WadiAl-Gedid, Northern Sinai, and Marsa Matrouh (4.4 deaths per 1000 population). This can mainly be attributed to the high demand of the comparatively high quality health services available in Cairo and Alexandria, thus most travel to theses metropolitan areas to seek health treatment. When deaths occurs, they are registered in these metropolitan areas which results in the higher death rate. Males experience higher death rates (6.6 deaths per 1000 population) than females (5.6 deaths per 1000 population).

Figure 1-2: Crude death rates in Egypt 1960-2014



Source: Births and deaths statistics for several years, CAPMAS

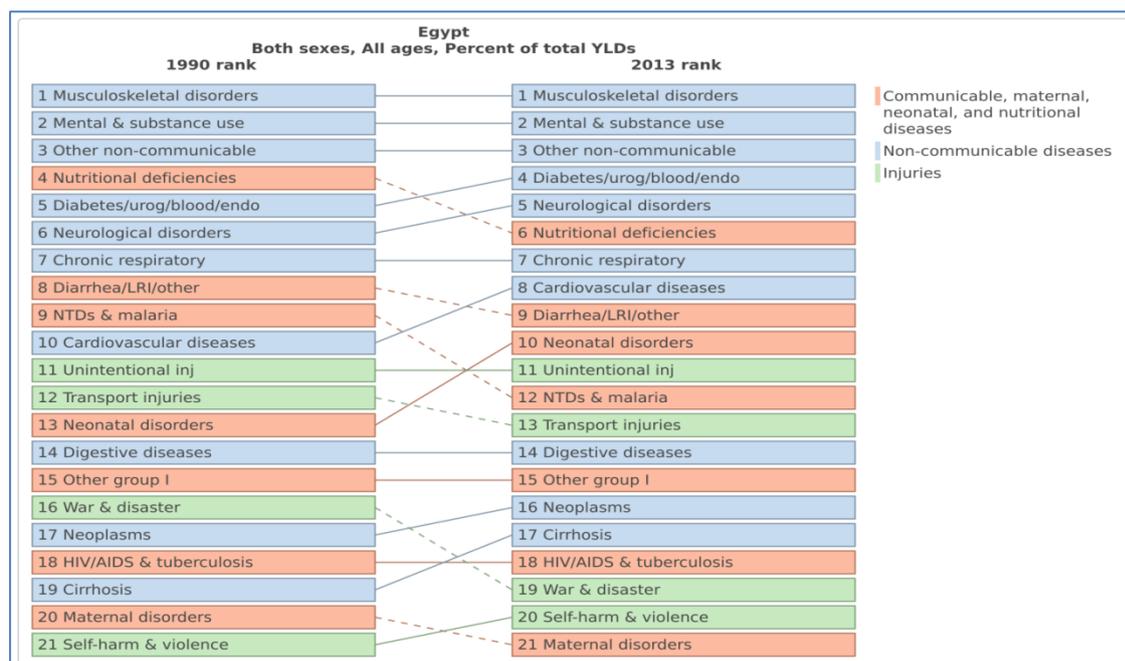
As a result of this decline in mortality levels, life expectancy at birth in Egypt has almost doubled during the period from 1937 to 2015. For males, life expectancy at birth was estimated at almost 36 years in 1937 and jumped to around 69 years in 2015. For females the index jumped from 48 years in 1937 to 73 years in 2015.

Causes of Morbidity and mortality

One of the main products of the Global Burden of Disease project is the years lived with disability by the cause and by the risk factor leading to this disability. Figure 4-7 shows that

between 1990 and 2013 the non-communicable diseases are gaining precedent over communicable diseases. Diabetes, urogenital, blood and endocrine diseases and Neurological disorders ranks increased by one rank while nutritional deficiencies lost 2 ranks. Similarly Diarrhea, lower respiratory infections and other diseases lost one rank. The largest loss in rank was observed for the Neglected tropical diseases and malaria that lost three ranks from the 9th rank to the 12th rank.

Figure 1-3: Changes in the rank of major health causes underlying YLD 1990-2013



Source: Institute for Health Metric and Evaluation, a

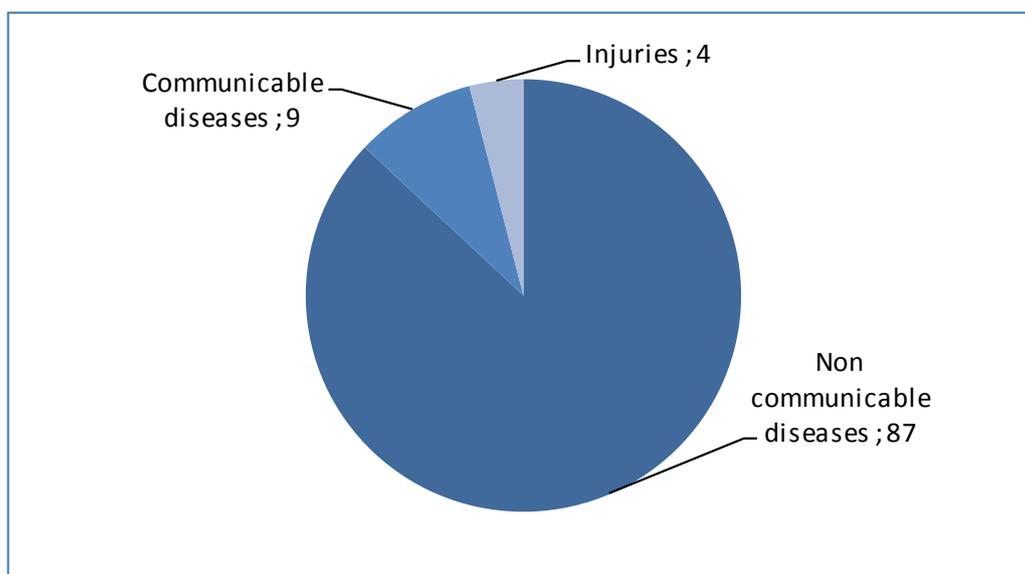
According to Gayed (2014), non-communicable diseases were the leading cause of death among Egyptians accounting for 87% of all deaths in Egypt (Figure 4-3). However, communicable diseases still maintain a significant share of deaths in Egypt accounting for 9%. Injuries had the lowest share and accounted for only 4% of all deaths.

A closer look at the causes of death and measuring the contribution of the major non-communicable diseases reveals that cardiovascular diseases were the main causes of death accounting for 43% of all deaths followed by communicable diseases accounting for 9% followed by Cerebrovascular disease and malignant Neoplasms accounting for 8% and 7%, respectively (Figure 4-4). For the Malignant Neoplasm, the data showed that 22% of all

Cardiovascular diseases were the main causes of death accounting for 43% of all deaths followed by communicable diseases accounting for 9%.

deaths in this category were due to liver cancer. Among the injuries, about 40% of the deaths were attributed to road traffic accidents.

Figure 1-4: Major causes of death in Egypt as reported by death certificates 2013



Neonatal, Infant and under-five mortality

Table (1-3) presents the trend in neonatal, infant and under-five mortality in Egypt during the period 1965-2014. The trend in the three indicators is going down as a result of better health and better health services. For those aged less than five years, the probability of dying in 1965 was nine times the one observed in 2014 (243 and 27 respectively) 2014. Infant mortality rate decreased six times from 141 in 1965 to 22 per 1000 live in 2014. The decrease in neonatal deaths was much lower, almost four times from 63 to 14 births. This clearly indicates a change in the pattern of mortality for those aged less than 5 years. Mortality became concentrated mainly in the earliest months in life. According to EDHS 2014, around 40% of under-five deaths occurred after completing the first year in life in 1965 compared to only 19% in 2014.

Table 1-3: Trends in early childhood mortality in Egypt (per 1,000 live births), 1965-2014

Year	Neonatal Mortality	Infant Mortality	Under-five mortality
1965-1969	63	141	243
1986-1990	37	74	103
2005-2009	19	30	33
2010-2014	14	22	27

Source: EDHS 2014

Early childhood mortality is more prevalent in rural areas compared to urban areas. The difference is almost 30% higher in rural areas, Females experience higher likelihood to die than males especially those aged less than one year, as shown in Table 1-4. The main outcome of these findings suggests that males are still prioritized and favored even when dealing with infants, thus arises the need to further promote and raise the public's awareness of the importance of gender-equality even among young children.

Table 1-4: Early childhood mortality in Egypt (per 1,000 live births) by residence and gender, 2014

Year	Neonatal Mortality	Infant Mortality	Under-five mortality
Urban	13	20	23
Rural	18	29	34
Male	17	25	30
Female	15	27	30

Source: EDHS 2014

Maternal Mortality

Complications of pregnancy and delivery are the leading cause of morbidity and mortality in women of reproductive age world-wide, accounting for about one fifth of the burden of disease among women in this age. Maternal mortality caused by pregnancy or childbirth is a

major cause for female mortality. In 1992/1993 the Ministry of Health and Population (MOHP) conducted a study on maternal mortality ratio estimates which showed that the ratio stood at approximately 174 per 100,000 live births in 1992/1993. In 2000, the MOHP undertook the same study which recorded a dramatic decline in maternal mortality ratio to 84 per 100,000 live births, with a reduction rate of 52%. The ratio decreased to 66 maternal deaths per 100,000 live births in 2010, with almost another 27% reduction in 10 years. The recent figures show a continued decrease as the ratio reached 52.5 deaths per 100,000 live births in 2013 which indicates that Egypt has achieved the MDGs goal 5 that is related to improve maternal health.

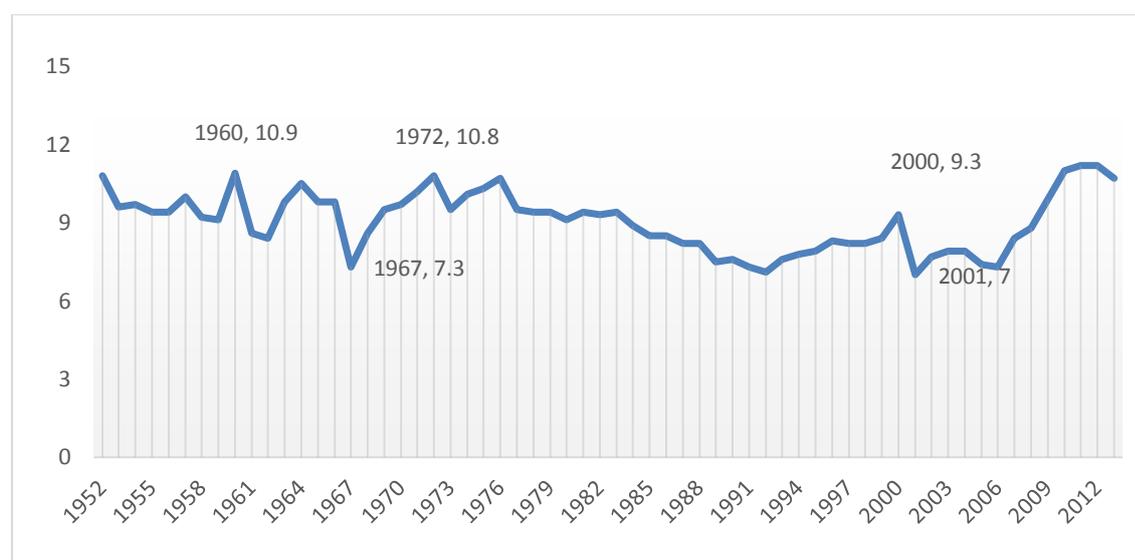
Although maternal mortality was high throughout Egypt in the early 1990s, women were more vulnerable in the less developed southern parts of the country. Women living in upper Egypt had a more difficult time accessing high-quality maternal care, making them about twice more likely to die as a result of pregnancy than women in lower Egypt. In response to these findings, Egypt's MOHP made reducing maternal mortality a national priority, and concentrated on the regions where rates of maternal death and injury were the highest. The Ministry expanded health services to increase access to skilled routine and emergency obstetric care. The Ministry also implemented a prenatal surveillance program, which helped to monitor the quality and frequency of prenatal care visits. These efforts led to substantial reductions in disparities in care. Upper Egypt experienced a 59% decline in maternal mortality rates during the late 1990s compared to a 30% decline in Lower Egypt.

1-3-2 Marriage and family patterns

Marriage is universal in Egypt, according to 2006 census results 3 out of each four females aged 16+ have got married. The percentage increase from 11% among those aged (16-19) to 96% among those aged (30 to 39). The percentage of ever married males reached 91% among those in the age group (30 to 39). Among males in the age group 45+ only 1% have never married.

Crude marriage rate showed a decline in the second half of the last century and the beginning of this century as it decreased from 10.8 per 1000 people in 1952 to 7.3 per 1000 people in 2006 than it started to increase again to reach it highest rate ever in 2011 (11.2 per 1000 people).

Figure 1-5: Trend of crude marriage rate during the period from 1952 to 2013



Source: CAPMAS

High marriage rates are usually associated with high number of births since most of ever married women in Egypt give births for the first child during the first and second year of marriage.

Age at first marriage at early ages increase the duration of woman's fertility life and accordingly her number of children. Trends of age at first marriage during the last 14 years show an increase of 1.3 years among ever married women aged 25 to 49 years. Median age at first marriage has increased in all the 5-year age groups.

Table 1-5: Median age at first marriage

	2000	2005	2008	2014
15-19	*	*	*	*
20-24	*	*	*	*
25-29	20.8	21.3	21.2	21.3
30-34	19.9	20.7	20.9	21.1
35-39	19	19.9	20.4	20.8
40-45	18.7	19.8	20	20.4
45-49	18.1	19.8	19.6	20
Total 25-49	19.5	20.4	20.6	20.8

Source: EDHS 2014

Table 1-6 shows the distribution of women (15-49 years) by their marital status, according to the 2014 demographic and health survey data. The table also shows that early marriage is widely spread in Egypt since around 6% of women in the age group (15-17) are currently or ever married. Median age at first marriage reached 21 years. It gets higher among urban residents (22 years), among those who completed at least secondary education (22 years), and those who belong to the highest wealth quintile (23 years).

Table 1-6: Distribution of women (15-49 years) by their marital status, 2014

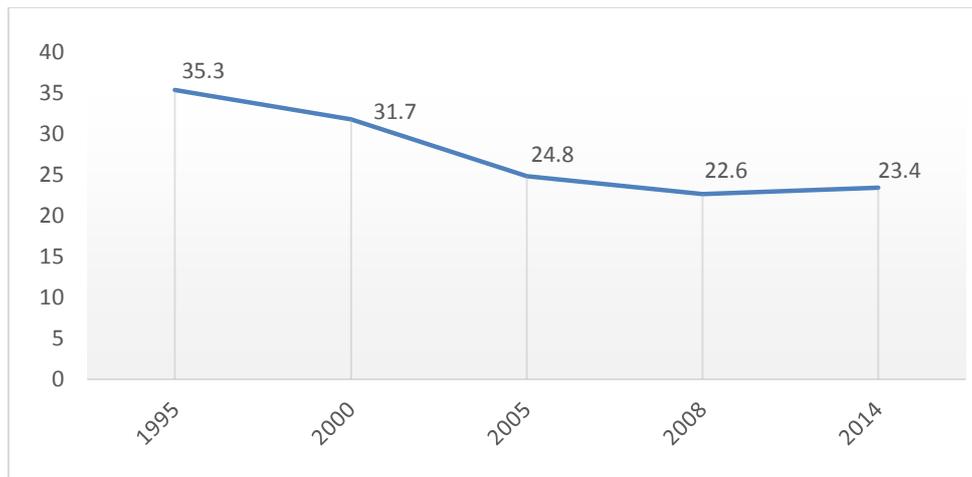
Age	Never married	married	divorced	separated	Widowed	Total
15-19	85.3	14.40	0.20	0.20	0.00	100
15-17	93.6	6.20	0.10	0.00	0.00	100
18-19	72.2	27.20	0.30	0.30	0.00	100
20-24	38.9	59.60	0.90	0.40	0.10	100
25-29	12.9	84.50	1.50	0.80	0.30	100
30-34	6.8	89.90	1.90	0.50	1.00	100
35-39	3.1	91.00	2.50	0.80	2.60	100
40-44	2	88.30	2.50	0.70	6.60	100
45-49	1.7	83.00	2.90	1.10	11.30	100
Total	25.9	69.70	1.60	0.60	2.30	100

Source: EDHS, 2014

Marriage among blood relatives in Egypt is common. Almost one-third of women are married to a relative. This percentage increase to 35% in rural areas compared to 22% in urban areas. It is also more prevalent among not educated women (37%) and those belonging to the lowest wealth quintile (43%). The highest prevalence was witnessed in rural Upper Egypt where almost half the marriages are to blood relatives.

EDHS 2014 data reveals that the percentage of those who are married to a first or second cousin has decreased from 35.3% in 1995 to 23.4% in 2014.

Figure 1-6: percentage of ever married women who are married to a first or second cousin

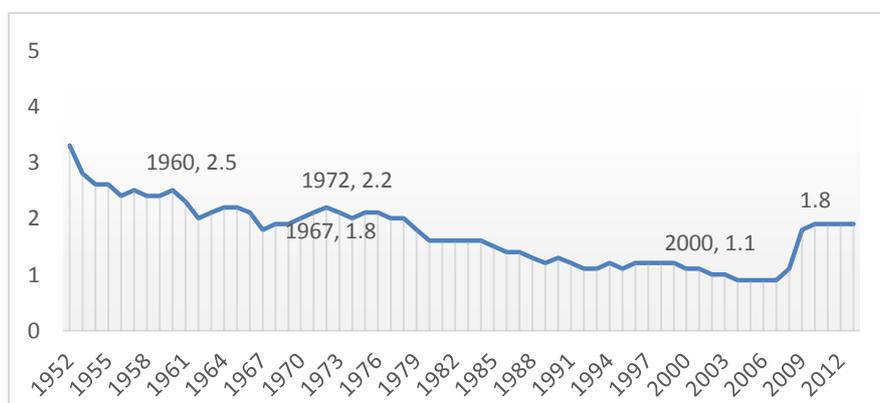


Source: EDHS 2014.

CAPMAS marriage statistics show that a high percentage of women are married to men who have less education than them. This percentage increase from 13% among women with less than intermediate education to 23% among those who have a university degree and 35% among those who have post graduate degree.

Crude divorce rate data show that the crude divorce rate has decreased from 3.3 per 1000 population in 1952 to one third this value in 2000 and continued at that low level till 2008 then it started to increase again to reach 1.9 per 1000 population in 2009 and continued at that level until 2013. The low level of divorce rate reflect stability in the Egyptian families which has positive impact on the children.

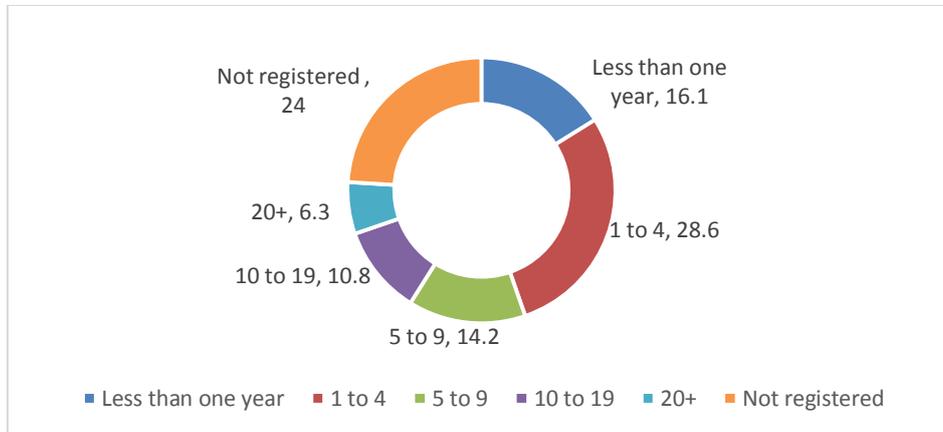
Figure 1-7: Trend of crude divorce rate during the period from 1952 to 2013



In 2013, the number of divorce cases reached 162,583 cases of which 16% occurred during the 1st year of marriage, 28% occurred between the 1st year and the 5th anniversary and 6.3%

occurred after more than 20 years of marriage. However, the length of marriage were not registered for 24% of these divorces.

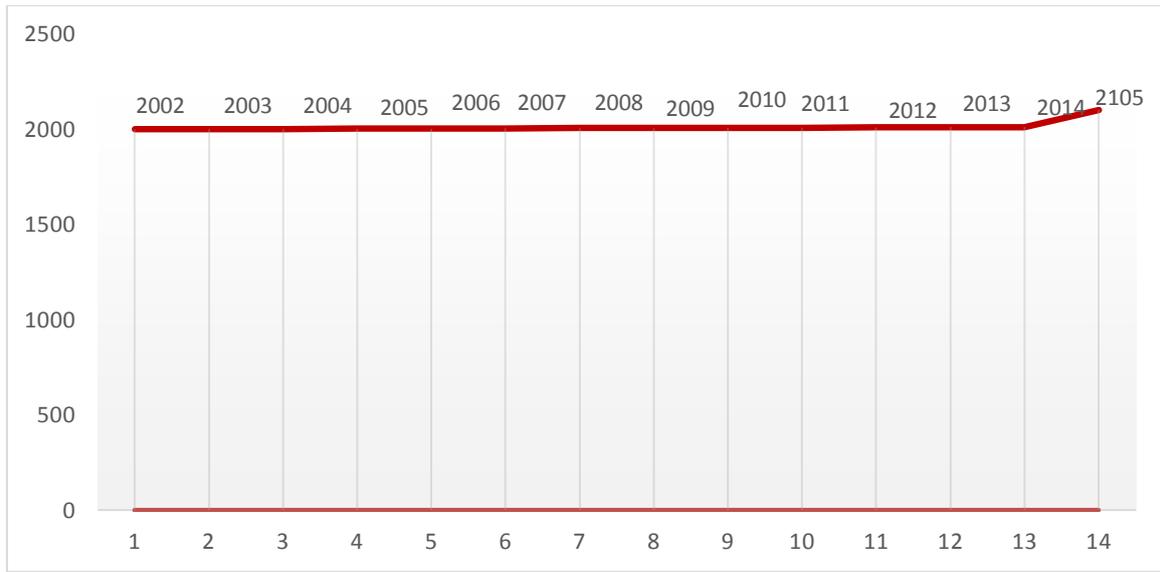
Figure 1-8: Percent distribution of divorces by marriage length



1-3-4 Fertility Transition

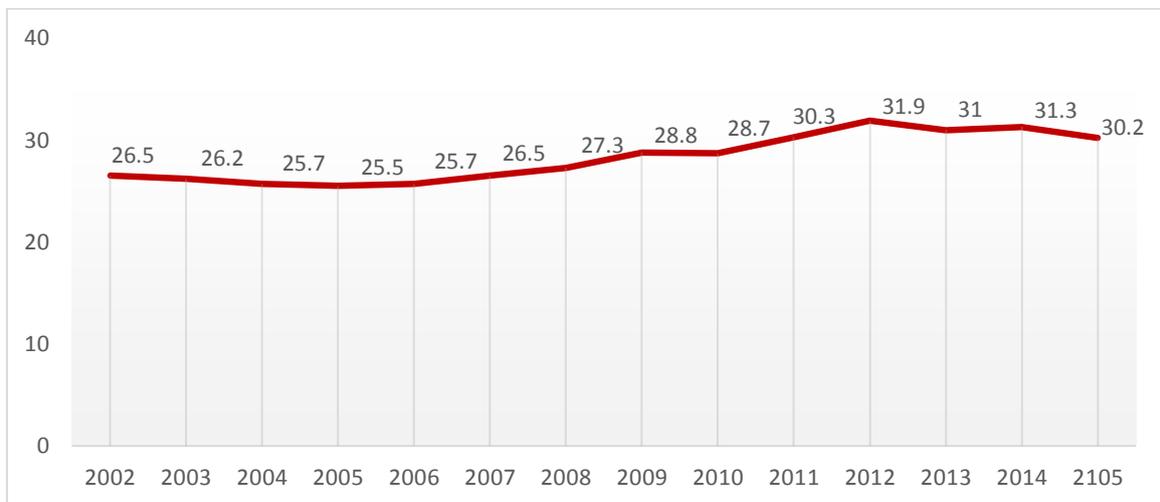
Egypt has been experiencing a rise in the annual number of live births since early 2000s. As shown in Figure 1-7, Egypt had less than 2 million live births in 2006 (1.85 million live births). The latest vital statistics figures in 2014 indicate that the size reached almost 2.7 million live births, reflecting an increase of more than 40%. Number of births in 2014 is more than one-half the sum of live births of the twenty eight countries comprising the European Union all together with a population size of one-half a billion people. This increase was confirmed also by the rise in crude birth rate (CBR) as reflected in Figure 1-10. In 2014, CBR reached 31 live births per 1000 population, a level that was prevalent in the late 1980s and early 1990s. The low CDR and the increasing CBR have resulted into a rising rate of natural increase in 2014 to 2.52% similar to that achieved in the late 1990s. the number of births decrease with about 35 thousand in 2015 indicating a decrease in the CBR for the first time in the last 10 years to reach 20 live births per 1000 population.

Figure 1-9: Number of live births 2002 – 2015 (million)



Source: Births and deaths statistics for several years, CAPMAS

Figure 1-10: Trend of CBR in Egypt (2002 – 2015)

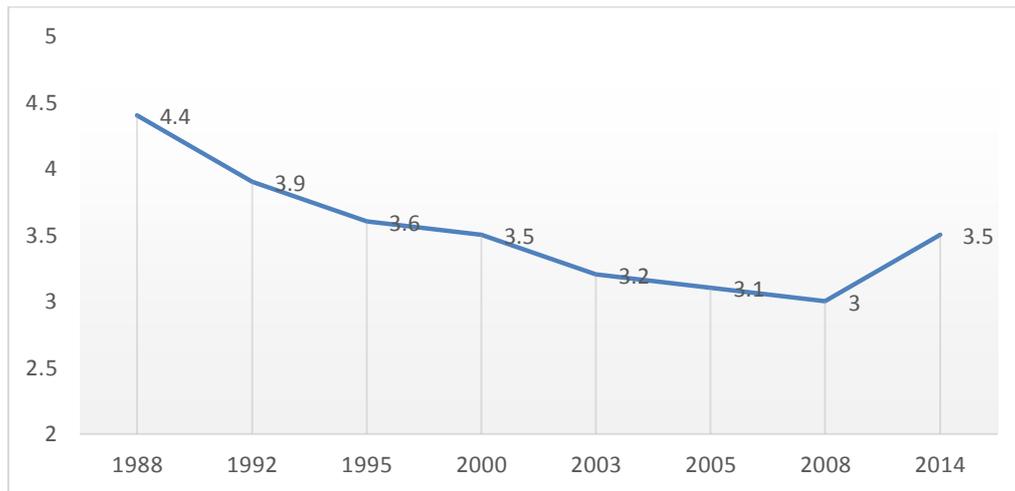


Source: Births and deaths statistics for several years, CAPMAS

According to the most recent Egypt Demographic and Health Survey (EDHS) that was conducted in 2014, total fertility rate (TFR) reached 3.5 live births. This rate indicated an increase of 0.5 live births during 6 years since 2008 EDHS. The current rate is equivalent to the rate that was prevalent during the 1990s as shown in Figure 1-9. This upward shift in TFR confirms the increase in both CBR and number of live births shown above. A study (Zaky, 2004) was conducted in early 2000s has predicted the current fertility status. It

predicted that one should not expect further dramatic decline in the fertility rate that was prevalent in the late 1990s. The rationale was that the relationship between female employment and fertility desires was not typical of a country at post-transitional stage of fertility. The idea of wife's opportunity cost and rational choices was not yet valid.

Figure 1-11: Trends in total fertility rate in Egypt, 1988-2014



Source: EDHS 2014

As expected, TFR in 2014 was higher in rural areas (3.8 births per woman) than in urban areas (2.9). It is also higher among women with no education (3.8) than among those with some primary education and higher (3.5 live births). Surprisingly, women belonging to the middle wealth quintile scored the highest in TFR (3.9 births) if compared to those belonging to the lowest and second wealth quintiles (3.6 births), and those who belong to the fourth quintile (3.5 births). Women in the highest wealth quintile had the lowest TFR of 2.8 births per woman.

The age specific fertility rates (ASFR) clearly indicates that there is a shift in the peak from the age group 25-29 to 20-24 as shown in Table (1-7). It is worth mentioning that the highest ASFR was always achieved in the age-group 25-29 in Egypt since Egypt Fertility Survey in late 1970s. The highest increase (almost 25%) in ASFR was observed in the second age group (20-24).

Table 1-7: Age specific fertility rates in Egypt in 2008 and 2014

Age	2008 EDHS	2014 EDHS
15-19	50	56
20-24	169	213
25-29	185	200
30-34	122	134
35-39	59	69
40-44	17	17
45-49	2	4
TFR	3.0	3.5

Source: EDHS 2008, EDHS 2014

However, not all the TFR is wanted fertility. As indicated in 2014 EDHS, 80% of the TFR is wanted (2.8 births), and 20% is not wanted (0.7 births). The unwanted fertility is more evident in rural areas and among those who belong to the lower three wealth quintiles. Education was surprisingly uniform in unwontedness. Overall, 16% of births in the five-year preceding the 2014 EDHS, were not wanted and half of them were not wanted at all. Many high parity women had more children than they would prefer. About 46% of the women with four children and reported 66% of those with five children that would have preferred to have fewer numbers of children. This clearly calls for immediate interventions to assist families to achieve their desires. Unwanted children could be attributed to the unmet needs which reached 12.6% in 2014 compared to 11.6% in 2008. This percentage reached in upper Egypt in 2014 around 16% and increased in rural upper Egypt to 17%.

1-3-5 Migration

Despite the absence of accurate statistics about the number of migrants, the IOM and ESCWA report on international migration released in 2015 estimates the number of Egyptian migrants by 3.47 million.

A recent survey by CAPMAS collected data about Egyptian migrants from their families. The study shows that 98% of the migrants are males with median age at first migration of 25.1 years.

Migration is a selective process. The hosting countries usually host migrants in the working age groups and those who have distinguished skills. CAPMAS study supports this fact as more than half the migrants (55%) are youth less than 35 years, 43% are in the age group (35-59), which means that almost all the migrants are in working age groups.

Arab countries are the highest destination country for Egyptians with 95.4% of total migrants. The highest destination country is KSA with 40% followed by Libya with 21%, Kuwait with 14%, Jordan with 11%, UAE with 4% and Qatar with 3.

Migration started playing an important role in population size changes during the last 3 decades. Although there is no adequate data about the numbers of Egyptians who migrated during these decades, there is many evidences that Egypt has hosted large numbers of migrants from other countries. This phenomenon was clear after Iraq war when many Iraqis migrated to Egypt seeking security and stability. After the Arab spring, Syrians and Libyans followed the same approach.

Syria and Libya are the most countries that suffered from instability after the Arab spring. Millions of their citizens migrated to other countries through different legal and illegal ways to neighbor countries. Egypt was one of the destination countries for those migrants. CAPMAS statistics show that more than 2.3 million Syrians and Libyans has come to Egypt during the period from 2011 to 2014, around 70% of them are Libyans. Most of those migrants don't register themselves as refugees, especially those who could live without formal financial aid, to avoid being refused if they seek visa to enter European countries later.

Table 1-8: Numbers of Syrians and Libyans who migrated to Egypt after the Arab spring

Year	Syrians	Libyans
2011	102367	524544
2012	259639	583044
2013	255820	307056
2014	63081	210957
Total	680907	1625601

Source: CAPMAS, 2015

The Egyptian state does not run its own asylum system. Asylum seekers in Egypt are processed by UNHCR. The number of refugees registered in the UNHCR didn't exceed 140 thousand Syrians.

This huge number of migrants caused many challenges to Egypt;

- 1- The need for more services and goods has increased to cover the needs of the migrants,
- 2- Migrants, especially Syrians, became competitors to Egyptians in labour market. A study by the Center for Migration and Refugee Studies (CMRS) of the AUC and baseera center showed that around three quarters of the Syrian migrants HHs in Egypt depend on work as a source of income, moreover work in the only source of income for 45% of them. Entrepreneurs don't mind to hire Syrians because they are more committed to their jobs work and accept lower wages than Egyptians.
- 3- Migrants increased the demand on housing units and the pressure on the infrastructure in Egypt.

1-4- Population Characteristics

1-4-1- Population Age Structure

It is well known that Egypt experienced a decline in fertility in the 1990s and early 2000s and this resulted into a change in the age structure. It is clear that Egypt is a youth country with a broad base narrowing towards the top. The age structure had previously shown a diminishing

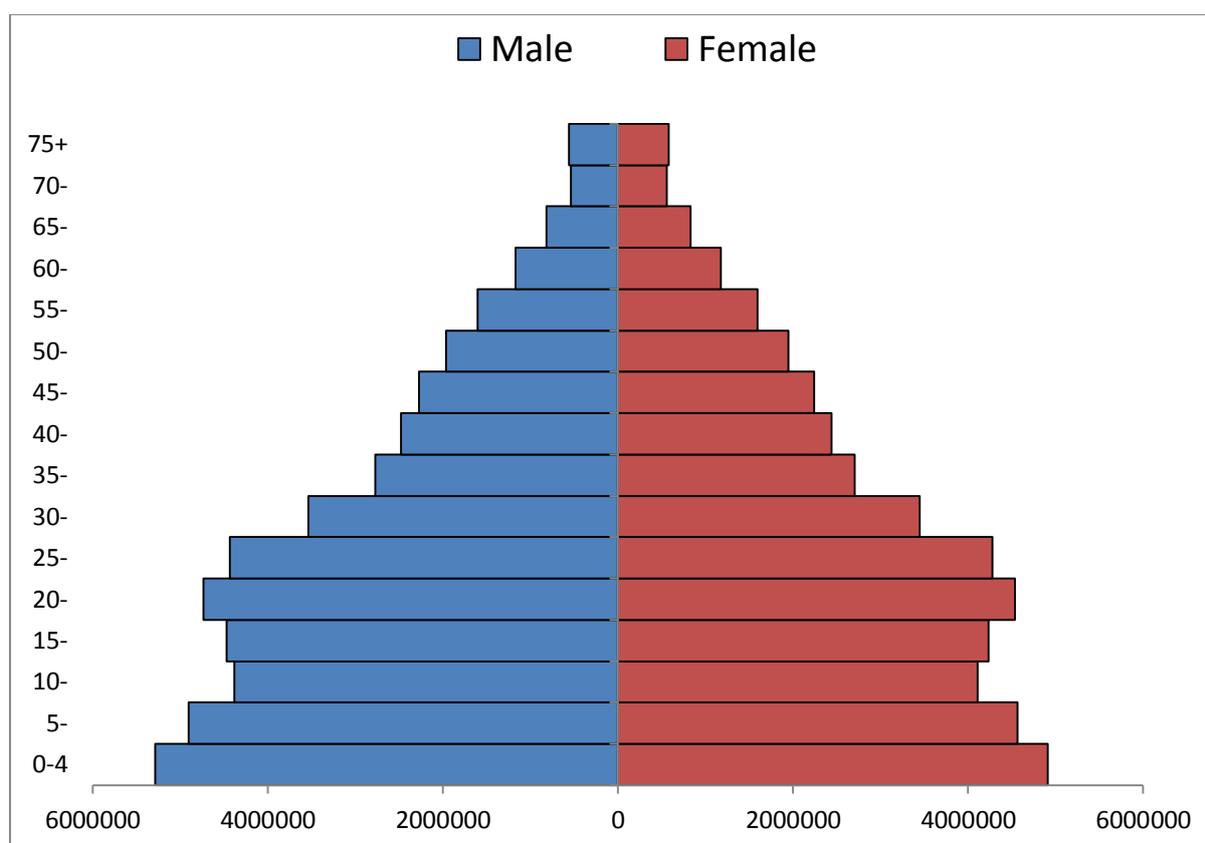
base owing to the previous declines in birth rates and the relative importance of the young age brackets falls compared to that of the labor age group resulting in what is called the demographic window of opportunity. The recent increase in birth rates and in fertility rates will have impact on that age structure. Although, it is not designed to answer such question, the EDHS data could shed some light on possible consequences of fertility on the age structure. Table (1-9) presents the trend in population distribution by broad age categories during the period 1988-2014 using the EDHS rounds during this period. The percent distribution of the population clearly shows that Egypt experienced a sharp decline in the percentage of population less than 15 during the period from 1992 to 2005 followed by a very modest decline between 2005-2008. For the first time in almost 20 years, the youngest age group is starting to catch up again by jumping from 34% in 2008 to 35.3% in 2014. These sharp and then modest declines followed by an increase in the share of the youngest age group is reflected in the middle age-group (15-64). The age group 15-64 gained what the young age group lost during the period 1992-2008 and lost what the young age-group regained again during the period 2008-2014. These changes in the age structure caused a decrease in the age dependency ratio from 82% in 1988 to 62% in 2008 showing a great opportunity for the demographic dividend, however the increase in the age dependency ratio to 66%, as a result of the increased TFR, vanished this opportunity as will be shown in section (1-5).

