

Arab Republic of Egypt



Ministry of Planning

EGYPT

Achieving the Millennium Development Goals

Successes & Challenges

2005

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Preface

Although Egypt has realized significant progress on all development fronts, it continues to tackle the economic and social challenges that lie ahead. On the economic front, a new tax law and a large number of legal and administrative reforms allowed Egypt to improve its economic record, encouraging the World Bank to postulate that a 5-6 percent economic growth is feasible in the next few years. On the social front, social insurance policies are being revisited to ensure the financial efficiency of the system and increase its payoff and coverage. The Egyptian government is also striving to formulate an integrated policy to address the poverty issue, moving from financial assistance to an empowerment approach. In addition, major political reforms have already been initiated, ensuring open, free presidential and parliamentary elections as well as accountable, transparent systems of governance. Also, the recent past has witnessed the establishment of the National Council for Women and the National Council for Human Rights, which are two very powerful independent entities that have already scored high in performance.

The government of Egypt has adopted several human development-oriented programs (SHROUK, MISR, and Urgent Plan) to promote rural development. The main objectives of these programs are to improve human development in a sustainable and participatory manner and to stimulate the move towards decentralized good local governance. A glance at recent performance of human development aspects in Egypt indicates that Egypt is on the right track towards achieving the MDGs. Poverty reduction, which represented the first MDG goal, was declared as one of the principal objectives of the long-term plan in Egypt. Extreme poverty, defined by the proportion of people with income below one dollar a day, is very low in Egypt, standing at less than one percent.

Achieving universal primary education represents a backbone for the development in Egypt. The Egyptian government is strongly committed to improve the quality of education and ensure easy access for all citizens. During the 1990s, the government raised the slogan 'Education for All' and undertook proactive measures to effectuate its implementation in order to strike a balance between quantity and quality of education. The current plan has identified 'Excellence for All' as an additional goal. Through a series of interventions, the decade of the 1990's witnessed major progress in expanding access to schooling in Egypt, with a steady increase in enrollment rates in primary education. In addition, dropout rates declined, especially among girls. Current trends indicate that Egypt will be able to achieve universal primary education by 2015. Moreover, fighting adult illiteracy, ensuring equity, and upgrading quality of education are priority areas for Egypt's current and future efforts.

It is worth noting that Egypt was among the first countries to respond to the UN Secretary General's Education Initiative and declare commitment to the Dakar Declaration on Education for All. This was manifested in the Egyptian Girls' Education Initiative, which places girls' education on top of the government priorities and aims at eliminating gender disparities by the year 2007. The female share in the Egyptian labor force, though still relatively low, has shown a steady increase. In particular, labor force participation of educated and married women has increased, merely underscoring strong government commitment to help women to combine work with household responsibilities.

Egypt is also working on many fronts to improve child health. Efforts in this regard include an efficient program of immunization. In addition, several donor-funded projects have been institutionalized and have become full-fledged programs with the Ministry of Health and Population (MOHP), thus ensuring sustainability. Egypt is clearly on a track to achieve the target set for under-five mortality, and even surpassing it, by year 2015. It has succeeded in significantly reducing its maternal mortality ratio and it is, thus, expected that by year 2015 the realized ratio will surpass the target set by the MDGs.

The Egyptian government is aware of environmental problems and is taking serious steps towards alleviating their negative impact. Underway is a policy to increase the efficiency of water utilization and improve water quality, since access to piped-water supply is highly prevalent in both urban and rural areas. Egypt has invested heavily in the water sector through major irrigation projects and drinking water and sanitation infrastructure. There is also a number of projects aiming towards the improvement of air quality and solid waste management. In short, this report concludes that Egypt is on the right track towards achieving the MDGs. Despite the challenges that hinder achieving some of the MDGs, the government is still eager to pursue reforms that would overcome these challenges, especially with the new direction towards decentralization and good governance. The government as well as scholars in the development community believe that the MDGs are quite attainable and that Egypt is likely to fully achieve most of these goals before the target year of 2015.

Minister of Planning
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FOREWORD

In the year 2000, Egypt joined 190 countries in signing the United Nations Millennium Declaration, culminating decade-long discussions and deliberations in major United Nations conferences and summits. In this document we review and update progress made by Egypt in achieving the Millennium Development Goals (MDGs), and efforts to revisit and fine tune the measurement of indicators. We also expand the scope of the discussion to address the context of work and major challenges encountered. To achieve all of the above, the document relies on a number of key reports, including the two country reports published by the United Nations and the Government of Egypt on Egypt's progress towards the MDGs, which provide the main framework.

This document synthesizes the outcome of three key national endeavors in Egypt. The first advocacy effort was undertaken by the National Council for Women (NCW)¹ For further details, review the NCW publications, particularly the proceedings of its fourth conference (NCW, 2004). See, also, website: <http://www.ncwegypt.com> to integrate the MDGs in public discourse and development programs, and adopt a gender-sensitive approach in assessing the MDGs. To achieve this goal, the NCW organized in March 2004 a national conference on "Egyptian Women and the MDGs" which was recognized and appreciated by the United Nations Secretariat. Egypt's international commitments in the area of women empowerment have also been reviewed. Further details are included in a number of publications available at NCW. Also consult website at <http://www.ncwegypt.com>. In addition, a gender-sensitive national monitoring plan has been developed, with clear benchmarks and a timeframe that are consistent with MDGs and all other international commitments.² The effort culminated in an international conference, inaugurated by the President of Egypt, Cairo, 2003. The third effort was the second United Nations Common Country Assessment (CCA)³ The first Common Country Assessment for Egypt (Second Country Report) was published in 2001. undertaken by the United Nations Country Team (UNCT) in consultation with the Government of Egypt (GOE) and UN system partners in the donor community, research institutions and non-governmental organizations (NGOs). The CCA attempted to provide a comprehensive analysis of the national development situation from the perspective of the UN system in the country.

In order to ensure that the overarching framework is regularly updated, the Ministry of Planning (MOP) in Egypt leads the process of critical assessment of the development indicators currently in use. Technical experts in three leading organizations in Egypt are major actors in this effort, including: the Social Research Center (SRC) of the American University in Cairo, the Information and Decision Support Center (IDSC) and the Institute of National Planning (INP).

Among partner institutions are different ministries, the National Council for Women (NCW) and the General Authority of Literacy and Adult Education (GALAE). The objectives of these activities are threefold: assess the accuracy of the main indicators reported in the 2004 Egypt Human Development Report; propose plausible indicators and recommend monitoring tools; and build consensus on refined indicators and formulate an action plan for the future.

¹ For further details, review the NCW publications, particularly the proceedings of its fourth conference (NCW, 2004). See, also, website: <http://www.ncwegypt.com>

² Further details are included in a number of publications available at NCW. Also consult website at <http://www.ncwegypt.com>

³ The first Common Country Assessment for Egypt (Second Country Report) was published in 2001.

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⁴ Large sections in these reports (particularly, the second MDG country report) have been copied verbatim in the present document

A HAWK EYE VIEW ON EGYPT'S MDGs PERFORMANCE-2005

Egypt is on the right track towards achieving the MDGs. In the following chapters, we depict the progress made by the government of Egypt in this regard, the challenges it has faced, conducive policies that provide a supportive environment, and future strategies for change. Egypt's recent development plan rests on four main cornerstones:

- 1) Economic reform that recognizes the importance of market forces, entrepreneurships and foreign investment.
- 2) A revisit to social policies to ensure that economic growth is translated into social gains and pro-poor policies and strategies.
- 3) Political reforms based on the notion that economic and social progress is embedded in democratic governance, the rule of law and respect of civil liberties.
- 4) A human rights- based approach to development allowing for full citizenship of women and gender- sensitive development.

Egypt has made a number of strides on the above fronts and continues to tackle the many challenges that lie ahead. For example, on the economic front, a new tax law and a large number of legal and administrative reforms allowed Egypt to improve its economic record, encouraging the World Bank to postulate that a 5-6 percent economic growth is feasible in the next few years. However, the challenge of coping with high unemployment resulting from a continuously high population growth rate and relatively weak market absorptive capacity, remains very much on Egypt's agenda.

On the social front, social insurance policies are being revisited to ensure the financial efficiency of the system and increase its payoff and coverage. The Egyptian government is also striving to formulate an integrated policy to address the poor, moving from monetary assistance to an empowerment approach.

However, the transition from a large number of segregated programs to a unified multidisciplinary approach is difficult to design, implement and remains a challenge. Major political reforms are also underway, ensuring open, free presidential and parliamentary elections as well as accountable, transparent systems of governance. Also, the recent past has witnessed the establishment of the NCW and the National Council for Human Rights, two very powerful independent entities that have already scored high in performance.

EMPOWERING THE POOR THROUGH A NEW SOCIAL CONTRACT AND EMPLOYMENT CREATION

Poverty reduction, which represented the first MDG goal (eradicate extreme poverty and hunger), was declared as one of the main objectives of the long-term plan in Egypt. Extreme poverty, defined by the proportion of

people with income below one dollar a day, is very low in Egypt, standing at less than one percent. Using the national poverty line, overall poverty in Egypt stands at 20 percent. However, poverty in Egypt is shallow, meaning that most of the income of the poor falls just below poverty line.

Poverty projections show that Egypt could achieve the first MDG with minor increases in average per capita expenditure and minor declines in income inequality. In order to accomplish that, a number of multi-dimensional strategies are to be implemented to raise standards of living. These include income generation initiatives and investment in human capital, in addition to a number of safety net strategies. The social policy reform agenda is on top of the Egyptian government's list of priorities.

INVESTING IN HUMAN CAPITAL

Achieving universal primary education (MDGs goal 2) represents a backbone for the development in Egypt. The Egyptian government is strongly committed to improve access, equity and quality of education. During the 1990s, it raised the slogan 'Education for All' and undertook proactive measures to ensure its implementation. Thus, the share of education in governmental budget allocation witnessed unprecedented increases, raising consequently the number of schools, classrooms and enhancing higher enrollment rates. In addition to expanding available education facilities, the government initiated a program of non-traditional community and one-classroom schools targeting children in deprived areas, especially girls. Finally, in order to strike a balance between quantity and quality, the current plan has identified 'Excellence for All' as an additional goal.

Through a series of interventions, the decade of the 1990's witnessed major progress in expanding access to schooling in Egypt, with a steady increase in enrollment rates in primary education. In addition, dropout rate declined, especially among girls. Current trends indicate that Egypt will be able to achieve universal primary education by 2015. Moreover, fighting adult illiteracy, ensuring equity, and upgrading quality of education are priority areas for Egypt's current and future efforts.

EGYPT'S EFFORTS ON THE ROAD TO EMPOWERING WOMEN ECONOMICALLY AND POLITICALLY

MDGs goal 3 works on tracking country efforts towards promoting gender equality and women empowerment. So far, Egyptian women achieved significant gains during the last years, mainly due to the support of the government of Egypt and the perseverant efforts of the NCW under the leadership of Egypt's first lady

Mrs. Suzanne Mubarak. The appointment of a female judge for the first time in Egypt, granting nationality to children of Egyptian women, as well as some reforms to personal status law, are among the major recent achievements.

Egypt was among the first countries to respond to the UN Secretary General's Education Initiative and declare commitment to the Dakar Declaration on Education for All. This was manifested in the Egyptian Girls' Education Initiative, which places girls' education on top of the government priorities and aims at eliminating gender disparities by the year 2007. As a result of these measures, the ratio of females to males in primary education has shown a steady increase during the last fifteen years, and gender disparity in secondary education has been eliminated. In tertiary education, the gender gap has declined, especially in arts and social sciences. Female literacy, though still lower than male literacy, has improved significantly.

Female share in the Egyptian labor force, though still relatively low, has shown a steady increase. In particular, labor force participation of educated and married women has increased, a sign that the government has respected its commitment to help working women reconcile their roles as wives and mothers.

On the political front, women's representation in parliament has witnessed a slight increase during the last two years, although it is still lagging behind targeted levels. There is a number of programs, by governmental and non-governmental bodies, to encourage women's public involvement, through training and capacity building, that aim at enhancing women's opportunities as political candidates. The government demonstrates strong commitment to promoting the political participation of Egyptian women and considers it an indispensable part of the political reform currently underway in Egypt.

The main challenge facing the achievement of this goal is the prevalence of conservative ideologies that use biased cultural and religious interpretations to perpetuate gender stratification. Significant improvements in women's empowerment are achievable only through societal endorsement of human rights and gender equity as basic elements of Islam and the Egyptian culture. Ideational changes need to take place first before any real improvements in the situation of the Egyptian women can be achieved.

CAN THE CHILD MORTALITY CHALLENGE BE ACHIEVED FOR EGYPT?

The fourth MDGs goal relates to the reduction of child mortality. In this regard and as a matter of fact, infant and child mortality rates have been greatly reduced in Egypt. In particular, the rates of decline in disadvantaged regions

have accelerated and surpassed the rate of decline in some of the more developed regions. Egypt is clearly on track to achieve the target set for under-five mortality, and even surpassing it, by year 2015.

And yet, despite the closure of gaps and reduction in disparities, the Egyptian government recognizes that both the level of mortality and its variations across social and regional groups call for more concerted action. Health sector reforms, with the objective of further developing Egypt's health system, are one major component in the recent efforts. Other activities address social determinants, particularly poverty reduction and education attainment.

The Egyptian government's remarkable concern with maternal and reproductive health is expected to reduce neonatal mortality rates, which have risen in relative share to under-five mortality.

Egypt is working on many fronts to improve the health of its children. Efforts in this regard include an efficient program of immunization. In addition, several donor-funded projects have been institutionalized and have become full-fledged programs with the Ministry of Health and Population (MOHP), thus ensuring sustainability. Examples include: the National Diarrhea Control Program, the Child Survival Program, and the Integrated Management of Childhood Illness (IMCI).

The introduction of the child insurance scheme and the inclusion of childhood illness in the basic benefits package of the health sector reform pilot project, presents a more comprehensive approach for health care provision and enhances children's access to health care in the different stages of their development. The Family Physician system is expected to play a positive role in improving access to quality care for the family.

HOW FAR HAS EGYPT FARED WITH RESPECT TO MATERNAL HYGIENE?

The fifth MDGs goal relates to the improvement of maternal health. Over the last decade, Egypt succeeded in significantly reducing its maternal mortality ratio. It is expected that reduction in the level of maternal mortality in 2015 will surpass the target set by the MDGs.

Improvement in maternal mortality is the outcome of major efforts directed towards reducing risks of maternal deaths and promoting safe motherhood, through increasing antenatal and postnatal care utilization, securing efficient and proper deliveries, and decreasing risks of unwanted pregnancies.

The reduction of population growth is a priority policy issue for the government of Egypt as it impacts all developmental efforts in the social and economic fields. Egypt recognizes that

reducing total fertility and increasing use of contraceptives to space births, would have a positive effect on maternal health and would contribute to the reduction of maternal mortality. They also reflect the quality of reproductive health services in the primary care setting.

Furthermore, the government seeks to fully integrate reproductive health services in the primary health care package, and implement cost recovery measures without jeopardizing the access of vulnerable groups to health care. The government of Egypt and NGOs work together to push forward the agenda for reproductive health, family planning and reproductive rights.

A LAUNCHED ATTACK ON MALADIES

MDGs goal six is devoted to combating HIV/AIDS, malaria and other major diseases. Although Egypt is one of the low prevalence countries for HIV/AIDS, serious preventive efforts have been in place for two decades. Blood surveillance systems, mass-media campaigns, and an effective hotline are the main channels for preventing the spread of HIV/AIDS in Egypt.

Malaria is not endemic in Egypt. However, because of its proximity to regions with high malaria prevalence, Egypt is constantly on alert to the risk of malaria. Although no malaria cases have been reported since 1998, the MOHP, in collaboration with Ministry of Agriculture and Land Reclamation (MOALR), and Ministry of Irrigation and Water Resources (MOIWR), are monitoring for malaria-carrying mosquitoes in villages and squatter areas and along the southern borders with Sudan. Regular blood surveillance campaigns are also underway. Tuberculosis used to be a major public health issue in Egypt. Long-term efforts by governmental and non-governmental organizations have resulted in a declining trend in the incidence rate of tuberculosis, as well as in its case fatality rate. DOTS (Directly Observed Treatment Short Course) strategy is incorporated within primary health care units. Complications are referred to specialized hospitals, and all services are free of charge. Preventive efforts also benefit from environmental upgrading.

Schistosomiasis has long been a serious epidemic disease in Egypt. As a result of a large number of successful preventive and curative measures, the incidence rate has largely declined and new cases appear to be concentrated in few scattered foci. Curative efforts use school-based and community-based campaigns, while preventive measures include mass-media campaigns and an ongoing upgrade of water and sanitation networks.

A SAFE AND SUSTAINABLE ECOSYSTEM FOR EGYPTIANS

With respect to ensuring environmental sustainability (MDGs goal seven), Egypt is considered to be endowed with a rich natural heritage, which the government seeks to preserve for the benefit of current and future generations. At present, there are 24 protectorates covering around ten percent of the country's total territory. Local communities are integrated in the management of these protected areas.

The Ministry of State for Environmental Affairs (MOSEA) seeks to integrate the environmental dimension in all national policies and programs, through monitoring the application of the National Environmental Action Plan 2002/2017. The plan's ultimate goal is to attain development that is economically, politically, and environmentally sustainable. Included is a direction towards preserving the national resource base and biodiversity in addition to reducing current pollution levels.

EGYPT AS MEMBER OF 'CLUB GLOBE'

Developing a global partnership for development is the ethos of MDGs goal eight. In this regard, Egypt is benefiting from relatively generous development assistance from a number of rich countries and international organizations, which have been allocated to a large number of sectors and used to fulfill diverse needs. Although the amount of assistance has declined during the previous years, its types and sectoral allocation have become more balanced to conform with national priorities. Egypt has also benefited from a number of bilateral and multilateral trade agreements. The share of exports to Gross Domestic Product (GDP) has been increasing, while the deficit in trade balance and the value of debt has been declining.

The government of Egypt is investing heavily in information and communication technology. This, in turn, has resulted in large increases in the number of land line and mobile phone subscriptions. There has also been an increase in the number of personal computers and internet users. This trend is expected to accelerate in the near future.

Development efforts in Egypt could benefit from improved international systems of assistance. The high and increasing cost of debt service is curbing Egypt's economic prospects. More efficient official development assistance (ODA), debt relief, and non-discriminatory trade systems are among the measures that can help Egypt fight poverty and reach its export potential. Assistance in areas of youth employment, access to affordable essential drugs, access to markets, and debt relief are particularly needed.