Table 1-9: Trends in population distribution by age in Egypt, 1988-2014

Age group	1988	1992	1995	2000	2005	2008	2014
Less than 15	41.2	41.7	40.0	37.3	34.2	34.0	35.3
15-64	55.0	54.6	56.3	59.1	61.7	61.9	60.4
65+	3.8	3.7	3.7	3.6	4.1	4.1	4.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Dependency Ratio	81.8	83.2	77.6	69.2	62.1	61.5	65.6

Source: EDHS 1988-2014

Figure 1-12 Population pyramid of 1/1/2016



Source: Egypt in figures, 2016

1-4-2- Education and Literacy

The educational level of the population is among the key characteristics because it has many implications on their perceptions, social and political participation, economic productivity, welfare and reproductive behavior. The EDHS-2014 shows that almost 1 in every 5 people (6 years and above) has not attend any type of education. Females are more vulnerable for illiteracy as almost 25% of Egyptian females (6 years and above) have no education compared to 14% among the males, as shown in Table (1-10). Although, the gender gap against women gets wider in rural areas and among the lowest wealth quintiles, the likelihood of a female (aged 6 years and above) to not have any education is almost double that of a male. The implications of this gap and the relatively high likelihood of illiteracy on female empowerment and accordingly fertility behavior are evident in the Egyptian literature. As the 2014 EDHS indicates, women who are less educated and less empowered are more likely to bear more children and less likely to be using contraceptives.

Table 1-10: Gender gap and educational attainment, 2014

Background characteristics	%No education		Median education years	
	F	M	F	M
Selected age groups				
10-14	2.0	1.5	4.7	4.7
30-34	20.7	10.0	10.2	10.4
50-54	51.7	25.7	0.0	8.7
60-64	64.6	37.5	0.0	5.2
Residence				
Urban	17.3	10.4	8.2	9.2
Rural	29.5	16.4	4.6	6.2
Wealth quintile				
Lowest	40.2	22.8	2.1	4.9
Second	34.5	19.2	3.3	5.5
Middle	21.4	11.7	6.2	7.6
Fourth	19.4	11.9	7.0	7.8
Highest	8.9	5.2	10.7	11.0
Total	24.7	14.0	5.8	7.4

Source: EDHS 2014

1-4-3- Labor Force and Employment

Similar to education, employment is a key population dynamic with vital implications on the population's behaviors and perceptions. CAPMAS data shows that the economic participation rate was 48% in 2014. The unemployment rate increased from 9% in 2010 to 13% in 2014. This rate was 9.6% among males compared to 24% among females in 2014.

The latest figures of the Egypt Labor Market Panel Survey (ELMPS) 2012 show persistently low participation of women in the Egyptian labor market over time and across the different economic sectors. Although the extended definition of employment gives comparatively no difference to the market definition of participation rate for men (80%), female labor force participation rate in 2012 notably differs especially in rural areas.

Table 1-11: Market and Extended Labor Force Participation Rates ages 15-64 by gender and location, 2012

	Males	Females
Rural Market	81.2	21.1
Urban Market	78.9	25.6
Total Market	80.2	23.1
Rural Extended	82.1	39.0
Urban Extended	79.1	28.7
Total Extended	80.1	34.4

Source: ELMPS 2012

As indicated in the EDHS-2014, women employed in a job for which they are paid in cash are more likely to make educated choices regarding their reproductive health and the health of their children. Working women use family planning methods than other women (67 percent and 57 percent, respectively). While the majority of women opt for modern methods, this percentage is notably higher among working women (65.9%) than women not working for cash (57.3%). Intervals between births are longer for women who working for cash than for births to other women (39.3 months and 36.5 months, respectively).

Table 1-12: Antenatal care by working status for women age 15-49 who had a live birth in the five years preceding the survey, 2014

	Working for cash	Not working
No ANC	5.6	10.2
Percentage receiving ANY antenatal care from a skilled provider	94.4	89.8
Percentage receiving REGULAR antenatal care from a skilled provider	88	82.2

Source: EDHS 2014

Procedures of pregnancy care were also more common among births to women who worked for cash than for births to other women.

Table 1-13: Postnatal care and working status for women age 15-49 giving birth within two years of the survey, 2014

	Working for cash	Not working
NO postnatal checkup for the baby in the first week after birth	75.2	78.3
NO postnatal checkup for the mother in the first two days after birth	12.6	19.1

Source: EDHS 2014

Mothers giving birth in the two years preceding the EDHS-2014 survey working for cash were somewhat more likely than other mothers to have had a postnatal checkup within two days after they delivered (87.4% and 80.9% respectively). Although 78% of newborns do not have a postnatal checkup at all, and only 14% were seen for the first checkup within two days following birth. The largest differential in the likelihood that a newborn received a postnatal checkup within two days was observed by birth order, further substantiating the importance of limiting preferred by working mothers.

1-5- Demographic dividend in Egypt

Demographic transition is the shift from high mortality to low mortality and from high to low fertility that countries generally go through as they develop. When mortality rates drop and the decline in fertility (births per woman) lags behind, countries enter a period of rapid population growth. The size of the population eventually stabilizes after the fertility rate settles at about two births per woman—the rate at which couples replace themselves. A rapid demographic transition can have positive implication on economic growth resulting in a demographic dividend.

Demographic dividend is “the economic growth potential that can result from shifts in a population’s age structure, mainly when the share of the working-age population is larger than the non-working-age share of the population, i.e., below 15 and 65+. In other words, it is “a boost in economic productivity that occurs when there are growing numbers of people in the workforce relative to the number of dependents.” A country with both increasing numbers of young people and declining fertility has the potential to reap a demographic dividend. In order for economic growth to occur the younger population must have access to

quality education, adequate nutrition and health including access to sexual and reproductive health.

With fewer younger dependents, due to declining fertility rates, and fewer older dependents, due to the older generations having shorter life expectancies, and the largest segment of the population of productive working age, the dependency ratio declines dramatically leading to the demographic dividend. In many countries, demographic dividend was associated with smaller families, higher female economic participation, rising income, and rising life expectancy rates. When the labor force grows more rapidly than the population dependent on it, resources for investment in economic development and family welfare become available. This population transition can last for several decades and is often called the first dividend.

By the end of this transition lower fertility reduces the growth rate of the labor force, while continuing improvements in old-age mortality speed growth of the elderly population. Now, other things being equal, per capita income grows more slowly and the first dividend turns negative. But a second dividend is also possible. A population concentrated at older working ages and facing an extended period of retirement has a powerful incentive to accumulate assets which lead to a national income rise.

In short, the first dividend yields a transitory bonus, and the second transforms that bonus into greater assets and sustainable development. These outcomes are not automatic but depend on the implementation of effective policies. Both the first and second dividends had positive effects between 1970 and 2000 in most part of the world.

1-5-1- Demographic transition in Egypt

Egypt's population more than tripled in the second half of the 20th century as a result of rapidly declining death rates—particularly among infants and children—and slowly declining fertility rates. The country's annual rate of population growth reached its peak of nearly 3 percent in the late 1950s, while the world reached its peak of around 2% in the late 1960s. Today, Egypt's population growth of 2.6% per year is much faster than the world's average of 1.2 per cent a year.

As shown in Figure (1-13), the crude birth rate declined from 38.8 per thousand in 1987 to 30 per thousand in 1991. Between 1992 and 2010, the rate fluctuated around 27 per thousand, then it started to increase to reach a peak of 31.9 per thousand in 2012. A similar conclusion

can be drawn from Figure (1-11) as the total fertility rates declined in the eighties and the first half of the nineties to reach 3.6 child per woman in 1995. A slower decline was observed in the following decade and a turnover was accentuated with an increase in TFR from 3 children per woman in 2008 to 3.5 in 2014. The trend of the TFR seems to confirm the CBR trend and is challenging potential for a demographic dividend in the near future.

Comparing CBR, TFR and percentage of population below 15 in selected developing countries, shows that the plateauing in fertility level in Egypt over the last two decades had its impact in maintaining a relatively higher dependency ratio. The percent of population below 15 is ranging between 17% and 22% in Indonesia, Iran, Malaysia, Morocco, and Turkey while it is 31% in Egypt. Such a higher dependency ratio is a challenge for increasing human capital and improving competitiveness of the country. An aggressive and effective family planning and reproductive health program is absolutely needed to curb the current fertility levels.

To show an example of the implications of the current fertility level, it is worth mentioning that the number of births increased from 1.85 million live births in 2006 to 2.6 million live births in 2012. The 40% increase in 6 years, has its tremendous implications on quality of life and on basic services including education. To respond to this increase, 40% more classes need to be built by year 2018, costing nearly 18 billion EGP. Such investment was not secure and the "baby boom" cohort of 2006-2012 will face hard time to get the same education offered to older cohorts who were not receiving the quality of education that can make prepare them to compete in the labor market.

Figure 1-13 Crude birth rate, Egypt 1987-2015

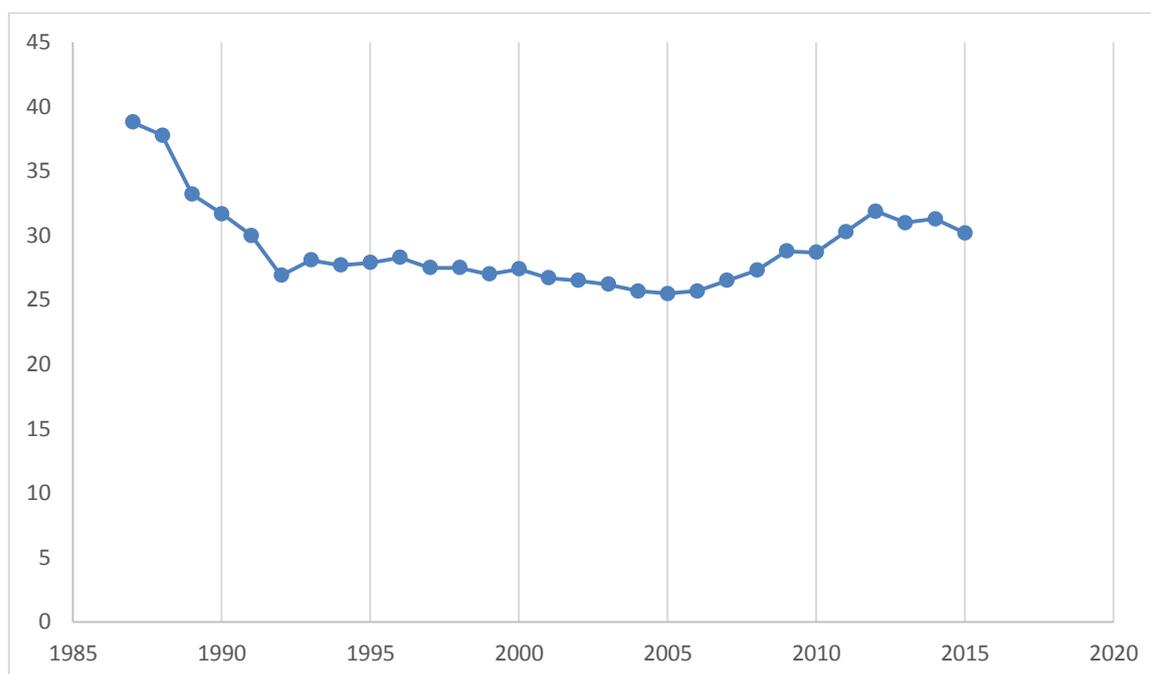


Table 1-14 Crude birth rate, total fertility rate and population below 15 in selected countries, 2015

Country	Crude Birth Rate	Total Fertility Rate	Population <15
Egypt	30	3.5	31%
Indonesia	21	2.6	29%
Iran	19	1.8	24%
Malaysia	17	2.0	26%
Morocco	22	2.5	25%
Turkey	17		

Source: Population Reference Bureau, 2015

Previous research on demographic dividend in Egypt expected that the country will witness a demographic window that can turn to a positive economic development. The recent increase in fertility requires a revision of the analysis to inform policy makers about the likelihood of a demographic dividend.

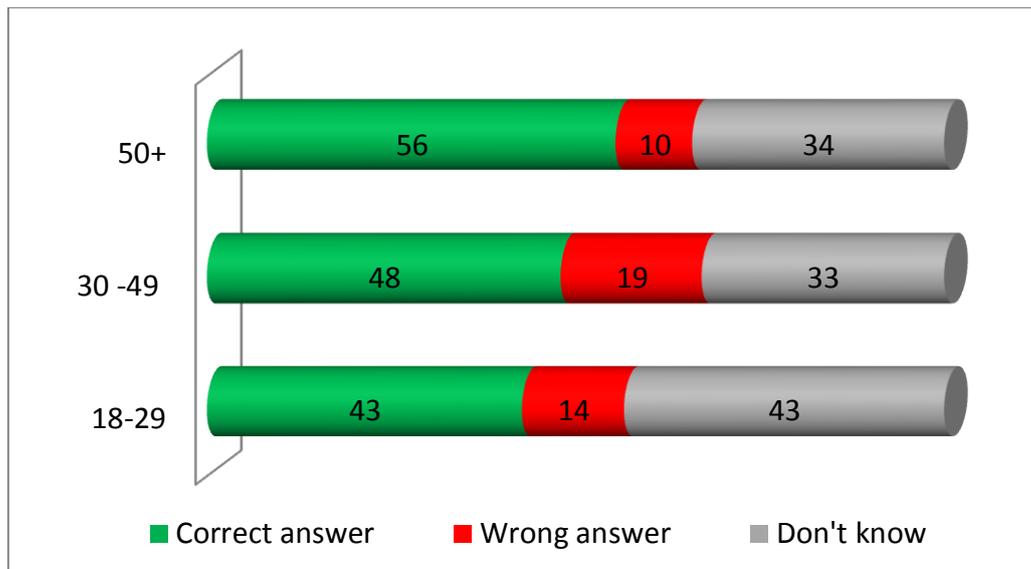
To maximize the benefits of this window of opportunity, Egypt needs to adapt their economic, social, health system and political institutions to the changes that will be brought by the unprecedented numbers of young people as they move into adulthood.

1-6 Awareness of the population growth challenges

In June 2016, population size in Egypt has reached 91 million which is twice the population size in 1984 and three times of that in 1966. A poll, conducted by The Egyptian center for public opinion research (Baseera) in January 2016 to reveal whether Egyptians are aware about the Egyptian population size and other issues related to the Population growth. The percentage of those who mentioned a number between 85 and 95 million, which was considered a correct answer, is 49% while 15% mentioned a size less than 85 million or more than 95 million and 36% said they don't know. Worth noting that youth (18-29 years) are more ignorant about the population size as only 43% mentioned a correct answer compared to 56% among those who aged 50 years or above. The same difference was observed between Upper Egypt where only 42% mentioned a correct answer and urban governorates, where 57% mentioned a correct answer.

Despite mentioning different values for population size, the majority of Egyptians (58%) mentioned that the population size is a disadvantage and only 29% mentioned that it is an advantage, 3% said it has an advantage and a disadvantage and 10% said that they don't know.

Figure 1-14: Knowledge of population size by age, 2016



Source: Egyptians' perceptions regarding the population problem, baseera, 2016.

When asked about water security, around 45% of Egyptians said that water resources in Egypt are enough for all the citizens to get enough share of water to live a healthy life which reflects that this percentage are not aware that Egypt is under water poverty line. A close percentage (40%) knows that the available water resources are not enough to secure Egyptians' needs and 15% said that they don't know whether the available resources can secure Egyptians' needs or not.

Egyptians are more aware that the agricultural production is not enough to cover Egyptians' consumption. Around 61% of the respondents said that the agricultural production is not enough to cover Egyptians' consumption compared to 26% said it is enough and 13% said that they don't know.

A recent study was conducted in five governorates, namely Sharkia, Ismailia, Port-Said, Souhag and Qena in 2015 (CSSA, 2015) to explore the awareness of Egyptians about the population challenges facing Egypt. The study showed that a high percentages of the respondents recognize that the Egyptian State is not able to provide the needs in education, health and service sectors. This percentage ranges between 80% in Port-Said and 43% in Ismailia. Three-quarters of the sample state that these sectors will significantly suffer as a result of more population increase. Recognizing the right of the State to intervene in fertility to provide better quality of life is split among the respondents and 20% either have no

opinion or object the idea of family planning. Almost 60% of the sample have not identified any tools to make people aware of the population problem. All state that there are no public campaigns about population.

A poll, conducted by The Egyptian center for public opinion research (Baseera) in November 2014, has revealed that 45% of the respondents mentioned that the ideal number of children for a family is two and 42% said that the ideal number is three children. In answering to the question whether the family has to have an additional birth if all births were females, 76% of the respondents answered with "No" while 18% answered with "Yes" and 6% couldn't decide. These results reflect that persons became more aware and they are trying to get rid of some customs and traditions which were very popular in Egypt years ago. Another question was asked to inquire about the persons' perception about when the couple decides to have children after marriage, 31% of the sample answered that immediately after marriage while 36% answered that this step should come after one year from marriage while a smaller percentage of 21% answered with two years after marriage.

To measure the opinions towards some issues concerning family planning which were thought to be overlapped with religious beliefs, the questionnaire includes four different questions to ask about the usage of contraceptives. The results reveals that 18% of the respondents agree that using contraceptives to postpone the pregnancy or to extend the period between births runs against religious thoughts, and an identical percentage of respondents agree that using contraceptives to prevent pregnancy after fifth birth runs against religious thoughts. However, a higher percentage of 22% answered that using contraceptives is prohibited to prevent pregnancy after the second birth and the same percentage answered that it's prohibited for couples to use contraceptives before the first birth. The results indicate that low percentages of Egyptians believe that contraceptives use contradicts with religious thoughts and that the main problem that the state faces is the relatively high preferred number of children.

Chapter 2

Population and development strategy

2-1- Introduction

The national strategy for population and development 2015-2030 was developed by a team of experts working under the supervision of the National Population Council (NPC) the strategy was launched in November 2014 under the auspices of the prime minister. The strategy and its implementation plan have drawn the road to each of the stakeholders to tackle their role in the population issue, and the strategy stressed on the necessity of cooperation and part focus on the private sector role then section 5 will discuss the NGOs role. Section 6 will suggest other complimentary actions to win in the battle against the population increase.

2-2- The national strategy for population and development 2015-2030

The need to draw up a new population strategy for Egypt emanates from the current population situation in Egypt which may place the nation at certain risk. If allowed to continue, the current population growth rates, combined with other population and development indicators, do not help improving the population quality of life for the country, as was illustrated in Chapter one.

2-2-1- Why do we need a new population strategy?

Over the past few years, remarkable developments occurred with regard to population and development, chief of which are:

1. Unemployment rates and the percentage of families living under the poverty lines rose after the 25 January 2011 revolution. Conversely, the role of women in the workplace and production diminished in a manner that had a negative impact on development rates and that led to an increase in the birth rate.
2. The increase in population growth rates, coupled with the drop in economic growth rates, in comparison with the rates seen in Egypt before the revolution, will decrease

per capital spending on health, education, and other services, while boosting the rates of unemployment and illiteracy, all of which is bound to have an adverse impact on the quality of the life in the country.

3. The increased influence of the conservative current on the public sphere has undermined the belief in small families and in having prolonged intervals between births, while encouraging values that are antagonistic to women empowerment, all of which led to a diminished role of women in public life and to reduced rates of women employment.
4. A new legislative reality was created through the inclusion of an article in the constitution (article 41) which notes that the state is committed to formulating a population program that strikes a balance between population and economic growth.
5. The media role in disseminating knowledge about the risks involved in population growth and about family planning has declined. Likewise, the role of civil groups in raising awareness and providing services related to family planning has diminished.
6. The continued disparity in population and development indicators between various areas (urban vs. rural areas, north Egypt vs. south Egypt, formal vs. informal urban areas).
7. The post 25 January 2011 phase brought about major challenges that cannot be overlooked, such as the irregular provision of public services, including those related to family planning, as well as the reduction in resources available for the provision and improvement of other basic services, for implementing capacity building programs, and for monitoring and assessment.

The 2014 Constitution (article 41)

“The state is to implement a population program that achieves a balance between population growth and available resources and maximize the investment in human capital in the context of sustainable development”.

2-2-2- Strategy objectives

The new strategy focuses on achieving a more homogenous society that balances its population growth and available natural resources, that meets the aspirations of the public for a better life, that offers members of the public equal access to basic services, that improves the population characteristics, and that attains higher levels of human development, social cohesion, and regional leadership.

The national strategy for population and development aims to:

1. Enhance the quality of life of all Egyptians through reducing the rates of population growth and restoring the balance between the rates of economic and population growth.
2. Restore Egypt's regional leadership through improving the population characteristics in terms of knowledge, skills, and behavior.
3. Redraw the population map in Egypt through a spatial redistribution of the population that promotes Egyptian national security and accommodate the needs of planned national projects.
4. Promote social justice and peace through reducing the disparities that exist in development indicators among various areas.

To achieve the above objectives, the authors of the new strategy set a number of quantitative objectives, most important of which is the reduction of the total fertility rate to an average of 2.4 by 2030, compared with 3.5 at present.

If the government succeeds in thus bringing down the birth rate, the population will reach 111 million by 2030. But if the current birth rates were to persist, the population will reach 119 million by 2030. For the birth rate to go down to 2.4 by 2030, the percentage of women using birth control methods must rise to 72%, from 59% at present.

The stakeholders of the strategy includes the ministry of health and population, Ministry of education, ministry of planning, ministry of finance, ministry communications and information technology, ministry of youths, Parliament, the National Fund for Development, CAPMAS, the National Council for Women, NGOs and the private sector.

2-2-3- The main pillars of the strategy

The strategy rests on six pillars, which are:

- More effective family planning and birth health services.
- Improved health services to the young.
- Enhancement of the population characteristics.
- Raising awareness of the population problem.

- Women empowerment.
- Energetic monitoring and assessment.

The strategy authors note that the most important factor in making the strategy a success is the firm and effective political resolve to limit the population increase. It is through such a resolve that all ministries and non-governmental organizations may work together in implementing the strategy's executive plan. President Abdel Fatah Al-Sisi and the government showed a strong commitment to the population issue in Egypt. In 2016, a national day for population was declared and the year was announced to be the year of Youths. It is planned to announce year 2017 as the year of Egyptian women and a new strategy for women empowerment and gender equality will be launched.

The main stakeholders of the strategy include but are not limited to the ministry of health and population, ministry of planning, ministry of education, ministry of interior affairs, ministry of youths, the national population council, the national council for childhood and motherhood, the national council for women, the non-governmental organizations and the private sector.

2-3- Other supporting strategies:

The Egyptian government and its councils developed a set of strategies that support the population and development strategy. The most important strategies are the child strategy, the early marriage strategy and Egypt sustainable development strategy.

2-3-1- The child strategy 2015-2020:

The child strategy was prepared by the ministry of population and the national council for childhood and motherhood in cooperation with the Egyptian center for public opinion research (Baseera) to cover the period from 2015 to 2020.

The vision of the child strategy is to improve the quality of life of children and mothers, and ensure their well-being and that the society support and protect them, and to involve them in making their own decisions, and take care of their physical and mental health, within the framework of equality and fair distribution between social groups and geographic regions.

The main objectives of the strategy are as follows:

- To provide a national vision and a national framework for the different axes of the strategy to improve the situation of children and mothers in Egypt.
- To ensure the fair distribution of services and the provision of children's rights among different social groups in different geographic regions.
- Prioritization of interventions, programs and policies.
- To improve networking, cooperation and coordination between the various development actors in the field of childhood and motherhood.
- To develop a system to measure the performance and evaluate the interventions in the field of childhood and motherhood.

2-3-2- The early marriage strategy 2015-2020:

The vision of the early marriage strategy is to create conscious society, that is health both physically and psychologically, where citizens have the highest health and education levels, believes in the concept of a strong family, and recognizes the equal rights of men and women, and the right of male and female children to thrive, and develop the pivotal role of women.

The main objective of the strategy is to reduce the proportion of early marriages to half the current level in five years, with a focus on geographical areas with high prevalence of early marriage.

2-3-3- Egypt sustainable development strategy “Egypt vision 2030”:

Egypt vision 2030 aims at maximizing the potential of Egypt's competitive advantage and reviving its historic role in the leadership of the region and improving the citizens' standard of living.

Egypt vision objective is to improve the quality of life of citizens through 3 main pillars; economic pillar which aim at achieving economic development, social pillar which aim at improving the characteristics of the population and environment pillar which aim at providing a better living environment. Each of these pillars has sub-issues as shown in figure (2-1). The integration of the population and development strategy and Egypt vision will accelerate the pace of strategy implementation and ensure the achievements of its objectives. Egypt vision will be discussed in details in chapter 8.

Figure 2-1: Egypt vision pillars



2-4- The Sustainable Development Goals (SDGs):

In 2000, the United Nations proposed the Millennium Development Goals that were adopted by almost all the countries including Egypt. Egypt succeeded in achieving some of the goals totally or partially while it failed in achieving other goals. Egypt succeeded to achieve the targets of gender equality of enrollment in primary and secondary education, decreasing under five mortality rate, increasing the Antenatal care coverage and increasing the Proportion of population using an improved drinking water source. Other targets were not achieved due to many challenges that will be discussed in the next chapters.

In September 2015, world countries adopted the 2030 Agenda for Sustainable Development which include 17 goals that aim to improving the quality of people' lives. Each of these goals have certain targets with a total of 169 targets. The SDGs covered the areas that have been covered by the MDGs in addition to new areas.

Egypt has a strict commitment to the SDGs. As a part of its commitment to the SDGs, a presidential decree was issued to form a national committee to follow up on the implementation of the SDGs. The committee is headed by the prime minister and includes 12 ministries and governmental entities. In each ministry a monitoring and evaluation unit have been established. The Central Authority for Public Mobilization and Statistics (CAPMAS) established a Sustainable Development Unit to be responsible for providing data and information related to the SDGs indicators.

The Sustainable Development Strategy (Egypt vision 2030) integrated most of the SDGs in its different pillars to guarantee the harmonization between the SDGs and the national strategy.

Box 1 SDGs

Goal 1: No poverty: End poverty in all its forms everywhere

Goal 2: Zero hunger: End hunger, achieve food security and improved nutrition and promote sustainable agriculture

Goal 3: Good health and well-being: Ensure healthy lives and promote well-being for all

Goal 4: Quality education: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all

Goal 5: Gender equality: Achieve gender equality and empower all women and girls

Goal 6: Clean water and sanitation: Ensure access to water and sanitation for all

Goal 7: Affordable and clean energy: Ensure access to affordable, reliable, sustainable and modern energy for all

Goal 8: Decent work and economic growth: Promote inclusive and sustainable economic growth, employment and decent work for all

Goal 9: Industry, innovation, infrastructure: Build resilient infrastructure, promote sustainable industrialization and foster innovation

Goal 10: Reduced inequalities: Reduce inequality within and among countries

Goal 11: Sustainable cities and communities: Make cities inclusive, safe, resilient and sustainable

Goal 12: Responsible consumption, production: Ensure sustainable consumption and production patterns

Goal 13: Climate action: Take urgent action to combat climate change and its impacts

Goal 14: Life below water: Conserve and sustainably use the oceans, seas and marine resources

Goal 15: Life on land: Sustainably manage forests, combat desertification, halt and reverse land degradation, halt biodiversity loss

Goal 16: Peace, justice and strong institutions: Promote just, peaceful and inclusive societies

Goal 17: Partnerships for the goals: Revitalize the global partnership for sustainable development

2-5- Social protection programs

Social protection aims at improving life conditions of vulnerable groups. Social protection schemes reduces risks and impact of life conditions on quality of life. This include reducing poverty and inequality.

As per the United Nations Research Institute for Social Development (UNRISD) “social protection is concerned with preventing, managing and overcoming situations that adversely affect people’s wellbeing. It helps individuals maintain their living standard when confronted by contingencies such as illness, maternity, disability or old age; market risks, such as unemployment; as well as economic crises or natural disasters”.

Many studies presented a new approach for social protection known as “Universal Social Protection”. Universal social protection means to cover the entire population with adequate benefits making social services and a basic income accessible to the country’s citizens.

Universal social protection helps achieving the following:

- Protect living standards
- Provide a basic level of services and consumption to those living in, or at risk of falling into, poverty
- Encourage investment in human capital to promote social mobility.

This approach focus on 3 main pillars; social insurance, social assistance and labour market standards. Social insurance are the programs that targets protecting employees through the contributions from employers and employees based on earnings while social assistance are the programs of money transfers to vulnerable households that their heads are unable to work. Labour market policies aims at guarantee decent jobs for those who are able and ready to work.

A number of countries achieved great success through this approach. A good example is Brazil. Brazil has implemented market-oriented reforms along with a conditional cash transfer programme, Bolsa Familia, which provides a monthly transfer to poor households with children up to 15 years of age or pregnant women and a monthly transfer to extremely poor households regardless of their composition. The conditions of the program is to enroll children in education and guarantee regular attendance of school and regular health care.

Costa Rica presented a different model with a strong commitment to universal education and health care and expanding the number of workers contributing to social insurance schemes, while securing protection for those unable to contribute through social assistance.

Egypt is on the trace of universal social protection. The SDS, as discussed above, aims at achieving universal social protection. The following sections presents some of the social protection polices and programs.

Poor households

The ministry of social solidarity provide monthly pensions for poor households that have children in primary, preparatory or intermediate schools. The pension ranges between 40 and 200 Egyptian pounds.

Lately, the ministry started Takafol and Karama program to fight poverty and help low-income families. The program connects cash transfer with education, health, empowerment of Egyptian women as a direct beneficiary of this program. The program provides monthly pensions to households in Upper Egypt.

During September 2015, Takafol and Karama program provided 151.6 million Egyptian pounds to more than 123 thousand households/ beneficiaries.

Children protection

Children in Egypt faces many risks including excessive use of violence as a method of discipline, FGM, child labour, early marriage, child trafficking, illegal migration of unaccompanied children, street children, children in jails and disabled children.

The child strategy 2015-2020 paid great attention for child protection with special focus on prevention and protection from violence, exploitation and abuse against children. It addressed each of the above mentioned risks in details. The strategy suggested the following:

- Re-forming the general Committee of child rescue line and activate its role.
- Preparation and activation of the case management system within the child protection committees and the concerned ministries.
- Linking child rescue line and the protection committees.
- Prepare a national program for parents to encourage positive upbringing of children.
- The development of information management systems to protect the child.
- Activate national protection mechanisms.

- Provide the institutional framework and human and financial resources necessary for the implementation of policies and legislation to protect the child.
- Pay special attention in the activities of all the axes to marginalized groups of children in remote areas, border, and poor areas, slums, and for children with disabilities, street children.
- The inclusion of civil society organizations in child protection activities, and provide the necessary training for its members to raise their ability to exercise these functions.

In addition, the ministry of social solidarity provide monthly pension for the children in unusual circumstances including the following groups:

- Orphans and children of unknown parents or Father,
- Children of divorced women if they married or imprisoned or died,
- Children of imprisoned for a period of not less than (3) years.

This pension is provided to children less than 18 who don't have other sources of income, in addition to the monthly pension for those who attend school on regular biases up to a maximum of 200 pounds per month for a period of 8 months from October to May of each academic year.

2-6- What else to do:

As multi-faceted and comprehensive as it is, the national strategy for population and development left out two important factors:

Firstly: The strategy and its executive plan didn't mention the need to invest in the large number of young people in the country. Because of the population increase in recent years, the number of young people in the country has significantly grown, to the point where the young constitute one-third of the population. Employing young people in development projects could give a big boost to the economy. But for this to happen, the young must undergo retraining to make them more capable of creativity and innovation. Many of the young people are unqualified to join the labor market and compete for jobs due to their low levels of education, skills, and motivation.

Secondly: Despite the large number of parties in Egypt, the strategy doesn't engage these parties to any extent. This may be due to the low popularity of the parties or the public's lack

of interest in them. Opinion polls indicate that most Egyptians have little knowledge of the parties or their programs. Still, the country's political parties have resources that can be used in addressing the population problem, including the offices they have all over the country and their members who have unhampered access to the rest of the population.

Public sympathy and enthusiasm are crucial to the success of any strategy. The national population strategy will only succeed if families start thinking not only in terms of what is good for them, but also in terms of what is good for their country.

Thirdly: There is a great need to more data and information in order to monitor the implementation of the above mentioned national strategies. Most of the indicators that are related to RH and fertility are driven from surveys that are conducted with wide time spaces and their sample sizes don't allow to calculate the indicators on small administrative units level. Thus, it is suggested to build an observatory for population related data and indicators. The observatory should be designed to:

- Collect and harmonize the available data and indicators: Egypt produce hundreds of indicators each year but there is no unique portal that collects these indicators and organizes them in a way that could be useful in planning, monitoring and evaluation of the strategy. Collecting these indicators, defining and even unifying the methodologies of calculations and providing them to researchers and decision makers would help improving the performance of the stakeholders.
- Assess and bridge the information gaps: the observatory may help in assessing the information gap that need to be bridged by new surveys or other research methods. This includes designing and implementing surveys to bridge the information gaps, utilize new methodologies to collect the needed data such as crowdsourcing and big data methodologies.