Millennium Development Goals Tracking Indicators

– Summary Table

Indicator	Level in 1990	Level in 2004	Target for 2015	Potential for achieving target
GOAL 1. ERADICATE EXTREME POVERTY AND HUNGER				
1. Percentage of population below \$1 per day	8.2	0.94	4.1	Met
1a. Percentage of population under national poverty line	24.3	20.2	12.1	Probable
2. Poverty gap (using national poverty line)	7.1	3.9	3.6	Met
3. Share of poorest quintile in national consumption		8.3		
4. Prevalence of underweight children under 5	9.9 ^a	8.6 ^b	5.0	Possible
5. Percentage of population below minimum level of dietary energy consumption	25.6 ^c	14.0 ^d	12.8	Possible
GOAL 2. ACHIEVE UNIVERSAL PRIMARY EDUCATION				
6. Net enrolment ratio in primary education	85.5 ^e	94.0 ^f	100	Probable
7. Percentage of pupils who reach grade 8	83.9 ^g	86.8 ^h	100	Probable
8. Literacy rate of 15-24 years-olds	73 ⁱ	87 ^f	100	Probable
GOAL 3. PROMOTE GENDER EQUALITY AND EMPOWER WOMEN				
9 ^a . Ratio of girls to boys in primary education	81.3 ^c	90.9 ^j	100	Probable
9 ^b . Ratio of girls to boys in secondary education	77.0 ^c	104.3 ^j	100	Met
9 ^c . Ratio of girls to boys in tertiary education (physical sciences)	51 ^e	66 ^b	100	Unlikely
9 ^d . Ratio of girls to boys in tertiary education (social sciences and humanities)	65 ^e	99 ^b	100	Met
10. Ratio of literate women to men, 15-24 years old	84.7 ⁱ	86.4 ^f	100	Possible
11. Share of women in wage employment in the non-agriculture sector	19.2	20.6 ^k	50	Unlikely
12 ^a . Percentage of seats held by women in People's Assembly		2.6	50	Unlikely
12 ^a . Percentage of seats held by women in Consultative Council	4.0	8.0	50	Unlikely
GOAL 4. REDUCE CHILD MORTALITY				
13. Under-five mortality rate	56.0	35.4 ^k	18.7	Probable
14. Infant mortality rate	37.8	28.2 ^k	12.6	Possible
15. Proportion of 12-23 months old children immunized against measles	81.5 ^a	95.6 ^b	100	Probable
GOAL 5. IMPROVE MATERNAL HEALTH				
16. Maternal mortality ratio	174 ^a	67.6	43.5	Probable
17. Proportion of births attended by skilled health personnel	40.7 ^a	69.4 ^b	100	Probable
GOAL 6. COMBAT HIV/AIDS, MALARIA AND OTHER DISEASES				
18. HIV prevalence among pregnant women aged 15-24 years	Not available	Not available	0.0	
19. Condom use rate among married women using contraceptives	4.2 ^a	1.5 ^b		
20. Number of children orphaned by HIV/AIDS	Not available	Not available		
21. Prevalence of malaria		0.0	0.0	Met
23. Incidence of tuberculosis	18.6	14.0 ^b		
24a. Proportion of tuberculosis cases detected under DOTS		58		
24b. Proportion of tuberculosis cases cured under DOTS		88		
GOAL 7. ENSURE ENVIRONMENTAL SUSTAINABILITY				
25. Proportion of land area covered by forest				
26. Ratio of area protected to maintain biological diversity to surface area	6.5	10	17	
27. Energy use (metric ton unit equivalent) per \$1000 GDP	3.9	6.3		
28 ^a . Carbon dioxide emission per capita	2.0 ^l	3.1		
28 ^b . Consumption of ozone-depleting CFCs	2.144	1.335 ^k		
29. Proportion of population using solid fuels	Not available	Not available		
30 ^a . Proportion of urban population with sustainable access to an improved water source	96.9 ^a	100.0	98.5	Met
30 ^b . Proportion of rural population with sustainable access to an improved water source	61.1 ^a	95.0	80.6	Met
31 ^a . Proportion of urban population with access to improved sanitation	94.7 ^a	100.0	97.4	Met
31 ^b . Proportion of rural population with access to improved sanitation	--	--		
32. Proportion of households with access to secure tenure	Not available	Not available		
GOAL 8. DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT				
47. Telephone lines and cellular subscribers per 100 population	8.3 ^l	21.2 ^b		
48 ^a . Personal computers in use per 100 population	1.2 ^l	2.2 ^b		
48 ^b . Internet users per 100 population	0.3 ^l	3.9 ^b		

^a data for 1992
^e data for 1995
ⁱ data for 1996

^b data for 2003
^f data for 2005
^j data for 2002/2003

^c data for 1990/91
^g data for 1991/92
^k data for 2001

^d data for 1999/2000
^h data for 1992/93
^l data for 1999

EMPOWERING THE POOR THROUGH A NEW SOCIAL CONTRACT

According to the Millennium Declaration 2000, eradicating extreme poverty & hunger is the first millennium development goal needs to be achieved by year 2015. According to that deceleration, signatory countries are committed to reaching two targets by 2015 in order to empower their poor people. The first target is to halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day. The indicators used to monitor progress under this target are proportion of population below \$1 per day, the poverty gap ratio, and the share of poorest quintile in national consumption. The second target is to halve, between 1990 and 2015, the proportion of people who suffer from hunger. The indicators used to monitor progress under this target are the prevalence of underweight children under five years of age and the proportion of population below minimum level of dietary energy consumption. Egypt does not generally suffer from lack of food for its population and it has experienced low level of overall poverty incidence as well as remarkable decline in poverty during the last decade. Poverty projections show that Egypt could achieve its MDG on poverty if per capita expenditure grows by 1.5 percent per annum and income inequality changes by one percent.

1.1. Status of Progress

1.1.1. Reducing Poverty

In 2004, overall poverty in Egypt stood at 20 percent, using the national poverty line (Table 1.1)¹. Thus, almost 20 percent of the population in Egypt, or approximately 14 million, could not obtain their basic food and non-food needs. Less than one percent of Egyptians spent less than \$1 a day evaluated at purchasing power parity, while almost 14.4 percent live on \$2 a day.

Poverty in Egypt is shallow, with relatively low values for the distribution-sensitive measures, implying that most of the poor were clustered just below the poverty line. This means that if there was perfect targeting of poverty-alleviating transfers, it would have required only about \$700 million per year to lift the population out of poverty².

Regional Disparities

Overall poverty measures mask differences in welfare among governorates. In general, poverty is concentrated in rural areas and the distribution of the poor is quite uneven across regions. Poverty, particularly extreme poverty, is relatively low in urban areas, where 43 percent of the population reside. In rural areas,

poverty is mostly concentrated in rural Upper Egypt, which has the highest contribution to national poverty. Almost 55 percent of the poor in Egypt live in the rural Upper Egypt region, whose share in poverty far exceeds its population share (26.8 percent). Metropolitan regions contribute a smaller share compared to their share in population.

Table 1.1 Poverty Measures for 1990/91, 1995/96, and 2004 and Projections for 2015

	1990/91	1995/96	2004	2015
National Poverty Line				
• Headcount (% below)	24.32	19.41	20.16	10.80
Poverty Line at US\$1 per day (PPP)				
• Headcount (% below)	8.24	2.50	0.94	0.88
Poverty Line at US\$2 per day (PPP)				
• Headcount (% below)	39.45	41.52	14.4	16.49
Food Poverty Line				
• Headcount (% below)	8.93	3.05	4.64	1.94

Source: Calculated from Household Income, Expenditure, and Consumption Surveys of 1990/91, 1995/96, and 2004 conducted by CAPMAS. Refer to the Appendix for methodological details.

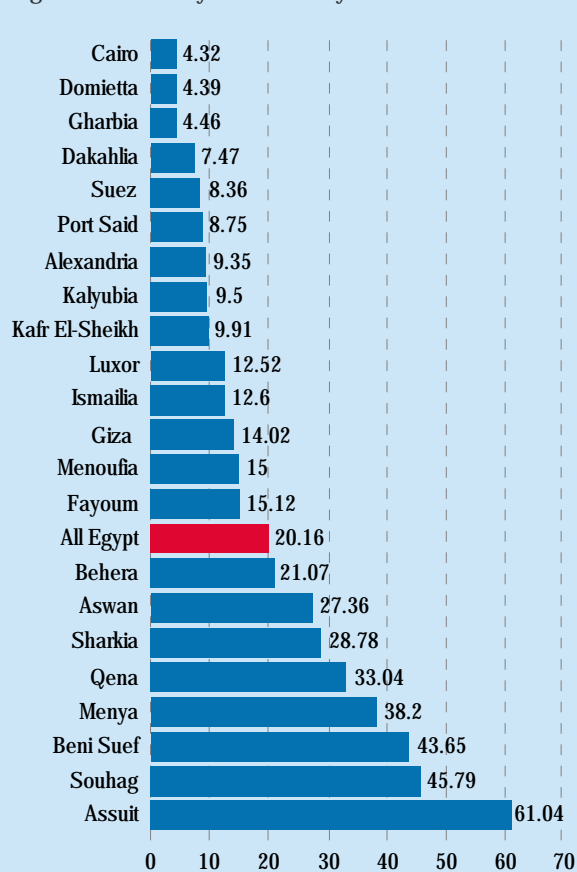
Poverty indices of all governorates in Upper Egypt, except for Giza, Fayoum and Luxor, exceed the average corresponding indices at the national level in 2004 (Figure 1.1 and Appendix Table (A1.1)). Poverty incidence is highest in the governorate of Assiut, more than three times the national average, followed by Souhag and Beni Suef. The same pattern holds for the poverty gap and severity indices. Moreover, all governorates in Upper Egypt, except for Giza, contribute to national poverty by a proportion greater than their population share. In Lower Egypt, Sharkia and Behera are the only governorates where poverty measures exceed the national level. The incidence of poverty in Cairo amounts to 4.3 percent, the lowest among all governorates.

Disparities between regions and governorates can be attributed to differences in educational levels, job availability, and the availability of public services, roads and markets. Variations in the quality, cropping patterns, and ownership of agricultural land may also contribute to the wealth gap between regions.

¹ Most of the poverty analysis in Egypt rely on four successive Household Income, Expenditure and Consumption Surveys (HIECS) conducted by CAPMAS, covering the period 1990-2004. Field-work for HIECS of 2004-2005 started in July 2004 and finished by the end of June 2005, and hence, only data for the second half of 2004 are available. These surveys are comparable in terms of sampling, duration and questionnaire coverage areas.

² This part relied on a background paper prepared for World Bank, 2004. See Appendix for more details.

Figure 1.1 Poverty Incidence by Governorate, 2004



Source: Table A1.1 in Appendix

The Evolution of Poverty

All poverty measures have decreased substantially, for Egypt as a whole, between 1990 and 2004. However the incidence of poverty has increased from less than 17 percent in 2000 to 20 percent in 2004 as a result of the inflationary pressures occurred in the first couple of years of the new millennium, in response to the devaluation of the Egyptian pound.

Changes in the poverty measures can be tracked quite closely to the changes in mean expenditure and the changes in the distribution of expenditure. Typically, when the mean declines and inequality rises, poverty increases, and vice versa. In fact, there is an increase in real per capita³ expenditure for the whole population, from LE 2671 in 2000 to LE 2874 in 2004. This trend was observed in all regions except rural Upper Egypt where mean expenditure slightly declined.

Despite the overall increase in per capita expenditure, there were losses for the poorest 20 percent of the population, demonstrated by the decline in average per capita expenditure for the first two deciles. The poorest decile experienced the largest decline (with average annual decline of 1.46 percent). Indeed, the increase in overall per capita expenditure is driven by gains of the richest decile of the population. This explains the trend in poverty during the period 2000-2004: poverty increased despite the overall increase in real per capita expenditure, and this increase in poverty resulted from worsening inequality (Table A1.2 in the Appendix).

There were three distinctively different regional patterns in terms of the distribution and change in expenditures, driving the large differences in poverty outcomes among the regions:

- The first was a worsening of the income distribution outweighing an increase in per capita expenditures.
- The second pattern was observed in rural Lower Egypt, where the increase in per capita expenditures outweighed a worsening of the income distribution.
- The third pattern, found in rural Upper Egypt, combined a slight decrease in per capita expenditures with a worsening of the income distribution – so that both factors contributed to a worsening of poverty.

Table 1.2 Progress in Poverty Measures

Year	1990/1991	2004	2015*
% poor	24.32	20.16	10.80
Number of Poor, in Millions	12.775	14	9.018
Most Deprived Region	Rural Upper Egypt	Rural Upper Egypt	Rural Upper Egypt
Best Region	Urban Lower Egypt	Metro-politan	Urban Lower Egypt
Most Deprived Governorate	Menya	Assiut	Assiut
Best Governorate	Ismailia	Cairo	Damietta
Ratio between Poorest and Richest Region	6.1	6.8	5.3

* Projected values.

Source: Table A1.2, and Population Projections, CAPMAS, 2000

³ Prices were adjusted by Metropolitan 2004 with relative values of average poverty line within each region as a deflator.

Poverty Projections

Expenditure and distributional effects were used to predict poverty measures in various regions in 2015, using different scenarios and different poverty lines. Poverty projections show that Egypt could achieve its MDG on poverty if per capita expenditure grows by 1.5 percent per annum and income inequality changes by one percent. Egypt's Development Plan targeted a GDP growth rate of 6 percent per annum, GDP per capita is expected to increase by more than 3 percent. This would virtually eliminate poverty overall. However taking a conservative scenario of an increase of 1.5 percent in per capita expenditure, poverty will reach 10 percent by 2015, using the national poverty line while the poverty rate would decline by 58 percent of the 1990/91 rate when using the poverty line of US\$2 a day (Table 1.3). The poverty rate will decline in all regions except the Metropolitan region. All regions are expected to achieve the MDG target, except Metropolitan and urban Upper Egypt under the 1.5 percent GDP per capita growth rate. In addition, Assiut, Beni Suef and Souhag will continue to have the highest poverty rate, although lower than the 1999/2000 levels.

Table 1.3 Poverty Rates and Projections for 2015

	1990/91	1995/96	2004	2015
National Poverty Line				
• Metropolitan	9.80	13.10	6.23	7.88
• Urban Lower Egypt	7.07	8.34	9.07	3.85
• Rural Lower Egypt	27.14	21.53	15.93	5.22
• Urban Upper Egypt	13.47	10.82	19.25	15.65
• Rural Upper Egypt	43.46	29.32	41.06	20.41
Total	24.32	19.41	20.16	10.80
Two US\$ a day				
• Metropolitan	22.23	15.52	3.17	7.99
• Urban Lower Egypt	26.57	21.12	6.64	5.67
• Rural Lower Egypt	46.71	44.58	10.05	11.23
• Urban Upper Egypt	33.19	32.66	14.77	19.17
• Rural Upper Egypt	64.47	67.19	31.12	32.29
Total	39.45	41.52	14.4	16.49

Source: Calculated from Household Income, Expenditure, and Consumption Surveys of 1990/91, 1995/96 and 2004, conducted by CAPMAS.

1.1.2. Hunger

Egypt does not generally suffer from lack of food for its population. The average caloric intake in 1999/2000 was 2960 per day, which is about 119 percent of the recommended requirements.

The series of Egyptian Demographic and Health Surveys (EDHS) indicates that the nutritional status of children under five has significantly improved during the second half of the 1990s, after a slight deterioration during the first half of the decade (Table A1.3). Wasting, which is measured by the weight-for-height index and is considered the best indicator of hunger and acute malnutrition, is not prevalent in Egypt.

Substantial regional differentials exist in the level of malnutrition among young children, with children in Upper Egypt faring much worse in comparison to children in other regions (Table A1.3 in the appendix). A study of the regional pattern of malnutrition among children under school age⁴ using the 2000 EDHS has indicated the existence of strong spatial clustering in malnutrition. The apparent clustering pattern at the governorate level seems to be more a matter of the geographical proximity than development levels. Specialized studies are needed to uncover the reasons behind this geographical pattern. Differences in child feeding practices and variations in the crop composition are among the candidate explanations.

1.2. Major Challenges

1.2.1. Poverty

Egypt can attain MDG poverty reduction goals if current trends in economic performance continue. However, many challenges face Egypt's medium and long-term development goals, among these are the following:

- The outlook for job creation is unclear in the medium-term.
- High fertility rate, resulting in high dependency ratio, affects poverty rates. Of concern is the fact that fertility rate is also affected by poverty through a feedback mechanism.
- High illiteracy rate, low enrolment rate, and child labour, especially among the poor, are major challenges that face Egypt. These factors explain how poverty is perpetuated from one generation to the next.

⁴ El-Zeini and Casterline, 2003.

1.3. Supportive Environment

Unlike most developing countries, Egypt experienced low level of overall poverty incidence as well as remarkable decline in poverty during the last decade. Middle East and North Africa (MENA) region stands out as the developing region with the lowest incidence of poverty throughout the 1990s, estimated at less than 2.5 percent of the population using international purchasing power parity of \$1.00 per day. The region's low poverty headcount is particularly striking in contrast with that of Latin America – a region at roughly twice the level of per capita income – which was 12.1 percent of the population in 1998. Moreover, compared to other developing areas, during the 1990s the Middle East stood among the regions that enjoyed equality of income distribution.⁵

In Egypt, poverty reduction was declared one of the main objectives of the long-term plan that aims at reducing poverty to 6 percent by year 2022. Several policies have been designed and implemented to help low-income groups. Although there is no designated government entity responsible for planning, monitoring and coordinating different programs and activities addressing the poor, Egypt has perused multi-dimensional strategies for raising standards of living. These include income generation initiatives, investment in human capital, and safety net strategies.

The Ministry of Planning (MOP) draws the overall economic and social development plans for short, medium and long terms. These plans are translated into plans of action through different ministries and agencies. The Egyptian government pursues poverty alleviation objectives using various channels, including free education and literacy programs through the Ministry of Education (MOE), free health care through the local health units and large public hospitals of the Ministry of Health and Population (MOHP), rural development projects through the Ministry of Agriculture and Land Reclamation (MOALR), and social security through the Ministry of Insurance and Social Affairs (MOISA).

Three main social safety net programs are currently active in Egypt: the consumer food subsidy program, cash transfers from the Ministry of Insurance and Social Affairs, and the Social Fund for Development (SFD).

Food subsidies are by far the largest direct consumer subsidy, and consequently the largest safety net component. They accounted for about 1.7 percent of GDP in 2004 and are expected to increase further in 2005. The largest of these is the universal subsidy on bread, offered at about one-third the cost of production. Subsidies on sugar, wheat flour and edible oil are targeted through a two-tier system of ration cards issued according to income and need. About 56 percent of the population holds ration cards. Following the introduction of a floating exchange rate and the subsequent rises in commodity prices, seven additional items were added to the ration card system in early 2004, including rice and grains. The government spends nearly US\$1.4 billion yearly on food subsidy, contributing to reduction in hunger and poverty. However, targeted programs addressing hunger and poverty are still needed to tackle regional disparities.

MOISA provides cash transfers through three special funds. In addition, the Nasser Social Bank (NSB) issues transfers or interest-free loans to poor families for school and medical expenses and in cases of personal crisis. Direct social assistance payments from MOISA reached just over 1,002,000 families in addition to 88,000 children, or about 7 percent of the national population. Collectively, publicly-provided social assistance accounts for just over 2 percent of GDP in 2004, a level that has remained relatively stable in recent years.

Egypt's poverty reduction strategy includes concerted efforts on five main fronts: 1) economic growth to increase income and employment with strong emphasis on small and medium enterprises (SMEs) development and job creation initiatives; 2) human capital development of the poor to raise their capabilities through education, health, nutrition and social interventions; 3) women's advancement and closing the gender gap in development; 4) safety net measures for the poor, especially women, against anticipated and unanticipated income and consumption shocks; and 5) participatory governance to strengthen the voice of the poor. In this last respect, several programs are underway, including: Shourok "Integrated Local Development"; Participatory Local Development Project; Participatory Urban Management Program; the Emergency Plan of the Ministry of Local Development; and the MISR (Municipal Initiatives for Strategic Recovery) executed by the Ministry of Planning.

⁵ Page and Adams, 2002.

Moreover, poverty reduction was declared one of the main objectives of the Socio-Economic Development Long-term vision⁶ 2002-2022. The World Bank and Ministry of Planning have jointly carried out a poverty assessment in 2002 and a poverty reduction strategy in 2004.

In addition, the MOP supported by UN agencies and the Donor Assistance Group (DAG) recently developed an Anti-Poverty Action Plan. The objective of this initiative is to ensure effective planning, implementation and monitoring of poverty reduction policies and programs, in consultation with all development partners, including civil society. The poverty strategy emphasizes three cornerstones for fighting poverty: creating income-earning opportunities, improving educational attainment, and enhancing the effectiveness and targeting of the social safety net. This work has led to: (i) drafting a poverty alleviation paper by the National Democratic Party (NDP) for its September 2004 Convention; (ii) formulating a poverty reduction action plan jointly by the United Nations Development Programme (UNDP), the Ministry of Planning, and the Economic Research Forum (ERF).

Recently, the government has given the social policy reform agenda high priority, as evidenced by the February 19, 2005 high-level retreat between the Egyptian cabinet, headed by the Prime Minister, and a World Bank team of senior managers and international resource experts. Following the retreat, a Ministerial Social Policy team, headed by the Prime Minister, was formed with a focus on improving the quality of life of Egyptians in areas such as health, education, transport, environment, and tasked the concerned line ministries with developing an overall integrated social reform package.

1.4. Priorities for Development Assistance

A review of poverty reduction efforts emphasizes the importance of developing a new strategy that focuses on making growth pro-poor, targeting equality, empowering the poor and generating employment. A new strategy against poverty needs to combine the available resources with a sharper focus and a stronger commitment by policymakers to formulate national programs to eliminate the negative effects of certain socio-economic policies during periods of economic transition.

Monitoring effectiveness and efficiency of poverty alleviation programs is also still needed. Several development priorities are called for. These are:

- Bring together government ministries, civil society and the private sector to coordinate their work and arrive at a division of labor that is in the best interest of the poor in the form of a new social contract. The poor have little or no voice in decision-making, and their different needs and constraints do not inform public policy choices and priorities. This means that measures are needed to ensure participation in the poverty reduction strategy and in the formulation of inclusive policies and programs. In this respect, gender needs to be a criterion of inclusion in poverty reduction. Introducing appropriate curricula, at the primary and secondary level, is also crucial to make students aware of the importance of participation in community activities. Awareness building should begin at an early stage of education, to contribute towards nurturing responsible citizens.
- Treat SMEs development as a national priority, designed specially for the poor. This requires the coordination of efforts among all government and non-government actors and entities. SMEs development requires reforming and stimulating the financial sector to address the financial needs of SMEs on sound economic basis as well as facilitating the access of poor women and men to appropriate financial services.
- Improve the effectiveness of public expenditures to increase opportunities for human capital formation for the poor. Supporting the eradication of illiteracy and school dropouts among the poor is the single most important strategy objective from a developmental perspective. Policies should be designed to encourage girls to join schools, taking into account cultural and social barriers.
- Envision and implement a well-designed program to improve the nutrition of vulnerable groups, with emphasis on the protection of vulnerable children. Some of the recommended strategies are:
- Providing daily meals for children in primary public schools: School feeding, as a way of targeting the poor, has the advantage of improving nutrition for children and indirectly encouraging them to enroll at schools.

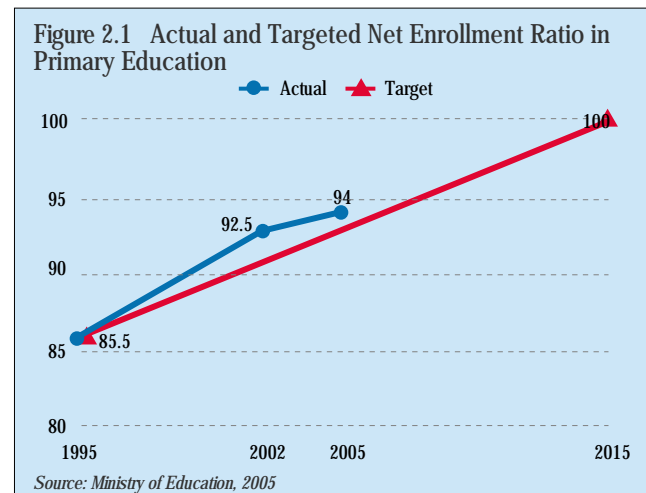
⁶ Ministry of Planning, the Fifth Five –Year Plan for Socio-Economic Development (2002-2007).

- Distributing the necessary food items to participants in literacy classes: This would help the poor to cope with food expenses. It would also provide an incentive for them to attend regularly. The government in collaboration with NGO's should secure sustainable sources of funding for such programs.
- Reforming the general level of subsidies to eliminate their pervasive economic distortions will lead to improved economic efficiency and growth potential. A well-designed safety net system could provide a better coverage of the poor and alleviate poverty more efficiently.
- Reducing fertility rates experienced by the poor. This requires not only providing subsidized contraceptive methods, but also providing better access to sound health services, and offering poor households incentives to send their children to school.
- Extending infrastructure, such as safe water and sanitation, to regions where poverty is prevalent. This provides a reasonably efficient method for improving the individual's health status and hence reducing poverty.
- Encouraging greater decentralization to guarantee a more balanced territorial development and more effective and accountable implementation of poverty alleviation programs.

INVESTING IN HUMAN CAPITAL

According to the Millennium Declaration 2000, achieving universal primary education is the second millennium development goal needs to be met by year 2015. According to that declaration, signatory countries are committed to ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling. The indicators used to monitor progress under this target are net enrollment ratio in primary education, proportion of pupils who reach grade 8, and literacy rate of 15-24-years-olds. Enrollment rates witnessed a steady increase during the 1990s. The proportion of pupils who reached grade 8 increased for both boys and girls, which reflected the decline in dropout. Egypt will probably not be able to eradicate illiteracy among female youth (15-24 years) completely by year 2015. However, with the increase in school enrollment, the decline in illiteracy among young adults is expected to surpass that of the population over 10 years of age.

for boys (2.8 percent) during this period (Tables A2.2 and A2.3 in Appendix).



2.1. Status of Progress

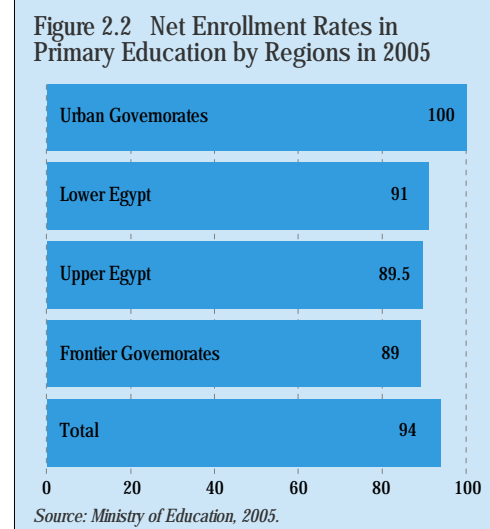
The decade of the 1990's witnessed major progress in Egypt in expanding access to schooling. During this period, the number of basic education schools increased by almost 11000 schools. The total number of pupils enrolled in pre-university education increased from 12.8 million in 1990/1991 to 15.5 million in 2003/2004.

Enrollment in Primary Education

Enrollment rates witnessed a steady increase during the 1990s. Net enrollment rates in primary education improved between 1995 and 2005 by about 8 percentage points. If this trend continues, Egypt will be able to achieve universal primary education by 2015 at the national level (Figure 2.1).

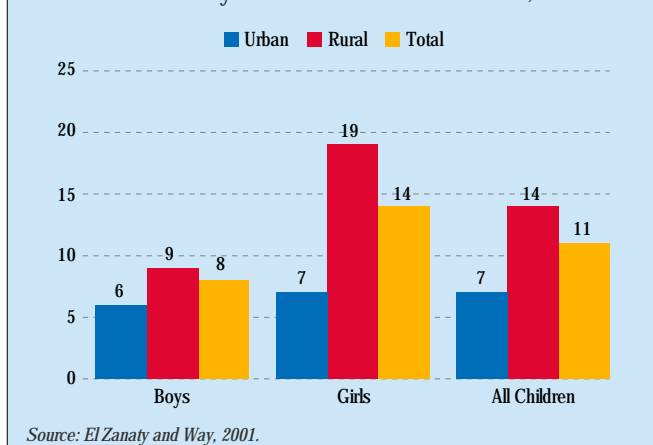
However, the current levels of net enrollment ratio exhibit large regional differentials (Figure 2.2 and Table A2.1 in Appendix). While urban governorates have achieved universal coverage in primary education for both boys and girls, other governorates in Lower and Upper Egypt are still lagging behind.

The proportion of pupils who reached grade 8 increased for both boys and girls, which reflected the decline in dropout. Dropout rates have decreased from 16.1 percent for the cohort of pupils starting grade 1 in 1991/92 and reaching grade 8 in 1998/99, to 13.2 percent for the cohort of pupils starting grade 1 in 1992/93 and reaching grade 8 in 1999/2000. The fall in the dropout rate for girls was slightly faster (3.0 percent) than that



The increase in the level of school attendance has been documented by national surveys. Findings of the 2000 Egypt Demographic and Health survey (EDHS) indicated that 93 percent of children aged 9-12 years have ever attended schools, compared to 90 percent among children aged 13-15 years. The proportion of children never attending school was higher among females than males of the same age group (Figure 2.3).

Figure 2.3 Percentage of Children Aged 6-15 Who Never Attended School by Sex of Child and Residence, 2000



Literacy

The literacy rate for the entire population aged 10 and above increased from around 60 percent in 1996 to 73 percent in 2005. Female literacy increased from 50 percent to 61 percent, while the literacy rate for males increased from 71 percent to 85 percent during the same period.

The literacy rate among the age group 15-24 years was 73 percent in 1996 (79 percent for males and 67 percent for females). Assuming that this is the same trend for the whole population, the literacy rate of this group would be 86.8 percent in 2005 (80.1 for females and 92.7 percent for males). This result indicates that Egypt will probably not be able to eradicate illiteracy among female youth (15-24 years) completely by 2015 (Table A2.4 in Appendix). However, with the increase in school enrollment, the decline in illiteracy among young adults is expected to surpass that of the general population over 10 years of age.

There are large differences in adult literacy between regions, with Upper Egypt ranking at the bottom of the list for both males and females. The most recent indicators of illiteracy in 2005 indicate that illiteracy rate among females aged ten and above exceeds 40 percent in 13 out of the 27 governorates of Egypt.

2.2. Major Challenges

Three major interlinked challenges are facing the Egyptian education system: attaining high quality education, increasing the accessibility of the poor to education and revisiting illiteracy eradication efforts.

The Need to Improve the Quality of Education

Despite Egypt's efforts to improve the quality of education since the mid 1990s, more work is needed for the educational system to become more flexible, diversified and relevant to the economic and social needs of the country. The NCW annual conference in 2004 addressed the quality of education and reviewed a number of indicators in this respect. Class density, pupils to teachers' ratio, and absence rates of pupils are examples of these indicators. In addition, the MOE delineated several criteria to improve the quality of education, and started to implement them in schools.

The three key determinants of education quality are school environment (where students are taught), learning processes (how students are taught), and learning contents (what students are taught). Concerning the school environment, a 1999 survey of public preparatory schools indicated that despite improvements, school facilities still need upgrading.¹ Many school buildings are unfit for use, and although triple shifts have been eliminated, a number of double-shift schools, particularly at the preparatory and secondary levels, continue to operate. Classroom crowding is also a concern in some governorates.

The 1999 survey further pointed to the importance of school sanitation facilities and classroom cleanliness. The lack of appropriate medical facilities was another concern raised by the study.

Concerning learning processes, classroom observations undertaken as part of the 1999 survey suggested that Egyptian students have relatively few opportunities to actively participate in the learning process. At the same time, only 24 percent of teachers in the sample used lesson time efficiently. Another survey² indicated that many Egyptian teachers continue to resort to corporal punishment in the classroom.

Considerable progress has been made in addressing the third determinant of education quality: learning contents. A specialized Center for Curriculum and Instructional Materials Development (CCIMD) was established in the early 1990s. Following its establishment, school curricula were completely revised and new textbooks and teachers' manuals were developed, tested, and published.³

¹ El Tawila et al., 2000

² Ibrahim et al., 1999

³ Arab Republic of Egypt and UNICEF, 2002

Increasing the Poor's Access to Education

The second major challenge facing the Egyptian educational system is inequality in access to education among different income groups and the low educational attainment of the poor.

There is a correlation between education and poverty, with illiteracy concentrating among the poor⁴. The proportion of illiterate individuals (aged ten and above) in the total population of Egypt was 31.1 percent. Among the poor, the proportion was 45.7 percent and 28.4 percent among the non-poor. Large inequalities in educational attainment also emerge among the literate: poverty was inversely correlated with the level of educational attainment. Thus, the majority of the poor has only basic education or virtually no education at all. However, large regional variations are observed in educational attainment and its correlation to poverty. The most significant feature is the low educational attainment in Upper Egypt and the high rate of illiteracy among the poor (49 percent) and the non-poor (37 percent).

There is also inequality in school enrollment, especially in basic education. Enrollment of children aged 6-15 years in basic education in 1999/2000 was 96.7 percent (Table 2.1).

Enrollment of poor children stood at 94 percent only compared to 97.5 percent for non-poor children. This means that about 6 percent of poor children were out of school in 1999/2000.

Dis-aggregation by region shows that the highest proportion of poor children not enrolled in basic education is in rural areas (8 percent in rural Lower Egypt and 6 percent in rural Upper Egypt). The modest access of the poor to education could be attributed, in addition to financial costs and the distributional pattern of public educational expenditures to the declining demand of the poor on education. Two major reasons explain this decline. The first is the low quality of education, and the second is the increasing household cost of education (including opportunity cost). Low educational attainment and poor quality of education have acted as a "push factor" for the poor. A CAPMAS Survey on the Educational Characteristics of the Egyptian Society⁵ showed that repeated failure accounted for 92.5 percent of dropping out among the poor. Limited learning among the poor produced limited expected economic returns, especially when compared to the rising household cost of education!

Table 2.1 School Enrollment of Children Aged 6-15 Years by Region and Poverty Status 1999/2000 (%).

Region	Enrolled	Not enrolled	No. of children
Metropolitan			
Non-poor	98.48	1.52	7283
Poor	94.68	5.32	583
All	98.19	1.81	7866
Urban Lower Egypt			
Non-poor	98.17	1.83	5143
Poor	95.11	4.89	491
All	97.91	2.09	5634
Rural Lower Egypt			
Non-poor	97.05	2.95	14574
Poor	92.12	7.88	2689
All	96.28	3.72	17263
Urban Upper Egypt			
Non-poor	98.89	1.11	4409
Poor	96.37	3.63	1572
All	98.23	1.77	5981
Rural Upper Egypt			
Non-poor	96.22	3.78	9708
Poor	93.98	6.02	6912
All	95.29	4.71	16620
Total Egypt			
Non-poor	97.47	2.53	41820
Poor	93.99	6.01	12363
All	96.67	3.33	54183

Source: The World Bank, 2002a

During the period 1990/91 – 1995/96, in both urban and rural areas and for the poor and the non-poor alike, education was the expenditure category that witnessed the highest increase in real terms⁶. During the period 1995/96-1999/2000, the increase in the cost of education to the household amounted to 70 percent for basic education, 19 percent for secondary education and 18 percent for university education⁷. In terms of expenditure shares, the most important expenditure item for both poor and non-poor was private tutoring.

⁴ World Bank, 2002a

⁵ CAPMAS, 1997/98. Also, the National Survey of Adolescents found that the common reason cited for dropping out was poor scholastic performance, which is a reflection of poor quality - Ibrahim et al., 1999

⁶ El Laithy et al., 1997

⁷ The high increase reflects private tutorship for the preparation of the final diploma.

The Need to Revisit Illiteracy Eradication Efforts

Despite higher rates of school enrollment among females compared to males, and the increase in adult literacy during the last decade, the level of illiteracy among females is still more than twice the level for males. A number of household surveys at the governorate level have been conducted to support, monitor and evaluate female illiteracy eradication efforts.⁸

Findings indicated that the main problem in the slow progress in eliminating women illiteracy is due to low demand for programs. The majority of illiterate women did not attend literacy classes and expressed no desire to do so in future. In-depth studies are needed to further explore reasons behind this reluctance, which might be related to the vast responsibilities assigned to women, and the large demand on their time and energy.

2.3. Supportive Environment

The Egyptian government is strongly committed to improve access, equity and quality of education, particularly since education is regarded as a safeguard for national security.

Government allocations in the area of education witnessed unprecedented increases during the 1990's. Consequently, the number of schools and classrooms increased, facilitating enrollment growth. In 1997, a household survey showed that 99 percent of all villages in Egypt had access to primary education, and 92 percent had access to preparatory education.⁹ Since 1996, the government has developed a comprehensive strategy for educational development covering all levels of education.

At the basic education level, an "Education Enhancement Project" supported by the World Bank and the European Union was designed and approved to address not only the increase of access, but also the improvement of equity and quality of education.

"Education for All" was the goal Egypt adopted during the 1990's and since then, the MOE initiated a long-term plan (2002/2003-2015/2016) to implement the initiative.

"Excellence for All" has also been identified as a goal for educational reform. In addition, the government seeks to strike a balance between the quality and quantity of education.

The Egyptian government has demonstrated a strong commitment to education as a key tool for development. It defined education as the "National Project of the Nineties". Increasing resources have been allocated to education in both nominal and real terms. This increase occurred during a period of sharp fiscal contraction when the share of the budget to GDP was reduced by about one fifth.

Public expenditure on pre-university and university education (in nominal terms) increased from L.E. 4.7 billion in 1990/91 (9.5 percent of total public expenditure and 5.0 percent of GDP) to L.E. 15.1 billion in 1996/97 (22.6 percent of total public expenditure and 6.6 percent of GDP). It further increased to L.E. 18.2 billion in 2000/2001 (18.1 percent of total public expenditure and 6.2 percent of GDP) and reached 24.2 billion in 2003. Public expenditure on pre-university education (primary and secondary) increased from L.E. 8.1 billion in 1996/1997 to L.E. 11.9 billion in 2000/2001, reaching L.E. 16.6 in 2002/2003 (Figure 2.4).

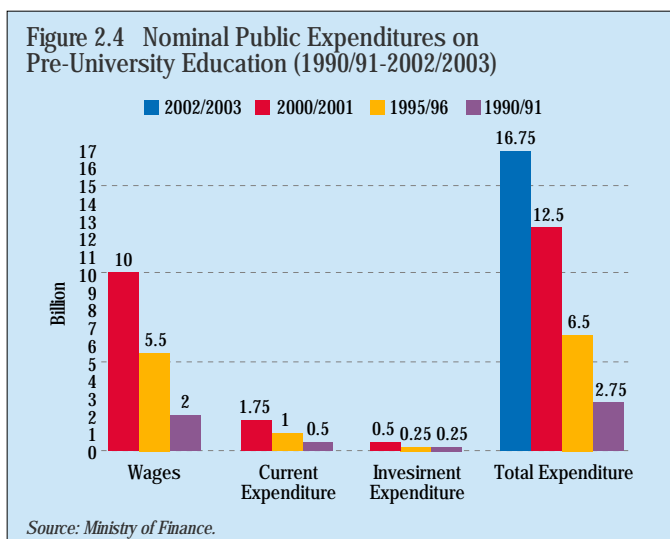
The increase in allocated budget was used to establish new schools and classes and to design new types of education systems targeting deprived areas. The number of public preparatory schools increased by 19 percent (in the period 1997/1998-2003/2004) to absorb the increasing number of pupils and reduce the class density from 43 pupils per class to 41 pupils per class. In 1993, Egypt started a new type of schools for female education (the one-classroom school) to encourage the enrollment of girls in the age group 8-14 who have never attended school. The number of one-classroom schools increased by around 5.5 times in the period 1993/1994 and 2002/2003 (from 418 to 2717).

⁸ The National Council for Women, 2005.

⁹ World Bank, 2002b

In addition, the government of Egypt has come to realize the importance of pre-primary schooling in the education process. Accordingly, the number of public pre-primary schools increased by around 70 percent, from 2356 to 4002, in the period 1999/2000 – 2003/2004.

Notwithstanding the significant increase in allocation of resources since the beginning of the late 1990s, more resources are still needed to make up for past shortcomings and respond to the needs of the increasing population.



2.4. Priorities for Development Assistance

To help Egypt achieve the MDG of universal primary education by 2015, international development assistance needs to focus on meeting the major challenges of quality and equity within the Egyptian educational system through the following measures.

- Support the government's efforts to improve the quality of education delivery system, including schools and teachers through private sector and community-based schemes.
- Assist the government and NGO's efforts in extending the reach of literacy classes, one-classroom schools and community schools to deprived females.
- Regarding equity issues, development assistance could focus on awareness campaigns for deprived and out of school children, as well as targeted subsidy programs at the community level to help reduce the household cost of education for poor families.