It is suggested that the observatory should give priority to provide the indicators that should be used in monitoring and evaluating the implementation of the national strategy for population and development according to the needed periodicity.

Chapter 3

Sexual and Reproductive health

3-1 Introduction:

Egypt adopted the Millennium Declaration in 2000, among 189 member states and more than 20 International Organizations. Like other member states, Egypt has committed to achieve the MDGs, after the deadline of the MDGs, the United Nations launched the SDGs. The SDGs based their priorities and goals on the progress achieved towards the MDGs, the lessons learned from their implementation, and the most important challenges that prevented their achievement. Promoting human wellbeing and raising living standards are not only ends of development, but are also important means to address population dynamics and promote more sustainable development pathways. Consequently, Egypt should integrate population dynamics in its developmental strategies.

As mentioned in chapter one, Egypt population is increasing rapidly.

Egypt's rapid population growth is putting pressure on the country's economy and environment and is threatening the health and well-being of the people. Egyptian government faces challenges in providing for the basic needs of its citizens, including education, health care, work opportunities, housing and sanitation.

3-2- SRH services:

As mentioned in chapter 1, the TFR increased from 3 to 3.5 children per woman during the period from 2008 to 2014.

About three fifths of married women in the reproductive age (15-49) use family planning methods according to demographic health survey 2014. This percentage witnessed many changes during the period from 1988 to 2014, as it increased from 38% in 1988 to reach its highest levels in 2008 with 60% and then it decreased slightly to reach 58.5% in 2014.

The usage of contraceptives reported in 2014 shows a different profile than that shown in DHS 2008, where the reliance on long acting methods decreased compared to short-term ones (IUDs was 36% in 2008 and decreased to be 30% in 2014).

Differences in the usage of family planning methods are clear with respect to place of residence as it decreases from 64% for those women living in Lower Egypt to 50% for those living in Upper Egypt. This low percentage comes mainly from those women living in rural areas in Upper Egypt with a percentage of 47% compared to 64% for rural areas in Lower Egypt. Additionally, the percentage of using family planning methods show differences across different socioeconomic levels, as it equals 56% for the lowest 20% and equal 61% for the highest 20%.

The unmet need for family planning increased in 2014 to be 13%, compared to 11% in 2008. On the other hand, family planning users in Egypt are more likely to obtain their method from the public sector (57%) than the private sector (43%), particularly for IUDs, injectables, and implants.

Regarding the evolution that occurred to the percentage of women in the reproductive age (15-49) receiving any antenatal care, it's obvious that this percentage significantly increased during the last 30 years from only 57% in 1988 to reach 90% in 2014. In the latest year, there are very clear positive trends within categories of educational status and socioeconomic class; as the percentage of women in the reproductive age (15-49) who receive any pregnancy care increases from 80% for those who have never been to school to 94% for those who have at least finished high school and from 83% for the lowest socioeconomic level to 90% for the highest one. There are also differences according to place of residency of mother as it equals 94% for those living in Lower Egypt and 85% for those living in Upper Egypt.

Medically-assisted deliveries witnessed a great change from late 80's till 2014 as the percentage of births delivered by skilled medical service provider increased from only 35% in 1988 to 92% in 2014 according to the demographic health survey. However this high percentage still doesn't have fair share from different socioeconomic levels as it equals 82% for the lowest socioeconomic level while it reaches 99% for the highest level. In addition to socioeconomic level, it's clear that educational level of mother has a significant effect on this percentage as it tends to increase when the educational level of mother increases, from 79% for those who have never been to school to 96% for those who at least finished high school. The same situation is repeated when comparing this percentage with respect to different places of residence, as it equals 97% for those women living in urban governorates and 95% for those living in Lower Egypt and decreases to reach the lowest level in Upper Egypt with a percentage of 86%.

The percentage of women receiving first postnatal checkup from a trained medical service provider reached 82% in 2014. This percentage differs significantly when it is compared with respect to different places of residency and socioeconomic levels as it equals 94% for those women living in urban governorates but this percentage decreases to reach 86% for women in Lower Egypt and a lower percentage of 74% for those in upper Egypt. Similarly, when comparing this percentage for different socioeconomic levels; it increases from 70% for the lowest level to 95% for the highest one. Additionally, it's clear that the percentage of women receiving the first postnatal checkup from a trained medical has a positive relationship with the educational level of mothers, as it is 66% for those who have never been to school while it equals 86% for those whose educational level is high school or above.

To reduce fertility, a set of actions are needed including the following:

- Provide high quality family planning services that include counseling and advice, focusing on young and poor population and highlighting the effectiveness of long acting modern contraceptive methods.
- Training and retraining of health providers to provide ~~proper~~ better ~~counseling~~ counselling and services.
- Increase in the national budget allocated to procurement of contraceptives
- Promotion of different kinds of long acting contraceptives such as sub-dermal implants
- Linking post-partum and post-abortion care to family planning.
- Community awareness on importance of birth spacing and immediate post-partum contraception

3-3- SRH, Health Systems and Service Delivery:

The in-depth interviews conducted by Baseera team with key informants who are experts in population and reproductive health issues and authorities in MOHP, show that the Egyptian health system has a pluralistic nature with a wide range of health care providers competing and complementing each other, allowing clients to choose the most suitable provider when seeking care according to their needs and ability to pay. However, the Government is committed to providing health care to poor and unprivileged population groups.

A major concern for the Key Informants was that the public health facilities are not considered responsive to patients, leading patients to pay for private sector care. Inequalities persist by income across governorates, and by gender. Supply-side payment mechanisms along with low wages for physicians and other health staff provide little incentives for better performance. Dual practice remains a pressing problem, the vast majority of doctors working in both the public and private sector.

The existing system of health financing mechanisms in place today, whether it is through the general revenues of Ministry of Finance or the Health Insurance Organization system or through private spending, establishes a regressive pattern of resource mobilization and resource allocation. Inequities are evident across many dimensions, in terms of income levels, gender, geographical distribution (rural and urban, and on governorate level), and health outcomes.

The coverage of Egyptians with the National Health Insurance scheme is increasing through the addition of new population groups under the umbrella of social health insurance, for example school children and newborn children.

3-4- Health Sector Reform Programme (HSRP):

As key informants suggested, the health system has significant strengths and weaknesses resulting from its continuing evolution. The system faces many challenges in improving and ensuring the health and wellbeing of the Egyptian people. The system faces not only the burden of combating illnesses associated with poverty and lack of education, but also respond to emerging diseases and illnesses. The MOHP and its main partners had identified fragmentation in the delivery of health services, excessive reliance on specialist care and low quality primary care service as the main constraints to achieving universal coverage. The Government of Egypt has embarked on a major restructuring of the health sector. The ultimate goal of health sector reform initiatives is to improve the health status of the population, including reductions in infant, under-five, maternal mortality rates and population growth rates and the burden of infectious disease.

The overall aim of the HSRP is twofold; firstly to introduce a quality basic package of primary health care services, contribute to the establishment of a decentralized (district) service system and improve the availability and use of health services. Secondly to introduce

institutional structural reform based on the concept of splitting purchasing/providing and the regulatory functions of the Ministry of Health.

A poll conducted by Baseera on “the role of the Egyptian state in basic services provision” showed that 34% of Egyptians seek health care services from public **health facilities**. **Among those who use public health facilities** services only 36% are satisfied with the services. Bad treatment from staff is the main reason for dissatisfaction (41%) followed by unavailability of medications (22%) and lack of equipment and crowded (13%).

Currently, Egypt has achieved remarkable progress with respect to its national health indicators over the past decades. Availability of basic health services is almost universal. Ninety-five percent of the population is now living within 5km of primary health centers.

The results of the 2014 EDHS show that several key reproductive health indicators including antenatal care coverage, medical assistance at delivery, and infant and child mortality have improved.

Key informants expressed their concerns regarding social justice in health care. They proposed the following recommendations:

- Providing an integrated package of family health services.
- Making sure that the health system is accountable
- Making sure of adopting the quality assurance and quality control measurement.
- Ensuring equal distribution and dealing with the bias of the health care system to urban areas.
- Making sure on continuous building capacities of the staff, especially through on job training.

ICPD Recommendations for Adolescent Reproductive Health Services*

The International Conference on Population and Development (ICPD) Programme of Action urged governments and nongovernmental organizations (NGOs) to establish programs to address adolescent SRH issues. Countries were urged to remove legal, regulatory, and social barriers to reproductive health information and services for adolescents. Important resources for adolescents were outlined, including:

- Family planning information and counseling;
- Clinical services for sexually active adolescents;
- Services for pregnant and parenting adolescents;
- Counseling about gender relations, violence, responsible sexual behavior, and sexually transmitted diseases; and
- Preventing and treating sexual abuse and incest.

Table 3-1: Number of youths and youths percentage to the total population (1975-2015)

Year	Youth (thousands)	Youth (% of Total Population)
1975	7.560	18.7
1980	8.718	19.4
1985	9.732	19.3
1990	10.260	18.2
1995	11.310	18.5
2000	13.224	20.0
2005	15.165	21.1
2010	15.406	19.7
2015	15.049	17.8

Source: <http://www.escwa.un.org/popin/members/egypt.pdf> accessed 5/10/2015

3-5- Reproductive Health Services for Young People:

Adolescent fertility affects not only young women's health, education and employment prospects, but also that of their children. Births to women aged 15-19 years old have the highest risk of infant and child mortality as well as the highest risk of morbidity and mortality for the young mother (WHO, 2011). In Egypt Adolescent age specific fertility rate was 72 in 1988 dropped to 48 in 2005 then rose to 50 in 2008 and 56 in 2014 (EDHS, 2014).

Table 3-2: Age Specific Fertility Rates among Females aged 15-29, 2000-2014

Age Group	2000	2003	2005	2008	2014
15-19	51	47	48	50	56
20-24	196	185	175	169	213

Source: EDHS, 2014

The universal value placed on marriage, compounded by religious and social condemnation of premarital and extramarital sexual relationships, places considerable pressure on young people, particularly women, to marry and begin childbearing soon thereafter. Egypt 2014 constitution poses a high value for the family and prohibits any assault on the sanctity of the body. It requires the State to provide health services for all citizens and give maternal and reproductive health high attention.

Health services in the region have evolved in this context and, as a result, services are largely provided to maternal and child health care.

In Egypt, there are approximately 30 Youth Friendly clinics¹ in Cairo and Upper and Lower Egypt that provide the following services at subsidized prices:

- (1) premarital counseling/examination
- (2) counseling, examination, and treatment/referral for STIs
- (3) counseling, examination, and treatment of pubertal disorders
- (4) counseling and provision of contraceptive methods for married youth
- (5) antenatal and postnatal care, and counseling
- (6) lab services
- (7) According to MOHP policies.

¹ These clinics are supported by MoHP, THO & EFPA.

The providers can only provide information and counseling and are not allowed to give physical examinations to unmarried youth. Cases that need medical treatment would be referred to specialists (El Damanhoury, and Abdelhameed, 2013; Roudi-Fahimi and El-Fiki, 2011).

Sustainable Development Goals and Adolescent Reproductive and Sexual Health

Increased investment in sexual and reproductive health, specifically for adolescents, will move the Egypt closer to reaching the proposed sustainable development goals with specific applicable targets. These include SDG target 3 realize sexual and reproductive health as rights for all, and promote the rapid reduction in fertility to replacement level or below through exclusively voluntary means and ensure universal coverage of quality health care, including the prevention and treatment of communicable and non-communicable disease, sexual and reproductive health, family planning, routine immunization, and mental health according to the highest priority to primary health care.

3-6- How Reproductive Health and Reducing Unwanted Births Contribute to Poverty Reduction:

Investments in better health, including reproductive health, are central for individual security and for reducing mortality and morbidity, which in turn improve a country's productivity and development prospects. The MDGs and SDGs recognize that reproductive health, including sexual health, is essential to human well-being. They also recognize that universal access to reproductive health information and services, including family planning and maternal health services, can affect population dynamics through voluntary fertility reduction, as well as reduce infant, child and maternal mortality, and prevent HIV infections. Improved reproductive health also helps individuals, families and countries break out of the poverty trap.

Providing family planning services and increasing its coverage will decrease unmet needs that reached 12.6% in 2014.

The national strategy for population and development aims at reaching a CPR of 71.6% and unmet need of 6%.

The increasing number of births witnessed in the last 8 years from 1.85 million in 2006 to 2.7 million in 2014 will increase the burden of providing public services for the additional 0.85 million births. For example, enrolling those births in education needs to allocate 18 billion Egyptian pounds to build new classes.

Achieving the objectives of the national strategy will reduce the number of annual births to 2 million which will help allocating the state resources to eradicating poverty and achieving social Justice.

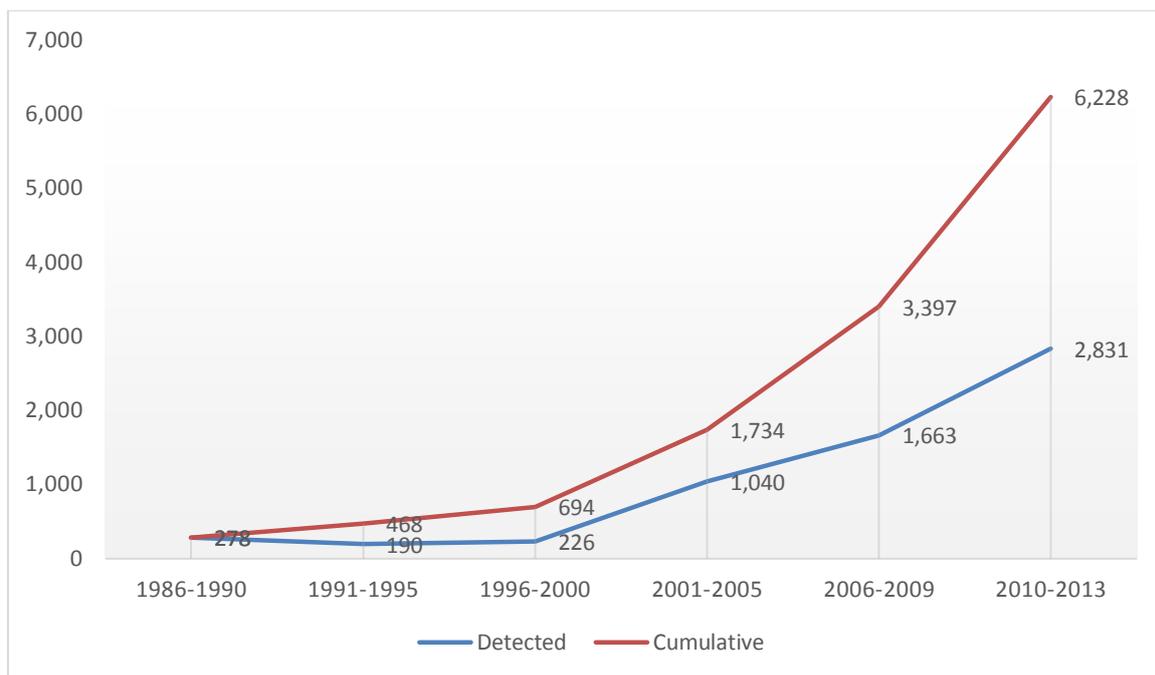
3-7- Situation and trend in HIV/AIDS and STIs

3.7.1 HIV/AIDS status and trend

Egypt's first HIV/AIDS case was declared in 1986, since then, there is an incessant rise in the number of HIV/AIDS detected cases (Figure 3-1). The perceived increase in the number of detected HIV cases can be partially explained by the epidemic growth but more plausibly by the incessant efforts of the National AIDS Program (NAP) to improve HIV/AIDS testing and reporting.

The magnitude of the HIV epidemic in Egypt has generated significant speculation and debate over the past decade. Till the end of 2013, 6,228 HIV infected cases were reported, from them 5,108 (82%) were Egyptians. By the end of 2011, 2,310 cases were stated to die from AIDS-related illnesses¹¹, yet three years later, 4,631 cases were known to be living with HIV. By saying this, it is evident that the available national statistics are far from depicting the HIV epidemic in the country. Furthermore, it can be speculated that at least one third of HIV cases die from AIDS-related illnesses.

Figure 3-1: Number of HIV/AIDS reported cases in Egypt, 1986-2013



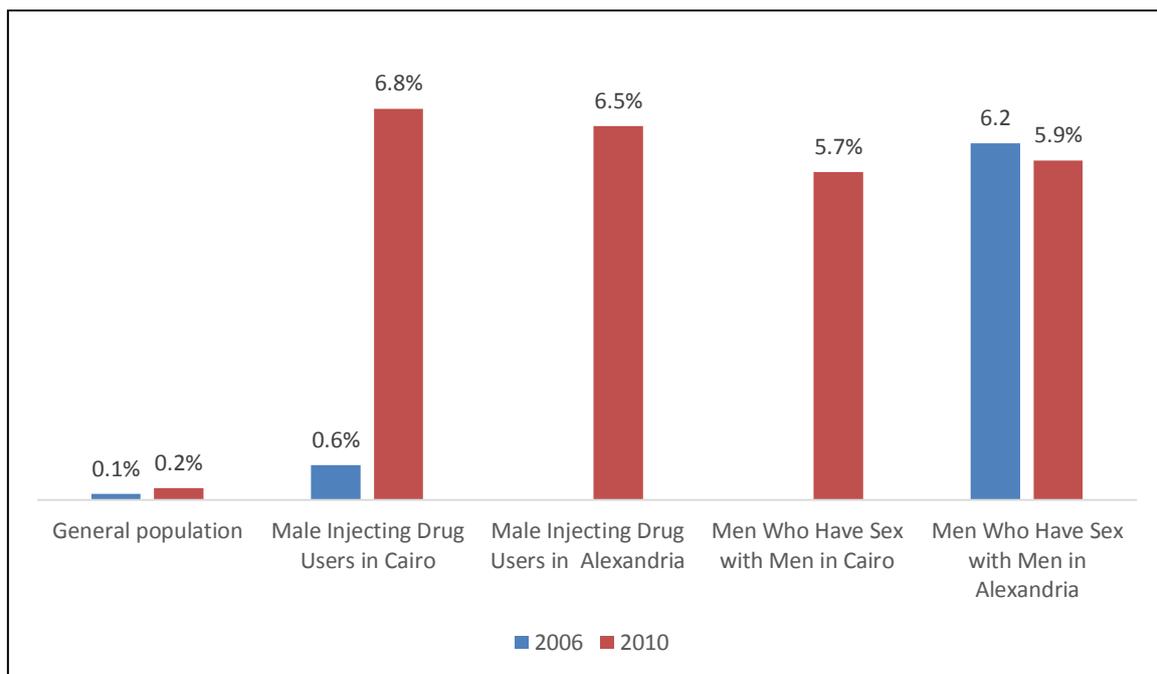
The estimates of the UNAIDS¹³ has shown that the number of PLHIV has nearly doubled from 3,200 [2,200-5,800] in 2005 to 7,400 [4,800-12,000] in 2013 and deaths from AIDS-related illnesses has tripled from 0.2% to 0.6% of HIV cases over the same period. The underestimation in the national statistics is attributed to the limited active surveillance mechanism and the prevailing passive approach for case detection. Given the wide spread low perception of risk, few people present for HIV testing voluntarily, in addition, the reporting relies mainly on blood screening and the passive reporting from Egyptians who are required to test negative as a pre-requisite for working abroad or foreigners resident in Egypt. Thus, it is apparent that the passive surveillance mechanism, though provides useful insights, is distant from stipulating the magnitude of the HIV epidemic in the country.

The estimates of the UNAIDS has shown that the number of PLHIV has nearly doubled from 3,200 [2,200-5,800] in 2005 to 7,400

Despite that the HIV epidemic is not considered a serious health threat in Egypt, there is emerging evidence that the epidemic is escalating (Figure 3-2). The UNAIDS estimates an increase in prevalence from <0.1% in the general population in 2005 to 0.2% in 2013. Several pockets have been identified in IDUs and MSM. In 2006, the first round biological and behavioral surveillance survey (Bio BSS), raised many doubts about the potential concentration of the

HIV epidemic in MSM with a population estimate prevalence of 6.2%. By that time, the population estimate of HIV prevalence in male injecting drug users (MIDUs) was 0.6%. These doubts were settled four years later with the second BioBSS⁶ which, confirmed the concentration of the epidemic in MSM and highlighted its concentration in MIDUs. According to the Bio BSS in 2010, the population estimates of the HIV prevalence among MSM in Cairo was 5.7% and in Alexandria was 5.9%. In the four years period, MIDUs showed a rapidly increasing HIV prevalence that reached 6.8% in Cairo and 6.5% in Alexandria. These signals have marked that Egypt is no more in the low prevalence era and has stepped to an HIV concentrated epidemic.

Figure 3-2: Trend in HIV prevalence in the general population and the most at risk populations in Egypt



Both active Bio BSS attempts revealed that MIDUs and MSM practice multiple overlapping risk behaviors of injecting drugs, sharing needles on injecting drugs, practicing unprotected commercial sex, having more than one sexual partner and MSM activity. It was clear from both surveys that several members of both MARPs groups have close links with the general population through marriage.

Furthermore, the actual numbers of MARPs are hardly known. In 2011, the UNAIDS has estimated that there are 24,000 female sex workers (FSW), 100,000 IDUs and 48,000 MSM in the country. According to the National Addiction Survey in the same year, there is at least half a million addicts in Cairo. In Egypt, high risk practices are socially unacceptable, whereas HIV infection is highly stigmatized and usually associated with risky behavior, which forces members of these groups to hide and refrain from seeking healthcare or reveal information about being HIV positive.

Egypt experiences a wide range of HIV transmission routes with 66.8% of infections occurring due to unprotected sexual activity. In 2013 Heterosexual transmission was responsible for 46.2% of HIV infections and homosexual transmission for 20.6%. The growing population of IDUs is another major route of infection responsible for 28.3% of HIV transmission. HIV infections in children represent 4.9% of cases, possibly due to mother to child transmission (MTCT).

The HIV epidemic in Egypt has a male dominance, yet the years have shown an increase in women's share representing around one quarter of HIV cases. The growth of the epidemic in the country puts both men and women in the path of the HIV infection through their own or their partner's high risk behaviors. In addition, poverty and unemployment were identified as potential catalyst for the growth of the epidemic. Furthermore, Egypt hosts plenty of heterogeneous groups who are vulnerable to HIV infection as street children, youth and prisoners. The country provides shelter to many migrants, asylum seekers, and others who have moved-in notably over the past half-decade as a result of the political instability in the region.

The available statistics provides evidence that HIV infection has spread all over the country. Highest numbers of HIV cases are reported in Cairo, Alexandria, Giza and Gharbia, while the frontier governorates (New Valley, Red Sea, Matrouh) and Luxor have the least numbers. This marked variation could be partly explained by the difference in population size between the governorates, the heterogeneity of the population subgroups, as well as the concentration of the HIV programs in the big cities, especially in the early years of the epidemic.

The intimate relation between HIV and hepatitis B virus (HBV) and hepatitis C virus (HCV) should not be neglected. HBV and HCV are among the major health threats and leading causes of death in Egypt. Both viruses share with HIV many common characteristics. Like HIV, they have similar modes of transmission, do not have an effective treatment to date and

cause inescapable death. The fact that HBV and HCV found route in Egypt and score high prevalence put the country at high risk of HIV transmission and indicate that Egypt is not out of the beaten path of the HIV epidemic.

Despite the incessant NAP efforts to reduce HIV transmission, comprehensive HIV knowledge remains insufficient in the population, especially youth and females. Abstinence and condom use are the least to be recognized as prevention measures. Several misconceptions exist and comprehensive HIV knowledge did not show remarkable improvement. There is limited information on the condom use among MARPs. Insufficient HIV knowledge and practice of unprotected sex among MARPs were tangible among female sex workers (FSWs), IDUs and MSM.

Furthermore, provision with lifesaving antiretroviral therapy (ART) remains insufficient. According to the national statistics, only 18% of HIV positive adults and children received ART and 25% of them stopped the treatment sometime during the first year.

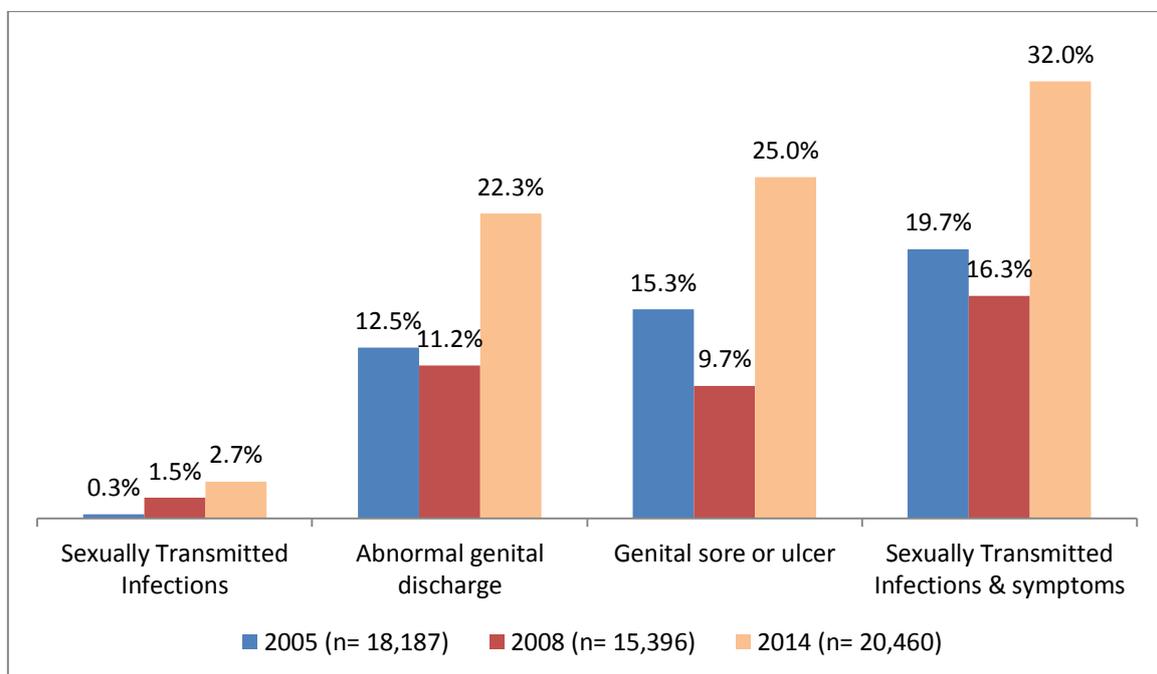
3.7.2 Sexually transmitted infections

The prevalence of STIs is not believed to be high in Egypt and little information is available on their magnitude in the population. The few available information on vulnerable populations and MARPs have documented the existence of STIs in the country. In the 1990s, STIs were estimated to be prevalent in around 8% of married women and MARPs. FSWs and MSM were the most affected. STIs were found to be caused by a variety of organisms. Gonorrhea, Chlamydia and Trichomoniasis were diagnosed in MARPs, in pregnant women attending antenatal care clinics and married women in family planning services; while Syphilis was only reported in MARPs. STIs were found to be more prevalent in low socio-economic, uneducated heterosexual single men with multiple sex partners practicing unsafe sex.

Human papillomavirus (HPV) is another STI which is increasing evident to be linked to the development of genital cancers. Little is known about the burden of HPV and related cancers in Egypt. However a recent report by the ICO Information Centre on HPV and Cancer have documented anal cancer incidence in 0.4 per 100,000 men and women and cervical cancer incidence in 2.1 per 100,000 women. Furthermore, HPV was reported as the underlying cause in 81.2% of cervical cancer cases in Egypt.

The demographic and health surveys have started collecting information on STIs in Egypt since 2005. This information has been restricted to married women 15-49 years old. In 2005, self-reported STI prevalence was 0.3% in married women 15-49 years old, yet over the past decade, it has increased around 10 folds. Over the years, there was, also, an apparent rise in the self-reported STI symptoms including abnormal genital discharge and genital sore or ulcer (Figure 3-3).

Figure 3-3: Trend in self-reported sexually transmitted infections and symptoms (abnormal discharge, genital sore or ulcer) in married women 15-49 years in Egypt



Source: EDHS 2005, 2008, 2014

The latest available information in 2014 documents numerous disparities in self-report STIs and STI symptoms in married women 15-49 years old. Self-reported symptoms have highlighted the emergency of STIs in several population subgroups notably youth, rural residents, residents in Upper Egypt and the poorest social groups. STI knowledge was apparently low and there is no available information on treatment coverage or cure rate.

3-7-3- Adolescents and youth and their emerge as a priority group in relation to HIV/AIDS and sexually transmitted infections

The share of youth in HIV infections is rapidly growing worldwide. In 2013, Around 670 thousand young people between the ages of 15 to 24 years were newly infected with HIV, of whom 250 thousand were adolescents between the ages of 15 and 19 years. Youth health is an indicator of health and productivity of countries currently and in the future. Youth health is affected by factors earlier in life. As everywhere, youth are often characterized as being rebellious and curious to experience new ways of approaching life.

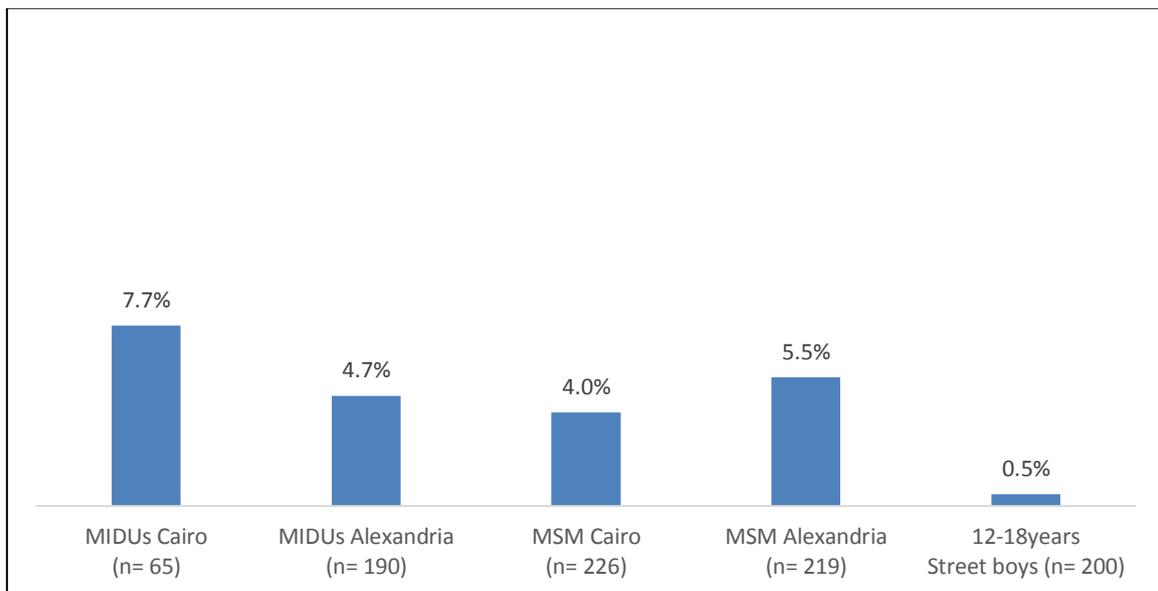
Egypt is relatively a young nation with around 40% of its population in the age group 10-29 years. The few data on risk behavior of Egyptian youth show that some of them may be indulged in drug abuse, and start sexual activity at an early age with very low condom use and presence of premarital sex, including commercial sex. In the Bio BSS in 2010, 15.7% of MIDUs, 56.5% of FSWs and 85.2% of MSM were under the age of 30 years. At this early age, MARPs practice multiple overlapping risk behaviors of injecting drugs, sharing injecting equipment and unsafe commercial sex.

There is dearth of information on youth HIV infections in Egypt. However, it is clear from the reported cases, that there is an annual expansion of the youth epidemic. The UNAIDS has estimated Egypt HIV prevalence in youth 15-24 years to be <0.1% while the UNICEF estimates that in Egypt, the share of adolescents (10-19 years) is 7% of all HIV cases. The latest available national statistics for youth in 2009 has revealed that that their share is around 29.2% of HIV cases, with a female dominance notably in the age group 20-29 years. This draws the attention to the risk of spread of HIV infection unperceived in young sexually active girls in the childbearing period and from them to their offspring. MTCT is already evident in Egypt and was declared in 15 infants below one year of age and 53 children under-five years. UNAIDS estimates that new HIV infections in 0-14 years children in Egypt has increased from 40 [30-70] in 2009 to <100 [<100-<100] in 2013.

The Bio BSS data in 2010 was another source documenting the HIV infection in youth (Figure 3-4). From all MARPs under the age of 30 years tested for HIV, the infection was detected in 5.7% of the MIDUs and 4.7% of the MSM. Street children were another group found to be vulnerable to HIV infection as 0.5% of street boys between 12-18 years were HIV positive. Street children in Egypt are a matter of concern, their actual number in the country is still not known, however, some estimate that they are in excess of one million

while others report them to be in thousands. Nevertheless, they lack economic security and protection under law, in addition they do not enjoy access to education and many of them practice several income generating activities. They are at great risk of contracting and spreading HIV as they inject drugs and are forced either by fear or poverty to practice several risk behaviors as unsafe sex and MSM activity.

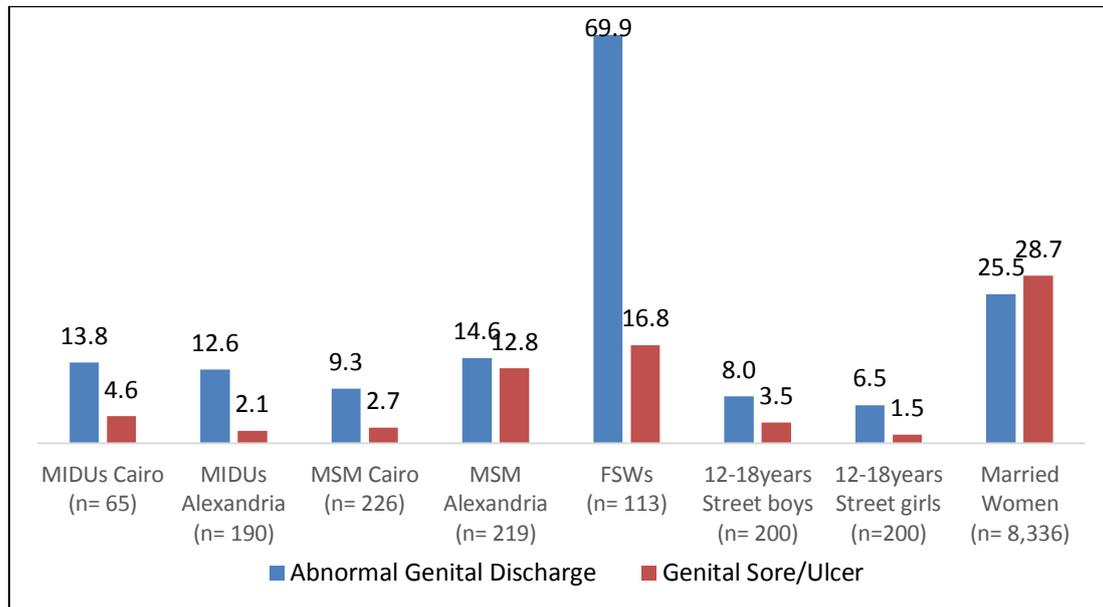
Figure 3-4: HIV prevalence among MARPs under 30years in Egypt



Source: BioBSS data, 2010

There is hardly information on STIs in youth. However, with the growth of the HIV epidemic in those below 30 years of age, it became evident that STIs other than HIV may be existing early in life. The few information available from the BioBSS and the Demographic and Health Survey (DHS) have provided evidence on self-reported STI symptoms in young MARPs and vulnerable populations. STI symptoms were reported by at least 70% of young FSWs and at least one quarter of young married women under 30 years. Moreover, STI symptoms were also reported by street boys and girls 12-18 years, as well as young MIDUs and MSM (Figure 3-5).