EGYPT'S EFFORTS ON THE ROAD TO EMPOWERING WOMEN

According to the Millennium Declaration 2000, promoting gender equality and empowering women is the third millennium development goal. According to that deceleration, signatory countries are committed to eliminate gender disparities in primary and secondary education, preferably by 2005, and to all levels of education no later than 2015. The indicators used to monitor progress under this target are ratios of girls to boys in primary, secondary and tertiary education; ratio of literate females to male in the 15-24 year old age group; share of women in wage employment in the non-agricultural sector; and proportion of seats held by women in national parliament. Gender disparities in education are improving rapidly due to considerable efforts exerted by the government over the last 15 years. Egypt has already eliminated gender disparities in secondary education, and is on its way to achieve that goal in primary education. However, in spite of the efforts made to address the imbalance, the target might not be met at all levels of education and in all regions by year 2015. Women have achieved substantial gains in terms of literacy. Egypt will be able to reach the goal of equality in literacy for the age group 15-24 years old. Egyptian women representation in the parliament has slightly improved in the last two years.

3.1. Status of Progress

Gender Gap in Education

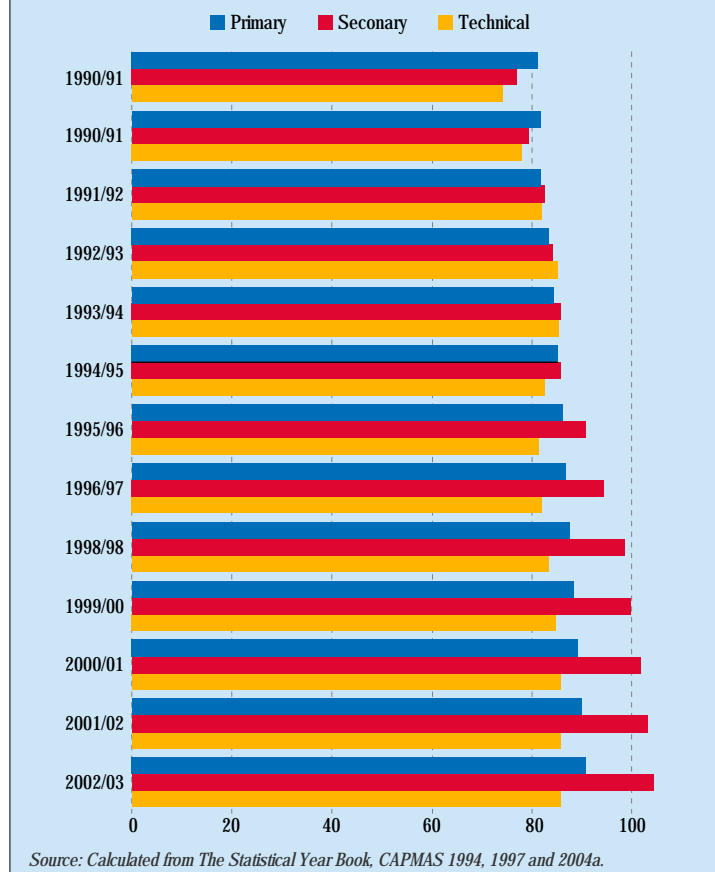
Gender disparities in education have been persistent in Egypt. However, they are improving rapidly due to considerable efforts exerted by the government over the last 15 years. The MOE data show that gender gaps in secondary and university education have been markedly reduced and that for some governorates there are more girls in secondary schools than boys.

The ratio of females to males in primary education increased from 81.3 percent in 1990/91 to 90.9 percent in 2002/2003. In secondary education, the pace of increase was faster: the ratio of females to males increased from 77.0 percent to 104.3 percent during the period. This ratio improved also for technical education, from 74.1 percent in 1990/91 to 85.7 percent in 2002/2003. These improvements reflect the growing access of girls to education. (Figure 3.1)

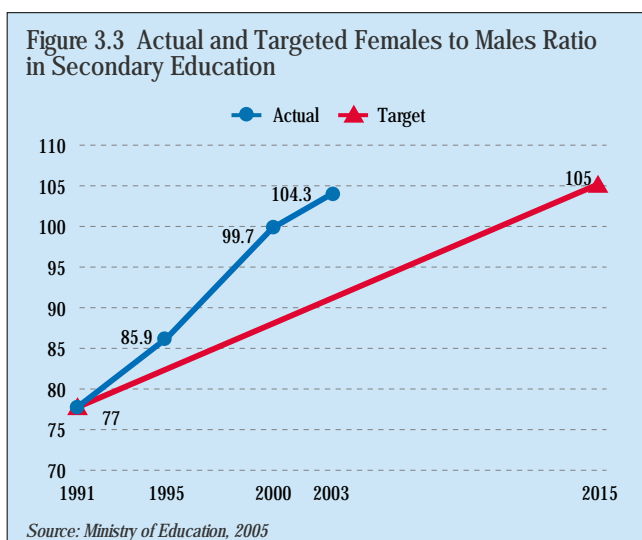
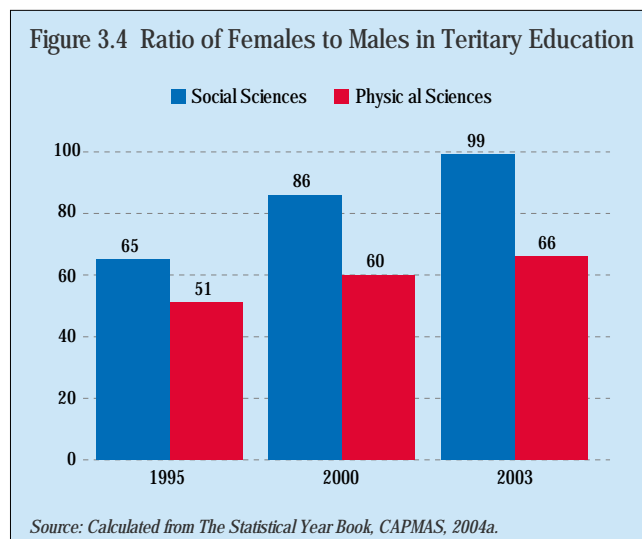
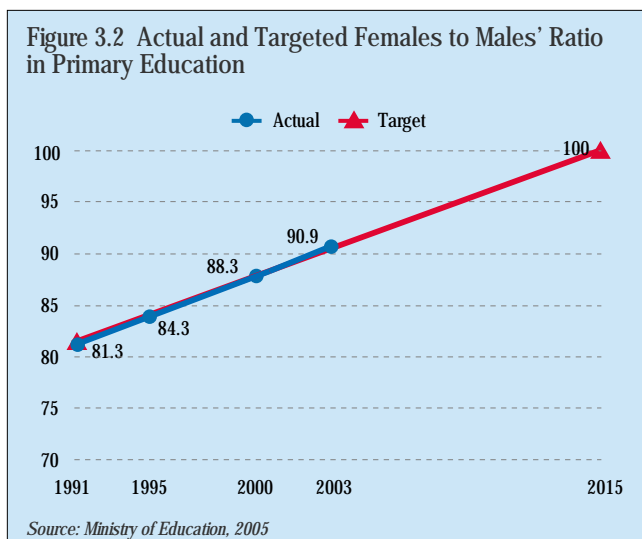
Significant progress has been achieved in school enrollment over the past few decades. Net enrollment rate in primary education (Table A2.1 in the Appendix) witnessed a noticeable

improvement, particularly for girls. Recent statistics show that the net enrollment rate in primary education for girls in 2004/2005 was 95 percent, two percentage points higher than that for boys (93 percent).

Figure 3.1 Ratio of Females to Males in Primary, Secondary and Technical Education



Egypt has already eliminated gender disparities in secondary education, and is on its way to achieve that goal in primary education (Figures 3.2 and 3.3). However, in spite of the efforts made to address the imbalance, the target might not be met at all levels of education and in all regions by 2015.

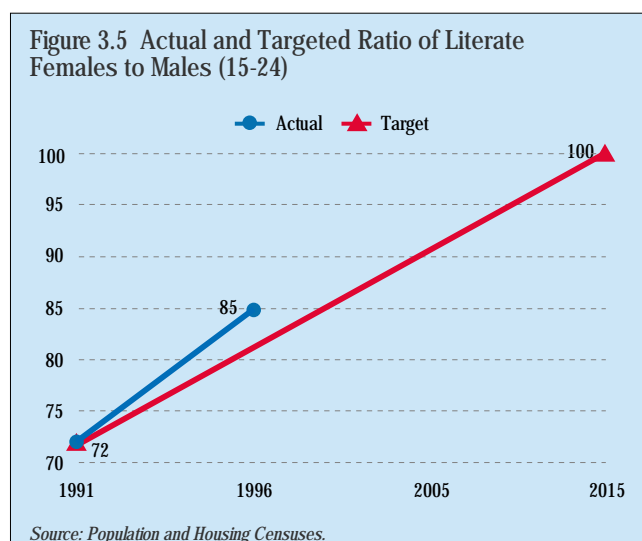


Women have achieved substantial gains in terms of literacy. As data in Table A2.4 in the Appendix indicate, literacy of females 15-24 years old, while remaining lower than males in the same age group, increased by slightly less than 30 percentage points in the period 1986-2005. However, there are still great differences among governorates in the ratio of literate females to males in the age group 15-24. In 2005, this ratio ranged from 71 percent in Beni Suif, Menya and Souhag governorates to 102 percent in Damietta, averaging 86 percent for total Egypt.

Although the ratio of literate females to males aged ten years and above is still high (72 percent in 2005), Egypt will be able to reach the goal of equality in literacy for the age group 15-24 years old at the national level (Figure 3.5). However, it is unlikely that it will be able to eliminate gender disparities in this indicator in Upper Egypt and the Frontiers governorates.

Gender disparities in tertiary education are declining over time (Figure 3.4). The enrollment of female students in the physical science faculties, although increasing over the years, remains lower than female enrollment in the social science faculties. Yet, the number of females in some physical science faculties (dentistry and pharmacy faculties) is more than the number of males.

The ratio of female to male students in physical science faculties has increased from 51 percent in 1994/1995 to 66 percent in 2002/2003. The corresponding ratios in the social science faculties were 65 percent and 99 percent, respectively. Thus, Egypt has eliminated the gender gap in social science education.



Gender Gap in Wage Employment

Between 1976 and 1996, the female share in the Egyptian labor force (15-64 years) increased from 7.3 percent to 15.3 percent. The average rate of growth in the female labor force participation amounted to 7.2 percent during 1976-1986 (against 2.43 percent for males) and to 6.5 percent during 1986-1996 (against 2.5 percent for males).

An important factor behind this gender-based shift in the labor force structure is the increase in the proportion of educated females. This led to higher rates of employment of females holding secondary and above intermediate education certificates. It is also attributed to more employment of married females aged 30 years and above¹. The gender composition of the labor force in 2001 is more balanced in urban than in rural areas, as the ratio of employed females to males is higher in urban areas. If compared with 1990 and 1995, it is evident that the gender gap is shrinking in both rural and urban areas (Table 3.1)

In spite of these improvements, female participation rate in Egypt's economy is still lagging behind that of males and is far less than the relative share of women in the total population. Female refined participation rate (15-65 years) accounted for 18.0 percent in 2001, while that of males accounted for 65.7 percent in the same year.²

Moreover, unemployment is much higher for women than for men, and its rate of increase was faster over the period 1990-2001. Unemployment rates for women increased from 14.4 percent in 1990 to 23.8 percent in 1995. It reached 22.6 percent in 2001 compared to 5.6 percent for men (about 4 times higher than men). The pattern is similar for both urban and rural areas (Table A3.1 in Appendix).

Table 3.1 Share of Females in Wages Employment in Non-Agriculture Sector by Region in 1990, 1995 and 2001

Region	1990	1995	2001
• Urban Govs.	22.0	19.5	22.6
• Lower Egypt	19.0	19.3	22.2
• Upper Egypt	15.9	17.5	14.6
• Frontier Govs.	25.9	25.4	22.4
Total Egypt			
• Urban	22.2	22.3	24.6
• Rural	13.6	13.0	15.1
Total	19.2	18.9	20.6

Source: Calculated from Labor Force Sample Surveys 1990, 1995 and 2001.

In 2004, a survey assessing investment climate in Egypt was conducted by the Social Research Center of the American University in Cairo under the auspices of the Ministry of Investment (MOI). The findings of the survey indicated that out of the 1036 firms surveyed, only 135 firms were owned by females i.e. 13 percent. They also represent about 17.8 percent of the firms owned by natural persons³, which points to the still limited role played by female entrepreneurs in the Egyptian business sector. Furthermore, only 7.6 percent of female principal owners act as managers of their firms. On the other hand, the results show that Egyptian female entrepreneurs are somewhat more successful than males. They are generally more technology-based, more innovative, and more outward-oriented despite the relatively uncondusive business environment.³

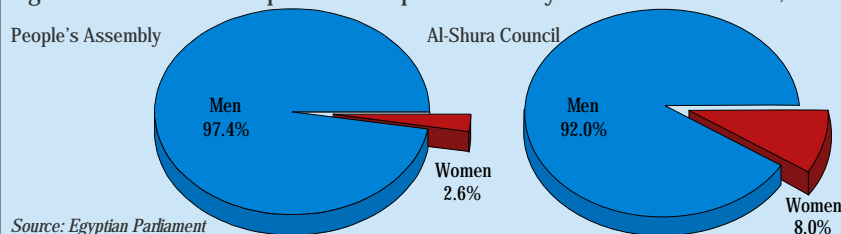
The increased participation of women in wage work and ownership of private enterprises has a significant impact on other development indicators, as women are more likely than men to use their incomes to improve their children's nutrition, health care and schooling.⁴

Women's Political Participation

Achieving gender equality and empowerment of women is even more difficult on the political front. However, Egyptian women representation in the parliament has slightly improved in the last two years. Women's representation in the People Assembly increased from 2.4 percent in 2002 to 2.6 percent in 2005, while the representation of women in the Shura Council reached 8 percent, following the recent appointments by the President. (Figure 3.6)

Although they are few in number, women are active participants in the parliamentary debates and discussions. It is promising for future directions to note that the political leadership in Egypt has stated that enhancing women participation in the political life is part and parcel of the political reform currently taking place in the country.

Figure 3.6 Women Participation in People's Assembly and Al-Shura Council, 2005



¹ El Ehwany, 2002

² CAPMAS, 2001

³ Social Research Center, Forthcoming

⁴ World Bank, 2001, World Bank, 2002

3.2. Major Challenges

Poverty is a major challenge facing the Egyptian government in closing the gender gap in primary and secondary education, and in reducing the gender gap in literacy among 15–24 year olds. Gender inequality, while limited among the rich, is quite large among the poor, and poverty exacerbates gender disparities in education⁵. Poverty was also among the principal reasons for dropping out of school⁶. Conservative attitudes and socio-cultural factors constitute an additional constraint to girls' education in Egypt.⁷

Regarding women's employment, the major challenge is the constraints enforced by the economic conditions and the expected rate of growth in the near future. It is uncertain that new job opportunities will be created for women on the basis of gender. Also, the traditional notion that women's sole role is in the private domain (as wives and mothers) still represents a major obstacle to their increased political participation and their role as entrepreneurs. As mentioned earlier, the business environment is relatively hostile to business-women. The challenge is to improve this environment to expand the role played by females in the business sector and in the political scene. Otherwise, a significant portion of the economy's potential resources will not be utilized.

3.3. Supportive Environment

Egypt was among the first countries to respond to the UN Secretary General's Education Initiative and declare commitment to the Dakar Declaration on Education for All. This was manifested in the Egyptian Girls' Education Initiative (2002/2003 – 2006/2007). The most important goals of the initiative are to:

- a) Place girls' education as a top priority on the next five-year national agenda for development (2002/2003 – 2006/2007);
- b) Eliminate gender disparities by the year 2007; and
- c) Achieve gender equality and enrollment of all girls in a high quality educational system by the year 2015.

In addition to increasing the number of schools, the government is conducting an "Awareness Campaign with Subsidy Program" that is successfully raising girls' enrollment in basic education.

Under this pilot project, the government provides financial support to 12,000 children to cover the private cost of education.

The Alexandria Declaration, adopted at the NCW Fourth Annual Conference, outlines a number of future actions addressing gender equality. These include: promoting gender equality in primary and secondary education; working towards the integration of women in the labor market and ensuring their access to social security; promoting greater representation of women in legislative councils and parliament; and revising articles in the penal law that discriminate against women.

It is worth mentioning that Egyptian women gained several significant achievements during the last few years, such as the appointment of a female judge for the first time, the right to pass their nationality to their children and the establishment of family court to facilitate litigation processes. In addition, a new election law is in the pipeline, and there is an opportunity to include special measures to ensure the representation of more women in parliament.

Governmental and non-governmental efforts are exerted to enhance women's political participation and ensure a representation that reflects their weight in society. Training programs are prepared to enhance women's political skills and create a pool of potential candidates that can run for the 2005 parliamentary elections. Discussions are also taking place with political parties to ensure their commitment to bring women to decision-making posts within party machinery. Voter sensitization programs focusing on women are also being implemented.

In addition, gender sensitive policies are formulated to enhance women's public participation. These include: reforming the electoral system; endorsing positive discrimination measures for women; creating mechanisms to support women leaders; building women's leadership capacity and skills; and capitalizing on the role of the media in projecting a more positive image of Arab women, their participation in politics and all decision making positions in all sectors.

⁵ El Baradei, 2002

⁶ El Baradei, 1994

⁷ El Baradei, 2002

3.4. Priorities for Development Assistance

- Promote girls' education through improving poor girls' access to education. This could be achieved through expanding awareness campaigns and the targeted subsidy programs, and financing on-going girl's education initiatives, which are facing funding shortages. Plans are also underway to expand the program to early childhood education.
- Encourage young females to initiate their own business, support the start-up of new female business and improve the investment climate in favor of female entrepreneurs. This could be achieved through training and awareness raising programs.
- Develop a national strategy to enhance women's public participation especially in political life, and increase efforts to promote women's empowerment and their more active participation in socio-economic and political life, while allowing them to also maintain their private role as wives and mothers.

CAN THE CHILD MORTALITY CHALLENGE BE ACHIEVED FOR EGYPT?

According to the Millennium Declaration 2000, reducing child mortality is the fourth millennium development goal. According to that declaration, signatory countries are committed to reduce by two-thirds, between 1990 and 2015, the under-five mortality rate. The indicators used to monitor progress under this target are the under-five mortality rate, the infant mortality rate, and the proportion of one-year-old children immunized against measles. Infant and child mortality rates in Egypt have undergone a sustained decline. There has also been noticeable progress in measles immunization coverage. Egypt is on track towards achieving this MDG and even surpassing the reduction of 2/3 between 1990 and 2015 in the under-five mortality rate. If estimated regional rates follow the same regional pattern of decline between 1995 and 1998, it is projected that all regions will achieve, and greatly surpass the targeted decline.