Figure 3-5: STI symptoms including abnormal genital discharge and genital sore or ulcer in MARPs and vulnerable populations under 30 years of age in Egypt



The practice of risk behaviors among youth has also been documented. There is a growing reliance on drug abuse and addiction by adolescents and youth with a decrease in the mean age of onset of drug use. The rate of drug addiction among adolescents under the age of 20 years, is almost 9.5% of the total number of drug addicts. Despite the prevalence of addiction in males more than females, there is a rise in the rate of addiction among girls, where the average age has fallen at the first drug use to 11 years.

Further to the high risk behaviors, both girls and boys may be subject to several social determinants which put them in the path of the HIV infection and other STIs throughout their lives. In childhood, boys and girls survive in a conflicting environment. Since birth, children live with their parents or guardians who avoid talks on sexual and reproductive health and believe that children should not be exposed to such information. There is wide spread resistance to sexual and reproductive health messages. HIV awareness campaigns are not welcomed to be put on air in TV programs or produced as sex education programs in schools. However, with the technology advancement and the open sky era, children are liberally exposed to all sort of risk behaviors that they watch on the internet, social media or television. They seek further knowledge from their immature peers who are left over with numerous misconceptions and risk behaviors. Furthermore, health promotion and prevention

services focus on two age extremes, child up to 5 years of age and married youth of at least 18 years old. There are no such services for the age group 5 to 18 years. To this end, children find no one to help them understand the biological changes that they live during puberty or respond to the many pending questions that they have. All these factors combined constitute a fertile milieu for risk behaviors to flourish early in life.

As they grow up, adolescents are bounded by the cultural norms which uphold the institution of marriage as the only legitimate context for sexual relations. Early marriage is encouraged, sexual relations outside marriage are prohibited and sex education is a sensitive issue. These culture norms are further translated into gender roles. On one hand, the ideals of premarital chastity and lifelong fidelity, make women face steep barriers to accessing accurate information about STIs in general and HIV in specific, as well as having a proactive role in negotiating safer sex because they are not expected to be sexually experienced. On the other hand, the prevailing norms of masculinity provide men with more privileges and freedoms. Men's experiences and multiple partners are often tolerated as part of the masculine ideals, putting them at risk of practicing risk behaviors and their masculine image prevent them from seeking accurate information or admitting their lack of knowledge about sexuality and risk reduction. These normative societal ideals increase both women's and men's transmission risk and ability to access care for those who are infected. Cultural norms and gender roles that subordinate women and trap men in damaging patterns of risk behaviors are increasingly recognized as fundamental forces that increase population health vulnerabilities, and Egypt is no exception.

Furthermore, the conservative culture and gender roles, in the country, reinforce a pervasive stigma which is widely recognized as root cause for the country's slow response to prevent HIV and STI transmission. The perceived shame and disgrace that people practicing risk behaviors, STI cases or PLHIV put on their families force them to conceal their lifestyles and avoid seeking counseling, HIV testing, social support or health care. The culture-gender-stigma triad is reflected on the low prevalence of HIV and STI knowledge and negative attitude towards such infections, in the country, coupled by low condom use even in MARPs. The tendency to down play the importance of the HIV epidemic growth and the existence of STIs have resulted in lack of evidence, suppression of facts and delayed interventions.

The current situation in Egypt is compounded by the political instability in the region over the past years. The country has become the refuge for many migrants with an increase in the

number of unaccompanied children, a pattern known as “child on the move”. According to recent reports of the Italian Government, Egypt occupies the second position in terms of the number of unaccompanied children refugees. While the law imposes HIV mandatory testing for non-nationals, refugees and persons of concern to United Nations Refugee Agency (UNHCR) are exempted from this mandatory testing for their residency needs in the country. Furthermore, the UNHCR and the government coordinated efforts have resulted in a reduction of expulsion of refugees who are HIV-positive. But still, fear of deportation restrains these children from accessing HIV testing and treatment. All these circumstances create a hub of children at risk of capturing HIV and STIs.

3-7-4- National efforts to halt HIV/AIDS and sexually transmitted infections

3.7.4.1 National response to HIV/AIDS and sexually transmitted infections

Since the detection of the first AIDS case, the Ministry of Health (MOH) established the National AIDS Program (NAP) for controlling the HIV epidemic in the country. In the early years, the HIV strategy was separate from the STI measures, however, the intimate relation between these infections made STIs control one dimension for halting the HIV spread.

The NAP strategy has built on multi-sector national response to halt the HIV epidemic and STIs with special focus on PLHIV, MARPs and other vulnerable groups notably women, children, youth, migrants/mobile populations and prison inmates. The NAP developed partnership with the Ministry of Education, Ministry of Higher Education and Ministry of Social Solidarity, as well as UN agencies, international agencies, Civil Society Organizations (CSOs) and PLHIV to mount a multi-sector approach for addressing the HIV epidemic.

The NAP strategy has built on multi-sector national response to halt the HIV epidemic and STIs with special focus on PLHIV, MARPs and other vulnerable
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In the initial phase, the NAP efforts focused on reporting of HIV detected cases through passive surveillance mechanism. Since 2004, screening of blood and blood products through strict infection control measures became mandatory in the country. Several blood banks throughout the country were renovated, a national blood donor tracking system was put in place to ensure safe voluntary blood donors attraction and retention. Blood units are screened for blood-borne diseases prior to transfusion. The MOH has called for the establishment of an

infection control committee in all hospitals and the application of infection control measures in renal dialysis units and blood banks. The HIV screening has also been extended to foreigners residing in Egypt for education or work and Egyptians studying or working abroad in countries applying HIV-travel restrictions, as well as those presenting for voluntary testing.

Since 1996, the NAP, supported by the Ford Foundation and UNICEF, developed anonymous toll-free 24-hours HIV telephone hotlines providing information on HIV/AIDS and sexual health, as well as referral for HIV testing and care. Since then, the NAP produced over million educational materials providing information on HIV/AIDS. Religious leaders and media personnel have been targeted with several activities aimed at sensitization to the risk of HIV spread in the country, stigma reduction and empowerment of PLHIV. Few TV spots were aired and the “World AIDS” Campaign events are conducted annually.

In 2005 a ‘youth train’ traveled from the north of Egypt to the south carrying students and in every stop national seminars and music concerts were held. Peer support programs in schools and youth clubs are also in place with support of various CSOs. This includes peer education programs led by youth and student groups such as student-led ‘Anti-AIDS’ clubs in high schools, student-led awareness activities in faculties of medicine, peer education among scouts, and outreach to refugees by their peers. Programs addressing vulnerable groups and MARPs (FSWs, MSM and IDUs) and prison inmates have been initiated. The NAP has worked in close collaboration with the Ministry of Education and Ministry of Higher education to include HIV education in the educational curriculum.

Since 2004, the NAP worked in conjunction with Family Health International (FHI360), USAID, UNFPA and the Italian Cooperation on establishing Voluntary Counseling and Testing (VCT) centers all over the country. There are 15 fixed and 9 mobile VCT centers in 17 governorates providing anonymous counseling and voluntary testing free of charge to attract MARPs and reduce stigma.

Since 2004, screening of blood and blood products through strict infection control measures became mandatory in the country

In 2004, the NAP outlined a national HIV surveillance plan for monitoring the HIV epidemic growth. A national electronic disease surveillance system (NEDSS) was put in place serving at least 13 governorates to collect and analyze data on 26 priority infectious diseases including HIV. Few serological and behavioral surveys have been conducted in MARPs but were done on an ad hoc basis and failed to produce disease trend information or risk behavior

pattern in the country. In the same year, the MOH in collaboration with UNAIDS and UNODC conducted a behavioral survey in IDUs in Cairo while in 2008, the MOH along with the UNICEF and the Population Council ran a behavioral survey among street children in Cairo and Alexandria. In 2006, the MOH, in collaboration with FHI360 and USAID conducted the first round Second Generation BioBSS, as the first of its kind in the region, collecting data on risk behaviors and STIs, as well as assessing HIV prevalence in street children, FSWs, MSM and IDUs. In 2010, the MOH, in collaboration with FHI360 and Global Fund conducted the second round BioBSS to monitor trend in HIV prevalence and risk behaviors.

The NAP worked on creation of support groups for PLHIV and their families. In the recent years, the civil society has been increasingly vocal within the governmental processes and many CSOs have become more engaged in HIV-related services.

The “Friends of Life” NGO launched in 2008, is the first NGO in Egypt led by PLHIV and supported by UNAIDS and UNICEF. Care of PLHIV is conducted through counseling, treatment of opportunistic infections, provision of ARV and follow-up.

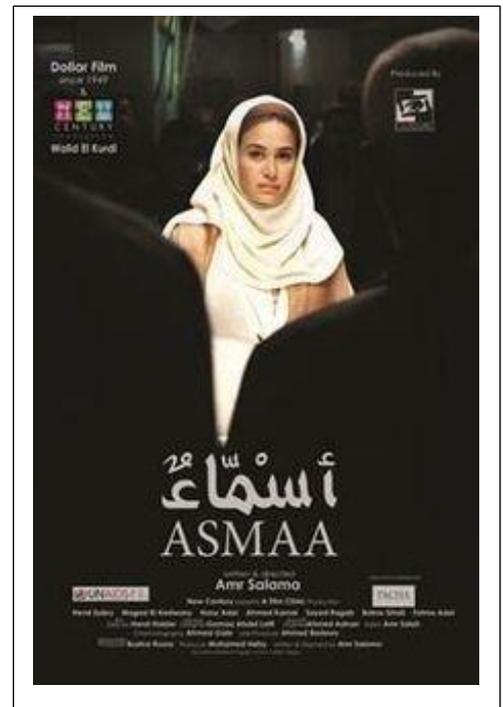
Caritas-Egypt is carrying out home-based care program for PLHIV through its “Greater Involvement of PLHIV” (GIPA) project. The MOH has integrated HIV counselling and testing with many tuberculosis services and few sexual and reproductive health, maternal care and child health services. To increase coverage of PLHIV with treatment, the NAP expanded the ART dispensing sites from six sites in 5 governorates to 11 sites in 11 governorates (3 in Upper Egypt, 4 in Delta region, 2 in Cairo and Giza, one in Alexandria, and one in the Suez Canal region)

The NAP has trained physicians and nurses all over the country on HIV care and support in collaboration with the Ministry of Social Solidarity. Egypt has a network of mother and childcare centers at governorate level, caring for abandoned children.

In 2013, with the technical assistance of FHI360; funding from Dross and FORD Foundation and support from UN agencies, the NAP worked with the CSOs and established the

“Network of Associations for Harm Reduction” (NAHR). NAHR is the first locally owned network aiming to unify, strengthen and sustain efforts invested in harm reduction for all key populations in Egypt. It works on strengthening the capacity and enhancing the collaboration among CSOs to share the goal of reducing stigma, promoting behavior change and expanding the harm reduction services available to MARPs. It provides wide range of services including voluntary counselling and testing for HIV, a clinic for detection and treatment of STIs and other illnesses, provision of syringes, condoms, information, education and communication (IEC), counselling, support groups and peer education, in addition to referral services to allow beneficiaries access rehabilitation and ART. NAHR members work in diverse governorates, and have access to a large number of beneficiaries and employ outreach teams that can target a greater number of people.

CSOs projects to fight stigma and discrimination are also becoming stronger. A project led by Caritas in Upper Egypt has started in 2013 to fight stigma and discrimination and includes PLHIV on each team. More light is being shed on human rights issues relevant to HIV/AIDS and to the stigma surrounding it. The release of the movie “Asmaa” addressing the societal stigma and discrimination against a woman living with HIV has brought the matter to public attention. A stigma research based on the stigma index methodology was commissioned by UNAIDS and UNICEF to develop a comprehensive evidence base for PLHIV perceived stigma in Egypt.



The NAP has worked with technical partners to develop the new National HIV Clinical Care Guidelines. There has been an improvement in the availability of CD4 and viral load testing, as well as ensuring there are no treatment delays.

The NAP has worked with technical partners to develop the new National HIV Clinical Care Guidelines

Despite that Egypt has a concrete HIV strategy and programs, the STI efforts are less evident. There is no clear strategy in place and the services focus on case management. However, the MOH has made gigantic strides in upgrading its services for the detection and treatment of STIs, through provision of laboratory diagnosis and treatment along the private sector and the governmental sectors. The

MOH has implemented the syndromic approach for STI case management and has also carried out etiological studies to validate the WHO flowcharts relating to the syndromic approach. Egypt is among the six countries in the EMR to provide special STIs services for MARPs in the form of outreach and peers education program among FSWs with provision of special consultation and treatment services for this group.

3.7.4.2 National Regulations Related to HIV and Sexually Transmitted Infections

The NAP efforts are founded on solid national environment. The Egyptian Constitution of 2014, as well as previous constitutions, value health and the right to health care for all citizens and prohibits discrimination. Egypt is signatory to the Millennium Development Goals (MDGs), the Declaration of Commitment on HIV/AIDS and the Sustainable Development Goals (SDGs), as well as all the international human rights treaties.

There are several regulations in Egypt that favor the right to health for MARPs and other vulnerable groups. The Prisons Law 396/1956 specifically guarantees the right of prisoners to receive health care, including HIV treatment. The Egyptian Anti-Narcotics Law 122/1989 has provisions that allow courts to refer drug users to treatment in rehabilitation facilities as an alternative to imprisonment. It is always the right of citizens to file a law suit to claim their rights against discriminatory acts. Violence against women, including sexual assault is criminalized under the Egyptian penal code (articles 268 and 306).

Furthermore, right to confidentiality and informed consent are mentioned in the MOH resolution 238/2003 on ethics of medical practice. The regulations also include provisions that prohibit doctors from denying medical care to anyone. In addition, social solidarity pension can be dispensed to PLHIV similar to that being dispensed for people with disabilities, if they are unable to work.

In Egypt social solidarity pension can be dispensed to PLHIV similar to that being dispensed for people with disabilities, if they are unable to work.
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3-7-5- Child protection regulations related to HIV and sexually transmitted infections

A set of child protection policies have been developed to protect the right of children to health and well-being which are further reflected on their HIV and STI vulnerabilities. A wide range of protection initiatives exist in the country, aiming to address such diverse problems as age at marriage, citizenship rights, female genital mutilation/cutting (FGM/C),

violence against children and child labor. Egypt has recently revised the laws to provide greater legal protection to children, and they are currently being implemented. These include, the Child Law 12/1996 as amended by Law 126/2008, and the relevant articles of the Penal Code. The Child Law has for the first time criminalized some practices injurious to child well-being, such as FGM/C and the criminalization of trafficking in persons. It, also, led to the amendment of Civil Status Law to raise the age of marriage to 18 years for both males and females.

Egypt signed a number of international conventions and was one of the first countries that have ratified the Convention on the Rights of the Child. It was one of the founding countries for the Children World Summit initiative held in 1990.

The Egyptian constitution in 2014 has stressed on the child rights and has confirmed that the country respects the agreements and international conventions ratified by Egypt, and came into force under Article 93 of the Constitution, including the International Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child in 2001, and other related conventions and treaties. Egypt has issued the first decade document in 1989-1999 and the second decade document in 2000 - 2010 on the protection and care of the Egyptian Child.

Finally the National Council for Childhood and Motherhood has developed the Childhood strategy 2017-2022²⁶ to ensure child protection, health and right to health. The strategy aims to translate the texts that laid the Rights of the Child in the Egyptian Constitution, and respond to the many social, economic and security challenges facing the child and the mother. The strategy represents a unified framework for all government and non-governmental institutions concerned with childhood and motherhood issues in Egypt.

The National Council for Childhood and motherhood has developed the Childhood strategy 2017-2022 to ensure child protection, health and right to health. The strategy aims to translate the texts that laid the Rights of the Child in the Egyptian Constitution, and respond to the many social, economic and security challenges facing the child and the mother.

The strategy was prepared in consultation with all partners including groups representing the children of Egypt. This strategy comes to reflect the aspirations of the new generation to promote child protection, health and access to knowledge and healthcare services.

Chapter 4

Inequalities and the exercise of rights

4-1- Introduction:

Vulnerability is the degree to which a population, individual or organization is unable to anticipate, cope with, resist and recover from the impacts of disasters. Environmental health in emergencies and disasters: a practical guide. (WHO, 2002).

People living in slum areas, malnourished people, and people who are ill or immunocompromised, disabled people and elder people are particularly vulnerable when a disaster strikes, and take a relatively high share of the disease burden associated with emergencies. Poverty – and its common consequences such as malnutrition, homelessness, poor housing and destitution – is a major contributor to vulnerability.

Previous reports on population status discussed the aging issues.² This chapter concentrates on slum areas, street children and fishermen in Egypt.

Although there are many definitions of poverty, the United Nation definition encompasses all the poverty factors and consequences. The UN defines poverty as the inability of getting choices and opportunities. This means not having enough to feed or clothe a family (food), not having a school (education) or clinic (health) to go to, not having a land to grow or a job to earn (income) and not having access to credit. The consequences of the lack of these factors would lead to insecurity, powerlessness, exclusion and marginalization.

Same as there are number of definitions of poverty, there are multiple methods of measuring poverty. Money metric poverty, Expenditure based methods, Gini index and multidimensional poverty indices are the most used poverty indicators.

One of the Money Metric Poverty measures is based on PPP\$ poverty lines. This measure relies on \$1.25 in purchasing power parity (PPP) as a reference threshold to measure poverty across the world in a “welfare consistent” approach. People earning (or spending) less than \$1.25 PPP are considered unable to meet the basic needs for survival in monetary terms anywhere in the world. The PPP represents comparable income (expenditure) across nations to purchase certain minimum needs (World Bank, 2013). However, whether or not the \$1.25

² Population status in Egypt: A way forward, UNFPA, Egypt 2012.

PPP line allows meaningful comparison of poverty across countries, or the PPP\$ based poverty line can meaningfully represent poverty at the national level, remains a matter of contention.

Another money metric approach is based on national lower and upper poverty lines. This approach establishes the lower and upper poverty lines on the basis of the expenditure surveys to identify poor and vulnerable population.

The Gini index is a measure of inequality. It assesses the extent to which the distribution of income (or expenditure) among individuals or households deviates from perfect equality. A Gini index of zero represents perfect equality while an index of 100 implies perfect inequality.

The multidimensional concept of poverty goes beyond money. The multidimensional measurement of poverty takes into account many factors, such as being deprived of a decent standard of living, social exclusion, a lack of decent employment and conditions that prevent people from achieving their potential all have an impact on human well-being and development.

The latest Egypt Household Income, Expenditure and Consumption Survey (2012/2013) shows that poverty is increasing in Egypt. The percentage of population under the national poverty line increased from 16.7% in 1999/2000, to 26.3% in 2012/2013, with a rate of change of 58%. During this period the number of poor people was almost doubled from around 11 million to around 22 million. Section 2 this chapter is to briefly describe the population inequalities by poverty, the intergenerational transmitted poverty, inequalities by religious or other cultural characteristics and inequalities related to habitat and health.

Number of poor people doubled between 1999/2000 and 2012/2013 from 11 million to 22 million people.

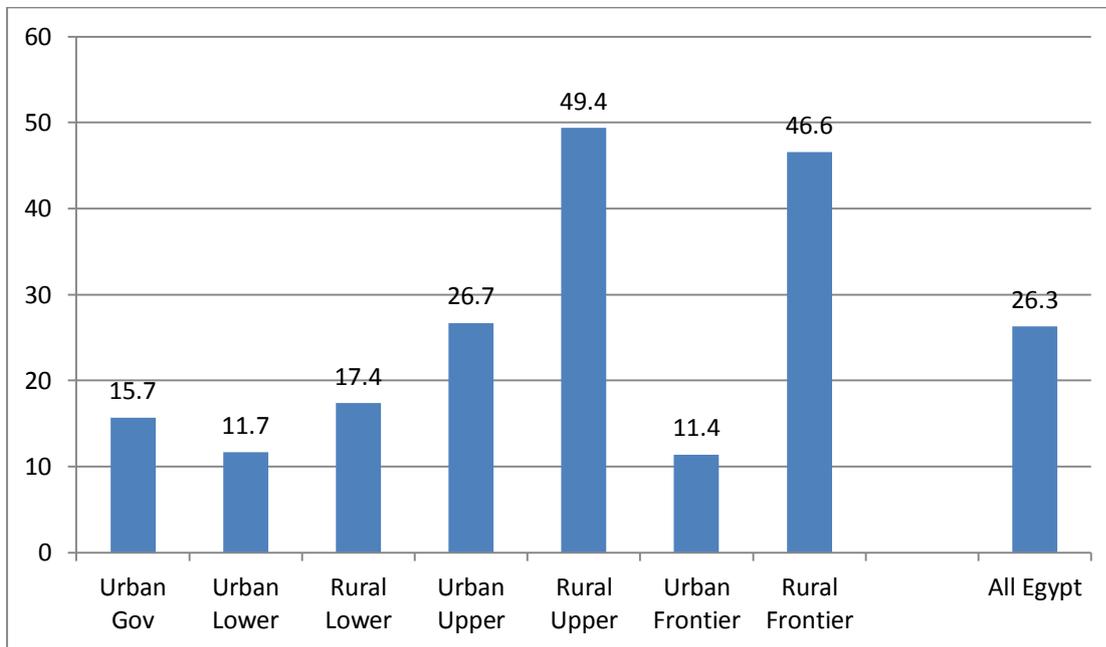
Section 3 concentrates on slum areas, street children and fishermen in Egypt.

4-2- Population Inequality by Poverty:

In 2012-2013, the poverty rate, in rural areas, was higher compared to urban areas. In particular, the poverty in rural Upper Egypt reached around 49% compared to around 17% in rural Lower Egypt - Figure (5-1). On the other hand, poverty rate at urban Upper Egypt was

higher than all other urban areas in Egypt. Around one quarter of population in urban Upper Egypt are poor compared to 16% in Urban Governorates and 12% in Urban Lower Egypt.

Figure 4-1: Poverty Rates in Egypt (2012/2013) by Region, HIECS (2012/2013)



Source: HIECS 2012/2013

To address the problem of higher poverty at rural areas in Egypt, the small-area estimation technique was used. The idea of the small area technique is to combine the rich information on household income and expenditure available from the HIECS and the complete coverage of the Census data, in order to estimate poverty rates for all locality-level in Egypt. Accordingly, the 5000 villages of Egypt are sorted by the poverty rates. Table (5-1) presents the distribution of the villages by centiles of poverty rate and region. The first centile includes the poorest 10% villages, the second centile includes 10% second poorest villages. The 10th centile includes the richest 10% villages.

The results in table (5-1) documented the fact that Poverty concentrates in Upper Egypt. More than 80 percent of the poorest 20% villages are located in rural Upper Egypt. Around 778 villages of the poorest 1000 villages are located in Upper Egypt. This number of villages accounts for more than one third of villages in Upper Egypt.

Furthermore, findings presented in Table (5-2) documented the fact that the poorest villages are less educated and less developed.

- The percentage of households with sewage doesn't exceed 5% in poorest 10% villages while it reaches 100% in some of the villages richest 10%.
- The percentage of households with water network ranges between 51% and 100% in poorest 10% villages compared to 99% and 100% in richest 10%.
- The illiteracy rate among population (10+) ranges between 18% and 79% in poorest 10% villages compared to 10 and 53 in richest 10%.
- The average number of persons per household ranges between 3.81 and 5.83 in poorest 10% villages compared to 3.33 and 4.55 in richest 10%.

Table 4-1: Distribution of villages by poverty rates centiles and region (2012/2013) *

		Centiles										Total	
		Poorest	20%	30%	40%	50%	60%	70%	80%	90%	Richest		
Region	Lower Egypt	Count	6	19	124	267	333	333	334	349	444	457	2666
		% within Centiles	1.28%	4.03%	26.33%	56.69%	70.70%	70.70%	70.91%	74.10%	94.27%	97.23%	56.63%
	Upper Egypt	Count	375	403	309	175	124	119	124	97	7	3	1736
		% within Centiles	79.79%	85.56%	65.61%	37.15%	26.33%	25.27%	26.33%	20.59%	1.49%	0.64%	36.87%
	Frontier	Count	89	49	38	29	14	19	13	25	20	10	306
		% within Centiles	18.94%	10.40%	8.07%	6.16%	2.97%	4.03%	2.76%	5.31%	4.25%	2.13%	6.50%
Total		Count	470	471	471	471	471	471	471	471	471	470	4708
		% within Centiles	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

* Calculated by the author

Table 4-2: Some characteristics of villages in Egypt, by centiles of Poverty rate and Region (2012/2013)*

		Poverty Rate		%Households with sewerage network		%Households with water network		Illiteracy rate		Share of unemployment		No. of persons per HH	
		Minimum	Maximum	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
Centiles	Poorest	47	74	0	5	51	100	0.18	0.79	0	0.06	3.81	5.83
	20%	38	48	0	6	60	100	0.17	0.75	0	0.06	3.84	5.61
	30%	28	38	0	10	73	100	0.15	0.70	0	0.11	3.79	5.57
	40%	22	28	0	11	75	100	0.11	0.70	0	0.14	3.45	5.50
	50%	17	22	0	15	74	100	0.13	0.65	0	0.13	3.57	5.25
	60%	13	17	0	12	86	100	0.10	0.62	0	0.14	3.67	5.10
	70%	9	17	0	10	93	100	0.07	0.64	0	0.08	3.52	5.06
	80%	6	9	0	50	97	100	0.06	0.57	0	0.08	3.37	5.00
	90%	4	6	0	100	98	100	0.10	0.53	0	0.08	3.50	4.69
	Richest	1	4	0	100	99	100	0.10	0.53	0	0.06	3.33	4.55

*Calculated by the author

4-2-1-Intergenerational Transmitted Poverty:

The poor children are more likely to be poor adults but this is not always the case. The household characteristics affect well-being over the life-course. In this section we consider some of these characteristics. The data used in this section depends on calculating the likelihood of the household being poor from EDHS (2014) data based on the Poverty Progress Index. Table (5-3) represents the distribution of households by size and poverty as calculated by the author from EDHS 2014. The poor household size is around two members more than the non-poor. The higher household size will lead to high dependency ratio which in turn can contribute to the intergenerational transmission of poverty by limiting children's human development and socialisation and their subsequent earnings. The costs of education, health care and food may be enough to ensure persistent severe poverty in high dependency ratio households. Children are less likely to be well fed and to complete secondary school.

Table 4-3: Distribution of households, by size and poverty.

	Poor	Non poor	Total
Mean number of household members	5.38	3.76	4.20
Total Cases	7570	20532	28157

Source: Calculated from EDHS 2014 data

The household possessions and access to services can influence income, investment, savings and consumption, nutrition, health and education, and indirectly that an individual will be chronically poor. Tables (5-4), (5-5) and (5-6) present the distribution of EDHS households by access to drinking water and sanitation and the material of floor for poor and non-poor. The poor household is less likely to have access to drinking water piped into dwelling (87% compared to 91%), less likely to have a toilet flush connected to piped sewer system (45% compared to 65%) and more likely to have earth/sand floor (10% compared to 3%).

Table 4-4: Source of drinking water among poor and non-poor

	Poor	Non poor	Total
Piped into dwelling	87.3	91.8	90.6
Piped to yard/plot	.5	.4	.4
Public tap/standpipe	4.4	2.5	3.0
Tube well or borehole	.7	.4	.5
Protected well	.8	.4	.5
Unprotected well	.0	.0	.0
Protected spring	.2	.1	.1
River/dam/lake/ponds/stream/canal/irrigation channel	.0	.0	.0
Tanker truck	2.5	1.4	1.7
Cart with small tank	.0	.1	.1
Bottled water	3.0	2.6	2.7
Other	.6	.3	.4
Total	100.0	100.0	100.0
	7570	20532	28175

Source: Calculated from EDHS 2014 data

Table 4-5: Type of toilet facility among poor and non-poor

	Poor	Non poor	Total
Flush to piped sewer system	45.0	65.5	60.0
Flush to septic tank	23.4	15.9	17.9
Flush to somewhere else	.1	.1	.1
Flush, don't know where	.1	.1	.1
Flush to vault (Bayara)	22.3	11.9	14.7
Flust to pipe connected to canal	8.8	6.5	7.1
Flush to pipe connected to ground water	.0	.0	.0
Ventilated Improved Pit latrine (VIP)	.0	.0	.0
Pit latrine with slab	.0	.0	.0
Pit latrine without slab/open pit	.0	.0	.0
No facility/bush/field	.2	.0	.1
Bucket toilet	.1	.0	.0
Other	.1	.0	.0
Total	100.0	100.0	100.0
	7570	20532	28161

Source: Calculated from EDHS 2014 data

Table 4-6: Main floor material among poor and non-poor

	Poor	Non poor	Total
Earth/Sand	10.1	2.7	4.7
Wood planks	.1	.1	.1
Parquet/polished wood	.1	.3	.3
Ceramic/Marble tiles	21.1	39.5	34.5
Cement tiles	37.0	40.2	39.3
Cement	31.0	16.7	20.6
Wall to wall carpet	.3	.3	.3
Vinyl	.1	.1	.1
Other	.2	.1	.2
Total	100.0	100.0	100.0
	7570	20532	28122

Source: Calculated from EDHS 2014 data

4-2-2-Health Inequalities:

Child and maternal nutrition and health status are often cited as the critical factors in determining the irreversibility of poverty transfers. Maternal malnutrition contributes to higher rates of maternal, infant and under five mortality. Poor in utero nutrition also leads to low birth weight babies with higher risk of the children being stunted, and experiencing a permanent limit to their physical and cognitive development, which in turn affects schooling performance and completion. These problems affect a very large number of children: over 200 million children are stunted worldwide; more than 150 million of pre-school children are underweight. Stunting and wasting have long term repercussions which could influence a child's likelihood of becoming a poor adult. Malnutrition reflected in low weight-for-age, contributes greatly to child mortality as it increases the risk of death from common illnesses. Table 5-7 documents the fact that poor children are more likely to be under weight and stunted relative to non-poor.

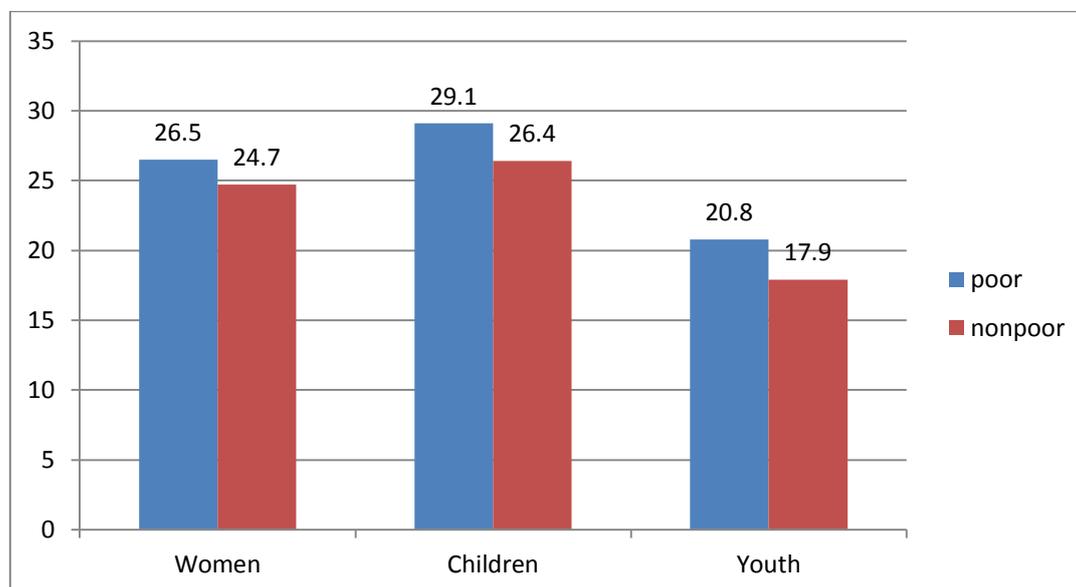
Table 4-7: Children under 5 years; Weight for Age standard deviation and height for age

	Poor	Non poor	Total
	93.9	94.7	94.4
Under weight	6.1	5.3	5.6
Stunted	23.1	21	21.7
	4557	9079	13674

Source: Calculated from EDHS 2014 data

In addition, Figure 5-2 shows that the prevalence of anemia was higher among women, youth and children of poor households compared to non-poor households.

Figure 4-2: Prevalence of Anemia among women, children and youth by poverty.



Source: Calculated from EDHS 2014 data

4-2-3-Educational Inequalities

The education differentials is very clear among poor and non-poor individuals in the age group 10 years and above. According to the EDHS 2014 data, 57% of poor population have not been to school or did not complete primary stage compared to 45% of non-poor. On the other hand, only 5% of poor compared to 14% of non-poor people completed higher education (Table 5-8).

Table 4-8: Distribution of individuals (10 years and above) by educational level attained and poverty (EDHS, 2014)

	Poor	Non poor	Total
No education	35.7	29.9	31.9
Incomplete primary	21.4	15.6	17.6
Complete primary	3.2	3.4	3.4
Incomplete secondary	18.7	15.6	16.7
Complete secondary	15.6	21.8	19.7
Higher	5.4	13.7	10.8
Total	100.0	100.0	100.0
	40733	77295	118364

Source: Calculated from EDHS 2014

The inequalities in education level is more clear among poor and non-poor ever married women (15-49 years). Table 9 indicates that around half the poor ever married women have not attended school or have not completed the primary stage compared to one fifth of the non-poor woman. The percentage of non-poor women attained higher education is three times the corresponding percentage of poor women (18 % and 6% respectively).