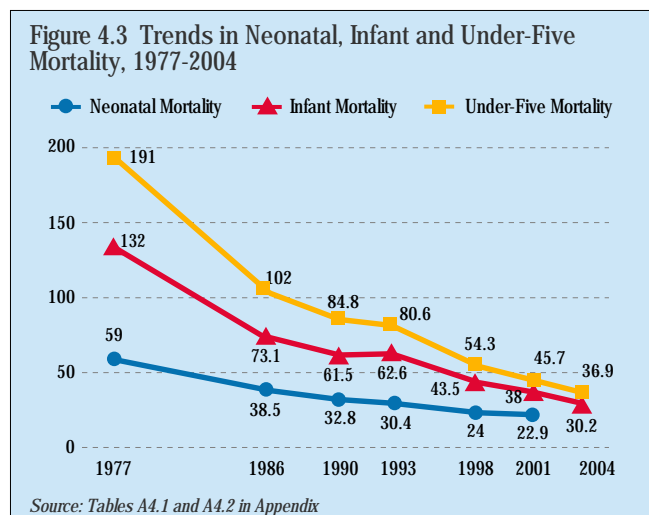
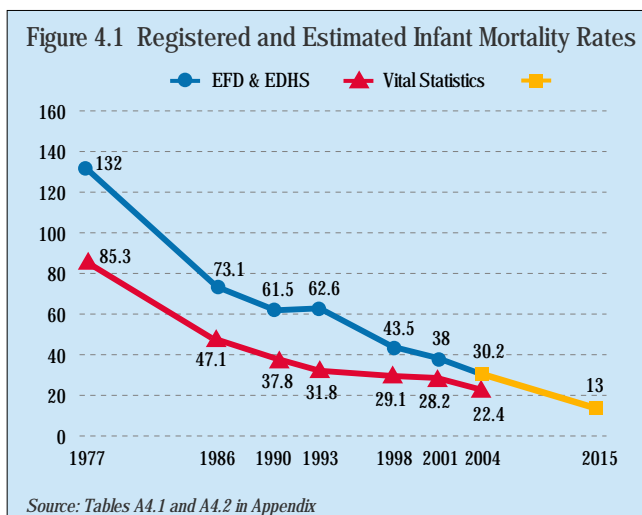
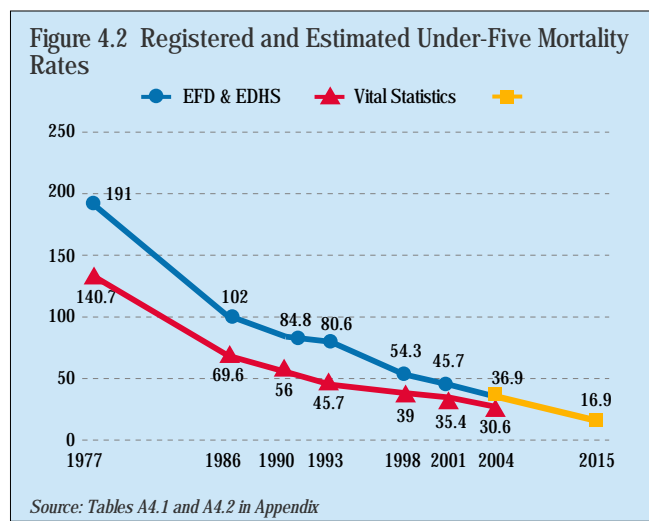
The decline in infant mortality rate has been focused mainly in deaths after the first month of age, resulting in increased share of neonatal mortality. The analysis of change across time indicates that deaths during the neonatal period are growing in relative significance (Figure 4.3). Neonatal deaths accounted for only around one-third (31 percent) of total under-five deaths during 1974-1979, but by 1995-2000 the neonatal deaths as a proportion of under-five deaths had grown to almost 44 percent and recently (1998-2003) reached 50 percent.

4.1. Status of Progress

Infant and Child Mortality

Infant and child mortality rates in Egypt have undergone a sustained decline (Figures 4.1 and 4.2). Estimates based on vital registration¹ and survey-based estimates portray remarkably similar declining patterns.

Registered infant and under-five mortality rates have declined by 41 percent and by around 50 percent respectively between 1990 and 2004.



¹ Estimates of infant mortality based on vital registration are suffering from under-registration, mainly in rural areas (see note 3)

As indicated in Table (4.1), the 2004 infant and under-five mortality rates are estimated to be 30.2 and 36.9, respectively. The estimates apply the recent pattern of decline in registered rates to the survey estimates of 2001.

If mortality rates follow the same recent pattern of decline in registered rates (decline of 7.67 percent and 7.11 percent between 2001 and 2004 in infant and under-five mortality rates, respectively), Egypt is expected to reach an infant mortality rate of 13.0 and an under-five mortality rate of 16.9 in 2015. Egypt is clearly on track towards achieving the MDG and even surpassing the reduction of 2/3 between 1990 and 2015 in the under-five mortality rate.

Regional and social variations in mortality indicators in Egypt have been consistent (Table 4.2 and Figure 4.4). The recent rate of decline within regions has also been uneven (Table 4.3).

If estimated regional rates follow the same regional pattern of decline between 1995 and 1998, it is projected that all regions will achieve, and greatly surpass the targeted decline (Table 4.4). However, the projected levels are extremely low in some regions and are not expected to materialize. It is unlikely that the assumption of same future rate of decline will hold true after a certain low level is achieved. The reason may be attributed to demographic mobility. In particular, the projected rate for rural Upper Egypt which is lower than the urban rate is attributed to the fact that the pattern of decline between 1995 and 1998 was much faster for rural Upper Egypt. This is related to the high initial value as well as success in accelerating progress in rural areas.

Table 4.1 Infant (IMR) and Under-Five Mortality Rates (U5MR) 1977-2015

Year	IMR		U5MR	
	EFS & EDHS	Vital statistics ⁽⁷⁾	EFS&EDHS	Vital statistics ⁽⁷⁾
1977	132 ⁽¹⁾	85.3	191 ⁽¹⁾	140.7
1986	73.1 ⁽²⁾	47.1	102 ⁽²⁾	69.6
1990	61.5 ⁽³⁾	37.8	84.8 ⁽³⁾	56.0
1993	62.6 ⁽⁴⁾	31.8	80.6 ⁽⁴⁾	45.7
1998	43.5 ⁽⁵⁾	29.1	54.3 ⁽⁵⁾	39.0
2001	38 ⁽⁶⁾	28.2	45.7 ⁽⁶⁾	35.4
2004	30.2 ^(b)	22.4 ^(a)	36.9 ^(b)	28.6 ^(a)
2015	13.0 ^(b)		16.9 ^(b)	

(a) Provided by Ministry of Health and Population

(b) Estimated assuming the same percentage decline between 2001 and 2004 as registered rates.

Sources:

(1) Hallouda et al., 1983

(2) Sayed et al., 1989

(3) El Zanaty et al., 1993

(4) El Zanaty et al., 1996

(5) El Zanaty and Way 2001

(6) El Zanaty and Way 2004

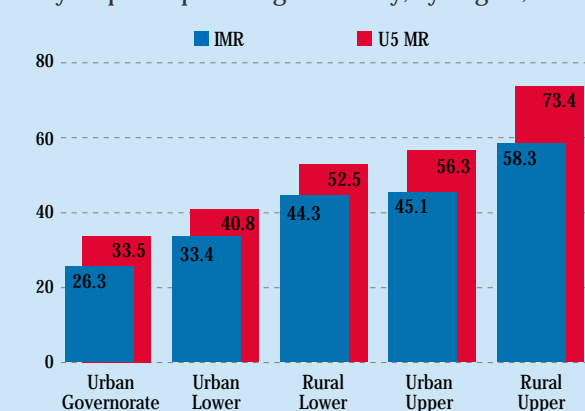
(7) Calculated from Births and Deaths Statistics 1977, 1986, 1990, 1993, 1998 and 2001.

Table 4.2 Infant and Under-Five Mortality Rates for the Ten-Year period preceding the Survey, by selected Socio-Economic Background Characteristics, 2003

Background Characteristics	Infant Mortality Rate	Under-5 Mortality Rate
Urban-rural Residence		
• Urban	34.0	42.5
• Rural	51.4	63.1
Place of Residence		
• Urban Governorates	26.3	33.5
• Lower Egypt	41.3	49.2
• Urban	33.4	40.8
• Rural	44.3	52.5
• Upper Egypt	54.8	68.8
• Urban	45.1	56.3
• Rural	58.3	73.4
Education of Mother		
• No Education	57.3	73.4
• Some Primary	52.6	62.2
• Primary Complete/some Sec.	43.6	53.3
• Secondary Complete/higher	28.6	32.2
Wealth Index of Household		
• Lowest Quintile	65.0	83.8
• Second Quintile	45.3	56.9
• Middle Quintile	43.1	50.7
• Fourth Quintile	37.1	44.4
• Highest Quintile	27.6	32.0

Source: El Zanaty and Way, 2004

Figure 4.4 Infant and Under-Five Mortality Rates for the ten-year period preceding the survey, by Region, 2003



Source: El Zanaty and Way, 2004

Table 4.3 Infant (IMR) and Under-Five Mortality Rate (U5MR) per 1000 Live Births by Place of Residence

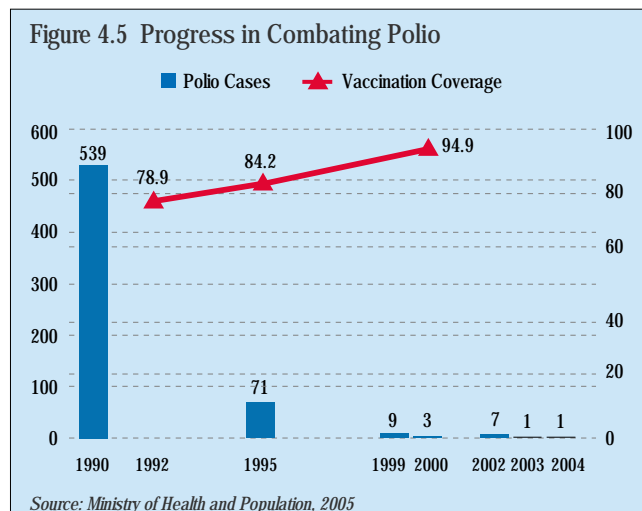
Survey	EDHS1995		EDHS2000		EDHS2003	
Approx. Midpoint of Calendar Period	1990		1995		1998	
Region	IMR	U5 MR	IMR	U5 MR	IMR	U5 MR
Urban Gov.	42.9	65.9	37.4	44.9	26.3	33.5
Lower Egypt	60.9	79.8	45.3	58.6	41.3	49.2
Urban	38.5	50.3	40.3	51.9	33.4	40.8
Rural	68.3	89.6	47.0	60.8	44.3	52.5
Upper Egypt	97.7	129.2	71.2	89.6	54.8	68.8
Urban	67.1	90.3	54.3	65.2	45.1	56.3
Rural	105.2	142.8	77.3	98.5	58.3	73.4

Sources: El Zanaty et al., 1996; El Zanaty and Way 2001, 2004

Table 4.4 Projected and Targeted Under-Five Mortality Rates

Year	2015		
	Projected (a)	Target (b)	
Region	IMR	U5MR	U5MR
Urban Gov.	3.6	6.4	16.3
Lower Egypt	24.5	18.3	26.2
Urban	11.5	10.4	19.4
Rural	31.7	22.9	28.6
Upper Egypt	12.4	15.4	37.4
Urban	15.8	24.5	23.8
Rural	11.8	13.9	43.9

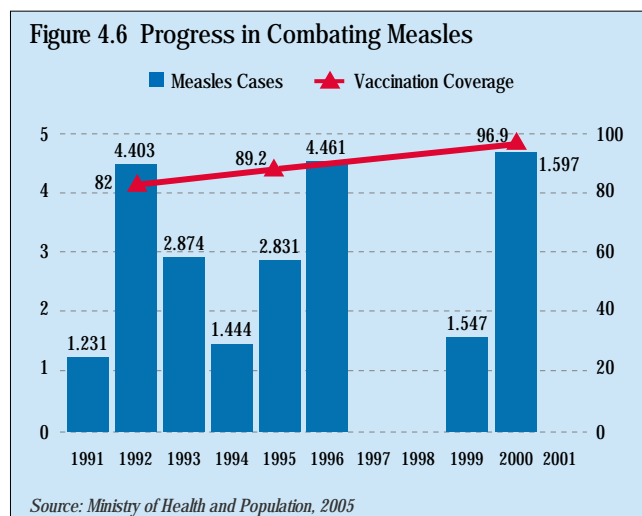
(a) Assuming rate of decline between 1995 and 1998 will apply to 1998
 (b) Two third decline between 1992 and 2015
 Source: calculated based on Table 4.3

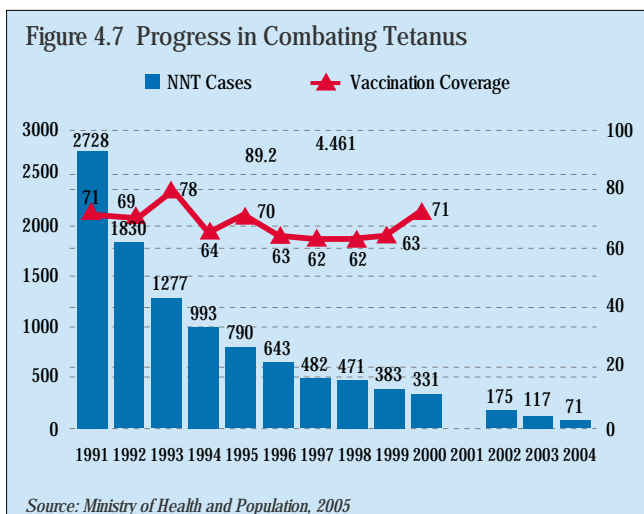


Vaccine-Preventable Diseases

Considerable progress has been achieved in combating Vaccine-Preventable Diseases. A successful national program of vaccination has greatly reduced the threat that Vaccine-Preventable Diseases pose to Egyptian children. MOHP data indicate that vaccination coverage levels for the nine main Vaccine-Preventable Diseases exceed 97 percent, with little variation by region. As a result, these diseases now affect relatively few children.

Figures 4.5-4.7 illustrate the progress in tackling the three vaccine-preventable diseases that have been prioritized globally – polio, measles and neonatal tetanus. They show that polio eradication efforts have been particularly successful. Indeed, with the last reported case occurring in 2004, there are hopes that polio is on its way towards eradication.





There has been noticeable progress in measles immunization coverage, increasing from 89 percent in 1995 to 97 percent in 2000. The proportion of children 12-23 months receiving measles vaccine is higher than that of children who are fully immunized against all other diseases (Table 4.5). Historically, Egyptian mothers have been aware of the negative effects of measles on child health and survival. In the 2003 Egypt Interim Demographic and Health Survey (EIDHS), vaccination against measles reached 95.6 percent, slightly less than the 2000 EDHS figure. Table 4.6 shows trends in measles vaccination by region from 1992 to 2003 and targets for 2015 at the current rate of progress.

Table 4.5 Percentage of Children 12-23 Months receiving Measles Vaccines by Region of Residence, 2003

Region	Measles	Fully Immunized
Urban Governorates	94.7	87.2
Urban Lower Egypt	97.6	86.5
Rural Lower Egypt	96.5	87.2
Urban Upper Egypt	96.2	93.7
Rural Upper Egypt	94.1	86.3
Total Egypt	95.6	87.5

Source: El Zanaty and Way, 2004

It is expected that Egypt will achieve the goal of full measles immunization by 2015 if the rate of progress remains the same as between 1995 and 2000 (Table 4.6).

Table 4.6 Trend in Measles Vaccination among 12-23 Month Old Children in the Years 1992, 1995, 2000, 2003 and 2015 Targets

Region	1992	1995	2000	2003	2015
Urban gov.	90.9	93.7	96.9	94.7	100
Lower Egypt	87.3	92.8	97.3	96.8	100
Urban	89.9	96.3	97.5	97.6	100
Rural	86.6	91.6	97.2	96.5	100
Upper Egypt	72.1	83.7	96.4	94.6	100
Urban	80.2	90.3	99.6	96.2	100
Rural	69.4	81.3	95.3	94.1	100
Frontier gov.	n/a	84.1	95.6	n/a	100
Total	82	89.2	96.9	95.6	100

Sources: El Zanaty et al., 1993, 1996; El Zanaty and Way 2001, 2004.

Other Communicable Diseases

Diarrhea and acute respiratory infections (ARI) represent two particularly important threats to the survival and good health of young Egyptian children. The prevalence of these infections is difficult to estimate and they vary widely by season. Table (4.7) demonstrates that a relatively high proportion of children suffer from respiratory and diarrheal diseases.

Table 4.7 Prevalence of ARI and Diarrhea in Under-Five children during the two weeks preceding survey according to Mothers' Reports

Survey	Time of Survey	ARI	Diarrhea
EIDHS 2003	May - June	10.2%	19%
EDHS 2000	Feb. - April	10%	7%
EDHS 1995	Nov. - Jan.	23%	16%

Sources: El Zanaty et al., 1996; El Zanaty and Way 2001, 2004

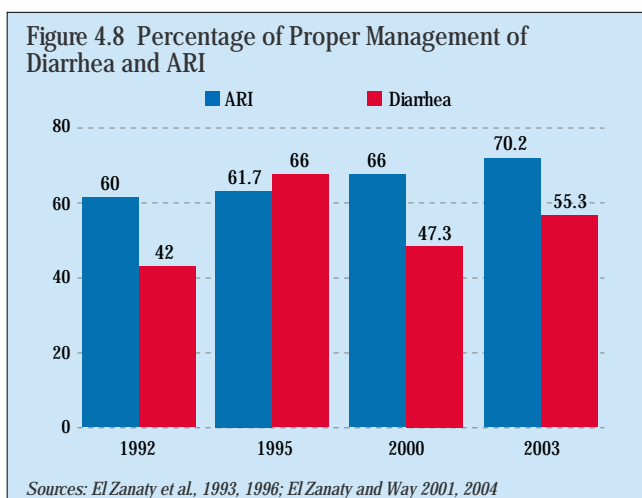
ARI is the leading cause of infant and childhood mortality in Egypt, responsible for almost 30 percent of total deaths in 1999². Mortality from diarrhoeal diseases dropped markedly due to the efforts of the national program, although it remains the second cause of infant death responsible for around 16 percent of total infant mortality in 1999.

The EDHS data from 1992 to 2003 for the proper management of diarrhea and ARI show fluctuations in the household response to childhood diarrhea and improvement in seeking care for ARI (Figure 4.8).

² Arab Republic of Egypt and UNICEF 2002

4.2. Major Challenges

Egypt recognizes the road- map for achieving the target by 2015 through, first and foremost, an increased focus on health equity. The disparities in mortality by regions and social groups are clear areas where current and future efforts should concentrate.



The current focus of MDG on poverty reduction and education and Egypt's performance on these fronts, particularly in disadvantaged communities in rural Upper Egypt, are very much associated with the expectation of future declines in mortality.

Discrepancies in performance indicators between geographic areas are a challenge to the health system. Upper Egypt, especially rural areas, needs to continue the recent pattern of progress to be able to achieve the 2015 targets. However, several socio-economic and cultural factors may impede the progress.

Rural Upper Egypt has the poorest development indicators compared to the rest of the country. In addition, gender gaps are known to exist in under-five mortality rates as a result of some cultural preferences for boys, particularly noticeable in poor families.

Discrepancies also result from inequitable distribution of trained human resources as well as financial allocations to health services at the governorates level. Physicians tend to concentrate in urban areas and a rapid turnover of personnel is usually noticed in rural areas. Other challenges related to the health care delivery system include poor supervision of service delivery and the modest level of care provided.

Another challenge for Egypt is to focus on reducing deaths during the neonatal period. Neonatal mortality is closely related to maternal health and maternal health care. Efforts to reduce neonatal mortality rates will need to focus on these issues.

A third challenge is the availability of reliable data on infant and child mortality and on childhood diseases. Due to high level of under-registration of neonatal deaths, the EDHS are the only available source for mortality indicators³. However, they do not provide mortality indicators at governorate levels.

Improving data collection through MOHP facilities at a decentralized level is essential to identify the level and causes of death by governorate and plan accordingly. Health care providers are not well trained to collect data in proper forms nor do they value the importance of information gathered at the level of service provision. In addition, there are several forms that providers are required to complete which creates an added burden to the many tasks they have to carry out.

Acute Respiratory Infections (ARI) have now shifted from being the second cause of IMR and U5MR to being the first. Those need to be particularly targeted. Enhancing access to information about home management and sources of treatment and ensuring the continuous availability of low-cost effective drugs are essential measures to reduce their complications. Diarrhoeal diseases are still a major problem for child morbidity. To continue to reduce their contribution to IMR and U5MR requires continued perseverance in enhancing knowledge and use of Oral Rehydration Therapy (ORT). This is particularly important in light of recent studies that showed a decline in the use of ORT.

Although Egypt has achieved good progress in terms of measles vaccination coverage, the Expanded Program of Immunization still faces major challenges. Eradication of poliomyelitis is among these challenges. Although the government is committed to reach 100 percent coverage of polio vaccination for all children below 24 months, rapid population growth coupled with poor sanitary conditions seem to be an obstacle. A case of Acute Flaccid Paralysis resulting from poliomyelitis was recorded in 2004.