Table 4-9: Distribution of ever married women (15-49 years) by educational level attained and poverty (EDHS, 2014)

	Poor	Non poor	Total
No education and Incomplete primary	48.2	21.6	30.1
Complete primary and Incomplete secondary	16.8	17.7	17.4
Complete secondary	28.9	43.1	38.5
Higher	6.0	17.6	13.9
Total	100.0	100.0	100.0
	6957	14746	21762

Source: Calculated from EDHS 2014

A household survey was conducted in 2011 in the poorest rural areas in Upper Egypt (in Assuit and Sohag). On Conditional Cash Transfer (CCT). The average number of school years of children no longer in school, whether dropped out or graduated according to the CCT survey is presented in table 10. The mean number of educational years among children in rural Upper Egypt age 8-17 is approximately 5.4 years in the CCT. The average number of school years for female's age 8-17 years is slightly higher than males regardless of wealth as presented in the CCT results (5.67 years and 5.25 years respectively)

Table 4-10: Mean number of educational years among children (age 8-17) not in school

Poverty Level Proxy	8-11			12-17			8-17		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Poorest	2.67	1.40	2.38	5.28	5.68	5.44	5.08	5.52	5.25
Poorer	6.00	2.67	4.33	4.89	6.06	5.51	4.95	5.91	5.45
Poor	1.00	2.50	2.00	5.98	5.78	5.87	5.88	5.67	5.77
Total	3.17	2.13	2.79	5.37	5.81	5.58	5.25	5.67	5.44

Source: Calculated from the finding of CCT surveys

4-3- Slum Areas:

Within the Egyptian context slums have been known as ‘Ashwa’iyyat’, which literally means ‘disordered’ or ‘haphazard’. It refers to informal areas suffering from problems of accessibility, narrow streets, the absence of vacant land and open spaces, very high residential densities, and insufficient infrastructure and services (World Bank, 2008).

UN-Habitat defined a slum as: “An area that combines, to various extents, the following characteristics (restricted to the physical and legal characteristics of the settlement, and excluding the more difficult social dimensions): inadequate access to safe water, inadequate access to sanitation and other infrastructure, poor structural quality of housing, overcrowding, and insecure residential status” (2003a: 12). An enhanced approach proposed by the UN-Habitat in its 2008 report to better describe the status of slums by grouping slum dwellers into broad categories of moderately deprived (one shelter deprivation), severely deprived (two shelter deprivations) and extremely deprived (three or more shelter deprivations).

In Egypt, the recent Building Unified Law No. 119/2008, which include all definitions related to planning and urban development, the term Ashwa’iyyat, otherwise known as slums or informal settlements, does not exist. Instead the term ‘unplanned areas’ is used which is defined as: “Areas developed in contradiction to planning and building laws and regulations”. On the other hand, the General Administration for Planning and Plan Monitoring defines Ashwa’iyyat, as “Residential areas characterized by being developed in contradiction to planning and building laws and regulations in the absence of state’s supervision. They, in essence, might lack services and/or infrastructure”

Such definitions implied a number of drawbacks. Therefore, current approaches to identifying and classifying slums were revisited in order to prioritize criteria for action. These included the risk posed to peoples’ lives and properties. The newly adopted Egyptian approach developed by the Informal Settlement Development Facility (ISDF), has been to replace what was formerly called ‘slums’ or ‘informal settlements’ or ‘Ashwa’iyyat’ with the two distinctive terms of ‘unplanned areas’ and ‘unsafe areas’ and classify the later according to the degree of risk to life and property is considered a sensible approach to solve this awkward situation.

Slums in Egypt are considered as ticking time bombs waiting to go off at any minute. The statistics provide conflicting numbers of slum areas and their populations. A study conducted by the Central Agency for Public Mobilization and Statistics (CAPMAS) stated that the number of slums in Egypt amounted to 1,221 areas among which 20 have been called for removal because they are not fit for development. However, the Information and Decision Support Centre attached to the Ministers' Cabinet estimated their number to be nearly 1,034 while the National Planning Institute confirmed the existence of over 1,109 slums covering 20 governorates.

A report by CAPMAS revealed that 14 million Egyptians live in cemeteries, huts, and mosques – particularly in cemeteries at Basateen, Imam Shafi'e, Bab El-Wazeer, El-Ghafeer, El-Megawereen, Imam Lethee, Ain Shams, and Nasr City.

A focus group discussion took place in Ezbet Abu Hashish, Hdayek Alqouba, Cairo, with four female participants and two male ones. The participants' ages ranged from 30 to 64 years. Two of the females had preparatory school certificate, one of them had intermediate education and the other one was illiterate. Two of the females were born in Azbet abu hashish, and the other two had moved there after marriage. One of the male participants had intermediate education and was born in Azbet Abu Hashish and the other one was only able to read and had moved there when he was four.

The discussion showed that slum areas face numerous problems include the lack of services especially education and health services, the poor quality of the available services and lack of safety due to the unsafe buildings that threaten the lives of the people who live in it and due to the absence of police and security.

The most stated problem is the narrow residences which are, mostly, rooms with shared toilets. Meanwhile, Respondents agreed that it is, almost, impossible for them to obtain one of the flats offered by the government. Another problem is the contraventions in the roads; a thing that hinder people from walking around easily in the streets.

4-3-1-Work

One of the males owns a local café, he assumed his income is quite good for his living. The other male works as a carpenter and receives a small retirement allowance which he believed cannot be sufficient for a living as he said:

“what can 380 LE do us!”

On the other hand, all female participants were unemployed housewives and they had concerns about their family income. Some of them complained from their husbands' seasonal work which doesn't guarantee a stable income,

“when he goes to work, we are fine. But there's no work in winter. All I want for him is to have a stable job”

Moreover, another female participant complained her husband salary doesn't cover the whole needs of the month.

4-3-2- Access to Public Services

All male and female participants confirmed water availability in their residence place and assumed it has reasonable quality. On contrary, although all of them confirmed electricity availability, the majority complained that Power outage happens a lot, especially in Ramadan.

Moreover, participants confirmed natural gas is not available in their residence area. They use LPG gas tanks instead, which they suffer from its shortage during winter, as one of the females said:

“It becomes expensive in winter and we don't even find it”.

Concerning sewage network, participants reported they have a new network developed in their area, majority of them reported it has a good quality until that time. On the other hand, participants complained the bad garbage service; as it's not removed on a regular basis, as reported by most of the attendees.

4-3-3- Education

Participants reported that there's only one mixed primary school in the area and another technical secondary school for boys. Moreover, they argued that the quality of education in both schools is very bad either because of the teachers or the students themselves.

The majority expressed their desire in, at least, a preparatory school for girls to be established in their residence area. Meanwhile, some of them reported that their children had joined schools outside Azbet Abu Hashish.

4-3-4- Health

Some of the participants reported there is a health unit in the area, which is newly constructed as they said. One of the females stated that the service quality in this unit is good as her child was vaccinated there, she also added:

“My sister has been examined there, and they gave her medicine as well”

Beside the health unit, participants mentioned two hospitals that lie outside their residence area and they don't consider them far from their place as they easily use transportations to reach them.

4-3-5- Transportations

Participants reported the streets in their area are considerably lightened and they have no problem about that issue. Moreover, they are content with the availability of transportation means; as most of them mentioned using the underground and minibuses. One of them mentioned the toktok as transportation mean.

4-3-6- Safety

The majority of participants reported their girls, as well as all family members, can wander in the area without any fears day and night. One of the males said:

“I think everyone can move freely; as we are all known to each other. Daughters, sons and wives”

On contrary, only one female complained that her girls cannot walk the streets safely because of the harassments that might happen to them.

Participants denied that their area might witness any sexual harassment problems, although one of them mentioned an incident happened to her sister and daughter.

Meanwhile, participants reported there might be some “small thefts”, as they described it. In addition, all participants reported that the area witness a lot of fights

either because of financial issues or social ones (i.e. shared toilets... etc.). They also agreed that the area had no longer witness any bullying practices as one of them said:

“That happened in the past, but now they’re dead and the area is clear from such bullying”.

4-3-7- Security

Majority of respondents argued that The Police are always late to show up as one of them says:

“They only come by the end of the fight”

Only one female respondent disagreed; as she reported police do exist more often now in the area. Moreover, all respondents showed a quite significant sense of safety in the area. Furthermore, when asked about the nearest police office, respondents mentioned “Hadayek Elobba police station” which lies outside their residence area, but only one participant said that there’s a police office inside Azbet Abu Hashish.

4-3-8- Problems

Respondents listed many problems from which they suffer while living in the slums. One of these problems is the lack of bakeries in their residence place which requires women to go outside the area to get bread for their needs. Moreover, some respondents showed resentment about the new system of the ration cards which combine bread with the rest of food supplements; as one of them said:

“it is unfair! I, for example, don’t have ration card, so I don’t get bread. One day I don’t buy bread, another day I pay 10 LE for the bakery. This is very unfair”

Majority of participants had complains about the contraventions in the roads; a thing that hinder people from walking around easily in the streets, many of them, also, demanded a quick governmental intervention about this issue.

The problem most commonly reported is the dilapidated buildings and how they are affecting people’s sense of safety, as one of the respondents said:

“A 70-year-old slum, you can see through the cracks of the walls while you pass by”.

The second commonly stated problem is the narrow residences which are, mostly, rooms with shared toilets. Meanwhile, Respondents agreed that it is, almost,

impossible for them to obtain one of the flats offered by the government; as one of them said:

“People who already lost their homes have been waiting for 7 to 8 years and they didn’t get anything until now. So, if I applied for any of these flats, and even before my home collapses, I will get nothing. They definitely have the priority”.

On the same context, one of the respondents complained about the bad service in the area as he said:

“People are buried alive, extremely narrow slums barely allow a couple of individuals to walk”.

4-3-9- Support and Aid

All Respondents denied that they had received any aid or support either from Government agencies or from private sector organizations. Meanwhile, they admitted the role of the NGOs in the area by offering some aid to the orphans. On the contrary, respondents demanded these organizations to serve people without favoritism; as one of them said:

“They only help their relatives”.

As for the private sector, participants’ most proposed demand was to establish projects in order to employ youth and help them abandon drugs. Moreover, participants agreed on being neglected by the government. In addition, respondents agreed on developing and reconditioning buildings and constructing schools as their main demands from the Government.

Finally, when asked whether mentioning their residence place embarrasses them or not, the answer came out clear that they do feel embarrassed; as people usually act offensive when they mention Azbet Abu Hashish. A participant stated that he was once rejected from a job when the employer knew where he lives. Another participant added:

“Schools outside always reject children from here, they don’t accept students from Azbet Abu Hashish”.

4-3-10- Individual requests

Participants emphasized their desire to live in Azbet Abu Hashish after being developed; as they are already attached to the place. They, all, had the same wish of having a proper flat to live in. In addition, female participants expressed their wish for their children to join any of the good schools that refuse to accept them, or only accept students after paying bribes as one of the respondents said:

“I knew someone who paid 500 LE in order to enroll her son in the school.”

4-4 Street Children:

It might be hard to tell how many children are living on the street in Egypt. However, observing the large numbers of children in the streets of Cairo and other large cities of Egypt - begging, running errands, parking/cleaning cars - and how these numbers have changed suggests that the problem is on the increase. These children lead an unhealthy and often dangerous life that leaves them deprived of their basic needs for protection, guidance, and supervision and exposes them to different forms of exploitation and abuse. For many, survival on the street means begging and sexual exploitation by adults

An in-depth interview took place with the director of one of children associations. The interview aimed, mainly, to tackle topics about street children.

Definition and Causes:

First of all, the interviewee was asked about the definition of street children from his association perspective, he answered:

“A less than 8 child, male or female, who abandoned his family and took the streets as a shelter; meaning that if a child works in streets but returns back to his family at the end of the day, he is not a street child for us”.

Moreover, the respondent reported that from 85% to 90% of families from which street children come are poor families. He, further, listed the causes of street children phenomenon as family disintegration-, for which he gave the highest share of the responsibility-, poverty, neglecting children and treating them with cruelty. The

respondent emphasized that the problem usually results as a combination of two or more from the previous causes.

In addition, when he was asked about the places where street children are most found, the respondent mentioned many districts like Al-Sayeda Zeinab, Al-Hossain, Al-Agouza, shooting club, Ramsis, Shoubra Al-Khaima, Helwan, Maadi and Ahmed Helmy. He, also, added that Lower Egypt is the most populated with street children. The respondent illustrated that street children usually take some places as their inconstant shelter according to the availability of their needs; they might be gathered around malls, restaurants and jammed streets until someone dismiss them in a way or another, the man said:

“Their main reason to inhabit a certain place is the opportunity to practice any work that will gain them some money accompanied with a place to sleep peacefully”.

He, also, stated that a street child could be a male or a female with a ratio of 4 to 1, but a female child needs to be treated quite differently as he said:

“Girls would be more aggressive than boys. They need a special way of treatment. For example, if a male and female street child were sexually abused, you can treat the boy by psychological sessions. But girls are hard to be treated from such incidents. Their problems are much more complicated than boys”.

4-4-1- Street children Community:

Furthermore, respondent reported that, from his experience, street children often construct a community of their own with certain systems, rules, incentives and even languages as he said:

“In one of our researches, we have studied their language and we have found 400 vocabularies only they can relate to. There is a language developed in this community. They have; their own behaviors, morals and laws. They have their own community in our community inside our streets”.

In addition, He added that they usually have a leader among them; someone to plan, regulate and control. This leader, as he mentioned, is not just the older among them, but also the most skilled or experienced. He, also, hinted that they often compete with each other to prove who's the one who deserves this title, and this competition, often,

consists of dangerous staff to do. In addition, he mentioned that this leader could be a girl in some groups.

4-4-2- Problems of street children:

Moving to another concern which is the problems that face street children, the respondent reported that physical; from headache to cancer, and psychological illness are the most common among street children. He reported that dental diseases are the common illness street children are exposed to, followed by scabies and skin diseases. He, also, added that cold and flu diseases arise among them in winter, in addition to, burns from the fire they use to warm themselves at night.

On the other hand, the interviewee stated how psychological issues and persistent comparison with other society members affect the street child and induce a significant violence, inside him, that is easily reflected on the society. Respondent said:

“From the psychological side, I can say that we work with shreds; Psychological Shreds. That child is probably in the streets because of a family fault. Either a violent mother or father or both parents or school is the reason behind him being homeless. He finds himself facing an ever crueler violence... He, as a child, becomes absolutely devastated with a psychological structure completely messed up”.

The interviewee showed a quite discontent about how society looks at street children and perceives them. In addition, he claimed that, from his point of view, Egypt needs a lot of interventions and plans in the track of awareness about street children phenomenon.

4-4-3- Government and non-government responses to help street children:

The respondent reported that he has worked with several governmental agencies over the years; from which he listed Ministry of Solidarity, Ministry of Interior and The National Council for Childhood and Motherhood as he said:

He expressed his opinion that the government can effectively contribute more in the confrontation of the street children problem:

The private sector role towards the cause is quite limited and needs to expand effectively by co-operating with the community development associations in Egypt.

He, further, commented on the charities role that he considered quite limited, as well. He said:

“The role of charities is quite inadequate. We have around 22000 associations in Egypt; from which only 7000 work with children in general. Out of which you may found 12 or 13 working with street children. And from these 12 or 13, the ones that actually work are very few”

The respondent gave international organizations, a medium rank in their performance. He summarized their role in offering funds.

The interviewee expressed his dissatisfaction with the policies dealing with the phenomenon. He admitted the dereliction of the several entities working on that issue as they couldn't absorb those children or take enough prevention actions.

4-4-4- Obstacles against solving the issue of street children:

The respondent considered unemployment and poverty as the main obstacles standing in front of obliterating the street children issue, as he said:

“In order to return a child, who has 12 brothers, back to his family, his father won't accept him as he cannot afford his expenses anymore”.

He also tackled the obstacles in his association as he always faces a shortage in the qualified staff. He stated that he cannot find the human resources, in addition to the financial resources, needed to achieve his work plans.

When he was asked about the needed legislations to solve the street children problem, he thought that Child Law is quite appropriate and it, only, needs to be implemented effectively.

4-4-5- Suggestions to confront the phenomenon:

The interviewee suggested the integration between government and the civil society as the pillar of solving the problem. In an attempt to prove his point of view.

He, also, added the importance of changing the mentality of the private sector in dealing with the several social causes. He stated that there should be awareness

campaigns to encourage the private sector to support the solutions of the existing social challenges.

Regarding the community development associations, he recommended applying specializations in their scoops of work; by each association being specialized in one of the social causes (i.e. street children, disabled handicapped, addicts... etc.), supported by the government and encouraged from the society.

He, also, stated his suggestion for the international organizations and donors to limit their interventions in the strategies by which the community associations actually work with social causes.

4-5 Fishermen:

Fishermen in Egypt face many problems, especially the policies of draining lakes that for instance led to the decrease of El Manzala fishing area from 750 thousand feddans in 1956 to 190 thousand feddans in 1982 and only 125 thousand feddans in 1994. Large areas of these lakes are also being rented by big businessmen who prevent fishermen from fishing in these areas. In addition, the fish catch has decreased in the last few years due to the increasing pollution caused by industrial and domestic waste dumped into the sea. Boatmen have to compete with bigger boats, which increase the number of fishermen without licenses or who just fish as a hobby. The prices of fishing nets have also increased, raising the prices of a kilo of fish. Without any intervention from the government, reduced tourism and inflation in the food market is putting fishermen's economic livelihoods at risk.

Three in depth interviews took place in Lake Burullus, Kafr El-Sheikh, with three fishermen, two of them were 53 years old, and the other one was 35 years old. The three fishermen had suffered, mostly, the same problem; which is favoritism, corruption and venality. Moreover, they agreed on the weak, and sometimes corrupted, role of the fishermen association that doesn't support their demands and have no positive impact in dealing with their problems.

One of the fishermen declared his daily struggle with water police in order to let him fish in the lake; the man admitted that he, as well as other fishermen, sometimes uses

a slight illegal dragnets and doesn't have licenses which always put them under pressure.

Another respondent stated that he cannot practice his work freely; as he, also, experienced a lot of pressures in order to get the needed license to go fishing for his living. Besides having five sons that he cannot afford their living, this man had Kidney transplanted to his body and he lives on medications. He had tried several times to get himself an exception because of his health conditions, but he didn't manage to reach someone to help him. He also mentioned being obliged to pay bribe, sometimes, to continue fishing in the lake.

The interviewees stressed on the necessity to have new laws to regulate fishing. They added that their associations are weak and can't take care of their daily problems.

Chapter 5

Women Status in Egypt

5-1 Introduction

Political discourse in Egypt always reflects the Egyptian Government's clear commitment to the improvement of the status of Women and their empowerment on all social, economic, cultural and political levels. Also, the majority of legislations regarding social and economic rights emphasizes the principles and values of social justice, as well as Women's right to equality with men, to a fair access to resources and services and to participation in public affairs. For more than half a century, the situation of Egyptian Women has witnessed great changes, in conjunction with relative improvement in opportunities for Women's education, employment, participation in public affairs, and appointment to senior posts. Still, Women continue to endure multiple forms of social, cultural, economic and political exclusion caused mainly by two important factors: First, the failure of public and social policies for more than half a century to advance the situation of Women in society and to bridge a gender gap which is ever-expanding on several levels. Second, the persistence and severity of social and cultural constraints facing any genuine efforts to provide women with liberty and equality. These constraints derive their potency from the hegemony of a macho patriarchal culture over the values and beliefs of many Egyptians, establishing priority of males over females with regard to access to human rights in general.

Although the experience of many developing countries has proven that the success of development efforts is contingent upon a strong political will to improve the situation of women, societal willingness, in the Egyptian context, is the cornerstone of strength or weakness of public policies concerned with justice and equity for women. In other words, the breadth of the gender gap in Egypt is associated with an even wider gap of modernity, between public policies which uphold the principles of gender justice and equity on the one hand, and prevalent socially conservative values, beliefs and perceptions invested in the legitimacy of gender differences on the other. Therefore, policies embodying women's rights fail to achieve gender justice as long as traditional conservative culture maintains the upper hand in light of low social demand on equal rights for women.

It is truly ironic, and indicative of the breadth of this gap of modernity, that the demands for freedom and social justice promoted by the revolutionary protests of January 25th, 2011 led to no tangible improvement in the situation of women over the past five years, not to mention persistent gender gaps in education, employment and social participation. It becomes clear then that the current reality of Egyptian women constitutes an important aspect of the challenges that the Egyptian democratic transition will be facing in the coming years, as reflected in the deprivation of women of their social, economic and political rights; their low quality of life, and their lack of confidence in their ability to effectively participate in the development of their country. In this regard, it can be assumed that there exists a strong link between any prospect for advancement of the social democratic process in Egypt on the one hand, and the betterment of the situation of Egyptian women on the other. As much as any measures of democratic nature could reflect positively on the situation of women, a true democratic transition can take place within the social and cultural structure of the entire Egyptian society.

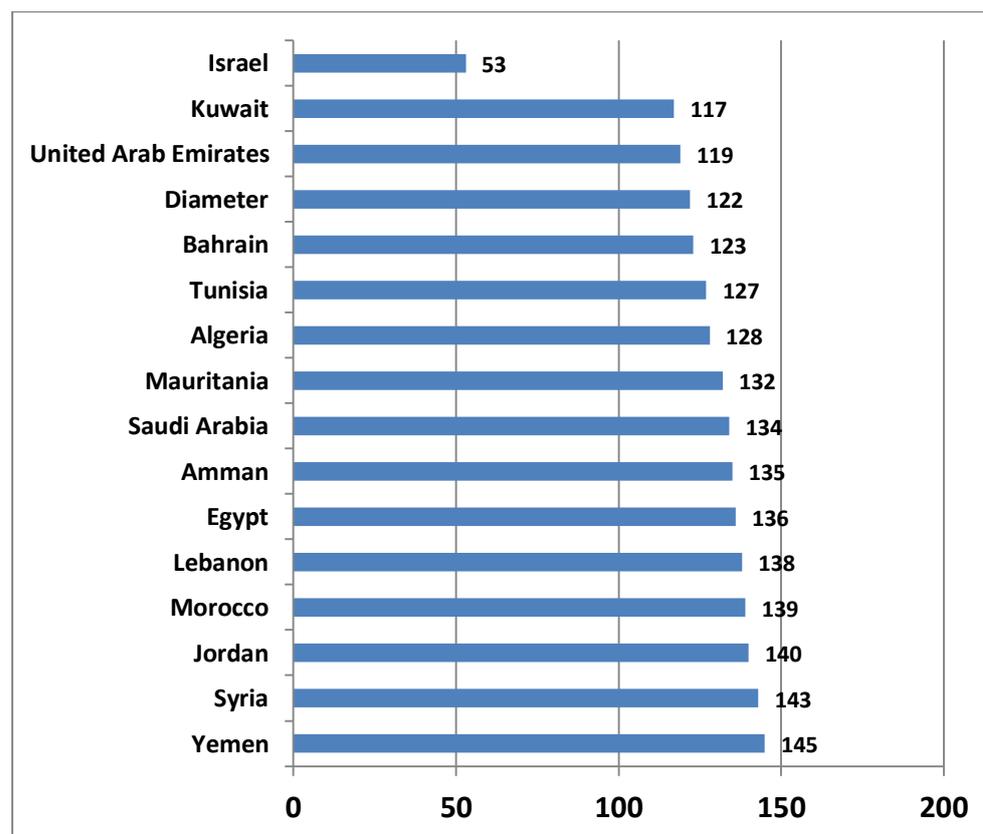
Against this backdrop, this chapter outlines the status of women in the Egyptian society, particularly with regard to the indicators, implications and causes of the gender gap through 7 key elements; starting with an overview of the main features of the gender gap in Egypt. Afterwards, the chapter introduces detailed gender gap indicators, pertaining to opportunities of education, employment and social participation; the impact of social and economic development programs on the empowerment of women. Additionally, the chapter analyzes the social and cultural pressures endured by women, as manifested in the different forms of violence against women, and the predominant patriarchal culture which gives males priority over females with regard to access to human rights.

5-2 Overview of the Gender Gap

Available data indicates that Egypt is still facing difficulties in achieving the millennium developmental goals (MDGs) with regard to the promotion of gender equality and the empowerment of women. This is particularly the case when it comes to education and participation in paid employment, as well as political participation. The world Economic Forum gender gap index reflects the gap between females and males in different dimensions including Education, health, economic participation and

political participation. The higher the index value, the narrower the gap is. In 2015 the World Economic Forum Gender Gap Index, ranked Egypt with a score of 0.599, 136th among 145 countries globally, and 11th among 16 countries in the Middle East and North Africa region, behind other countries such as Israel, most countries of the Arabian Gulf, Tunisia, Algeria and Mauritania.

Figure 5-1: Egypt Ranking in the Gender Gap Index for the MENA Region - 2015



Source: *The Global Gender Gap Report 2015*. 10th Anniversary Edition. World Economic Forum, 2015.

Table (5-1) shows a general trend of improvement in the gender gap with a score increase of 0.020 between 2006 and 2015. Amid the wave of economic, social and political turmoil that Egypt has witnessed following the outbreak of the 2011 protests, improvements in the gender gap index have become fractional and fluctuating from one year to the next. The year 2014 saw the highest level of improvement, with the gender gap increasing once more in 2015, almost reaching the same levels of 2010 and 2012.

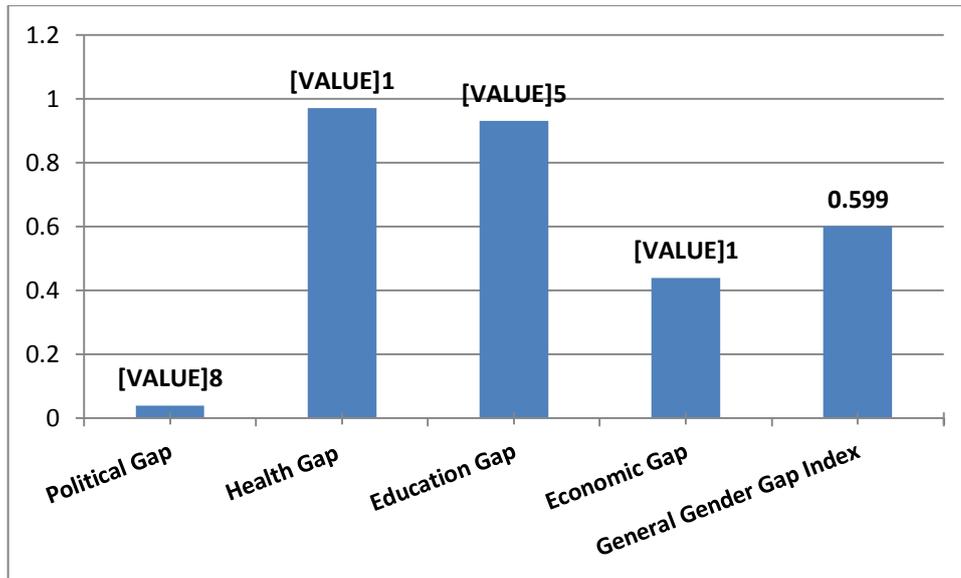
Table 5-1: Egypt Gender Gap Index Scores (2006-2015)

Year	Number of Countries	General Index	
		Ranking	Score
2015	145	136	0,599
2014	142	129	0,606
2013	136	125	0,594
2012	135	126	0,597
2011	135	123	0,593
2010	134	125	0,590
2009	134	126	0,586
2008	130	124	0,583
2007	128	120	0,581
2006	115	109	0,579

Source: *The Global Gender Gap Report 2015*. 10th anniversary Edition, World Economic Forum, 2015.

The low score of Egyptian the current gender gap index could be attributed to a widening gap between males and females in economic and political indicators in particular. Figure (5-2) shows a widening gender gap in the economic sphere with a score of 0.441, with Egypt ranking 135th globally in the economic participation index. In the political sphere, the gender gap reached a maximum of 0.048 in favor of males, with Egypt ranking 136th globally in the political empowerment index. That said, the gender gap saw substantial improvement in the fields of health and education. Egypt's ranked 97th globally in the health and survival index with a score of 0.971, and 112 in the education gender gap index with a score of 0.935.

Figure 5-2: Components of the Gender Gap Index in Egypt, 2015



Source: The Global Gender Gap Report 2015. 10th Anniversary Edition. World Economic Forum, 2015

In 2015 parliamentary elections, women got 15% of the seats which is expected to improve Egypt's rank in the political participation index.

5-3 Gender Gap in Educational Attainment

Data from the 2015 Gender Gap Index shows that the education gender gap index score was 0.903, with Egypt at the 90th rank globally. In 2007, index improved to reach a score of 0.909, however Egypt rank deteriorated to 101 globally. The gap continued to widen gradually over the years to reach its peak in 2010 followed by an improvement between 2011 and 2015 when it reached 0.935. With Egypt ranking 115th globally. The general ascending trend between 2006 and 2015 points to an overall increase in the gender gap by 0.032 points. The severe economic crises of the past ten years, was reflected on the gender gap in education. This can be illustrated through analysis of a set of subindexes relating to the gender gap in education according to different levels of education as follows:

Table 5-2: Egypt Gender Gap Index Score - Educational Attainment (2006-2015)

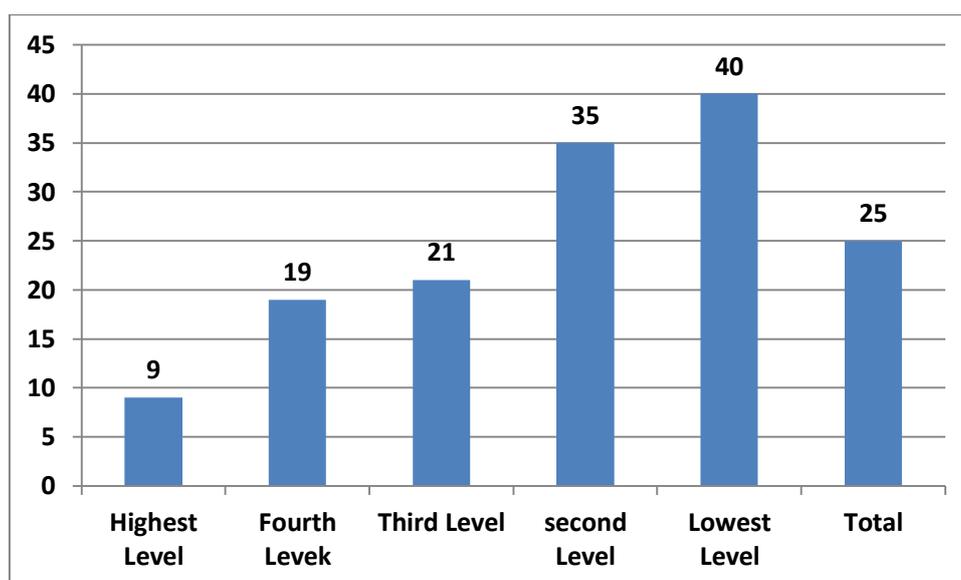
Year	Number of Countries	Ranking	Score
2015	145	115	0,935
2014	142	109	0,947
2013	136	108	0,920
2012	135	110	0,925
2011	135	110	0,908
2010	134	110	0,899
2009	134	107	0,900
2008	130	105	0,902
2007	128	101	0,909
2006	115	90	0,903
Change between 2006-2015			0.032

Source: "The global gender gap report 2015. 10th anniversary Edition. World Economic Forum, 2015.

5-3-1- Out-of-School Females

Despite government efforts to accommodate all school-age population within the different stages of the educational system, females still make up the majority of the population deprived of access to education. The non-enrollment percentage for the 6-18 age group is 7% among females, compared to 5% among males. An obvious correlation exists between household economic status and non-enrollment of females in schools. Data from the EDHS 2014, as shown in figure (5-3), reveals that non-enrollment among females from households in the lowest and second lowest economic levels reached 40% and 35%, respectively. The percentage of non-enrolled females decreases gradually with the increase in economic level with 9% in the highest economic level. This shows a strong correlation between poverty and lower levels of education among Women.

Figure 5-3: Non-enrollment by Economic Level



Source: Population Health Survey, 2014.

Table 5-3: 2015 Egypt Gender Gap Subindexes - Education

Index	Males	Females
	%	%
Percentage of out-of-school children in primary school age	24	76
Percentage of enrollment in higher education in science, technology, engineering and mathematics	68	32
Percentage of graduates in higher education in science, technology, engineering and mathematics	66	34
Percentage of PhD recipients	45	55
Percentage of Internet users	24	19
Percentage of mobile phone users	83	76

Source: *The Global Gender Gap Report 2015*. 10th Anniversary Edition, World Economic Forum, 2015.

Data from the 2015 Gender Gap Report, as shown in table (5-3), indicates that three quarters of out-of-school children in the age of primary school are females. Despite general illiteracy rates dropping from 30% to 26% between 2007 and 2013, Women still make up the bulk of the illiterate population, with 34% illiteracy among females, compared to 19% among males in 2013. Official data, as shown in table (5-4), indicates a lower percentage of female dropouts in the 6-18 age group with 2%, in comparison to 3% among males.

Table (5-5) also reveals that male dropout rates remain higher than female dropout rates in primary and preparatory education between 2004/5 and 2010/11, meaning that females who have access to education are more serious and diligent with respect to completing their education than males. However, the percentage of female dropouts is on the rise over the years, and increases from one stage of education to the next, due to social and cultural constraints which undermine the importance of education for girls, tying their future to early marriage prospects, especially in rural areas.

According to data provided by the 2009 Survey of Young People in Egypt, Upper Egypt governorates recorded the highest percentages of non-enrollment in the education system, with females under the age of 30 accounting for the majority of non-enrollment. Of them are in the lowest economic level, and mont.

A World Bank study on Women in Upper Egypt shows that 82% of those who never attended school are female, 80% of them live in rural areas, especially in rural Upper Egypt. Female illiteracy rates in those areas reaches 24%, nearly double the rate among males. The gender gap in education grows much wider in Upper Egypt. The findings of the study indicate that one in five girls in the 6-15 age group never attends school. This confirms that female dropout rates in rural Upper Egypt reaches up to 65%.

5-3-2- Rising Illiteracy Rates

The 2015 Gender Gap Report shows a severe gap in literacy rates between males and females, estimated at 65% versus 82% for males, with Egypt scoring 0.80 in the literacy gender gap index, and ranking, very poorly, 123th globally; last among countries of the Arab World and of the Middle East and North Africa region. The high illiteracy rates among females Could be attributed to the lack of serious governmental

and social efforts to better the status of female education and combat female illiteracy, especially in rural and poor areas.

Table 5-4: Dropout Rates for the 6-18 age group according to the 2006 census

Gender	Population 6-18	Never enrolled	Enrolled and did not dropout	Enrolled and dropped out
Male	9084697	5	93	3
Female	8500384	7	91	2
Total	17585081	6	92	2

Source: Central Agency for Public Mobilization and Statistics (CAPMAS), September 2015

Gender disparity in enrollment clearly varies for different types of education. It is remarkable that gender disparity in enrollment in government schools is less than it is in other types of schools. The difference in enrollment between males and females in government schools is 6%, increasing in private schools to 8% and doubling in Azhar education to reach 14%. This reflects significant improvement in female access to government schools, and relatively lower access to private schools.

The fact that males have higher enrollment rates in private schools can be explained by the tendency of some middle-class families to direct their spending on private schools to male children, on the grounds that prevailing values justify this behavior as males are expected to bear heavier future burdens compared to females in the context of marriage and family-making, which entails more investment in male children.

As for the severe disparity in favor of males in Azhar education, it is evident in all stages of education and increases drastically in Azhar tertiary education with males and females making up 61% and 39% of Azhar tertiary students, respectively. This disproportionate distribution is related to the prevalence of patriarchal values in regions where religious education is generally on demand. Also, religious education has traditionally been more common among males for a very long time, with a general perception that males are better suited for this type of education. Therefore, female access to religious education is a new phenomenon to religious institutions of this

sort. Moreover, the nature of religious educational institutions is marked by a general tendency in favor of severe gender disparity and strict separation, justified by interpretations of religious texts, between male and female students and teaching staff.

Table 5-5: Gender distribution of dropout rates in primary and preparatory education, 2004/5 vs. 2011/12

Level of Education	Dropout Percentage %			
	2004/ 5		2011/ 12	
	Males	Females	Males	Females
Primary Education	0,5	0,3	0,2	0,5
Preparatory Education	2,9	2,7	6,5	5,8

Source: Central Agency for Public Mobilization and Statistics (CAPMAS), 2014

Looking at the gender distribution of enrollment in all stages and types of education, a relative disparity can be detected in the total number of enrolled students in all stages and types of education, where males and females making up 52% and 48%, respectively. Data in this regard reveals several points with respect to mapping gender disparity in Egyptian education:

Disparity in favor of males increases demonstrably in enrollment distribution by gender in both preparatory and secondary stages of education. This is associated with the tendency of many Egyptian families, especially low-income and rural families, to prioritize male education while granting females only the bare minimum of education, giving males a greater opportunity to pursue their post-primary education.

Table 5-6: Distribution of enrolled students in different stages of education by gender (2013/2014)

Educational Stage	Males		Females		Total	
	Number	%	Number	%	Number	%
State Kindergarten	437228	52	402440	48	839668	3.7
Private Kindergarten	140184	52	130466	48	270650	1.2
Azhar Kindergarten	34310	52	31869	48	66179	0.3
State Primary Schools	4644755	52	4363489	48	9008244	39.6
Private Primary Schools	466679	52	431326	48	898005	4.0
Azhar Primary Schools	592856	54	505069	46	1097925	4.8
State Preparatory Schools	2040373	50	2012250	50	4052623	17.8
Private Preparatory Schools	154315	54	130767	46	285082	1.3
Azhar Preparatory Schools	263112	56	204940	44	468052	2.1
State General Secondary Schools	580793	45	698401	55	1279194	5.6
Private General Secondary Schools	92821	53	83457	47	176278	0.8
Technical Education	900509	56	709370	44	1609879	7.1
Azhar Secondary Schools	204771	57	151700	43	356471	1.6
Special Education	23515	63	13821	37	37331	0.2
State College Education	844565	50	844385	50	1688950	7.4
Technical and High Institutes	341421	67	170319	33	511740	2.3
Private Tertiary Education	64526	58	46996	42	111522	0.5
Total	11826733	52	10931065	48	22757798	100

Table 5-7: Enrolment rates for male and female students in various stages of education according to the census

Enrolment rate	Male	Female	Total
Primary	93	116	113
Preparatory	87	94	91
Secondary	74	72	73
university	34	29	32

Source: EDHS 2014.

The enrollment rates in various stages of education according to the EDHS 2014, compiled in table (5-7), point to a gender gap at the various levels of education. In primary education, the rates of enrollment of girls is 116% compared to 93% for boys, which indicates a sizeable gender gap of 23 points in girls' favor. The gender gap continues to favor girls in preparatory education by 7 percentage points. At the higher levels of education, the gap is reversed in favor of the boys, measuring 2 percentage points in high school and 5 percentage points in college. This situation shows a remarkable improvement in the opportunities of female education in the early stages of education, although males have a better chance of completing high school and enrolling in college.

Comparing changes in enrollment rates in primary education across three time points (years 2003/4, 2007/8 and 2012/13), as shown in table (5-8), reveals relative improvement in female enrollment rates in primary education going up from 87% in 2003/4 to 97.2% in 2012/13, despite a drop in 2007/8.

Data for female enrollment in the preparatory stage points to a decrease from 99% in 2003/4 to 93% in 2007/8 followed by an increase to 95% in 2012/13, with noticeable improvement in female enrollment rates compared to male enrollment rates particularly in 2012/13.

The overall trend points to a diminishing gender gap for basic education as a whole, which is attributed to tangible success of government efforts to grant females better opportunities to attain primary education on the one hand, and the positive change in society's outlook on female primary education, on the other hand. The majority of

Egyptian families now see primary education as an essential component of a girl's upbringing and as a necessity to improve girls' options in life, even if they get married at an early age as is the case in poor rural areas.

Table 5-8: Developments in enrollment rates in different stages of education by gender

Educational Stage	Total enrollment rates %					
	2003/ 2004		2007/ 2008		2012/ 2013	
	Males	Females	Males	Females	Males	Females
Pre-primary	17	16	22	21	26.5	26.6
Primary Education	94	87	110	105	96.6	97.2
Preparatory Education	106	99	94	93	91.1	95
Secondary Education	86	81	80	82	66.8	66.3

Source: Central Agency for Public Mobilization and Statistics (CAPMAS), 2014

5-3-3- Females in Secondary Education: Gender-Just Decline

Starting from preparatory education, a decline in female access to education can be detected along with an increase in equal opportunities among males and females in secondary education. According to data shown in table (6-8), a sharp decline can be noticed in female enrollment rates from 81% in 2003/4 to 66.3% in 2012/13. However, the gender gap is shown to diminish consistently from 5% in 2003/4 to 0.5% in 2012/13, meaning that the decline in female access goes hand in hand with more gender-just opportunities in secondary education. Thus the gender gap index in secondary education falls to a score of 1.0,

5-3-4- Low Levels of Female University Education

Female enrollment rate in higher education reaches 31% compared to 35% for male enrollment. With this disparity, the Gender Gap Index for higher education falls to 0.89, thereby placing Egypt in the 108th rank among 141 countries worldwide.

Although access to higher education is not as socially significant as pre-university education according to welfare programs in many countries, Egypt still fares quite poorly in the Arab World and the Middle East, where many countries are among the leaders of this index including Qatar, Kuwait, Bahrain, Tunisia, Algeria, Oman, and Israel.

A study on equal opportunity in college education indicates that low funding has a major impact on accessibility. Most of the 23 government-run universities are located in Greater Cairo and Delta and their capacity falls short of the national demand for higher education. Besides, most students cannot afford private universities. In Upper Egypt, families refuse to allow their girls to travel for long distances or live in other cities for the sake of education. So female students have difficulties leaving their home to pursue higher education in far-off governorates. Also, the opportunity cost for particular specializations in higher education (joining private universities) is prohibitive for low-income families. Therefore, most families opt for sending their girls to art colleges or intermediate institutions that are within their budget.

When it comes to gender disparity in enrollment by specialization, data from the 2015 Gender Gap Report, reveals great disparity among males and females enrolled in Science, Technology, Engineering, and Math (STEM) programs, with females and males making up 32% and 68% of enrollment, respectively, with an extreme gender gap of 36% in favor of males.

Table 5-9: Enrollment in STEM (Science, Technology, Engineering, and Mathematics) and Non-STEM programs by gender in 2013/14

Specialization	Males	Females	Total
Non-STEM Programs	49	51	100
STEM Programs	52	48	100

Source: Central Agency for Public Mobilization and Statistics (CAPMAS), September 2015

Data shows a clear imbalance in the distribution of students according to specializations in college. Nearly 78% of college students study humanities while only 22% study sciences. About 51% of students opt for humanities, are females.

While their percentage sciences education is 48%. Still, there is a gender gap even within some branches of humanities. Female students are reluctant to join several colleges that are quite popular among males. So female students make up 27% of the student body in physical education, 39% in law, and 39% in business. The College of Art Education is remarkably popular among female students (86.6%). In science colleges, most of the students are male, with the exception of the College of Fine Arts, and the Nursing College, which have a female student percentage of 76% and 75% respectively. Data points to a massive gender gap in the fields of science, technology, engineering, and mathematics, with young women constituting only 32% of the student body, leaving 68% to male students.

The official figures for graduate studies in 2013, compiled in Table (6-10), indicate that there are less women with post-graduate degrees (48%) than men (52%). Still, women lag behind men by only 1% in master and doctoral degrees. Figures for 2015, compiled in Table (3), indicate that women are ahead (55%) of men (45%) in the case of doctoral degrees. This goes to show that, given half a chance, women can excel despite the discrimination.

Table 5-10: Holders of post-graduate degrees by gender, 2013

Degree	Males	Females	Total
Diploma	52	48	100
Master's	53	47	100
Ph.D.	53	47	100

Source: CAPMAS, 2015.

5-4- The gender gap in the labor market

The 2015 gender gap data in the labor market for the past ten years points to an improvement over five of these years and a deterioration in the other five. As we can see from Table (5-11), the gender gap for economic participation and life opportunities, of which work is an important factor, stood at 0.416 in 2006, putting

Egypt in the 108th ranking among world nations. In the following three years, the gap narrowed gradually, to reach 0.450. Then, with the exception of 2011 and 2014, the gender gap gradually grew between 2010 and 2015, to reach 0.441 in 2015, which placed Egypt in the 135th ranking among world nations. The general trend of the past ten years points to an increase in the economic gender gap by 0.025. Knowing the economic difficulties of the past few years, it is safe to assume that these difficulties left an unfavorable impact on the labor gender gap. This assumption seems to be in harmony with some of the sub-indexes of the labor gender gap, as we shall see in the course of the following analysis.

Table 5-11: the labor gender gap index in Egypt (2006-2015)

Year	Number of countries	Rank	Score
2015	145	135	0,441
2014	142	131	0,461
2013	136	125	0,443
2012	135	124	0,454
2011	135	122	0,457
2010	134	121	0,453
2009	134	124	0,450
2008	130	120	0,437
2007	128	120	0,421
2006	115	108	0,416

Source: "The global gender gap report 2015. 10th anniversary Edition" World Economic Forum, 2015.

5-4-1- Participation in the workforce

Table (6-12) points to a relative increase in the gender gap for participation in the workforce, with participation in the labor market standing at 26% for women and 79% for men. In other words, the rate of participation in the labor market for men is three times that of women, putting the gender gap in 2015 at 0.33. This places Egypt in a low ranking (139th worldwide) and behind other Arab, Middle East, and North Africa countries including Israel, Qatar, Kuwait, the UAE, Bahrain, Turkey, Mauritania, Tunisia, Oman, and Morocco.

Table 5-12: Sub-indexes for the labor gender gap in Egypt in 2015

Indicator	Rank	Score	Male	Female	Proportion of females to males
participation in the workforce	139	0.33	79	26	0.33
high-level and technical professions	104	0.55	64	36	0.55
legislators and managerial positions,	121	0.08	93	7	0.08
percentage of workers in the accounting sector to the total	-	-	18	9	-
percentage of workers in the informal sector	-	-	93	7	-
unemployment rates	-	-	9.9	24.2	-
equality of payment for similar job	24	0.75	-	-	0.75
estimated income in dollar purchasing power parity (\$PPP)	133	0.30	17,353	5,218	0.30
total gender gap in economy and opportunity	135	0.441	-	-	-

Source: "The global gender gap report 2015. 10th Anniversary Edition" World Economic Forum, 2015

Because the percentage of men in the labor market is three times greater than that of women, unemployment among women is particularly rampant. The total rate of women unemployment in the labor force is more than double that of men, The official figures for participation in the labor force – compiled in Table (5-13) – show a decline in the participation of women in all age groups between 1995 and 2013, which is particularly pronounced among the young, although women in older age groups, from 30 to 60 of age, experienced a slight increase in participation in the labor market. This reflects the late entry of women in the labor market and the diminishment of their economic role in society. The highest rate of participation of women was just over one-third in the (20-24) age group in 1995, compared to 32% in the (25-29) age group in 2013.

EDHS 2014 shows that only 16% of women are working, with the percentage higher (23%) in the (45-49) age group. Unemployment among women, at 84%, is highest in among young women, married women, and women from rural or low-income backgrounds. The ratio of unemployment is 87% among women in the 25-29 age

group and 85% among married women. Although the ratio of women unemployment is high across the board, it is highest (86%) in the bottom income bracket than in the top income bracket (77%).

Figures from the survey of young people (sype 2009) Egypt show that the participation of women in the workforce is influenced by the level of education and marital status. About 82% of women who did not attend school are not working, compared to only 13.6% of men who did not attend school. In other words, there are nearly 5.6 million women who are neither studying or working. Still, the higher the level of women education the more likely they are to have a job. Just under 10% of women with a secondary education have jobs, but among those with a technical school degree the same ratio climbs to 18%. Nearly 32% of women with above-intermediate technical education and 47% of women with college degrees have jobs.

Marriage clearly interferes with the economic participation of women, as the percentage of married women in the workforce is 11% among previously married women compared to 25% among women who were never married. Nearly 66% of women who are outside the workforce are housewives. Furthermore, 87% of women who have college degrees but no jobs cited family as being the reason for not working. This indicates a certain conflict between work and family, as even women with college education tend to sacrifice work for family responsibilities.

In key professions and posts, figures show that the participation of women in high-level and technical careers is 36% compared with 64% among men. In other words, men are twice as likely as women to have a good job. The gender gap in powerful and technical careers stood at 0.55 in 2015, placing Egypt in a relatively low ranking (104 among world nations), trailing behind Israel, Lebanon, Tunisia, and Turkey. Egypt, however, was ahead of Morocco, Kuwait, Bahrain, Saudi Arabia, and Qatar in this respect.

Table 5-13: Rates of participation in the workforce (15-64) by age and gender (1995 – 2013)

Age	rates of participation in the work force %			
	1995		2013	
	Male	Female	Male	Female
-15	30	11	26	8
-20	56	35	74	32
-25	94	33	96	32
-30	99	27	99	30
-40	99	21	97	28
-50	98	16	91	24
64 -60	48	5	46	6
Total	74	22	78	23

Figures also point to considerable gender gap in the distribution of careers according to business ownership, specialization, and economic sector. The percentage of women running their own business is extremely low (1.6%) compared to that of men (13.7%). Besides, the distribution of work opportunities is unequal among various careers. Figures show that only 9% of women work as accountants, compared to 18% of men. This points to a limited opportunity for women to work in quality jobs compared to ones that need no special skills and abilities. Although the quality of jobs held by women is relatively low, that doesn't lead to higher employment for women the informal sector, where jobs are usually of a low quality and working conditions are unenviable. Figures show that most jobs in the informal sector are held by men (93%), leaving only a few (7%) for women. The reason may be that women prefer the well-structured jobs of the formal sector for reasons of economic and social security. A high percentage of previously-married women hold public sector jobs for reasons that may be related to better working hours, generous maternity leave and other advantages. Other reasons may be related to the disadvantages of working for the private sector, including forms of discrimination to which married women are particularly loathe.

5-4-2- Gender disparity in wages

Available data on the gender gap in wages indicate that the proportion of women working for cash wages is 39% compared with 57% for men. Over one-fourth of women perform jobs for the family without wage, compared to 5% of men. The proportion of women working for their families for no wage is especially high in rural areas (40%), while only 7% of men share that experience. Besides, the proportion of women who own their business is lower than that of men, which tells us that women in general have lower access to economic resources than men, which impedes them from running their own business.

When we turn to the distribution of income according to gender, we find that the total income for all women is about one-third that of all men. In Egypt, women make generally 30% of what men make, which places Egypt a ranking of 133 among world nations. Discrimination in wage among men and women performing similar jobs, however, seems to be less pronounced in Egypt. According to a survey of several countries including Egypt, the gender gap of wage equality is slight. Egypt scored 5.22 on that index, with women lagging behind men by 0.75, which places Egypt at a relatively good ranking (24th) worldwide, even ahead of other Middle East countries that tried hard to reduce the other indexes of the gender gap, including Kuwait, Tunisia, Turkey, Lebanon, Israel, Algeria and Saudi Arabia. This is one aspect of success in the women's struggle for wage equity in Egypt's labor market.

According to a World Bank study, the wages of women are lower in general than those of men, particularly in the private sector. The gender-based discrepancies in wages are not mainly due to differences in education or absenteeism or performance of women, but to the number of working hours. Egyptian women operate under numerous prejudices about the impact of their family life on their work. One such prejudice is that women are less committed to work, cannot perform difficult tasks, and are prone to absenteeism, which makes most companies hire men instead.

5-4-3- Social protection and mobility in women's work

Available data suggest that women working in the private sector tend to have less job security and less social protection, whether this protection is integrated in the work contract or offered through health and social insurance. According to one study, there is a gender gap that allows men to have 10% better terms than women in job contracts and health insurance. The gender gap in social insurance is also more favorable to men than women by about 3.5%. Conversely, women who work for the public sector and the government have a better opportunity for social protection. In some cases, women working for the government receive even better social and health insurance than men. The gender gap in social protection in the government and the public sector is under 3%.

It is worth noting that social protection programs at work are no longer a key demand for relatively large section of the men and women who work in the private sector. A study on social protection suggests that low-income workers refuse to sign up for social protection programs if they are asked to pay contributions to these programs, saying that their wages are too low to afford such programs which they see as a burden. Many of the women who work in the private sector are not insured in any way. The same study also indicates that young women working for the private and public sector do not understand insurance schemes and their advantages, and many are not even sure if they are enrolled in such schemes. Most younger working women do not want to joint social insurance schemes and have little interest in social insurance, which they do not see as a motivation to work, nor as a necessary work condition. Even those women who recognize the importance of such schemes have doubts about the employers' willingness to abide by the terms of social insurance. The study concludes that the main reason young women are not interested in insurance is that social traditions see women as dependents on the male members of their family, such as the fathers and husbands, and that men should take care of women and support them. Although training opportunities are scarce for most working people in Egypt, men and women alike, the access of these women to such opportunities, whether in the public or private sector, is particularly meager. According to available data, one half of the companies that hire women do not offer them training. Interestingly, available data also suggests working women are 50% less likely than

men to change jobs. In other words, women are more committed to the jobs they already have and more reluctant than men to quit.

5-5- Empowering women

The current state of women empowerment can be assessed through various indicators including: the difference in income between the spouses, the wife’s ownership of immovable assets, decisions related to the expenditure of the husband’s income and the wife’s income, and the wife’s participation in making family decisions. Table (5-14), compiled from the data of the EDHS 2014, indicates that of all married women, 15% work for wages. Among women aged 35 and upwards, the proportion is even higher, for one out of 5 women in that age group said she work for wages. Generally speaking, women who work receive a wage. More than 8 out of 10 working women reported having a wage. Women aged 20-24 are the least likely to receive a wage for their work. Only 5% of previously married women aged 15-29 own a home, and only about 2% own land.

Table 5-14: Comparison between the wife’s income, the husband’s income, and the wife’s ownership of assets

Women working for wage	Comparison between the income of the wife and the husband %			Ownership of assets	
	Higher income	Lower income	Same income	Doesn’t own a home	Doesn’t own a land
15.4	9.1	62	23	95.2	98.2

Source: EDHS 2014

What table (5-15) shows is that most married women who have an income do make decisions related to the manner of spending their income. About 29% of such women make financial decisions on their own and 63% make such decisions in collaboration with their husbands. The more women are making as much money as the husbands, the more likely they are to make decisions on financial matters. Available data also

suggests that three-quarters of women participate in making decisions about their husbands' income, while 6% take sole charge of deciding how the husband's income is spent. About 23% of women said that their spouses do not consult with them on how to spend the husband's income. In general, the closer the income of both spouses, the more chance there is of women deciding the manner of spending the husband's income.

Table 5-15: Comparison between the spouses' role in financial decisions, and the manner it is affected by their relative income

Income of the wife's income compared to the husband's income	Who decides the manner of spending the wife's income %			Who decides the manner of spending the husband's income %		
	Wife	Both spouses	Husband	Wife	Both spouses	Husband
Higher income	32.4	60.3	6.4	14.3	70.2	15.1
lower income	34	58.3	7.1	6.3	80	14
same income	16.1	80.4	3.4	3	90.4	6.4
Total	29.4	63	6	7	69	23

Source: EDHS 2014

According to the EDHS 2014, most married women participate in making many decisions regarding personal life. More than 80% of married women make decisions related to their health care. Of those, about 15% said they make such decisions alone and 64% said they take decisions in consultation with the husband. Figures also show that three-quarters of women make decisions to visit friends or family, either alone (11%) or in consultation with the husband (64%). Women participate less when it comes to the basic purchases of the family. But even in such decisions, about two-thirds of women said that they make these decisions, either alone (6%) or in consultation with the husband (51%). As for the level of participation by wives in decision making (regarding health care, purchases, and visits), 59% of women who participated in all three of these decisions, while 19% of women participated in making two kinds of decisions, 12% participated in making only one kind of decisions, with about 10% of women took no part in such decisions. This seems to

suggest that there is a considerable level of empowerment of women within the confines of family life, in a manner that exceeds that of women empowerment in public life.

There is little research on the impact of development programs and projects on improving women conditions and empowering them. But available data about development projects indicate that there is a gender gap in access to micro loans and finance for small enterprises. Although the volume of credit to development projects by men or women alike increased over the past few years, the gender gap has grown over time. Figures released by the Ministry of Social Solidarity show that women's share in micro loans dropped from 46% in 2009 to 38% in 2014, while the men's share of the same loans grew from 54% to 62%. Figures of the Social Fund for Development show that women's share in the finance of small projects dropped from 24% in 2009 to 18% in 2014, while men's share of the same increased from 76% to 82% over the same period. The gender gap in the finance of small projects is quite considerable, with men receiving more than triple the amount funding that went to women in 2009 and more than quadruple that amount in 2014. The gender gap in micro loans was relatively small (8%) in 2009, but it grew in 2014, with men obtaining more than 50% of these loans than women in that year.

Some development projects for women, had a positive impact on the lives of targeted women in poor and conservative rural areas in Upper Egypt. Two projects that were particularly successful in empowering women, especially young women, socially and economically, are worth noting here. The first is called Niqdar Nisharek (We can participate) and the other is called Ishraq (Dawn). Both projects were sponsored by the Population Council assisted by the USAID and several civil society groups.

The main aim of Niqdar Nisharek was to empower women, socially and economically, through providing them with work skills and helping them find jobs or start their own business, as well as giving them basic life skills that helps them understand their rights and responsibilities as citizens. The project also aimed to enhance societal acceptance of women's work and the integration of women in public life and social activities in impoverished rural areas in Upper Egypt. The program, which targeted 4,500 young women aged 16-29 in 30 villages in the governorates of

Fayoum, Qena, and Suhag, lasted for three years, from September 2011 till December 2014.

One of the most remarkable success of Niqdar Nisharek is that nearly one-fourth of the targeted women were able to start their own projects in handicraft, sewing, raising chicken, hairdressing, commercial kiosks, food services, maintenance of cellphones and computers, garments, and nurseries. About 14% of the women participating in the program landed jobs with schools, literacy programs, hospitals, nurseries, pharmacies, social society development groups, law firms, and factories. In addition, fathers, husbands, and brothers in the targeted villages were mobilized to give their support to women joining the labor market.

The Ishraq program aimed at social and cultural empowerment of girls aged 12-15 in rural areas in several south Egypt governorates. Many women in this demographic, especially in the rural areas in south Egypt, are exposed to the risk of missing out on school, by not enrolling in the first place or dropping out later. Many are also prone to early marriage, early childbearing, and poor health, let alone a continued life of poverty. Ishraq introduced traditional educational activities such as literacy classes and also trained women on life skills related to nutrition, sports, and financial prudence. The program, which lasted over ten years, from 2001 to 2013, was carried out by the Population Council in collaboration with Caritas Egypt, CEDPA, Save the Children, and local NGOs.

One of the remarkable achievements of Ishraq is that it reached out to 3,321 girls in 54 villages in five governorates. An empirical study assessing the social impact of Ishraq concluded that the program helped the girls improve their knowledge and ability to read and write. Nearly 88% of the participants who took the literacy exams passed them successfully, and 52% of those enrolled in schools. Ishraq raised the participants' awareness about reproductive health, marriage, and female circumcision, as well as gender roles. The study noted a change in the participants' view about marriage, with 85% of the girls favoring a delay of marriage and many adopting a positive view of birth control after marriage and voicing desire to have less children and to reject the practice of female circumcision in the future.

In terms of life skills, Ishraq instructed the girls on the basics of project planning and the best health practices. The study found that 82% of participants became more

inclined to seek medical help for health problems, compared to 60% among non-participants. The program offered girls a chance to learn physical sports and engage in sports activities, an activity that was previously confined to boys. The program also boosted the ability of girls to move around, develop social relations, and have access to safe venues, and it broadened the circle of their social acquaintances. Some of the participants in Ishraq said that the skills they gained in the program improved their status in the family and gave them a voice in decision making.

Despite the importance of such projects for women empowerment, it is unfortunate that such efforts are scattered among various agencies and societies that are otherwise disconnected. Also, the government is not doing enough to allow civil society a greater opportunity to engage forcefully in these efforts, expand the scope of beneficiaries and replicate successful models into different areas and women groups. Therefore, these programs lack the ability to sustain themselves through local efforts and capabilities once the foreign support and funding has ended.

5-6- Violence against women

Violence against women constitutes a major part of the violation of the women's human rights. It speaks volumes about the lack of equality in status and rights between men and women in Egypt. Data collected in the EDHS 2014 include several indicators for violence: the habitual exposure of girls to scenes of violence against women during their formative years, the fear felt by wives toward their husbands, the restrictions husbands impose on the freedom of their wives, wife beating, as well as other types of physical, sexual, and psychological violence.

With regard to the habitual exposure of women to violence, data shows that 18% of women reported seeing their fathers beat their mothers, 9% of women expressed constant fear of their husbands, and 36% of women approved of husbands beating wives. Most of the women who approved of wife beating are in the young, rural, impoverished, and under educated. Conversely, older women tend to reject wife beating. This suggests a link between the acceptance of wife beating and the low quality of life among women. The justification cited for the acceptance of wife beating varied, with 7% of women citing negligence in preparing food as a reason,

13% citing “talking back” to husbands, 20% citing refusal to have sexual intercourse, 24% citing neglect of children, and 26% citing leaving the house without permission.

Available data suggests the leading types of violence against women are five: circumcision practices, limiting women’s freedom, physical violence, sexual violence, and psychological violence. Following is a discussion of these five types.

5-6-1 Female circumcision

Although official laws criminalize the practice, female circumcision is still a common practice in Egypt. Available data suggest that 92% of previously married women aged 15-49 are circumcised. The phenomenon is more prevalent among in rural areas, and among the less educated and the poor. Of every five women under 19, one has been circumcised. The percentage of circumcision increases as girls approach puberty. One of every 10 girls aged 8-9 is circumcised. Circumcision is prevalent among older girls and women, reaching 32% among those aged 11-12 and rising to 68% among those aged 18-19. Estimates indicate that 56% of females under 19 are going to be circumcised in the future, which is more than double the current percentage of circumcised girls. The expected rise in female circumcision in the future is likely to take place in rural areas, especially in south Egypt. Still, among educated mothers and high-income families, the percentage of circumcised girls is likely to drop in the future.

There are several misconceptions among many women about circumcision; 62% of women consider it a religious duty, 50% believe that men approve of circumcision and with to marry circumcised women, 46.3% believe that circumcision is a bulwark against adultery. These views are common among older, rural, and less educated women, especially those who don’t work for wage and who are of low-economic standing. Since the 1990s, the percentage of women who support circumcision has dropped. The percentage of women who support the practice declined from 82% in 1995 to 58% in 2014. Women who believe that men prefer circumcised women fell from 61% in 1995 to 50% in 2014. This suggests that as the quality of life increases for Egyptian family, the perception of circumcision would change from a practice associated with women virtue to an assault on women’s dignity.

5-6-2- Limiting women freedom

Husbands place social limitations on their wives' freedom, including jealousy and expressions of extreme anger when their wives speak to another man. About 73% of women, most of whom young and with a small number of children, reported such behavior, which may be a sign that jealousy is more pronounced in the early years of marriage. What is unusual, however, is that jealousy and anger on the part of the husband was even more frequent among women with higher education than with low education, which means that education alone does not have a positive impact on the constraints on women's freedom. About 36% of women, most of them young and of low income, reported that their husbands insist on knowing their daily movements.

5-6-3- Physical violence

Physical violence by men toward women is common. About 25% of ever-married women were subjected to physical violence at least once by their husbands. The most common incidents involve slapping across the face (22%), forceful pushing (17%), and arm twisting (12%). Other forms of extreme violence against women exist, but are less frequent. Most instances of physical violence were perpetrated against older women and those who are less educated and with less income. There is an apparent correlation between women being subjected to violence by husbands and the history of violence in the family. Women who reported that their father hit their mothers were twice as likely to be subjected to physical violence by their husbands (53%) than women whose fathers did not hit their mothers (24%).

5-6-4- Sexual violence

Sexual violence against women is less common than physical violence. About 4% of women said that their husbands forced them to have intercourse with them or to engage in certain sexual acts against their will. There is no clear difference in this respect among various demographics, although previously-married women seem to be more likely to face sexual violence than women in their first marriage. Sex seems is

sometimes used as way of alleviate marital disputes, but it can also exacerbate the daily conflict between the spouses, especially in ill-matched marriages.

5-6-5- Psychological violence

Available data shows that 19% of women have been subjected to a form of psychological violence by the husband. About 13% of women reported recent incidents of psychological violence, most of them are poor and under educated. Most divorce women reported various forms of psychological violence. Psychological violence, in its various forms, includes making the wives experience humiliation, sadness, and shame which was reported by 16% of women. About 11% of women said that they were subjected to words or deeds by the husbands aiming to insult or humiliate them. About 5% said that they were subjected to abuse or beating in a manner that humiliated them in front of relatives or friends. The daily life of Egyptian women seems to be filled with forms of indirect psychological violence that women find may not always find easy to describe. This includes forms of sexual harassment of women within the family and at school, work, street, and public places. There are no accurate or up-to-date data on the scale of this phenomenon and its social impact on women empowerment. A recent study indicates that women's concern about sexual harassment, their fear of neglecting home and children, as well as the complications associated with the segregation of sexes and the patriarchal bias against women in the workplace, all these were cited by women as impediments to women's work.

5-7- Cultural constraints on women empowerment

There is a wide-spread belief in Egypt that the right place for a woman is at home with her family and children, regardless of any educational or practical advantage she may have otherwise. Women's educational and practical achievements are often seen as matters that would help them succeed in family life, especially in caring for children and raising good offspring that embraces the right social values and identity. Religious discourse in the course daily life often glamorizes women only within the framework of home responsibilities. The message that resonates in this discourse is

that the home is the “kingdom” or “crown” or the sanctuary for her dignity, chastity, and beauty.

Women’s ambitions for education and work are influenced by the social constraints the family places on her life and future. A study on the aspirations of Egyptian women following the 25th January Revolution conducted by the Egyptian center for public opinion research (baseera) indicates that although a large percentage of Egyptian families encouraged their girls who are enrolled in schools to study and give them a sense of confidence in their ability to succeed, about three-quarters of those polled said that marriage is more important for young women than work, or that having a career is not important for women. Two out of every five Egyptian girls, according to the same study, have no say in running their parents’ household. In other words, few women had the chance to practice decision making while growing up. Ironically, many women express admiration for the manner their families brought them up especially with regard to moral values, respect for others, kindness and religiosity. This goes to show that the family succeeds in passing on to their daughters much of the traditional values that shape the latter’s view of the world.

This being the case, the aspirations of women are often confined to family life, having a bigger house, buying quality food and getting reliable health services. Evidence suggests that the personal aspirations of Egyptian women are confined to work, pilgrimage, having an independent household, enjoying good health in old age, and having access to adequate health care and a decent pension in later life.

A major part of the gender gap for women has to do related with the cultural restraints that confine women’s aspirations to family life and marital relations rather than public life. Women are thus more preoccupied with their families’ logistics and problems than they are with their own issues. The personal aspirations of many women focus on two main goals; marriage and children. Existing literature suggests that such constraints stunt the ability of women to attain even these modest goals. This problem is common and continually compounded by the bias against women and the tendency to favor over girls in education.

Although women are one half of society, their participation in the workforce is lower than men, and lower also than women in more advanced countries. A study on the aspirations of Egyptian women suggest that most women justify their lack of pursuit

of a career by saying that their role is in the home, and that working outside the home is a man's responsibility. They are also convinced that women are not fit for working outside the home or that workplaces fail to offer women the right working conditions.

Despite these restrictions, working and non-working women alike have career aspirations, ones that often undermined by the restrictions their families impose and the social constraints that them feel insecure and unappreciated. Within the family, most women admit the main motive for women's work is the need for income. Even though some women may not agree that women's place is necessarily at home with their children, they regard home making as their most valued endeavor and are willing to sacrifice their salaried jobs if they were to conflict with their obligations toward the family. Besides, women's sense of insecurity often imposes constraints on their daily life. A large percentage of women cannot leave any of their children at home alone, not even for a short time. Others cannot stay at home alone at night or avoid daily errands or visits to relatives because of their feelings of insecurity.

In conclusion, the aspirations of women in Egypt following the revolution do not match the rhetoric about women's rights and empowerment. These aspirations also fall short of the promises of democratization and of profound reforms of women's status and the need for their active participation in society. Any change in women's status is ultimately a function of improved education, integration mechanisms, and a change in the patriarchal system of values that is hostile to women liberation. In other words, the democratic transition that the January 25th Revolution promised for is unlikely to materialize in the absence of determined efforts to change the status of women in a profound manner, enhance the quality of their lives, and empower them.

Chapter 6

Youth and adolescents' emerging issues

6.1 Introduction:

Egypt is a young population; one quarter of the population is between 12 and 22 years old and another quarter is between 23 and 39 years old. Youth and adolescents face the same issues faced by all the Egyptian citizens in addition to some specific issues related to youths' lives and roles in the society. This chapter focuses on youth and adolescents related issues. Section 2 discusses Gender based violence among female adolescents and Section 3 focuses on youths' access to sexual and reproductive health services. Section four is dedicated to present youths' civic engagement and political participation.

6.2 Gender based violence among female adolescents:

Gender Based Violence is an overall term for any harm that is perpetrated against a person's will and that results from power inequities that are based on gender roles. Globally, gender-based violence always has a greater negative impact on women and girls; thus, the term is often used interchangeably with violence against women. GBV takes many forms, including physical, sexual, and psychological.

Physical violence including slapped, pushed or shoved, struck with fist, kicked, dragged, threatened with weapon and having a weapon used against her. The most recent data reveals that less than a fifth of women age 18-64 have ever experienced physical violence (17%; ECGBVS 2015). The Egypt Economic Cost of Gender-Based Violence survey 2015 shows the percentage of young women who have ever experienced violence perpetrated by family members/persons in close relation and within surrounding environment since age 18 reached 19.5% among women aged 18-19, 19.7% among the age group 20-24 years and 18.9% among the age group 25-29 years. The most recent data also shows that this percentage reached over a third

among ever married women age 15-49 (35.5%; EDHS2014). The EDHS 2014 shows that the percentage of ever married young women that have ever experienced physical violence since age 15 perpetrated by any individual since age 15 reached 35.3% among ever married women aged 15-19, 39.9% at the age 20-24 years and 35.3% at the age 25-29 years.