³ The difference in figure between the registered and survey mortality rates is mainly due to the method of data collection. EDHS captures more accurately the neonatal mortality rate (mortality of infants less than one month of age), since the survey is conducted at household level, and includes those infants who die early in life before they are issued a birth certificate. These deaths are therefore missing from official birth and death registration data. Registration-based and survey-based estimates are largely similar in urban areas and for post-neonatal mortality.

Other challenges facing the goal of reduced child mortality are attributed to social and cultural factors. Female illiteracy is still high particularly in rural Upper Egypt where total fertility also remains high compared to other rural and urban areas. Short spacing between births, high birth order after the fourth child, and young maternal age all correlate with higher infant mortality. Environmental factors and poor sanitary conditions also contribute to poor health, particularly in rural Upper Egypt.

4.3. Supportive Environment

The Government of Egypt is committed to achieve the goals of reducing infant and child mortality. Many programs target the major causes of childhood mortality and morbidity, either through prevention (immunization, growth monitoring, and health education) or through management of illness such as the Integrated Management of Childhood Illness (IMCI).

Institutionalization of programs that began as donor-funded projects, such as the National Diarrhoeal Control Program, the Child Survival Program, and the Integrated Management of Childhood Illness (IMCI) within the MOHP accelerated the efforts to reduce mortality from diarrhoea and ARI. Oral rehydration salts for diarrhoea and antibiotics for ARI are locally produced and are provided through MOHP facilities or sold at reasonably low prices. Media campaigns played a crucial role in raising awareness among mothers and health care providers on the importance of these two major child killers and their proper management both at the household and health facility levels.

Other programs such as family planning, antenatal care, and immunization of pregnant mothers against neonatal tetanus play a major role in lowering neonatal mortality. MOHP is now supporting programs for emergency obstetric care and neonatal units and linking those programs to Primary Health Care and Maternal and Child Health services. Such programs contribute to the reduction of neonatal mortality.

The “Healthy Mother, Healthy Child” project provides neonatal and maternal care, focusing on Upper Egypt. The program has had a positive impact on neonatal and maternal mortality rates. Neonatal mortality accounts for more than half of the IMR and curbing it will lead to a significant decline in the total IMR.

Nutritional programs such as iron supplements for pregnant mothers, fortifying subsidized bread with iron, iodization of salt and breastfeeding programs are improving the nutritional status and reducing nutritional deficiencies. Still, they do not fully address the problem of under weight and wasting, which contribute to ill health and repeated infections. Such problems could be captured with better implementation of growth monitoring activities.

The introduction of the child insurance schemes and the inclusion of childhood illness in the basic benefits package of the health sector reform pilot projects allow a more comprehensive approach for health care provision and access to care for children in the different stages of development. The family physician system is also expected to play a role in improving access to quality care for the family.

4.4. Priorities for Development Assistance

- Improve access to quality health care services and support initiatives to build capacities for health planning and financing at the decentralized district level.
- Strengthen the identified weak points of the health system to combat childhood illness and consolidate the gains achieved.
- Develop public/private partnerships and strengthen NGOs to provide basic child health services and contribute to raising health awareness in the community.
- Identify methods of increasing community involvement in funding and regulating service provision at the local level.

HOW FAR HAS EGYPT FARED WITH RESPECT TO MATERNAL HYGIENE?

According to the Millennium Declaration 2000, improving maternal health is the fifth millennium development goal. According to that declaration, signatory countries are committed to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio. The indicators used to monitor progress under this target are maternal mortality ratio and the proportion of births attended by skilled health personnel. Over the last decade, Egypt succeeded in achieving significant reduction in maternal mortality ratio. The proportion of births attended by skilled personnel has shown substantial increases over the last ten years. If the health system continues to provide quality maternal health services such as increased utilization rates for antenatal care and increased number of births attended by skilled health professionals, it is estimated that the maternal mortality ratio will continue to decline. Improved utilization of antenatal care services in the public sector and the increased proportion of births attended by skilled health personnel in all geographic areas reflect an improvement in the quality of services in government health facilities and a commitment to achieve the fifth MDG. However, Egypt still faces some challenges in improving maternal health. Some of these challenges relate to use of maternity care services.

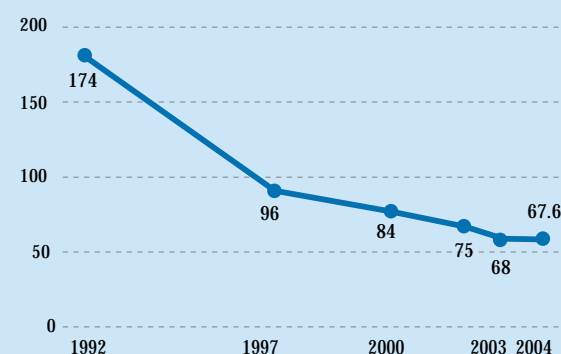
5.1. Status of Progress

Maternal Mortality

Over the last decade, Egypt succeeded in achieving significant reduction in maternal mortality ratio (MMR). Through the period 1992 to 2004, maternal mortality ratio decreased by more than 60%, from 174 maternal deaths per 100,000 live births in 1992 to 67.6 maternal deaths per 100,000 live births in 2004 (Figure 5.1).

Improvements in maternal mortality are outcomes of substantial efforts directed towards decreasing risks of maternal deaths and promoting safe motherhood care through increasing antenatal and postnatal care utilization, securing efficient and proper deliveries and reducing risks of unwanted pregnancies.

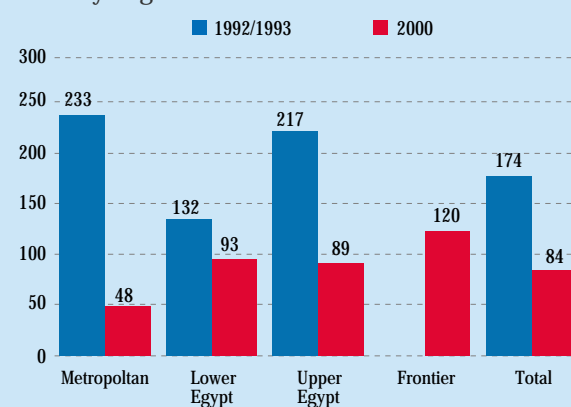
Figure 5.1 Trends in Maternal Mortality Ratio 1992-2004



Source: Table 5.1

Although Egypt has experienced 61% reduction in maternal mortality ratio over the period of 1992-93 to 2004, these gains were not equally distributed in different regions. Egypt National Maternal Mortality Study (2000) revealed that, between 1992-93 to 2000, Egypt succeeded in reducing its maternal mortality by more than 50 percent, with the largest reduction in maternal mortality ratio observed in the metropolitan areas (79%) followed by Upper Egypt (59%). The slowest reduction in the MMR was in Lower Egypt, where a 30 percent decline was achieved, from 132 maternal deaths per 100,000 live births to 93 maternal deaths per 100,000 live births. (Figure 5.2)

Figure 5.2 Maternal Mortality Ratio per 100,000 Live Births by Region 1992/93 and 2000



Source: Table 5.1

As shown in Table 5.1, the MMR is expected to reach 30/100,000 live births in the year 2015 if the rate of decline remains constant as the rate between 2000 and 2004. This figure surpasses the 3/4 reduction (43.5/100,000) of the 1992 figure and hence the MMR goal could be achieved.

If the health system continues to provide quality maternal health services such as increased utilization rates for antenatal care and increased number of births attended by skilled health professionals, it is estimated that the maternal mortality ratio will continue to decline.

Maternal mortality surveys in Egypt (1992/93 and 2000) identified the significant contribution of avoidable factors associated with maternal deaths in Egypt. While in 1992/93 Maternal Mortality Survey one or more of the avoidable factors were associated with 92% of the maternal deaths, the percentage of deaths due to avoidable factors declined to 81% in the 2000 survey. Between the two surveys, the contributions of all avoidable factors to maternal deaths declined substantially (Table 5.2).

Inadequate care by obstetricians was the main factor contributing to maternal mortality, accounting for more than half of the avoidable factors and more than two fifths of maternal deaths in both 1992/93 and 2000 surveys.

Antenatal Care

Among the main avoidable factors identified in Maternal Mortality Surveys is non-utilization of or poor antenatal care. In 1992/93 Maternal Mortality survey, 33% of the maternal deaths were attributed to this factor. In 2000, only 20% of the maternal deaths were associated with non-utilization of antenatal care.

Over the period of 1995- 2003, the DHS monitored a systematic increase in the antenatal care utilization by women from 28.3% in 1995 to 55.6% in 2003. Furthermore, tetanus toxoid vaccination increased during the same period from 69% to 78%. (Figure 5.3)

Table 5.1 Maternal Mortality Ratio by Region in 1992/93-2004 and Projection for 2015

Region	Urban Gov.	Lower Egypt	Upper Egypt	Frontier	Total
1992/93	233	132	217	n/a	174
1997	122	91	92	n/a	96
2000	48	93	89	120	84
2002*					75
2003*					68
2004*					67.6
2015					30

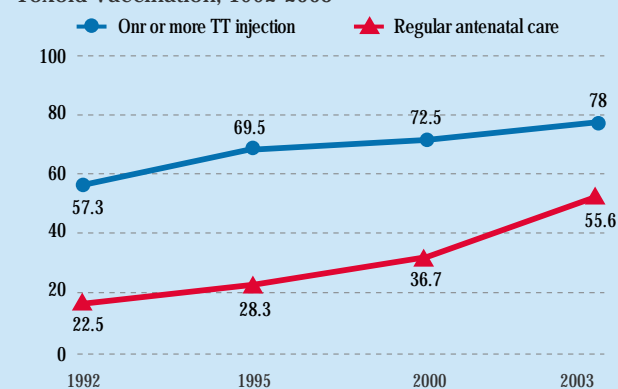
* Data only available at the national level
Source: Ministry of Health and Population, 1994, 2001 and 2005

Table 5.2 Avoidable Factors associated with Mothers' Deaths, 1992/1993 and 2000

Factors	Percent of maternal deaths associated with each factor ^a	
	1992/1993	2000
Woman and Family Factors		
• Delay in recognizing Problems/Seeking Medical Care	42	30
• No Antenatal Care	*	19
• Unwanted Pregnancy	5	2
Health Facility Factors		
• Lack of Blood	6	16
• Lack of Drugs, Supplies, and Equipment	2	6
• Lack of Transportation	4	5
• Lack of Anesthesia	Not assessed	4
• Long Distance to Hospital	Not assessed	4
Medical Team Factors		
Substandard Care from:		
• Obstetrician	47	43
• General practitioner	12	11
• Daya	12	8
• Midwife	Not assessed	4
• Poor quality antenatal care	*	15
Total Avoidable Factor	92	81
• No Avoidable Factor	8	19

* The categories of "no antenatal care" and "poor quality of antenatal care" were reported together in 1992 study, which showed that poor quality or no antenatal care was associated with 33 percent of the maternal deaths.
a. Numbers do not add up to 100 because each death may have more than one factor associated with it.
Sources: Ministry of Health and Population, 1994 and 2001

Figure 5.3 Percentage of Births whose Mothers received Regular Antenatal Care and One or More Dose of Tetanus Toxoid Vaccination, 1992-2003

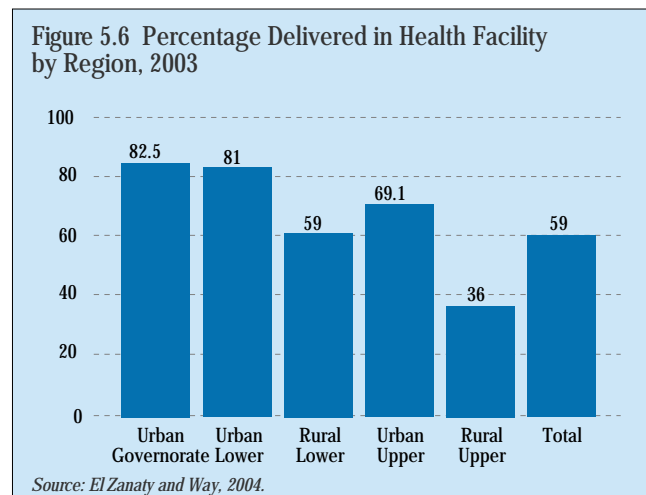
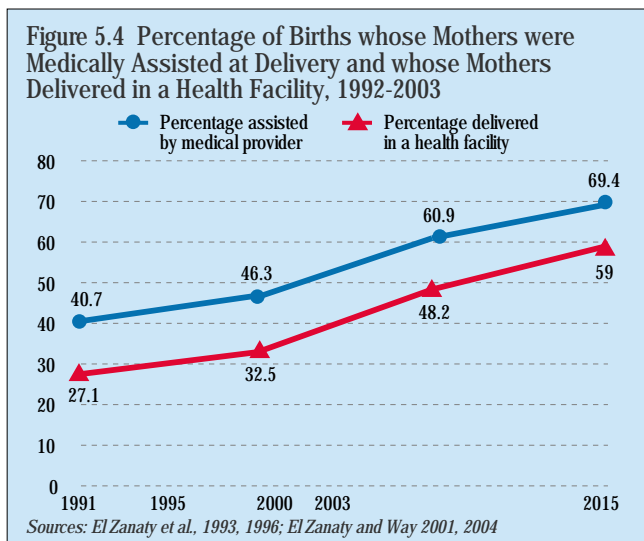


Sources: El Zanaty et al, 1993, 1996; El Zanaty and Way 2001, 2004

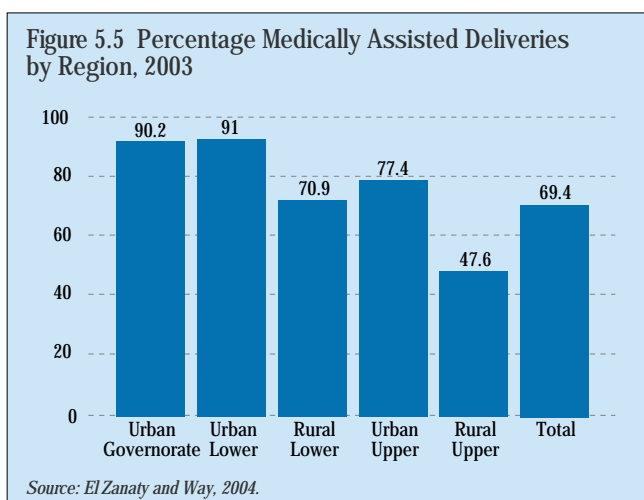
Births Attended by Skilled Health Personnel

The proportion of births attended by skilled personnel has shown substantial increases over the last ten years. The EDHS revealed a significant increase in the proportions of mothers assisted at delivery by medical provider from 40.7% in 1992 to 69.4% in 2003 (Figure 5.4).

Increases in medically assisted deliveries were also associated with increases in the proportions of women who delivered in health facilities from 27% in 1992 to 59% in 2003 (Figure 5.4). The 2003 Egypt Interim Demographic and Health Survey (EIDHS) revealed that rural Upper Egypt still maintains the lowest proportions of facility-based deliveries with only 36% of all deliveries carried out in health facilities (Figure 5.6).



Regional differentials in this indicator persist, with urban regions showing the highest proportions of medically assisted deliveries and rural Upper Egypt exhibiting the lowest proportions, with only 47.6% of deliveries assisted by medical personnel (Figure 5.5).



Postnatal Care

Postnatal care also plays a significant role in maternal health. The 2003 EIDHS indicated that the proportion of women who received postnatal care in Egypt was 42.7% of all births. Regional differences in safe motherhood care services, including use of antenatal and postnatal care services, and tetanus toxoid vaccination, showed that women in urban areas were more likely to receive these services compared to women in rural areas. Rural Upper Egypt exhibited the lowest utilization percentage with only 35% of mothers of all births receiving antenatal care and 27% using postnatal care. Research has revealed that utilization of antenatal and postnatal care is more prevalent among women with higher standards of living, among educated women and among women working for cash.

Contraceptive Prevalence

Use of contraceptives to reduce total fertility and to space births has a positive effect on maternal health and contributes to the reduction of maternal mortality. It also reflects the quality of reproductive health services in the primary care setting. Since 1990, the total fertility rate (TFR) has been slowly declining from 4.1 in 1991 to 3.5 in 2000. Additional decline in TFR to 3.2 was shown by EIDHS 2003. Egypt's target is to reach TFR of 2.1 by 2017. This requires accelerated efforts to raise contraceptive prevalence and reduce total fertility (Table 5.3).

The contraceptive prevalence rate (CPR) in Egypt has shown increasing trend overtime from 37.8 percent in 1988 to 60.0 percent in 2003. Use of modern methods has increased from 35.4 percent in 1988 to 56.6 percent in 2003. However, the rate of increase slowed down since mid 1990s (Figure 5.7).

There are large regional differentials in CPR. In particular, rural Upper Egypt lags behind all other regions with a rate of 44.7 percent in 2003.

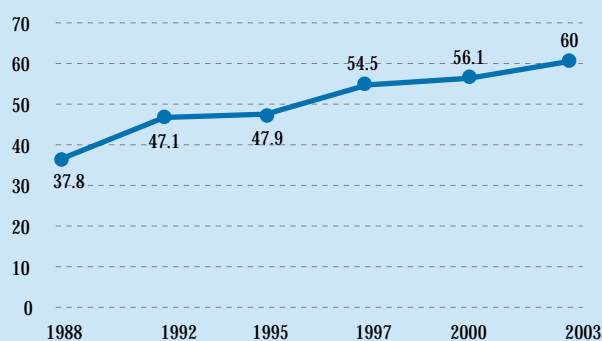
Most governorates in Upper Egypt have lower CPR than the national average (Figure 5.8). This could be explained by inadequate resources, both technical and financial, lower female literacy and participation in the formal labor sector, and cultural norms that encourage large numbers of children. All Lower Egypt governorates exceed the national average, indicating better quality of health services and higher female education compared to Upper Egypt. Still, all governorates without exception have witnessed improved access to family planning services, including the least performing governorates in Upper Egypt.

If Egypt maintains this upward trend in contraceptive use, the country could reach a CPR of 70 to 72 percent by 2015 at the national level. Nevertheless, rural areas of Upper Egypt governorates that reached a CPR of 44.7 percent in 2003 would still be far below national average in 2015. Lower Egypt, both rural and urban, would exceed the national average reaching a CPR of 68 percent and 71.8 percent by 2015, respectively.

Egypt has to accelerate its family planning program to reduce population growth and limit its negative impact on socio-economic indicators. A focus on Upper Egypt is essential.

DHS showed that almost 29% of women discontinue the use of modern methods within 12 months of use, mostly due to reasons that could be avoided by proper counseling. Contraceptives are used in Egypt mainly for limiting births and not for spacing. Contraceptives are rarely used before having the first child.

Figure 5.7 Trend in Contraceptive Prevalence Rates 1988-2003

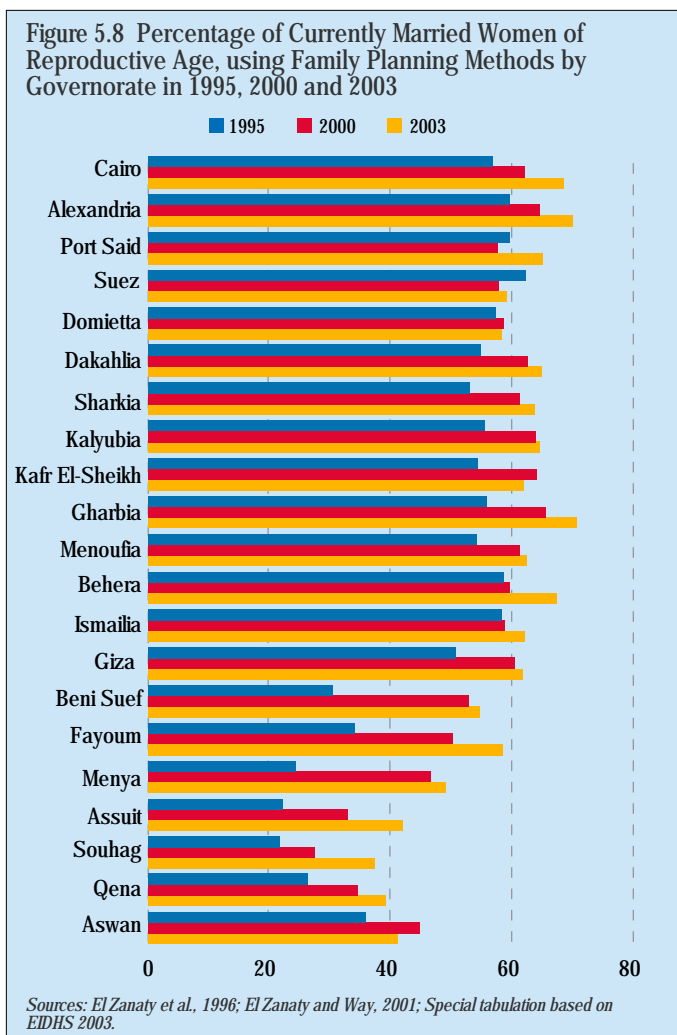


Source: El Zanaty and Way, 2004.

Table 5.3 Trends in CPR and TFR and Target for 2017

Year	CPR	TFR
1991	47.6	4.1
1992	47.1	3.9
1995	47.9	3.6
2000	56.1	3.5
2003	60.0	3.2
2017	72.0	2.1

Source: El Zanaty and Way, 2004.



5.2. Major Challenges

Egypt still faces some challenges in improving maternal health. Some of these challenges relate to use of maternity care services. There are marked differences among Egyptian women with regard to use of maternity care services. Women who have 4 or more children, live in rural areas, specifically rural Upper Egypt, are less educated (with no or some primary education) and are relatively poor are less likely to use maternal care services. Private facilities are the main source of the majority of antenatal care services, while the public sector remains the primary source of tetanus toxoid vaccination.

Requirements for further reduction of maternal mortality include the expansion of nation-wide coverage of Essential Obstetric Care (EOC) program with an efficient referral system.

Another challenge is the quality of the training of medical professionals and their ability to follow guidelines in service delivery. Health providers must be trained to provide quality services to attract and retain clients.

Regarding contraceptive use, a major challenge is the provision of high quality family planning services, including clinical and counseling services. The quality of these services is vital in increasing CPR, reducing rates of discontinuation and decreasing unmet needs and unwanted pregnancies. EDHS revealed a slow decline in the proportion of women with unmet needs, which fell from 16 percent in 1995 to almost 12 percent in 2000. They also showed that 18.4 percent of births were not wanted at the time of conception. The rate of discontinuation of a method within a 12 months period of beginning use is very high and almost constant since 1992 (29 percent), indicating the need for a new approach to service provision.

MOHP has maintained a continuous supply of contraceptives through MCH and PHC centers. Nevertheless, the availability of Intra-Uterine Device (IUD), which is the most commonly used method in Egypt, still relies on donor's funding for continuous availability. Funding for family planning programs must be secured from national resources.

The full integration of reproductive health services in the primary health care package is a central component in reducing maternal mortality and improving women's health. Adequate financial and human resources are key challenges in Egypt. The implementation of cost recovery systems that does not jeopardize access to health care for vulnerable groups clearly stands as a major challenge for the health system.

It should be noted that tackling population policies and strategies requires a multidisciplinary perspective and the mobilization of several ministries and community-based organizations in order to provide a more integrated and sustainable approach. The integration of civil society, religious figures and community leaders is important in shaping people's perceptions regarding reproductive health issues and promoting the adoption of more proper attitudes and behaviors regarding maternal health.

Some of the major challenges are attributed to non-health related elements, particularly cultural attitudes encouraging early marriage, early pregnancy, and short spacing between pregnancies. Couples, particularly in rural areas of Upper Egypt, seldom adhere to the two-year spacing advocated for by the family planning program. Almost 25 percent of pregnancies occur before the 24 months period recommended for spacing. Preference for boys contributes to an increased number of repeated and closely spaced pregnancies.

Although EDHS showed that decisions related to the use of family planning are usually made jointly by husband and wife, female illiteracy is a factor influencing women's access to health care and their ability to make decisions.

5.3. Supportive Environment

Improved utilization of antenatal care services in the public sector and the increased proportion of births attended by skilled health personnel in all geographic areas reflect an improvement in the quality of services in government health facilities and a commitment to achieve the fifth MDG.

The MOHP is currently implementing and testing several programs on emergency and essential obstetric care in many governorates particularly in Upper Egypt. These programs include upgrading maternal and neonatal health facilities with particular emphasis on the quality of Essential Obstetric Care and the management of obstetric and neonatal emergencies. MOHP also developed national standards for obstetric and neonatal care and revised medical schools curricula. It also ensures that maternal care remains an essential component of the basic benefits package of services developed for the health sector reform initiative.

NCW plays a major role in ensuring gender equity in access to health care. The National Council for Childhood and Motherhood (NCCM)-led Girls Education Initiative will help improve girls' and women's access to information and their decision-making power.

Reduction of population growth is decisively a priority policy issue for the government of Egypt as it impacts all developmental efforts in the social and economic fields. The government, in collaboration with several NGOs, plays a key role in pushing forward the agenda for enhanced reproductive health,

family planning and reproductive rights. Fighting early marriage and female genital cutting receive special emphasis within this agenda.

5.4. Priorities for Development Assistance

- Develop the capacity of the health team and expand programs on emergency and essential obstetric care to reduce maternal mortality.
- Target groups with the highest needs for family planning and improve the quality of service delivery, particularly counseling, to reduce the discontinuation rates.
- Develop integrated information, education and communication campaigns and use mass media to raise awareness about the importance of maternity care and family planning services for maternal health. These campaigns should adopt culturally sensitive approaches in addressing these issues.
- Improve maternal health services and develop models to test several packages of maternal and reproductive health and scale-up successful models of the "Healthy Mother, Healthy Child" project in Upper Egypt, particularly given the imminent withdrawal of donors and the impact of this development on the reproductive health programs in the country.

A LAUNCHED ATTACK ON MALADIES

According to the Millennium Declaration 2000, combating HIV/AIDS and other major diseases is the sixth millennium development goal. According to that deceleration, signatory countries are committed to reaching two targets by 2015. The first target is to have halted by 2015 and begin to reverse the spread of HIV/AIDS. The indicators used to monitor progress under this target are the HIV prevalence rate among 15-24-year-old pregnant women, the condom use rate, and the number of children orphaned by HIV/AIDS. Although, Egypt is a low prevalence country for HIV/AIDS, prevalence of condom use is still very low. The second target is to have halted by 2015 and begun to reverse the incidence of malaria and other major diseases. The indicators used to monitor progress under this target are prevalence and death rates associated with malaria, proportion of population in malaria risk areas using effective malaria prevention and treatment measure, prevalence and death rates associated with tuberculosis, and proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS). For decades the Egyptian government has been active in combating malaria and since 1998, no malaria cases were reported in Egypt. Since 1951, there has been a constant decline in the prevalence of tuberculosis. Also, the prevalence of schistosomiasis has shown constant decline.

6.1 Status of Progress

6.1.1 HIV/AIDS

Egypt is a low prevalence country for HIV/AIDS. The first AIDS case in Egypt was reported in 1986. Until December 2003 the total number of reported cases of HIV infections among Egyptians was 1,312 cases, among whom 390 were AIDS cases. The majority of reported HIV cases was found among males and was sexually transmitted. These reported numbers, however, are likely to be far below the actual prevalence. UNAIDS 2004 report estimates that the number of people living with HIV in Egypt is 3,584. Still, this corresponds to one of the lowest prevalence rates, less than 0.01 percent. However, the aforementioned report has warned of the risk of an increase in the prevalence of HIV/AIDS due to increasing intravenous drug injections, use of non-sterile syringes and the low prevalence of condom use.

Although condoms are readily available in family planning and reproductive health units and in pharmacies, prevalence of condom use is still very low (Table 6.1). Available data,

restricted to currently married women, indicate that the share of condoms among contraceptive methods used is decreasing. In 2003, contraceptive prevalence rate was 60 percent. Of those, only 0.9 percent of currently married women reported current use of condoms. These figures exclude use outside marriage and use of condoms in combination with other methods, for which no data is available. Knowledge of condoms among Egyptian youth is alarmingly low. Among adolescents aged 16-19 years interviewed in a national study on youth in 1997¹, only 14 percent of boys and 5 percent of girls indicated knowledge of condom as a family planning method.

Table 6.1 Contraceptive Prevalence Rate among Currently Married Women and Share of Condom Use, 1992 – 2003

Year	1992	1995	2000	2003
Contraceptive prevalence rate (% of currently married women)	47.1	47.9	56.1	60.0
Condom share (% of users)	4.2	2.9	1.8	1.5

Source: El Zanaty et al., 1993, 1996; El Zanaty and Way 2001, 2004.

6.1.2. Malaria and Other Major Diseases

Malaria

For decades the Egyptian government has been active in combating malaria. The malaria-carrying mosquito was eliminated from Egypt by the mid twentieth century, and since 1998, no malaria cases were reported in Egypt. Efforts are underway to preserve this progress.

Tuberculosis

Tuberculosis had been a major health problem in Egypt during the first half of the twentieth century. Since 1951, there has been a constant decline in the prevalence of tuberculosis, with the rate of decline estimated at 1.5 percent annually during the period from 1951 to 1997.

Although the prevalence rate of the disease declined from 350 per 100,000 in 1951 to 32 per 100,000 in 2000, it is still considered a main public health problem in Egypt. Current prevalence rate of tuberculosis is 32 cases per 100,000. Incidence rate was 14 per 100,000 in 2003 (Table 6.2). Current death rate among sputum positive patients is 3 percent.

¹ Ibrahim et al., 1999.

Table 6.2 Incidence Rate of Tuberculosis

Year	1985	1990	1995	1999	2000	2002	2003
Incidence Rate per 100,000	21.3	18.6	16.1	16.0	16.0	14.0	14.0

Source: Ministry of Health and Population, 2005.

Schistosomiasis

Schistosomiasis is endemic in Egypt. Several environmental and behavioral factors have contributed to the high prevalence of schistosomiasis and other intestinal parasites in Egypt. As a result of the efforts of the MOHP over the past years, the prevalence of schistosomiasis has shown constant decline (Table 6.3). In addition, the epidemiological pattern of schistosomiasis has changed and it now appears to be concentrated in few scattered foci.

Table 6.3 Prevalence Rate of Urinary and Intestinal Schistosomiasis

Year	1988	1993	1995	1997	1999	2000	2001	2002	2003	2004
Urinary	11.9	6.6	5.4	5.0	3.2	3.0	2.5	1.9	1.7	1.6
Intestinal	16.4	14.8	14.5	9.3	4.8	4.2	3.6	2.7	2.6	1.9

Source: Ministry of Health and Population, 2005.

6.2 Major Challenges

6.2.1 HIV/AIDS

Low prevalence of condom is a main challenge facing efforts to combat HIV/AIDS. Other challenges include lack of an information base on the true prevalence of HIV and other sexually transmitted infections. This is due to the stigma connected with the disease, sensitivity of risky sexual practices, and the difficulty of institutionalizing periodic epidemiological studies and surveillance systems.

6.2.2. Malaria and Other Major Diseases

Malaria

The main challenge facing efforts to keep Egypt free of malaria is its closeness to epidemic regions in Africa and being a major crossroad for international transportation. Egypt also receives many students from epidemic countries, which necessitates constant alertness for any incoming cases of malaria.

Tuberculosis

High population density, environment degradation, and the spread of smoking especially among young people are the main challenges facing the tuberculosis control program. Wrong treatment habits that result in lower drug effectiveness are another major challenge.

Schistosomiasis

Low sanitation coverage in rural areas, and hard-to-change behavioral patterns are the main challenges facing efforts to eradicate the schistosomiasis epidemic in Egypt.

6.3 Supportive Environment

6.3.1 HIV/AIDS

Since the discovery of the first HIV/AIDS case in Egypt, the MOHP has established an HIV/AIDS control program, the National AIDS Program (NAP). The program has three goals: to eliminate HIV/AIDS transmission, to reduce incidence rates and AIDS-related deaths, and to reduce the incidence rates of other sexually transmitted diseases. These goals are to be reached through a number of activities that aim at increasing awareness among the general population especially youth, targeting the most susceptible groups, supervising laboratories and blood banks, providing counseling to HIV/AIDS patients and their families, in addition to improving the diagnostic abilities through training and better equipment. An HIV/AIDS hotline was introduced in 1996. This hotline was considered one of the pioneer innovative activities in the region. It receives an average of 800 calls per month from Egypt and other Arab countries. The majority of callers are young unmarried males.

A surveillance system was established, through which more than 5 million blood samples were tested since 1986. In addition to the vulnerable categories, samples from pregnant women were screened. Each year, more than 750 thousand blood units are analyzed in all public and private blood banks. An upgrading of blood banks was performed in collaboration with the Swiss government through the establishment of the National Reference Blood Bank. Measures are taken to prevent HIV transmission through blood or medical instruments.

MOHP laboratories, as well as more than 120 specialized laboratories located in Cairo and other governorates provide on-request diagnosis and counseling.

6.3.2. Malaria and Other Major Diseases

Malaria

Although Egypt is malaria-free, proximity to endemic regions necessitates constant alertness to the appearance of new cases. During 2003, the MOHP collected two million blood samples during visits to villages and health clinics. All samples proved to be negative to malaria.

Efforts of MOHP and other concerned ministries (e.g. Ministry of Agriculture and Land Reclamation and Ministry of Water Resources) include the following preventive measures:

- Monitoring malaria-carrying mosquitoes in villages and squatter areas.
- Blood surveillance systems.
- Monitoring and securing the southern borders, through a bilateral protocol with Sudan.
- Monitoring incoming visitors and students from epidemic countries.

Tuberculosis

In 1996, the national program for tuberculosis control started a DOTS strategy in five pilot locations. The recovery rate in treatment locations reached more than 80 percent, compared to less than 70 percent in control locations. As a result, the program embarked on a strategy to expand DOTS to cover all locations by the year 2000. Currently, DOTS success in case detection reaches 58 percent and treatment success is 88 percent.

This expansion was facilitated by the inclusion of tuberculosis mitigation strategies within primary health care units. Tuberculosis implications are treated within specialized hospitals, and all services are free of charge. In addition, several NGOs are active in caring for tuberculosis patients and their families.

Schistosomiasis

The MOHP is active in four areas of services: curative, preventive, educational, and environmental. On the curative front, the current strategy seeks to apply curative campaigns to school children and general rural public in locations where prevalence rate is

high. This approach has been applied effectively since 1997. Preventive efforts target carrying snails in villages with high prevalence rates. An intensive and highly effective mass media campaign has aimed at raising public awareness of the disease, how it spreads, and preventive and curative measures. These efforts are part of a larger endeavor to improve the living conditions and environment in rural areas, through extending water and sanitation networks.

6.4. Priorities for Development Assistance

6.4.1. HIV/AIDS

- Strengthen and expand the existing surveillance systems for HIV/AIDS.
- Strengthen and raise the efficiency of blood monitoring systems.
- Expand manufacture and use of single-use medical supplies, and criminalize their re-use.
- Expand infection control programs and waste disposal in medical establishments.
- Promote use of condom for prevention.
- Promote NGO's role in health education and community mobilization.

6.4.2. Malaria and Other Major Diseases

Malaria

- Strengthen and expand existing surveillance and preventive systems.
- Expand coverage of safe drinking water to reach all Egypt.
- Map potential lands for mosquito breeding and expand covered drainages.

Tuberculosis

- Control population increase, overcrowding, and poverty and alleviate their negative health impact.
- Raise detection rate to reach 70 percent.

Schistosomiasis

- Continue and expand current preventive and curative efforts.
- Extend outreach to children outside school. Monitor and evaluate current control programs.

DEVELOPING A SAFE AND SUSTAINABLE ECOSYSTEM FOR EGYPTIANS

According to the Millennium Declaration 2000, ensuring environmental sustainability is the seventh millennium development goal. According to that declaration, signatory countries are committed to reaching three targets by 2015. The first target is to integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources. The second target is to halve, by 2015, the proportion of people without sustainable access to safe drinking water and sanitation. The indicators used to monitor progress under this target are The proportion of population with sustainable access to an improved water source (urban and rural) and the proportion of population with access to improved sanitation (urban and rural). The proportion of households with sustainable access to an improved water source has increased. The proportion of people with access to improved sanitation has increased over the period from 1995 to 2003. The third target is to have introduced significant improvements to the lives of at least 100 million slum dwellers by 2020. Despite the government's policies and increasing investments, ensuring environmental sustainability in Egypt is still a challenge. The major challenge is to curb population growth and the increasing demand on natural resources.

7.1. Status of Progress

Egypt suffers from water, air, and noise pollution. Also, solid waste management is still a problem in some governorates. A recent World Bank study on cost assessment of environmental degradation, estimates the damage cost of environmental degradation in Egypt at LE 10-19 billion per year or 3.2-6.4 percent of GDP.¹

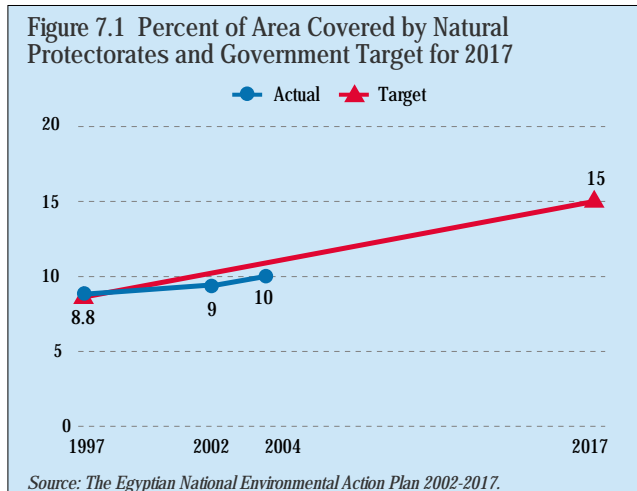
The National Environmental Action Plan 2002/2017 recognizes the gravity of Egypt's multifaceted environmental problems, and emphasizes the changes needed in areas of water, sanitation, energy and biodiversity. The National Plan states that the ultimate goal is "attaining development that is economically, politically, and environmentally sustainable".

The Ministry of State for Environmental Affairs (MOSEA) seeks to integrate the environmental dimension in all national policies, plans, and programs relevant to the protection of human health and management of national resources. It also aims to preserve the national resource base, national heritage, and biodiversity within context of sustainable development. The MOSEA seeks to reduce current pollution levels and thereby minimize health hazards and improve the quality of life.

Natural Protectorates

Egypt is endowed with rich natural heritage, which the government of Egypt seeks to conserve for the benefit of present and future generations.

At present, there are 24 protectorates covering about 10 percent of the country's total territory² (Figure 7.1). It is planned to add further protectorates in the coming years to reach 40 by 2017, covering about 17% of Egypt's total area.



Efforts to maintain the protected area network and to enhance nature conservation in Egypt include the development of extensive infrastructure, such as visitor centers and educational facilities; the integration of local communities in protected area management; and the implementation of international and regional agreements concerning biodiversity.

The MOSEA pays special attention to deepening local involvement in environmental issues to ensure sustainable environment. Through effective participation, local communities would enjoy better educational and health services, wider scope for employment, and higher standard of living. There are at present 550 workers engaged in the management of protectorates, with high educational qualifications. The MOSEA exerts tangible efforts in capacity building and skill upgrading of current work force.

Climate Change

In 2004, carbon dioxide emissions per capita reached 3.1 tons in 2000/2001 compared to 2 tons in 1999 and 1.1 tons in 1980.

Egypt dependence on fossil fuels has decreased from 92% to reach 84.4% at present.