Table 6-1: Percentage of ever-married women age 15-29 who have ever experienced physical violence perpetrated by any individual since age 15 by age group, Egypt, 2014. Percentage of women age 18-64 who have ever experienced violence perpetrated by family members/persons in close relation and within surrounding environment since age 18, Egypt, 2015

Age	EDHS 2014		ECGBV 2015	
	% ever married women experienced physical violence since age 15	Number of women	% women ever experienced physical violence since age 18	Number of women
15-19	35.3	240		
18-19			19.5	667
20-24	39.9	980	19.7	1641
25-29	35.3	1,422	18.9	2620

Source: EDHS 2014/ ECGBV 2015

Sexual harassment was reported by around 43% of female SYPE 2014 respondents, 13 to 29 years of age. Sexual harassment was most common among females in informal areas, where 65% had experienced it and in urban areas with 50%. Sexual harassment was least common in rural areas, as only 36% reported such.

Among the SYPE respondents who had experienced sexual harassment, only one third (35%) told someone about their experience. Younger females were more likely than older females to tell someone about their experience; 44% of those aged 15-17 told someone, while only 27% of those aged 25-29 did so. Fewer females living in rural areas told someone than females living in urban or informal urban areas. Among SYPE respondents who experienced sexual harassment, 23% told a parent, 15% told a

friend, and 3% told another relative. Almost no one told the police or a doctor about their experience (0.2%).

Moreover incidences of **sexual violence** perpetrated by family members/persons in close relation and within surrounding environment since age 18 was reported by the ECGBV survey of 2015; 5.2% among young women age 18-19, 3.4% among women 20-24 years of age and 2.9% of those 25-29 years of age have ever experienced sexual violence.

Psychological or emotional violence including insulted or made to feel bad, humiliated or belittled in front of others, intimidated or scared on purpose, threatened with harm and controlling behavior.

The EDHS of 2014 shows that 20.6% of ever married women aged 15-19 had experienced psychological violence at the hand of her spouse, 18% of ever married women aged 20-24 and 19% of ever married women aged 25-29.

The ECGBV survey of 2015 reports notably higher prevalence of emotional violence among ever married women at the hand of their husbands. With 35.9% of ever married women aged 18-19 had experienced emotional violence at the hand of her spouse, 46.1% of ever married women aged 20-24 and 47.5% of ever married women aged 25-29.

Table 6-2: Percentage of ever-married women age 15-29 who have ever experienced emotional violence committed by their husband

Age	EDHS 2014		ECGBV 2015	
	%	Number	%	Number
15-19	20.6	240		
18-19			35.9	133
20-24	18.1	980	46.1	913
25-29	18.8	1,422	47.5	2343

Source: EDHS 2014/ ECGBV 2015

Female Genital Mutilation is another type of gender based violence against female youths. The practice of female genital mutilation has been a tradition in Egypt, and adherence to the custom remains widespread although the government has banned the practice (El Zanaty and Way, 2015). Ninety-two percent of the ever-married women age 15-49 in the EDHS 2014 had been circumcised and virtually all of them were circumcised before age 15.

The grand majority of SYPE 2014 respondents have heard of FGM (94%); slightly more so among female respondents (98%) than male respondents (89%). Of all females SYPE 2014 respondents aged 13-35 that have heard of FGM, 79% mentioned that they were circumcised, 13% said they were not, and 7% refused to answer.

In Egypt the EDHS estimated total proportion of daughters age 0-19 years who are circumcised is 21% and the proportion that may be expected to be circumcised is 56%. Looking at the variations by place of residence, the expected prevalence of circumcision is lowest in the Urban Governorates (31%) and highest in rural Upper Egypt (75%).

The EDHS of 2014 shows that, the proportion of circumcised girls aged 11-12 is 32% and the expected proportion to be circumcised in the future at the same age group is 27%, the proportion of circumcised girls aged 13-14 years is 50% and the expected proportion to be circumcised at the same age group is 13%, the proportion of circumcised girls aged 15-17 years is 61% and the expected proportion to be circumcised at the same age group is 6% while the proportion of circumcised girls aged 18-19 years is 68% and the expected proportion to be circumcised at the same age group is 2%. It is clear from this that there is a sharp increase in the rate of circumcision when girls are close to puberty.

Child marriage is a human rights violation. Despite laws against it, the practice remains widespread, in part because of persistent poverty and low education attainment. According to the latest figures, in developing countries one in every three girls is married before reaching age 18 and one in nine is married under age 15 (UNFPA). Girls pressed into early marriage often become pregnant while still adolescents, increasing the risk of complications in pregnancy or childbirth. These

complications are a leading cause of death among older adolescents in developing countries.

In fact, child marriage is closely associated with no or low levels of schooling for girls. Poverty leads many families to withdraw their daughters from school and arrange marriage for them at a young age. These girls are denied the proven benefits of education, which include improved health, lower fertility, and increased economic productive.

The EDHS 2014 shows the percentage of married women aged 15-17 is 6% and percentage of divorced women at the same age is 0.1%. The percentage of married women aged 18-19 is 27%, percentage of divorced women is 0.3% and percentage of separated women is 0.3%. About 7% of ever-married women in the age group 15-19 have alive children and 4% were pregnant in their first child. About 7% of those who aged 20-24 had their first child before their 19th birth day.

The ECGBV survey of 2015 examines the proportions of ever-married young women who had not consented freely to the marriage of their current or most recent husbands (i.e. forced to marry their husbands). The findings clearly indicate a positive association between prevalence of forced marriage and age; where older women are more likely to be forced to marry. Four percent of ever-married women 18-19 years of age, 5.3% of those age 20-24 years and 4.6% of those 25-29.

6.3 Youth access to Sexual and Reproductive Health

Information provided to young people about their sexual and reproductive health can support them in developing values, attitudes, and practices that respect individuals and protect their health and rights. The attitudes they develop during adolescence will influence their lives as adults, affecting them as individuals and their future relationships as spouses and parents.

6.3.1 Establishment of Youth Friendly Clinics

In 2003, Egypt embarked on the establishment of Youth Friendly Clinics (YFCs) within government affiliated Teaching Hospitals throughout Egypt. YFCs in Egypt were started through a joint project of the United Nations Population Fund and the Egyptian Family Planning and Reproductive Health Association (EFPRHA), called

“Meeting Adolescents’ Reproductive Health Needs in Egypt.” Under this project, the Ministry of Health established nine YFCs in government-affiliated teaching hospitals in six governorates throughout Egypt. By 2014, Egypt had 25 YFCs in 14 governorates run by either the health ministry or EFPRHA, serving both married and unmarried youth.

Initially the establishment of the clinics within the government-affiliated teaching hospitals was designed to take advantage of these hospitals’ prime location in areas that are heavily trafficked in order to ensure accessibility to the general population.

The objective of establishing the YFCs was the provision of comprehensive RH services, including information and counseling to young people in need, regardless of gender, economic status, religion, disability, or any other factor. Comprehensive RH services include premarital counseling and examination, FP, management of STIs, and pubertal problems such as menstrual irregularities, as well as recommended laboratory investigations and ultrasound. All of the above services are supposed to be delivered in a youth friendly manner, ensuring client privacy and confidentiality. Achieving the above objective entailed training selected health service providers on provision of youth friendly comprehensive RH services and counseling and community mobilization activities.

The FHI was approached to assess these clinics and provide a general assessment of the established YFCs in-depth interviews with clinic managers, service providers and clients revealed a number of points constrains:

- Discussion with service providers revealed that client flow in the beginning was much higher due to the promotional campaign for the clinics in schools and universities. However when this campaign was interrupted, it had a negative impact on client flow.
- Internal staff at the THs were not aware of the existing YFCs or their services. Others perceived them as FP or sexology clinics and the majority believed that the clinics were specialized in premarital counseling and examination. The staff of the THs represent a missed opportunity in terms of promotion of the clinics.

- Doctors being of the same sex as their clients contributes to a feeling of ease between client and physician, a factor in making services youth friendly that was mentioned by all physicians in the in-depth interview.
- Issues with the lack of required equipment such as an ultrasound, which is needed for checking male and female internal organs, instead being referred to the radiology department would boost client flow

6.3.2 Access to Comprehensive Sexuality Education

The World Health Organization (WHO) recommends that sexual and reproductive health (SRH) education be provided within the context of school programs and activities that promote health. Moreover the United Nations Family and Population Agency has worked with various governments to implement comprehensive sexuality education, both in schools and through community-based training and outreach. A large body of scientific research in both developed and developing countries has shown that SRH education programs have improved the overall wellbeing of young people.

According to a report issued in 1994 by the United Nations Conference on Population and Development, the Egyptian Ministry of Education incorporated a few short lessons on sexuality and reproductive health in the public school curriculum. The science syllabus for the second year of preparatory school (grade 8) contains a description of the structure and functions of the male and female genital systems along with a brief mention of reproduction. The only genital diseases discussed are puerperal sepsis (genital infection after delivery) and syphilis. However teachers do not always present this lesson; they often ask pupils to read it at home or discuss it with their parents. If the lesson is given in class, the teachers usually do not allow questions or laughter. The information in this lesson is not tested in any examination.

In 2011, following the revolution and the subsequent political instability, the newly appointed minister ordered the removal of the same topics, along with family planning methods, from the 12th grade curriculum for the sake of shortening its contents.

The most notable provision of SRH services mandated by the Ministry of Health are in the form of pre-marital counseling which provide youth with reproductive health

information. This pre-marital counseling and testing were made mandatory on 12 June 2008; as a presidential decree regarding the Child Law. In addition to increasing the minimum age of marriage for males and females to 18 years, and the establishment of premarital testing and counselling as a precondition to issue a marriage certificate.

Some programs such as the Youth Hotline and the website shababna.org and Ma3looma.net, offer information services on sexuality to young people aged 15-24. Naturally, other health concerns besides sexuality, such as nutrition or smoking, are included in these initiatives. However in reflection of the absence of a national policy on youth sexual and reproductive health and rights that targets different segments in the population, the number of young people exposed to available sexuality education programs in Egypt is fairly limited.

SYPE 2014 included a series of queries pertaining to the knowledge of young people aged 13-35 in Egypt about the sexual and reproductive health issues. An important finding of this survey reveals the lack of a formal setting and the absence of credible sources of information, as young people usually turn to their peers, internet or mass media which may not necessarily provide accurate information.

Just over one-third of the SYPE 2014 sample (34%) had talked with a parent about puberty. Youth were also asked about their main source of information regarding puberty. Further more than twice as many female respondents (48%) than male respondents (22%) had spoken with a family member about puberty. The most commonly cited source of information was “friends, neighbors, and/or relatives” (41%) followed by “family” (27%). When disaggregated by sex, 41% of female respondents indicated “family” compared to 13% of male respondents. For male respondents, 51% reported “friends, neighbors, and/or relatives” were their main source of puberty information. A substantial percentage of the sample (14%) reported that their main source of information was films and cinema. Overall, 59% of youth indicated that the amount of information they received about puberty was sufficient.

The survey continued with a series of questions asking young people aged 13-35 their opinions regarding the appropriate age, if ever, to talk to adolescents about puberty. The largest percentage of respondents (38%) believed that this discussion should take place at the onset of menstruation/puberty. The second most common response was that no one should talk to youth about puberty, comprising 15% of youth; more young

men than women gave this answer. Furthermore, 11% of respondents believed that this conversation is best had at marriage. Finally, 11% of the sample was unsure of the best age to discuss puberty.

All the surveyed SYPE 2014 respondents were asked if they had ever heard of sexually transmitted infections (STIs). Just over half of the sample (54%) had, with substantially more male respondents (60%) having heard of STIs than their female counterparts (48%). Altogether, those who indicated that they had heard of HIV/AIDS comprised 73% of the total sample. While the data reveals that a notable percentage aware of HIV/AIDS did not identify it as a sexually transmitted infection; as 43% of the SYPE respondents who indicated that they had not heard of any sexually transmitted infections have heard of “AIDS.”

A large percentage of the SYPE sample (61%) indicated that they had heard of HIV/AIDS through media, radio, or cinema, followed by school (12%) and friends (6%). Male respondents and female respondents were equally likely to report school as a source of information; however male respondents were nearly three times as likely (73%) to report friends as a source than female respondents (27%).

The EHDS of 2014 reveals a higher level of knowledge among young ever married women where 78.3% of those between 25-29 years of age have heard of infections that can be transmitted through sexual contact and 72.9% have heard of AIDS, among those 20-24 years of age 74% have heard of STIs and 72.9% have heard of AIDS. The lowest level of knowledge appears among the youngest age group of ever married women as 58.4% of those 15-19 years of age have ever heard of sexually transmitted diseases and 49.9% have heard of AIDS.

Despite the wide efforts and initiatives set in place to increase the general public’s awareness of the many health damages caused by female genital mutilation / cutting (FGM/C), it remains widely practiced due to the strong religious argument of its necessity. The fact that six out of ten young people believe the practice is necessary calls for interventions that target young people (both male and female) early enough to help them question their own beliefs and is conceptions before they get married and subject their daughters to this practice.

As reported in the latest EDHS of 2014, discussions with relatives, friends or neighbors remain the primary source of information. A fifth (19.4%) of ever-married women age 15-19 discussed female circumcision with relatives, friends or neighbors, 23% of ever-married women age 20-19, and 26% of ever-married women age 25-29.

Around 62% of SYPE 2014 respondents aged 13-35, regardless of marital status, knew of family planning methods that could delay or prevent pregnancy. This percentage was 72 among females compared to 52% of male's respondents (52.0%). The most commonly cited source of information about contraceptives was health care providers (33%), followed by radio and television (27.5%).

The most commonly identified contraceptive method among all SYPE respondents aged 13-35 was oral contraceptive pills (OCPs), which 57% of the respondents knew of. Intrauterine devices (IUDs) were the second most identified contraceptive method, with 50% followed by injectable (43%), sub dermal implants (10%) and condoms (9%). Overall, female respondents had more knowledge of contraceptive methods than their male counterparts with the exception of male condoms.

6.4 Youth political and civic participation

Political and civic participation is essential for youth to successfully transition to meaningful adult roles in which they can participate fully in society and contribute to community and national development. Egypt constitution of 2014 contained a significant number of articles that encourage political participation of Egyptians.

Although youth were the torch of the January 25th revolution, several evidences on youth low political participation after the revolution were observed. The presidential elections exit poll conducted by the Egyptian center for public opinion research "Baseera" reveals that despite the percentage of youths (18-30) among eligible voters is 37%, their percentage among the actual voters was 27%. The same pattern was observed in 2015 parliamentary election.

The "Political participation in Egypt: perceptions and practice" poll conducted by Baseera as a part of Masar project showed that only 23% of youths (18-29) have ever voted before 2011. This percentage increased to 75% after January 25th revolution.

From Mubarak’s ouster till Mohamed Morsi was elected president in June 2012, the percentage of Youth that took part in protests or demonstrations reached 17%. The overall level of participation was highest at 19.3% during the period of Mohamed Morsi’s presidency till his overthrow following the demonstrations of June 30th, 2013.

Following the ouster of president Morsi, the former president of the Supreme Constitutional Court Adly Mansour was appointed interim president. The level of political participation in informal activities decreased notably during this period. The findings of the survey show that 90% of Egyptian youth did not participate in any protests or demonstrations during Adly Mansour’s interim presidency. Moreover, since the election of Field Marshal El-Sisi (former Minister of Defense) up to the time of the poll in late November, 2014, 91% of Egyptian youth claim to have not participated in any demonstrations or protests.

Table 6-3: Participation in any protests or demonstrations during each of the following periods among youth (18 to under 30 years of age) in 2014

	Never	Once or twice	More than twice
1. Before the revolution in 2011	97.9	1.4	.7
2. From January 25th until the Mohamed Morsi took office	83.1	10.8	6.1
3. During the reign of Mohamed Morsi and till June 30 demonstrations	80.8	15.8	3.5
4. during the period of the interim president Adly Mansour till El Sisi took office	89.5	8.0	2.5
5. Since El Sisi took office	90.8	7.4	1.7

MASAR CITIZEN 2014; Political Participation in Egypt: Perceptions and Practice

In the "Social and Political Transition in the Arab countries" survey, conducted by Baseera in November of 2014, centering on the general public opinion and views of the period of political transition, the respondents were asked about their participation in key events during the Arab Revolution. As revealed in the table below, 36% of youth supported the Arab Revolution (Arab Spring) of January 2011.

Table 6-4: Notions towards Arab Revolution among youth (18 -29) in 2014.

Youth 18-29	
Support the Arab Revolution (Arab Spring)	36.2
Participation in any protests within Arab Revolution (Arab Spring)	16.6
Vote in the last national election	53.2

Source: Social and Political Transition in the Arab countries" survey, baseera, 2014

The respondents of the Survey were then asked whether they have actually taken part in certain political actions, or would take part, or would never take part under any circumstances. The highest form of actual political participation was attending demonstrations reported by a fifth of youth under 30 years of age. Signing the petition and joining boycotts were the highest mentioned political actions youth were willing to do, however, have not.

Table 6-5: Self-reported political actions of youth (18 -29) in 2014.

	Have done	Might do	Would never do
Signing the petition	11.1	19.0	70.0
Joining boycotts	8.8	21.9	69.3
Attending demonstrations	20.5	10.1	69.4
Joining unofficial strikes	2.2	9.1	88.7
Occupying building or factories	1.5	2.1	96.4

Source: "Social and Political Transition in the Arab countries" survey, Baseera, 2014

Directly following the January 25th, 2011 revolution and the June 30th, 2012 movement, Egyptians held a greater sense of duty to be civically engaged and help change the direction of their nation. The importance of youth in igniting change in their communities through civil engagement has been highlighted time and time again. However data collected by Baseera in the "Social and Political Transition in the Arab countries" survey in November of 2014, reveals notably low self-reported membership in civic establishments among youth. The highest reported percentage of

civic participation among youth from 18 to 29 years of age was through professional association/trade union (5.1%), followed by youth/cultural/sports organization (2.1%), and charitable organizations (2.1%). A single respondents under 30 years of age reported being a member of a political party.

Table 6-6: Self-reported civic engagement of youth (18 -29) in 2014.

Membership in	%
Charitable society	2.1
Professional association/trade union	5.1
Youth/cultural/sports organization	2.1
Political party	0.4
Civil society organization that was not mentioned above	0.1

Source: Social and Political Transition in the Arab countries" survey, baseera, 2014

Chapter 7

Public policies and Management of the population program

7-1- Introduction

Any discussion of the management of the population program or the available options for a more effective management of Egypt's population program must include three crucial issues. One is the interplay between demographic changes and other economic, social, and environmental developments. The second is the objectives of the Egyptian government as embodied in the Sustainable Development Strategy and in Egypt's international commitment to the Sustainable Development Goals (SDGs) which has the approval of the international community. The third is Egypt's institutional framework and the need for coordination among various government agencies and between those agencies and civil society, as well as the questions of follow-up, evaluation, and funding. This chapter will tackle each of these issues.

7-2- The interdependence between demographic changes and economic, social, and environmental developments

The main point of development is to broaden the scope of options available to people. Such a task involves the improvement of human knowledge, skills, and health, so that people have a longer, healthier and better life. The link between population and development is therefore a strong one, since people are the target and driving force of development. Unless we provide Egyptians with quality skills and knowledge and encourage them to embrace habits and values that are compatible with development, we may be derailed from the path of development for which we all aspire. To stay on that path, we must pursue a planning process that is rigorous and based on facts and figures.

Egypt's population characteristics leave much to be desired. Our human capital is impaired, with productivity below average and women's participation economic activities is fairly low. A low household income and dwindling market would lead to reduced state revenues, thus making it harder to finance basic services. The failure to

provide such services, in return, undermines the country's human capital. We are thus caught in a vicious circle where low demographic characteristics impede our quest for development.

One thing that makes it harder to break free from this vicious circle is the high birthrate, which puts immense pressure on services, specially education. The birthrate in Egypt declined steadily during the 1970s and 1980s; then it plateaued for a number of years. But since 2006, the birthrate surged once more. In 2014, the crude birthrate came to about 31.2 per 1,000, significantly higher than the 25.5 per 1,000 recorded in 2005. This was translated into a gradual increase in the number of births, from 1.85 million in 2008 to just over 2 million in 2008 and then again to 2.7 million in 2014. With a more than 40% increase in the number of births between 2006 and 2014, the country's ability to build up its human capital was significantly curtailed.

In the last three decades of the twentieth century, Egypt saw a remarkable improvement in school enrollment, especially for females. Between 2005 and 2014, the percentage of people aged 15-19 who never attended school dropped from 4.4% to 2.6% among males and from 12.8% to 3.9% among females. But over the same period, the dropout rate climbed, with the percentage of those who didn't finish elementary school in the age group 15-19 rising from 5.2% to 7.1% for males and from 4.2% to 4.6% for females. This phenomena poses questions about the ability of the country to educate all of its children when the population keeps growing in the manner described above. If poverty persists, the invisible cost of free education may drive the children of low-income families out of school.

The birthrate boom seen between 2006 and 2014 makes it harder for the school system to accommodate all children in basic education. To make room for the 40% increase in the number of births, an equivalent increase is needed in the number of classrooms, even without attempting to reduce the high number of students per class that currently impedes the quality of education. The cost of building 90,000 classrooms, the number needed to accommodate the increase in the number of students, is upwards of 18 billion EGP. Unless these new classes are built, access to education would be curtailed in a manner that would harm the children of poor families most of all.

To turn to the quality of education, the system of education has so far mostly favored quantity over quality. The quality of education now depends to a large extent on the family's finance. Children of families with less income receive worse education, and have less prospects in life as a result. Under these circumstances, improving the quality of education, which is the core of human capital, may be turning into a mirage.

Furthermore, the high rates of population growth impose a tremendous pressure on natural resources, such as water and energy, and thus contributes to the deterioration of the environment. The resulting failure to improve the quality of life, coupled with increasing expectations, is bound to increase frustration and tensions among the population in a manner that endangers political stability and undermines social peace.

As poverty increased in Egypt – due, among other things, to the rise in the birthrate – the quality of life for a large segment of the population dwindled. Admittedly, Egypt experienced periods of high economic growth in the past, but these were not durable enough to trickle down or improve the quality of life for low-income groups. The significant population increase seen in Egypt, compounded by the economic difficulties of the post-revolution period, resulted in increased rates of unemployment and inflation. And with the country's foreign currency earnings dropping, its ability to invest in human capital dwindled.

Demographic dynamics, such as the population growth rate and age composition, are bound to have an impact on the labor market. The higher the birthrate, for example, the younger the population gets, and the greater is the number of people seeking to join the workforce. When the economy fails to create real job opportunities, the demand on jobs would outstrip the supply. To compound the problem, newcomers to the labor market might lack the skills necessary to compete in the local, regional, and international labor markets. Without mastering technology or coming up with innovations, they may not be able to launch new businesses, which is one way to absorb the labor surplus. To reiterate, if the economy cannot generate enough jobs, and if the workforce is uncompetitive, joblessness would rise, causing frustration among the young and boosting the chance for political instability.

In the light of the above, one must never examine population issues in isolation from economic and social factors, nor should one focus on population growth alone, or treat it as a mere health issue. There is a need to forge a multi-faceted approach to this

complex issue that poses undeniable peril to the future of this country. One must, however, note that the health-dominated approach had some successes in the 1980s. But in the absence of a more comprehensive approach, Egypt's efforts to strike a balance between its population and resources eventually failed. Since 1996, Egypt has grown by over 30 million people, a 50% increase over two decades.

Cost-benefit analysis of SRH programs:

A joint study by the Minister of Population, the Center for Economic and Financial Research Studies (CEFRS) at Cairo University in cooperation with the United Nations Population Fund, assessed the cost benefit analysis of Egypt Family Planning Program for the period 2014 to 2050. This study comes as a follow up of an earlier study conducted by the Policy Project (Chao, 2005) aimed to demonstrate the financial benefits and costs of family planning programs in Egypt and to compare its monetary costs to the monetary benefits in terms of reduced levels of social services required at lower levels of fertility.

The study on the cost-benefit analysis of Egypt family planning program for the period 2014 to 2050 was an attempt to estimate the impact of family planning programs on government expenditures on social services including: health, education, housing, and food subsidies. The study relied on the actual expenditure on social services according to the Egyptian budget for the fiscal year 2012/2013 and estimated the number of births averted due to the family planning program at more than 43 million births for the period (2014-2050), and measured the cost for family planning program at around 8 billion EGP during that period. When comparing the reductions in government social services spending as a result of family planning programs to the costs of family planning services, the study concluded that the average return on each Egyptian Pound spent on the family planning program, is 56.12 EGP for the period (2014-2050). These figures suggest that over the next 35 years, Egypt can reduce social spending by nearly 450 billion EGP as a result of its family planning program. This high benefit-cost ratio suggests that continuing a successful family planning program would help the Egyptian government as it will be able to use the saving in the general expenditure on social services in the improvement of the quality of social services provided in the health, education and housing sectors.

It is worth mentioning that despite this huge saving, the results reflect only the direct monetary returns of investing in family planning which is only a part of the societal benefits that this investment will bring. Furthermore, the return on investment of a control of population explosion will be considerably higher if the implications of such explosion are taken into consideration. Implications include additional investment needed to satisfy demand on water, energy, housing, infrastructure and environment degradation. If such additional costs are included, the return on investment is expected to be several folds. Furthermore, unmeasured cost related to political stability and human security make the return on investment even higher.

Such results support the argument that a family planning program in Egypt is a financial investment with a high internal rate of return and should get more attention from policy makers.

7-3- Sustainable Development Strategy: Egypt Vision 2030

The concept of “sustainable development” involves a comprehensive, multi-sector approach. International experience shows that focusing on sector-by-sector development and a one-sided approach to development is problematic. To integrate sustainable development in national and regional planning, we must emphasize the interdependence among various sectors. Only then we may proceed down a path that is compatible with the goals of sustainable development.

Lessons learned from international experience underline the need to integrate sustainable development in long-term strategies, in ten-year and medium-term development plans, as well as in various planning systems and development indicators on the national, regional, and sectoral levels. Such lessons also stress the need for a supporting political climate and the presence of strong institutions capable of leading the planning, development, and production efforts. Other requirements include access to information and enhanced efficiency of government, civil society, and media institutions.

There are several matters that may impede the transition to sustainable development especially in developing countries. These include the absence of genuine participation

by all stakeholders, corruption, political instability, lack of security, internal and external turbulence, high public indebtedness, and lack of adequate resources to finance the programs and projects of sustainable developments. Other impediments to sustainable development include the lack of an effective system for governance, transparency, and accountability, as well as population increase and the inability to create enough jobs for the young who are trying to join the workforce.

In the light of all the above, Egypt's Ministry of Planning, Monitoring, and Administrative Reform (MoPMAR) led a multi-agency quest to create "Sustainable Development Strategy: Egypt Vision 2030," a document widely seen as a recipe for utilizing available resources, improving competitiveness, restoring Egypt's historical role as a regional leader, and providing a decent life for its people.

The authors of Vision 2030 brought Egypt up to speed with the international efforts to adopt the goals of sustainable development for the post-2015 period, which were endorsed by the member states of the UN General Assembly. Vision 2030 endorses the concepts of "sustainable development" and "participatory growth" as a basis for development at a time when the "trickledown" concept was discredited. The "trickledown" concept has become politically and socially unacceptable because it exacerbates poverty, increases the gap between various groups, amplifies the feelings of injustice and inequity, and hampers development on the economic, social, and environmental level.

Egypt is trying at present to come up with a system to follow up Vision 2030. Such a task calls for developing integrated data systems and databases to be used in the support of long-, medium-, and short-term planning and development decisions. Therefore, we need to formulate a comprehensive plan for administrative and institutional reform that is compatible with the multi-faceted drive to achieve sustainable development. To succeed in this endeavor, we need an efficient administrative apparatus that is capable of implementing Vision 2030.

While formulating Vision 2030, every effort was made to benefit from the strategies and initiatives previously prepared in the past by government, civil society, and business institutions, as well as strategies that were implemented successfully in other countries. In other words, Vision 2030 is an inclusive framework that brings together all previous efforts while developing an integrated approach, one that includes

specific ways of addressing Egypt’s main problems, while taking into account various risks that may surface on the world stage in the next few years.

Vision 2030 attempted to link its goals with quantifiable indicators, while assigning the implementation of such goals to particular agencies in a realistic manner and according to a specific timetable, thus asserting the need for accountability in future work.

Figure 7-1: The main goals of the “Sustainable Development Strategy: Egypt Vision 2030”



- Formulating a cohesive long-term political, economic, and social vision to serve as a reference point for medium- and short-term development plans on the national, local, and sectoral levels
- Turning Egypt into an effective player in a dynamic and fast-paced international environment
- Meeting the aspirations of the Egyptian people, improving their standards of living, and boosting the efficiency of services that impact on their daily life
- Enabling civil society and the parliament to follow-up and evaluate the implementation of Vision 2030 by setting clear objectives, performance indicators, quantitative goals, programs, and projects and by implementing them within a well-defined timeframe
- Acting in line with the UN post-2015 Sustainable Development Goals (SDGs) and Africa's Agenda 2063

Figure 7-2: Comparing the current situation with the goals of Egypt Vision 2013



Components of the Sustainable Development Strategy, Egypt Vision 2030

Egypt vision presents a framework for improving the Egyptians' quality of life. It also support the main objectives of the population and development strategy 2015-2030 as shown in the following table.

Table 7-1: Population strategy and Egypt strategy 2030

Objectives of population strategy	Strategy Egypt 2030
Decreasing the population growth rate	Seventh pillar: Education and training
Improving population characteristics	First Pillar: Economic development
	Seventh pillar: Education and training
Narrowing the gap between regions and population groups	Fifth pillar: Social justice
	First Pillar: Economic development
More balanced geograohical distribution for population	Tenth pillar: Urban development
	Fifth pillar: Social justice

III. Institutional framework:

Now we may turn to the institutional framework that impedes the efficiency and effectiveness of the Egyptian population program.

1) Limited achievements

Few would dispute the fact that in the last two decades, not much progress was made toward achieving the goals of the population policy. Whether we look at the rate of population increase, the quality of the population characteristics, the demographic distribution of the population, or the imbalance among population groups and geographical areas, the shortcomings are clear. Even when ambitious goals were gradually abandoned in favor of more modest goals, the latter also remained unmet.

The outcome of previous efforts must not be disassociated from the general performance of cash-strapped government institutions. Due to inadequate, or total

lack, of resources, successive strategies launched in the past two decades failed to bear fruit.

To bring down the birthrate, a successful population strategy needs to increase demand on reproductive health and family planning services and also to improve and stabilize the quality of these services. The way to increase demand on family planning and reproductive health services is to get the public to embrace the ideas of a small family and the spacing of births. Furthermore, families must be aware of available contraceptives and have access to health consultations in order to reduce the chance of contraceptives being abandoned altogether because one type has adverse side effects on some users.

In the age of global communication, with intense competition among television and radio networks and with diverse social media outlets, it is crucial to come up with creative ways to promote planned parenthood.

Equally crucial is the diversity of the media message and its adaptability to the needs of the audience. To promote planned parenthood, we need to neutralize the negative messages sent out by some religious preachers. Getting the clerical establishment to side with family planning values, as it turned out, proved of little use. The need is still great, therefore, to neutralize religious discourse and not depend solely on clerical exhortations to spread the values of planned parenthood.

Meanwhile, every effort must be taken to provide contraceptives in an adequate way while meeting any subsequent increase in demand. The lack of diverse methods of contraception in some locations and the lack of a motivated medical teams to work in rural and distant areas, as well as a below-average health infrastructure in some rural and informal areas, are all matters that call for our immediate attention. If multiple contraceptives are made available, free or charge or at a minimal cost, in poor areas, there is every chance unwanted pregnancies would be curtailed.

The lack of resources is not the only problem, however. Despite the oversized government apparatus, there is a shortage of health personnel who are trained to provide reproductive health services and encourage women to use various methods of birth control. In particular, there is a shortage of female doctors and

nurses in conservative areas, where women tend to feel awkward seeing male doctors.

In short, when trying to implement comprehensive development programs, we need to give priority to families who are most in need of reproductive health services.

2) Coordination problems

Coordination among government agencies leaves much to be desired. This is especially true in situations of multi-faceted development issues that require the harmonious cooperation of government agencies. Population issues are intricate by their very nature and require multi-agency action. If there is anything to learn from the slew of population policies that we embraced vis-a-vis population growth, demographic characteristics, spatial distribution, and developmental gaps, it is that we must approach the population issues from a multi-faceted perspective that combines the health, social, religious, economic, environmental, and urban factors. This cohesive approach is best suited to a development vision that places people at the heart of development efforts. To reiterate, we need to have a greater level of integration among government ministries and institutions.

The success of coordination, one may add here, depends on the level of decentralization of the service. The more decentralized the service is, the greater is the need for improved coordination on the local level, whether through the development of effective frameworks for coordination or the creation of local capabilities that are capable of performing the planning, implementation, follow-up, and evaluation tasks.

Conversely, the more centralized the service is, the greater is the need for coordination on the central level, as well as for the creation of vertical coordination inside each agency, so as to be able to bring central policies to fruitful outcome the local level.

Aside from the challenges facing coordination among government institutions, other problems exist when it comes to coordination among government agencies

and NGOs. For starters, government agencies – which see themselves as constitutionally responsible for providing such services – are averse to collaboration with NGOs. The lack of trust between the two sides undermines cooperation while accentuating rivalries in a manner that undermines the common goal of serving the public. This problem is compounded by the lack of adequate finance for civil society organizations, which hampers the sustainability of their efforts and further discourages government agencies, with a few exceptions, from forging partnerships with CSOs.

3) Problems of follow up and evaluation

Successive population strategies made a point of attaching quantitative indicators to their goals, a commendable practice that allows for an objective performance evaluation. At times, these strategies embraced ambitious goals in the hope of getting the competent agencies to put in their best performance, while at other times the objectives became more realistic but less ambitious. In both cases, however, these strategies failed to check the rates of population growth, improve the population characteristics, or bring balance to the geographical distribution of the population.

Administratively speaking, the National Population Council is the agency in charge of following up and evaluating various components of the Egyptian population program in all its components. And yet the follow up and evaluation procedure leave much to be desired, and may actually explain a part of previous failures. Consequently, the current follow-up and evaluation mechanism needs to be refurbished through the following steps:

- a. Improving the follow up and evaluation tools, including the indicators to be used on the local level and the methods of collecting data in a neutral and credible manner.
- b. Linking the follow up and evaluation tools with accountability on the local and national levels

- c. Integrating the follow up and evaluation outcome in local and national decision-making, especially insofar as resource allocation and prioritization are concerned.

4) Funding problems

Studies conducted in the last two decades establish the fact that spending on family planning programs is a high-return investment. Although estimates may differ, the return on such investment is believed to be at least 100 times the money you spend. In 2006, it was estimated that for every pound spent on family planning programs 143 pounds were saved in public spending.

Nevertheless, the budgets allocated to family planning programs in the last two decades did not seem to take this consideration into account, a matter that led to an increase in the number of births and more pressure on education, health, and food supply systems, not to mention the long-term impact on the infrastructure, housing, water, energy, agricultural land, and food sufficiency. The allocation of adequate funds to ensure the supply of family planning is needed to meet current and future demand. To reduce the number of births, however, the demand on family planning services needs to rise beforehand. In other words, we need to change the public thinking on planned parenthood by encouraging the idea of small family and the spacing of births. So we need to spend more on campaigns aiming to change the public perception of contraceptives and the side-effects for their use. In short, there is a need to increase demand on family planning while dedicating resources to meet that demand.

7-4- Toward a more efficient and effective management of the population program

The interdependence of population issues with economic and social developments, coupled with the ambitious development objectives stated in Vision 2030, call for a more effective and efficient management of the population program. But to increase the efficiency and effectiveness of the population program, we must recognize the

current problems; namely, the modest achievements of the past, the ineffective mechanisms of coordination on the central and local levels, the absence of a well-managed follow up and evaluation system, and inadequate finance.

Following are some proposals to increase the effectiveness and efficiency of the population program:

7-4-1 Political commitment

It is imperative to send out regular messages to the public concerning the grave consequences of population increase on the quality of life and the ability to improve living standards. These messages must be issued on the central and local levels and must have the full support of executive and legislative powers. Furthermore, the messages must be consistent and yet diverse enough to appeal to all types of audience. The sending of messages, one has to add, must be steady and persistent, rather than erratic or seasonal.

7-4-2 Institutional framework

Egypt has explored different ways of running its population program. At times, a ministry was placed in charge of this effort, and at other times the task was given to an independent council. The powers of the population council also shifted over time. From planning, coordination, follow up, and assessment, the council was placed in charge of providing family planning services. Debating which institutional framework is best is a moot point, as neither alternative (ministry or council) seem to have a track record of consistent success to recommend it. In short, the existence of an independent ministry in charge of the population program, or lack thereof, is not the deciding factor as far as success is concerned.

7-4-3 Planning on the central and local level

Egypt's population strategies willingly recognize the link between population and development. A certain effort was made to ensure that these strategies adopt a

participatory approach. Still, these strategies mostly failed to achieve their objectives. To ensure the success of population strategies, we must introduce detailed plans on the central and local levels, establish a mechanism for follow up and evaluation, and put together a rigorous system for accountability, all of which should be integrated into future efforts.

7-4-4 Incorporating the population aspect in development programs

While launching programs that integrate the population dimension in development goals, it is advisable to strike a balance between the health and development inputs. This is particularly true when the population program is placed under the roof of the Ministry of Health. Such a balance would amplify the successes associated with the programs of conditional financial support (Takaful wa Karama) and some of development programs conducted in other developing countries.

7-4-5 Follow up and evaluation

The formulation of a comprehensive system for follow up and evaluation is necessary condition for the success of the population program. Such a system must involve indicators representing multiple population and development questions and reflecting the various goals of the strategy. Still, the design of quantitative indicators on the local levels is not an easy task, and it would be advisable to proceed with a limited number of indicators that lend themselves to fast and periodic measuring on the local levels. Furthermore, the system of indicators must somehow include a way of measuring the quality of the services provided. Also, the indicators must keep track of any shortage or inconsistency in the provision of family planning and reproductive health services. Any such shortages must be addressed with utmost speed so as to avert a rise in unwanted pregnancies.

7-4-6 Funding

Success in family planning can only be achieved through the provision of adequate and sustainable funding needed to provide contraceptives, to train the healthcare team providing the family planning and reproductive health service, and to launch awareness campaigns aiming to keep the rates of population growth in check and inform the public about the availability of contraceptives. The executive and legislative powers must take into account the savings in public expenditure that the successful implementation of such programs can make, as well as the opportunity cost of failure to allocate the right resources at the right time.

7-4-7 Public-Private Partnership in Population (4Ps)

Egypt adopted the policies of economic openness since 1980s. During these years the private sector size has enlarged in terms of number of firms, capital and number of employers. Many firms has proven success in building administrative systems that led to great success in their business. Private sector has advantages over the public sector that leads to fast achievements. These advantages include the absence of routine that leads to a slowdown of work and the availability of highly skilled and innovative human resources in addition to funds that could be re-allocated to different issues with less complexity.

After the January revolution the businessmen became more convinced about the impact of population quality of life and the success and stability of their business which encourage them to be more involved in corporate social responsibilities activities.

In-depth study of the population and development strategy and its implementation plan suggests 3 areas for Public-Private Partnership in Population issues:

- **Strengthening FP & RH on the ground:**

One of the obstacles that face the achievement of the population and development strategy is the under coverage of the family planning and reproductive health services and contraceptives. DHS 2014 show that the

unmet need for contraceptives reached 12.6%, a 1% increase if compared to 2008 level. Around 9.7% of mothers who got pregnant during the 5 years prior to the survey didn't get any pre-natal care.

Surveys on health services quality show also that one of the reasons of dissatisfaction about health services is that the health services providers are not well trained.

Private sector can have a great role in funding the provision of FP and RH services, provision of contraceptives and training for health services providers.

- **Advocacy & Mass Media/ Communication**

The private sector had a limited participation in the advocacy activities during the previous decade when one of the mega firms funded the production of a TV advertisement on population increase consequences. Private sector could be widen to secure financial resources for the following activities to raise awareness about the population increase consequences and FP and RH related information:

- Generating updated evidence based content/messages related to population issues.
- Producing media materials segmented (age, residence, educational level.)
- Securing airing during pick times.
- Producing drama that promote positive messages: limiting number of children to two and spacing between births.
- Using social media (22 million users on Facebook) to change attitudes of youth and to provide information related reproductive health.
- Production of innovative products.

- **Information, Research, Monitoring & Evaluation**

The absence of monitoring and evaluation for Egyptian government policies and programs in general is one of the factors of inefficiency of them. Success

of monitoring and evaluation systems depend on the availability of information. Egypt 2014 constitution included an article that guarantee freedom of information and obligate different authorities to produce and disclose information.

However, the production of the information needed to monitor and evaluate the implementation and achievements of the population strategy needs huge financial resources. Private sector could play a role in securing these financial resources to produce information and build computer systems needed to organize and utilize the produced information in monitoring and evaluation processes.

7-4-8 Governmental-Non-Governmental partnership:

NGOs role in the implementation of the population strategy emerges from the spread of the NGOs in all the Egyptian governorates. Most of Egyptian NGOs have volunteers who dedicate their time and efforts to their community. Those two advantages qualify NGOs to handle the following:

- **Monitoring and Evaluation of the strategy implementation**

NGOs human resources could be utilized in monitoring and evaluation of the services related to the different aspects of the population problem including FP, RH, education, .. etc through regular field visits. During these visits, data could be collected on the service quality and coverage then reported to the central level to take necessary actions to raise the quality and coverage of the services.

- **Raise society awareness about population and development issues**

NGOs can work on organizing advocacy campaigns in their local community to change the negative values of the community regarding the different aspects of the population problems. This needs a prior step to train the NGOs management teams and volunteers on the current values and how to change them to create a general acceptance for the new positive values.

Chapter 8

Challenges and recommendations

8-1- Introduction:

The report presented in the previous chapters the population status in Egypt and discussed the issues related to development and improving the quality of Egyptians' lives. This chapter presents the most important challenges building on what have been discussed in the report ends with a map to the way forward.

8-2- Challenges:

Few would dispute the fact that in the last two decades, not much progress was made toward the goals of the population policy. Whether we look at the rate of population increase, the quality of the population characteristics, the demographic distribution of the population, or the imbalance among population groups and geographical areas, the shortcomings are clear. Even when ambitious goals were gradually abandoned in favor of more modest goals, the latter also remained unmet.

8-2-1-Population growth:

Egypt population witnessed dramatic increases during the last decade. The total fertility rate (TFR) reached 3.5 live births per woman in 2014 compared to 3 live births per woman in 2014. This led live births to increase from 1.85 million in 2006 to reach 2.7 million live births in 2014, an increase of 40%.

This increase puts great pressure on services and natural resources including water and land. The fact that around half of Egyptians don't know that the available water resources are not enough to secure Egyptians' needs and 2 out of every 5 are not aware that the agricultural production is not enough to cover Egyptians' consumption worsen the situation.

The IOM and ESCWA report on international migration released in 2015 estimates the number of Egyptian migrants by 3.47 million. Migration is selective. The hosting countries usually host migrants in the working age groups and those who have distinguished skills. Thus, migration effect negatively the characteristics of the population and its ability to innovate and produce. On the other hand, more than 2.3 million Syrians and Libyans has come to Egypt during the period from 2011 to 2014. Most of those migrants don't register themselves as refugees. This huge number of migrants caused many challenges to Egypt; including the need for more services and goods has increased to cover the needs of the migrants, high competition to Egyptians in labour market. Migrants increased also the demand on housing units and the pressure on the infrastructure in Egypt.

8-2-2- Population characteristics:

Egypt is a youth country with a quarter of the population ages between 12 and 22 and another quarter ages between 23 and 39. The population window of opportunity was expected to occur in Egypt as a result of the decreasing fertility until 2008. However, the TFR observed lately in the EDHS 2014 decreases the probability that the population window of opportunity would occur soon in Egypt.

The EDHS-2014 shows that almost 1 in every 5 people (6 years and above) has not attend any type of education. Females are more vulnerable for illiteracy as almost 25% of Egyptian females (6 years and above) have no education compared to 14% among the males. Women who are less educated and less empowered are more likely to bear more children and less likely to be using contraception.

The unemployment rate increased from 9% in 2010 to 13% in 2014. This rate was 9.6% among males compared to 24% among females in 2014. Data on women participation in labour force shows low participation of women in the Egyptian labor market over time and across the different economic sectors. Working women use family planning methods than other women (67 percent and 57 percent, respectively) and intervals between their births are longer which decreases their TFR.

8-2-3- Sexual and reproductive health:

- Despite that Egypt is exerting numerous efforts to halt the HIV epidemic and control STIs, these infections constitute a threat to the population. The information presented in this Chapter shows that the burden of HIV in Egypt is on rise. The country has stepped towards a concentrated epidemic in MIDUs and MSM. In the early stages of the HIV epidemic, most PLHIV were MARPs, but now transmission routes are varied. Transmission through injecting drugs and MSM activity accounted for around half of the cases but heterosexual transmission represent a significant proportion of infections accounting for the remaining half. In addition women and children became part of the HIV epidemic.
- Furthermore, STIs incidence cannot be neglected. A variety of STIs caused by a number pathogens affect both men and women in the country. STIs go beyond being a health threat to being a catalyst for the spread of the HIV infection in the country.
- Adolescents and youth have emerged as a priority vulnerable group for HIV and other STIs. The experiences early in life influence the health status and quality of life of young people. Adolescents and youth, particularly the unmarried young people remain highly neglected in terms of access to promotion and prevention health services in general and sexual and reproductive health services in particular. Moreover, the lack of a life-cycle approach from early childhood to post-reproductive stage of life is evident. By saying this, it is evident that there is a need for health services to copy with the many adolescents and youth health needs. Health promotion early in life and building awareness on the biological changes that occur to girls and boys during puberty are corner in the health care but are missed in the country's healthcare services.
- Culture norms and gender roles affect people's vulnerability to HIV and STIs. The stigma and discrimination is a shared experience for MARPS, PLHIV and people harboring STIs. Conflict in the region, makes Egypt experience massive forced displacements from surrounding countries which strains the capacity of the health system to respond and creates numerous vulnerabilities for HIV and STIs. Furthermore, a major issue that appeared is the disparities in HIV and STIs status and knowledge including the lived experience in poverty, illiteracy, unemployment and rural residence. These different experiences in the life paths

expose the population to numerous vulnerabilities. They highlight the need for directing programs to identify people's needs and ensuring that no one is left out. There is a need for strengthening the intersectoral approach and social participation engaging the various stakeholders in the control of HIV and STIs through not only health policies but relevant policies for health.

- Egypt response to HIV/AIDS involves a wide array of policies, strategies and regulations with several organizations and communities significantly engaged. There is an HIV strategy in place, in addition networks and organizations are becoming more dynamic. However, such efforts are still not enough to halt the epidemic. Furthermore, STIs remain a neglected area with no clear strategy in place and no comprehensive national response. This emerges the need for strengthening the national health system efforts for halting the HIV epidemic and STIs.

8-2-4- Morbidity and mortality in Egypt:

- While life expectancy at birth in Egypt increased by 4 years over the period 1990 to 2013, women and men in Egypt lose 11 and 9 years, respectively, of their lives for disability and premature death
- Evidence from both analysis of cause of death and the Global Burden of Disease project indicates that these lost life years were attributed to a combination of communicable and non-communicable diseases.
- Hypertension and Diabetes were the most prevalent chronic diseases in Egypt. Disparities in their prevalence were strongly related to vulnerable social categories among women, but not among men.
- Risk factors of both Hypertension and Diabetes showed different direction by social groups. While overweight and obesity were more prevalent among the privileged social groups, smoking was more prevalent among vulnerable groups
- Egypt had the highest prevalence of Hepatitis C infection and experienced significant increases in mortality levels because of liver diseases.
- Disparities in the prevalence of HCV indicates that vulnerable social groups are commonly overburdened with this infection

- All evidence refers to iatrogenic transmission in formal and informal health care. Vertical transmission was largely responsible for infection among children <5 years
- Enduring efforts on behalf of the Egyptian government, non-governmental organizations and World Health Organization in tackling HCV, securing effective medication and manufacturing these medication locally paid off in significant success the battle against HCV and the prevalence declines from 14.7% in 2008 to 7% in 2014.
- Comorbidity accounts for less than 5% in the population. However vulnerable groups are more likely to suffer more compared to other social groups.
- Data on health issues are significantly limited and outdated. Most of this profile is based the EDHS2008, almost 8 years old. Unfortunately, other sources of data are too small in size or unrepresentative of the population. There is a significant need for data to monitor and assess the real situation of the population health. Health surveillance has already become a part of the MOHP activities and has many potentials in securing health information. It is essential that becomes fully activated and offering its data for researchers to highlight areas for policy interventions and assess their real on the ground impact
- Inequalities as the available data prove is hard hitting the vulnerable population. While improving the average health is of substantial importance, it is more important to monitor these inequalities. The increasing gap between the vulnerable and the privileged population calls for policy intervention to address the pitfalls through which these vulnerable social categories fall in heavy burden of diseases and special tailored program for these social groups should be set in place whether through universal health coverage or targeted health promotion.

8-2-5- Inequalities and vulnerable groups:

8-2-5-1- Poor Households

During this period the number of poor people was almost doubled from around 11 million to around 22 million. More than 80 percent of the poorest 20% villages are located in rural Upper Egypt. Around 778 villages of the poorest 1000 villages are located in Upper Egypt.

The poor household size is around two members more than the non-poor. The higher household size will lead to high dependency ratio which in turn can contribute to the intergenerational transmission of poverty by limiting children's human development and socialisation and their subsequent earnings. The costs of education, health care and food may be enough to ensure persistent severe poverty in high dependency ratio households. Children are less likely to be well fed and to complete secondary school.

Poor children are more likely to be under weight and stunted relative to non-poor. the prevalence of anemia was higher among women, youth and children of poor households compared to non-poor households.

The education differentials is very clear among poor and non-poor individuals. 57% of poor population have not been to school or did not complete primary stage compared to 45% of non-poor. Only 5% of poor compared to 14% of non-poor people completed higher education.

8-2-5-2- Slum areas:

Slum areas face a set of problems include the lack of services especially education and health services, the poor quality of the available services and lack of safety due to the unsafe buildings that threaten the lives of the people who live in it and due to the absence of police and security.

The most stated problem is the narrow residences which are, mostly, rooms with shared toilets. Meanwhile, Respondents agreed that it is, almost, impossible for them to obtain one of the flats offered by the government. Another problem is the contraventions in the roads; a thing that hinder people from walking around easily in the streets.

8-2-5-3- Street Children

Street children usually come from poor families. They often construct a community of their own with certain systems, rules, incentives and even languages with a leader among them; someone to plan, regulate and control. Physical; from headache to

cancer, and psychological illness are the most common among street children. The common illness street children are dental diseases, followed by scabies and skin diseases.

Street children were found to be vulnerable to HIV infection as 0.5% of street boys between 12-18 years were HIV positive. They lack economic security and protection under law, in addition they do not enjoy access to education and many of them practice several income generating activities. They are at great risk of contracting and spreading HIV as they inject drugs and are forced either by fear or poverty to practice several risk behaviors as unsafe sex and MSM activity.

8-2-5-4- Fishermen

Fishermen in Egypt face many problems, especially the policies of draining lakes that for instance led to the decrease the area of lakes. Large areas of these lakes are also being rented by big businessmen who prevent fishermen from fishing in these areas.

8-2-6-Gender inequalities

- Available data indicates that Egypt is still facing difficulties in achieving the millennium developmental goals (MDGs) with regard to the promotion of gender equality and the empowerment of women. This is particularly the case when it comes to education and participation in paid employment, as well as political participation.
- The 2015 Gender Gap Report shows a severe gap in literacy rates between males and females, estimated at 65% versus 82% for males. Data shows that the non-enrollment percentage for the 6-18 age group is 7% among females, compared to 5% among males. The percentage of non-enrolled females decreases gradually with the increase in economic level. Females who have access to education are more serious and diligent with respect to completing their education than males. However, the percentage of female dropouts is on the rise over the years, and increases from one stage of education to the next, due to social and cultural constraints.

- Female enrollment rate in higher education reaches 31% compared to 35% for male enrollment. Most of the 23 government-run universities are located in Greater Cairo and Delta and their capacity falls short of the national demand for higher education. In Upper Egypt, families refuse to allow their girls to travel for long distances or live in other cities for the sake of education. So female students have difficulties leaving their home to pursue higher education in far-off governorates. Also, the opportunity cost for particular specializations in higher education (joining private universities) is prohibitive for low-income families. Data shows a clear imbalance in the distribution of students by age and specializations in college.
- Available data on the gender gap in wages indicate that the proportion of women working for cash wages is 39% compared with 57% for men. Over one-fourth of women perform jobs for the family without wage, compared to 5% of men. In Egypt, women make generally 30% of what men make. The gender-based discrepancies in wages are not mainly due to differences in education or absenteeism or performance of women, but to the number of working hours.
- According to one study, there is a gender gap that allows men working in private sector to have 10% better terms than women in job contracts and health insurance. The gender gap in social insurance is also more favorable to men than women by about 3.5%. Conversely, women who work for the public sector and the government have a better opportunity for social protection.

8-2-7- Empowering women

Available data reveals that most married women who have an income do make decisions related to the manner of spending their income and three-quarters of women participate in making decisions about their husbands' income. More than 80% of married women make decisions related to their health care. Women participate less when it comes to the basic purchases of the family as about two-thirds of women said that they make these decisions, most of them in consultation with the husband.

8-2-8- Violence against women:

- Available data suggest that 92% of previously married women aged 15-49 are circumcised. Of every five women under 19, one has been circumcised. There are several misconceptions among many women about circumcision; 62% of women consider it a religious duty, 50% believe that men approve of circumcision and wish to marry circumcised women, 46.3% believe that circumcision is a bulwark against adultery.
- Three in every four women reported that their husbands place social limitations on their wives' freedom, including jealousy and expressions of extreme anger when their wives speak to another man.
- About 25% of ever-married women were subjected to physical violence at least once by their husbands. The most common incidents involve slapping across the face (22%), forceful pushing (17%), and arm twisting (12%). Sexual violence against women is less common than physical violence, reported by only 4% of ever-married women.

8-2-9-Child marriage:

Despite laws against it, the practice remains widespread, in part because of persistent poverty and low education attainment. Around 6% of females aged (15-17) are ever-married. This percentage reaches 27% among females aged (18-19).

8-2-10-Youth political participation:

Egypt constitution of 2014 contained a significant number of articles that encourage political participation of Egyptians including Articles 73 and 74. However, youth political participation is low. This was observed in the presidential elections 2014 and the parliamentary elections. Youth participation in informal political participation forms is low too.

8-3- The way forward:

In addition to the institutional aspects discussed in chapter 8, the following should be taken into consideration:

- 1- The national strategy for population and development 2015-2030 was developed by a team of experts working under the supervision of the National Population Council (NPC) the strategy was launched in November 2014 under the auspicious of the prime minister.

The national strategy for population and development aspires to:

- Enhance the quality of life of all Egyptians through reducing the rates of population growth and restoring the balance between the rates of economic and population growth.
- Restore Egypt's regional leadership through improving the population characteristics in terms of knowledge, skills, and behavior.
- Redraw the population map in Egypt through a spatial redistribution of the population that promotes Egyptian national security and accommodate the needs of planned national projects.
- Promote social justice and peace through reducing the disparities that exist in development indicators among various areas.

The starting point is to bring down the birthrate. Thus, a successful population strategy needs to increase demand on reproductive health and family planning services and also to improve and stabilize the quality of these services. One of the opportunities that Egypt should not miss is that the unmet need reaches 12.6% and around 16% of births in the five-year preceding the 2014 EDHS, were not wanted and half of them were not wanted at all. This clearly call for immediate interventions to assist families to achieve their desires. This requires to train public health services providers on good service delivery and provide public health facilities with the needed equipment and medication

- 2- Egypt can harness its demographic dividend through investments that would improve health, education, economic policy, and governance—and ultimately slow population growth. These efforts are needed to break the vicious cycle of poverty, low education, early childbearing, and high fertility that has trapped a

large segment of the Egyptian society. International experiences have shown that the most effective investments are those that focus on improving the health and wellbeing of girls and women, including their sexual and reproductive health³.

Demographic dividend can be addressed within the context of the sustainable development goals. The triple E's, namely, Educate, Empower and Employ can serve as a framework for not missing the demographic dividend⁴:

- Educate (SDG4): A demographic dividend depends on people generating and capitalizing on new opportunities and new information-based economies. Fulfilment of SDG4 is essential to ensuring lifelong access to universal and high quality education.
- Empower (SDG3 and SDG5): All people need access to essential health care services, and women and girls must be assured the rights and freedom to decide when and whom to marry, and when to start a family. Ensuring that all young women have the freedom to define their lives also demands that they are protected from harmful practices such as FGM and child marriage, and all forms of violence.
- Employ (SDG8): A demographic dividend can only be realized if education and skills are deployed in productive activity, enabling all persons to contribute to the economy through decent work.

On the national level, the sustainable development strategy for year 2030, is the road map adopted by the Government of Egypt. The strategy which was developed in a participatory way is fully synchronized with the SDG's. In addition, sectoral strategies for population, and for early marriage have been launched in 2014 and 2015 to guide the way for a demographic dividend⁵. Such strong framework need to be complemented with political will on all levels and with monitoring and evaluation mechanism coupled with accountability on the central and local level.

3- Success in family planning can only be achieved through the provision of adequate and sustainable funding needed to provide contraceptives, to train the healthcare team providing the family planning and reproductive health service,

³ Yousef, H., Osman, M. & Roudi, N. (2014) Responding to rapid population growth in Egypt, Population Reference Bureau.

⁴ UNFPA (2016) Monitoring progress towards a demographic dividend.

⁵ A strategy for women empowerment is expected to be launched in 2017.

and to launch awareness campaigns aiming to keep the rates of population growth in check and inform the public about the availability of contraceptives.

- 4- Egypt has a large number of NGOs and political parties that have a huge number of volunteers and members. Many private sector firms allocate a significant percentage of their income to social corporate responsibilities (SCR). Coordination between government organizations, NGOs, political parties and private sector to provide RH services and awareness campaigns will accelerate the pace of achieving the goals of the national population and development strategies.
- 5- The Government of Egypt has embarked on a major restructuring of the health sector. The ultimate goal of health sector reform initiatives is to improve the health status of the population. These initiatives resulted in a decline in mortality levels. The trend in neonatal, infant and under-five mortality is going down due to improvements in health services and vaccinations. However, recent surveys show that health services, both governmental and private, need to be improved to match the expectations of Egyptians.
- 6- Political discourse in Egypt always reflects the Egyptian Government's clear commitment to the improvement of the status of Women and their empowerment on all social, economic, cultural and political levels. For more than half a century, the situation of Egyptian Women has witnessed great changes, in conjunction with relative improvement in opportunities for Women's education, employment, participation in public affairs, and appointment to senior posts. However, Women continue to endure multiple forms of social, cultural, economic and political exclusion caused mainly by two important factors: First, the failure of public and social policies for more than half a century to bridge a gender gap which is ever-expanding on several levels. Second, the persistence and severity of social and cultural constraints facing any genuine efforts to provide women with liberty and equality. There is a great need to change the society values regarding women and to eradicate negative images and stereotypes of women that still endure to this day.
- 7- Some development projects for women, had a positive impact on the lives of targeted women in poor and conservative rural areas in Upper Egypt. Two projects that were particularly successful in empowering women, especially young women, socially and economically, are worth noting here. Repeating these projects and extending them may bring out unexpected success.

- 8- In 2003, Egypt embarked on the establishment of Youth Friendly Clinics (YFCs) within government affiliated Teaching Hospitals throughout Egypt. The objective of establishing the YFCs was the provision of comprehensive RH services, including information and counseling to young people in need, regardless of gender, economic status, religion, disability, or any other factor. By 2014, Egypt had 25 YFCs in 14 governorates run by either the health ministry or EFPRHA, serving both married and unmarried youth. Increasing the number of young people who benefit from the YFCs requires increasing the number of the YFCs and encouraging youths to visit it through a promotional campaign for the clinics in schools and universities and through different media.
- 9- Egypt has reduced its maternal mortality ratio from 120 per 100,000 births in 1990 to 45 in 2013, a 62.5% reduction. The decline in maternal mortality is likely associated with high rates of family planning use, antenatal care and skilled birth attendance. The coverage of maternal health services has expanded substantially. The percentage of medically assisted births tripled from 35 % in 1988 to 92 % in 2014. According to the 2014 EDHS, 90 % of mothers received antenatal care from a trained provider. However, the last 6 years witnessed a decrease in CPR which resulted in an increase in TFR and CBR. In spite of the achieved success, there is a need to reduce maternal mortality more through:
- Promoting community participation in the care of pregnant women. This require greater use of the media and community outreach (Raedat Rifiat).
 - Educating women and communities about the importance of antenatal care, delivery with skilled health personnel in health facilities and receiving postnatal care.
- 10- Egypt have succeeded in tackling most of the major communicable diseases. The only exception is the Hepatitis C Virus (HCV) infection and its complications. A study of the WHO pointed out that a high percentage of those who register on the NCCHV portal to get the treatment don't show up in the successive stages of the treatment which requires a new strategy to guarantee the commitment of the patients with the treatment course.
- 11- Since the detection of the first AIDS case, the Ministry of Health (MOH) established the National AIDS Program (NAP) for controlling the HIV epidemic

in the country. The NAP strategy has built on multi-sector national response to halt the HIV epidemic and STIs. It is evident that the available national statistics are far from depicting the HIV epidemic in the country. STIs are not believed to be high in Egypt and little information is available on their magnitude in the population. A key theme that emerged is the insufficiency or lack of information on HIV and STIs. Statistics are only gained through passive surveillance and the BioBSS data needs to be updated. There is very limited STIs information to portrait the burden of such infections in the country. Furthermore, HIV and STI research is very limited and there is rarely solid evidence to guide policies. Thus, there is a need for strengthening the HIV and STI information and conducting regular MARPs surveys, in addition to making use of the available DHS activities for monitoring HIV and STI status and knowledge in the country.

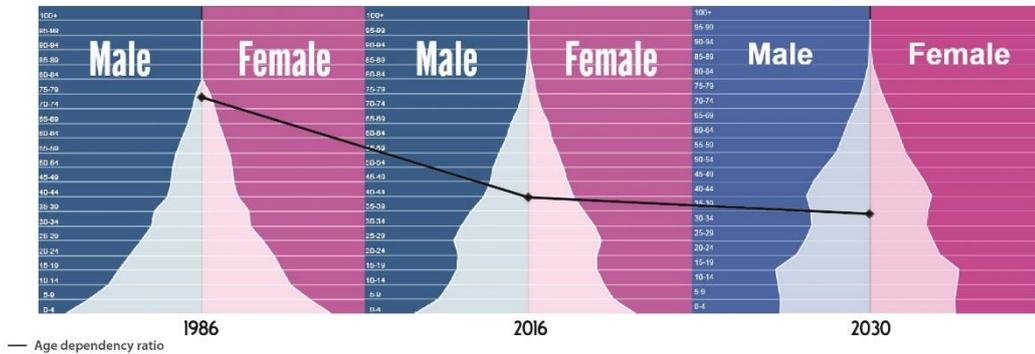
- 12- It is suggested to build an observatory for population related data and indicators. The observatory should be designed to Collect and harmonize the available data and indicators and assess and bridge the information gap. The national council for population (NPC) started building an information system to monitor the progress in a set of indicators on different administrative levels. However, the system depends on the available data which is limited if compared to the needed data to monitor the progress the different pillars of the population and development strategy.

Annex 1: Demographic Dividend

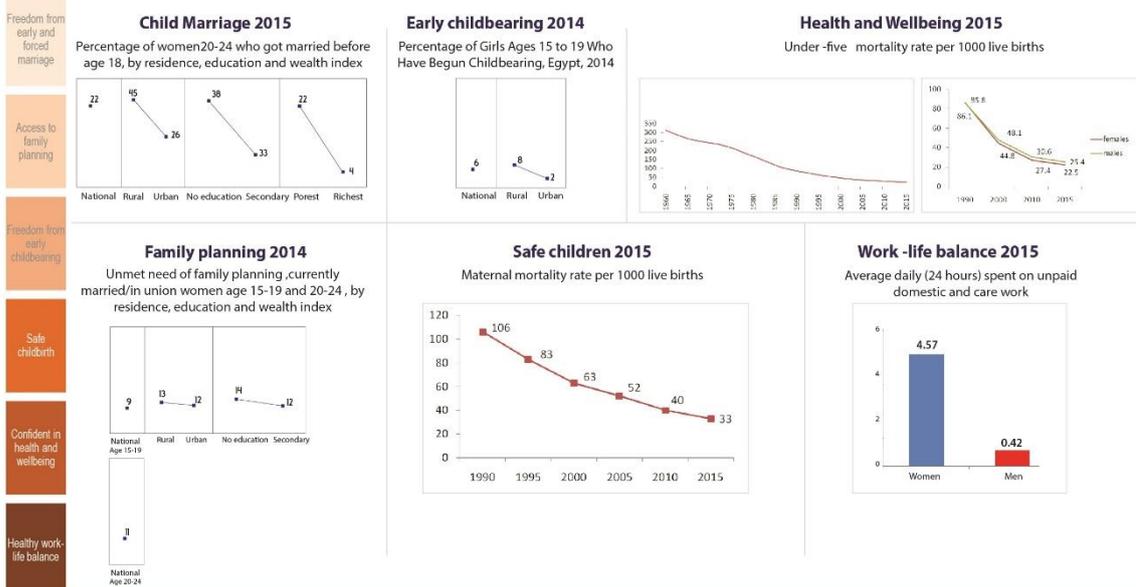
Egypt

Demographic Dividend Profile

Population



Empowerment

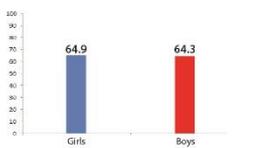


Education

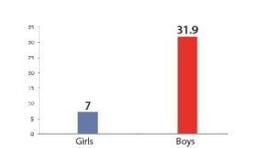
Employment

Economy

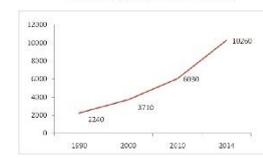
Secondary school enrolment, gross percent of secondary school-age children, 2014



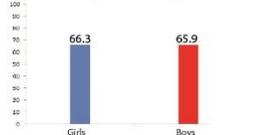
Employment to population ratio, ages 15-24, 2014



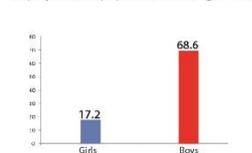
GNI per capita, PPP (US dollar)



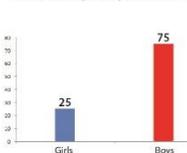
Percent of population age (25-29) completed secondary school or higher, 2014



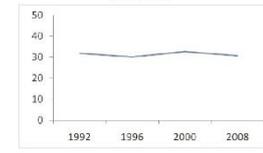
Employment to population ratio, ages +15



Labor force participation 2014



GINI Index



Empowerment Policy Situation Analysis

	Policy Outcome Indicator	Narrative
Freedom from early and forced marriage	Minimum legal age for marriage with parental consent - Girls: 18 Boys: 18	Law number 31 (bis) of the Child law No. 126 of 2008 states that: It is illegal to issue marriage contract for those who did not reach eighteen years old.
Access to family planning	Number of Clinics providing contraceptive methods in 2016: 5600	Article (41) of the Constitution of The Arab Republic of Egypt 2014: The State shall implement a population program aiming at striking a balance between population growth rates and available resources; and shall maximize investments in human resources and improve their characteristics in the framework of achieving sustainable development.
Freedom from early childbearing	PUBLIC expenditure ON EDUCATION; TOTAL (% OF GDP) IN EGYPT: 4%	Article (19) of the Constitution of The Arab Republic of Egypt 2014: The State shall allocate a percentage of government spending to education equivalent to at least 4% of the Gross National Product (GNP), which shall gradually increase to comply with international standards.
Safe childbirth	A doctor or trained nurse/midwife assisted at the delivery of 92 percent of all births in the five-year period before the 2014 with 87 percent occurring in a health facility	
Confident in health and wellbeing	a percentage of government spending to health equivalent to at least 3% of Gross National Product (GNP)	Article (18) of the Constitution of The Arab Republic of Egypt 2014: The State shall allocate a percentage of government spending to health equivalent to at least 3% of Gross National Product (GNP), which shall gradually increase to comply with international standards.
Healthy work-life balance	<ul style="list-style-type: none"> • promulgated and enforced laws against workplace discrimination against women –yes • facilitating compatibility between labour force participation and parental responsibilities- yes • promulgated and enforced laws that enable maternity leave- No • promulgated and forced laws that enable paternity leave -Yes 	

Education and Employment Policy Situation Analysis

Education	Employment
<p>Egypt vision 2030 included a pillar for education . It's objectives are :</p> <ul style="list-style-type: none"> • A high quality education and training system available to all, without discrimination within an efficient, just, sustainable and flexible institutional framework. • Providing the necessary skills to students and trainees to think creatively, and empower them technically and technologically. <p>Contributing to the development of a proud , creative , responsible, and competitive citizen who accepts diversity and differences, and is proud of his country's history.</p> <p>Targets :</p> <ul style="list-style-type: none"> • Illiteracy rate (15 -35 years old) reaches 7% (absolute zero) in 2030. • Egypt's rank in primary education quality index reaches 30 or less in 2030. 	<ul style="list-style-type: none"> • By 2030, the Egyptian economy is a balanced, knowledge-based, competitive, diversified, market economy, characterized by a stable macroeconomic environment, capable of achieving sustainable inclusive a growth. An active global player responding to international developments, maximizing value added, generating decent and productive jobs, and a real GDP per capita reaching high-middle income countries level. <p>Tragets:</p> <ul style="list-style-type: none"> • Unemployment rate reaches 5% in 2030. • Female labor force participation reaches 35% in 2030.

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