Energy use per \$1 GDP (PPP) is currently at 6.33 Kilogram Oil Equivalent (Kgoe) compared to 4.8 Kgoe in 2000 and 3.9 Kgoe in 1990. The main source of green house gases "GHG" emissions is fuel combustion in the energy sector (22 percent), in industry (21 percent), in the transport sector (18 percent), and in the agricultural sector (15 percent).³

¹ World Bank and Arab Republic of Egypt, 2002. The study shows that the cost to health and quality of life is about 3.2 percent of GDP followed by 1.6 percent for natural resources.

² The Egyptian National Environmental Action Plan 2002/2017.

³ Egyptian Environmental Affairs Agency, 2000.

Compared to industrialized countries, Egypt's carbon dioxide emissions are still considered low, and are insignificant on a global level. On the other hand, Egypt is one of the countries to which the global climate change represents a real threat due to its densely-populated areas. Further development of projects to reduce the GHG emissions would offer Egypt an opportunity to upgrade its energy, transportation, and industrial sectors. One such project has been Carbon Dioxide Sink actions - planting trees and thereby increasing the country's carbon dioxide absorptive capacity.

In the last 10 years, around 2200 feddans were cultivated as forests. Most of these man-made forests are located in Upper Egypt (Qena, Luxor, and Idfu) and in the New Valley. The proportion of land area covered by forest is still very limited in comparison to the inhabitable areas in Egypt. The government is currently in the process of allocating the proper fund to cultivate 80,000 feddans as forests. These man-made forests will be irrigated using treated waste water. Pilot projects in this respect had achieved remarkable results. As of June 2005, Afforestation covers nearly 11200 feddans under the national program for safety use of waste water.

The GDP per unit of energy use in Egypt has changed from US \$3.9 per Kg of oil equivalent in 1990 to US \$4.8 in 2000. The government puts efforts into promoting energy efficiency policies, the use of natural gas, hydropower electricity, and other renewable sources of energy. The MOSEA is cooperating with the industrial sector to achieve this, and to raise awareness about the negative health impact of Ozone depletion. As a result, Egypt's consumption of Ozone-depleting Chlorofluorocarbons "CFC" decreased from 2.144 ozone-depleting potential (ODP) metric tons in 1990 to 1.335 in 2001.

Population Growth

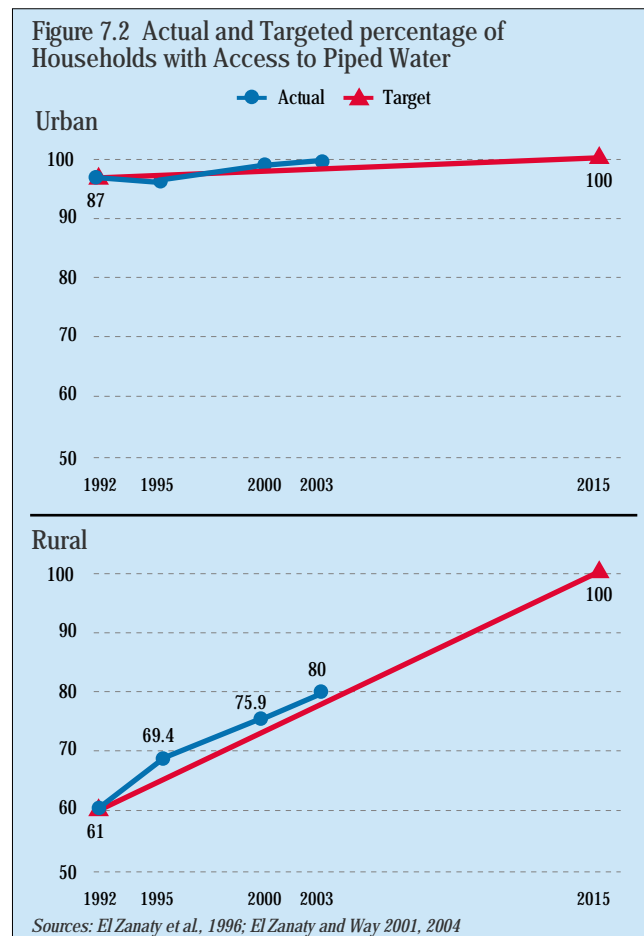
The environmental situation is worsened by the rapid population growth, which puts a strain on Egypt's natural resources. Egypt relies on the Nile for 97 percent of its water resources in addition to 1.4 billion cubic meters rainwater. There has been a rapid decline in the per capita share of water in light of Egypt's fixed Nile water quota, which is currently 55.5 billion cubic meters annually. Average annual per capita share, which was almost 1000 cubic meters in the early 1990s, will reach 600 cubic meters in 2020, and decline to 400 cubic meters by 2030 if the current birth rate continues.

Furthermore, population growth puts pressure on desert land reclamation projects, to provide food for the increasing population.

Access to Water and Sanitation

The Government policy has been directed to increase the efficiency of water utilities and implement a National Water Quality Management Program. Approximately all urban population and 95 percent of the rural population of Egypt rely on piped water supply (Figure 7.2). Recent figures for 2004 reveal continuous improvement as piped water services are extended to all urban population and to 95% of rural population. However, these figures do not reveal the disparities that exist between governorates.

As for the status of water and sanitation on the level of governorates, the proportion of households with sustainable access to an improved water source has increased over the years 1986, 1996, and 2001 for all governorates. As of 2001, the governorates with the largest access were Cairo and Suez at almost 100 percent. The worst were Beni suef (72.1 percent) and Menoufia (75.4 percent). It is projected that by 2015 almost all Egyptian governorates will reach full access to improved water sources.



The proportion of urban people with access to improved sanitation (Figure 7.3) has increased over the period from 1995 to 2003. The improvement affects all governorates, with Port Said, Suez, Damietta, Dakahlia, Kalyubia, and Ismailia at 100 percent. The worst access to sanitation was in Souhag (92.4 percent), and South Sinai (92.5 percent). Again, it is projected that by 2015 all governorates will have reached 100 percent.

However, it should be noted that the current methodology used globally for measuring the indicators of access to piped water and sanitation are often criticized for not providing a realistic picture of the level of access to these two basic services.

Slum Areas

The well-being of Egypt's slum dwellers is negatively affected by their limited access to education, health services, and water. According to the environment situation in Egypt 2004, Egypt contains 1174 slum dwelling areas inhabited by more than 9 million people.

Poor people and those living in slum areas need access to better education and health services, including reproductive health, to improve their well-being and bring down their birth rates. Several social problems seriously impact the lives of the most vulnerable groups, especially women. Overcrowding affects the health and self-esteem of slum dwellers, while large family size limits their participation in the labor force and, also, is an impediment to reproductive health privacy. The unavailability of transportation constrains access to health services and poverty limits working opportunities.

Slum areas also house many young people who are suffering unemployment, poverty, and lack of proper guidance and information.

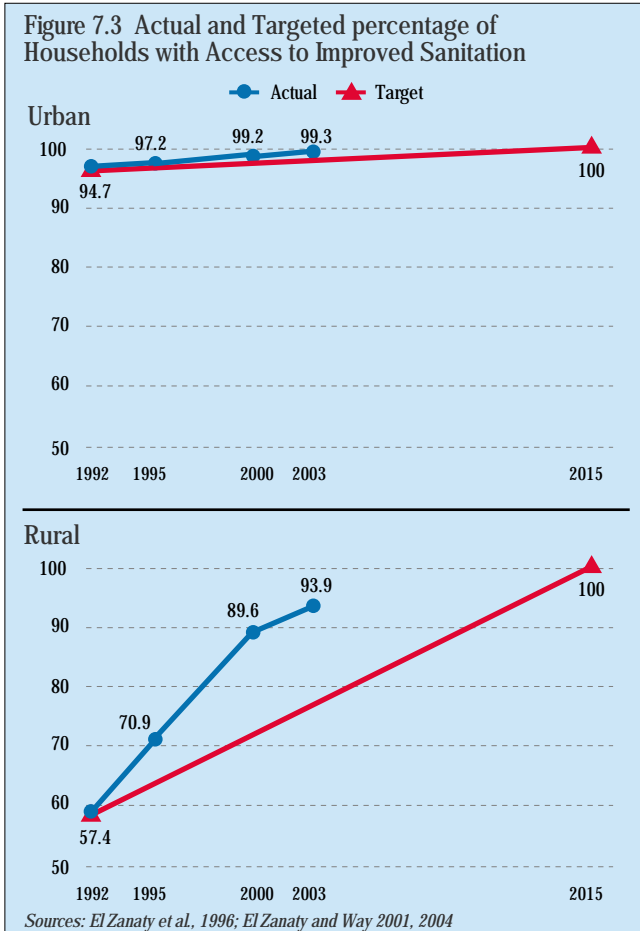
The government implemented several projects to improve living conditions in 286 slum areas in 10 governorates up to the year 2001. Currently, it is involved in similar endeavors to improve the living conditions of 435 slum areas. However, in order to address this problem adequately, reliable data is needed. This can be done through the establishment of monitoring units to report on slum conditions.

7.2. Major Challenges

Despite the government's policies and increasing investments, ensuring environmental sustainability in Egypt is still a challenge.

The major challenge is to control population growth and the increasing demand for natural resources. In addition, environmental education and awareness activities appear to have had little impact so far developing environment-friendly behavior among citizens.

The current efforts of MOSEA with the assistance of aid donors aim at effectuating environmental awareness programs to create public concern about conservation of natural resources.



The absence of a systematic monitoring system of environment health indicators is another major challenge facing Egypt's ability to meet the goal of environmental sustainability. One can also add the environmental risks arising from speedy uncontrolled tourism development in some recreational destinations well-endowed with natural resources.

7.3. Supportive Environment

The Egyptian government is concerned over Egypt's pollution and environmental degradation problems, and is taking serious steps towards achieving the millennium goal in this regard.

Egypt has invested heavily in the water sector, through major irrigation projects, drinking water supply, and sanitation infrastructure. It has played a central role in cooperating with other Nile riparian countries on water resources.

Several steps have been taken towards improving the quality of air in Egypt. The Minister of Interior issued a decree linking the issuance of a vehicle's license with its emissions test. The MOSEA formulated a plan to relocate heavily polluting activities outside populated areas. In addition, it established Environmental Inspection Units at the central level, which drafted the first policies and procedures manual in the field.

The MOSEA is also implementing the Green Belt project around Greater Cairo in order to improve the quality of air and reduce dust and sand rates.

There is strong donor-government cooperation in the area of protectorates development. Examples are the collaboration with the European Union in South Sinai, with USAID in the Red Sea, with the Italian Government in Fayoum, and with UNDP in North Sinai. The project of Sustainable Use and Conservation of Medical Plants in Arid and Semi-arid Lands will be implemented in collaboration with the UNDP during the next five years.

In addition to the above, there are several other activities in which the MOSEA is involved with the view of ameliorating the environment. Among these are:

- Reduction of carbon dioxide emissions using renewable energy sources, improving the efficiency of energy utilization, and

expanding the cultivation of man-made forests.

- Establishment of wind-energy forests with capacities varying between 60 and 220 Mega Watt with financial assistance from international donors.
- Implementation of a number of solar energy projects in Toshka and some coastal cities; in addition to the establishment of a power-generating plant with a capacity of 150 Mega Watt.

7.4. Priorities for Development Assistance

In order to ensure environmental sustainability, the international community should support the following issues:

- Support capacity building for environmental planning and management as a tool to achieve sustainable development.
- Implement initiatives to bridge geographical disparities and guarantee equal access to resources and services.
- Raise environmental awareness through the encouragement of consumer awareness and community-based interventions.
- Develop, and expand the use of, alternative sources of energy, especially solar energy.
- Enhance efforts targeting water demand management.
- Curb Egypt's population growth.
- Implement monitoring units to report on slum conditions and manage policies related to water and sanitation as well as housing and land tenure.
- Implement urban development strategies to guide local action.
- Monitor national participatory policy implementation within the context of urban and environmental development efforts.
- Strengthen environmental institutions and enforce sound environmental behavior.

EGYPT AS A MEMBER OF 'CLUB GLOBE'

According to the Millennium Declaration 2000, developing a global partnership for development is the eighth millennium development goal. According to that declaration, signatory developed countries are committed to achieving seven targets by 2015. First, develop an open, rule-based, predictable, non-discriminatory trading and financial system. Second, address the special needs of the least developed countries (LDCs). Third, address the special needs of landlocked developing countries and small island developing states. Fourth, deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term. Fifth, developed countries, in cooperation with developing countries, are to develop and implement strategies for decent and productive work for youth. Sixth, developed countries, in cooperation with pharmaceutical companies, shall provide access to affordable, essential drugs in developing countries. Seventh, developed countries, in cooperation with the private sector, are to make available the benefits of new technologies, especially information and communications. Egypt has benefited from relatively generous international development assistance. Grants and loans have been allocated to a wide variety of sectors and have satisfied diverse needs. The government of Egypt is embarking on a process to ensure effective utilization of development cooperation and is emphasizing on benefiting from technological advances, especially in the area of information and communication.

8.1. Status of Progress

The eighth MDG represents the commitments of the advanced countries towards the developing world. It covers critical aspects connected to international development assistance, trade and market access, and debt sustainability. This chapter discusses Egypt's benefits from advances in the global partnership for development.

Official Development Assistance (ODA) Egypt's ODA disbursements during the fiscal year 2003/04 amounted to US \$1,521.7 million, equivalent to US \$20.56 per capita. Total ODA disbursements in 2003/04 were slightly lower than the corresponding amount in 2001/02. In light of the population increase, this resulted in a noticeable decline in ODA per capita (Table 8.1).

As many as 42 donors provide assistance to Egypt. The majority of disbursements come through bilateral assistance (58.6 percent), mainly from USAID. Non-UN multilateral assistance constitutes 34.5 percent of total

ODA received. The remaining 6.9 percent is provided through UN organizations. Compared to assistance disbursements in 2001/02, the share of multilateral donors (including UN) has increased from 30 percent in 2001/02 to 41 percent in 2003/04.

Most ODA disbursements are in form of investment project assistance. During the period from 2001/02 to 2003/04, the share of ODA for program budgetary aid declined, while the technical assessment share increased. (Table 8.1)

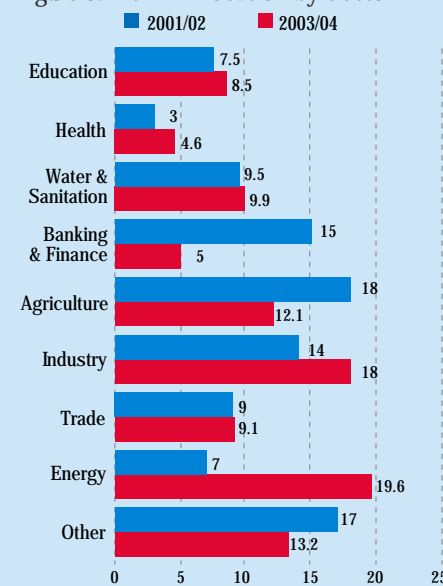
The allocation of disbursements to different sectors also changed favorably during the analysis period (Figure 8.1). The share of ODA disbursements allocated to basic social services (education, health, water supply and sanitation, and other social infrastructure) increased from 24 percent in 2001/02 to 25.8 percent in 2003/04. Other noticeable changes are the large increase of the share of ODA allocated to energy and the decline in the share of banking and financial services.

Table 8.1 Percent Classification of ODA Disbursements by Type of Assistance

Assistance Type	2001/02	2003/04
• Investment Project Assistance	50	59.6
• Program Budgetary Aid	20	10.1
• Technical Cooperation	29	30.1
• Food Aid	1	0.1
• Emergency & Relief Assistance	-	0.1
Total	100	100
Total Value (Billion US \$s)	1.6	1.5
ODA per Capita (US \$)	24.2	20.6

Source: Ministry of International Cooperation, 2005

Figure 8.1 ODA Allocation by Sector



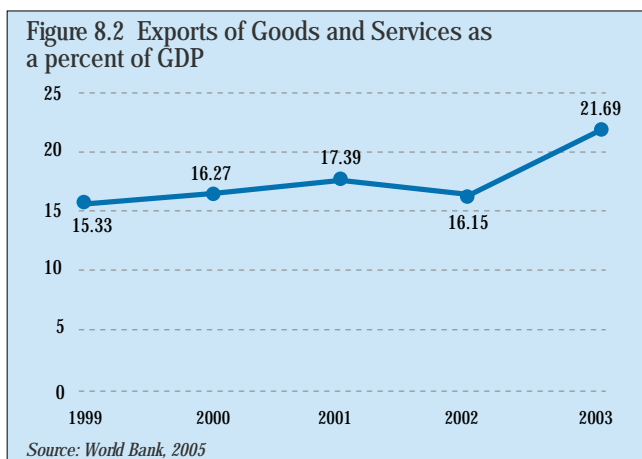
Source: Ministry of International Cooperation, 2005

Market Access

The share of exports of goods and services in Egypt's GDP has been mostly increasing since 1999 (Figure 8.2). Accordingly, the deficit in the balance of trade has been declining during the period from 1998 to 2003.

Further opportunities for trade expansion are offered through a number of bilateral trade agreements, the European Union (EU) partnership agreement, and the Qualifying Industrial Zone (QIZ) agreement with the United States.

Italy, India, and United States are the main export markets. However, Egypt's trade is diversified among a large number of countries, which makes it less vulnerable to external shocks.

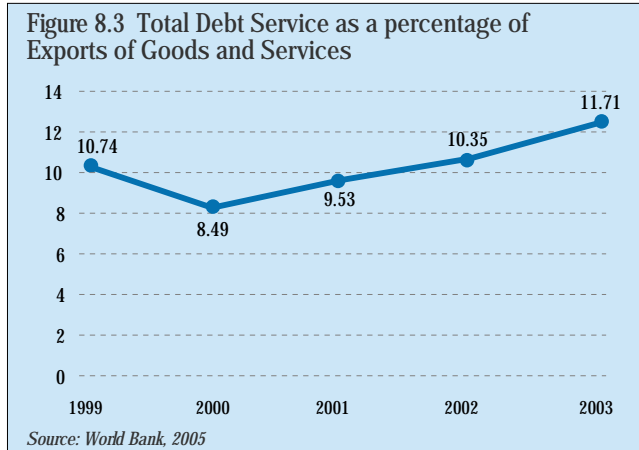


Debt Sustainability

The volume of Egypt's total external debt has declined over the years since 1990. The present value of debt was US \$30 billions in 2000 and US \$28 billion in 2003.¹

However, despite the increase in exports, debt service as a percentage of exports of goods and services has been on the increase since 2000 (Figure 8.3).

In 2003/04, 56 percent of ODA was in the form of grants while 41.1 percent were loans. Only 2.9 percent of ODA were debt swaps.²



Access to Information and Communication Technology

Egypt has made large strides in the direction of building a knowledge-based society. Recent years have witnessed significant investments in information and communication technology.

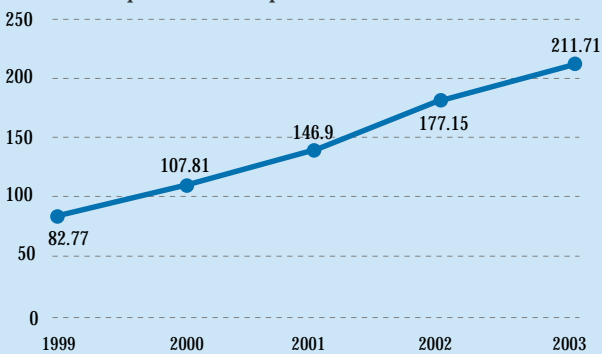
During the 1999 - 2003 five-year period, the number of land line and mobile phone subscribers per 1,000 people more than doubled (Figure 8.4). Number of personal computers per 1,000 people also increased significantly, from 12 to 22 per 1,000 during the same period (Figure 8.5). With a large program initiated by the Egyptian government in 2004/05 to guarantee "a computer for every household" through a subsidized credit system, further doubling in the spread of computers is expected.

The government's strong support to information and communication technology is also manifested in the relatively low cost of local telephone calls, and in providing free internet access to the public. Number of internet users has jumped from 7 per 1,000 in 2000 to 39 per 1,000 in 2003. Large increases in the number of internet users are expected in the coming years.

¹ World Bank, 2005

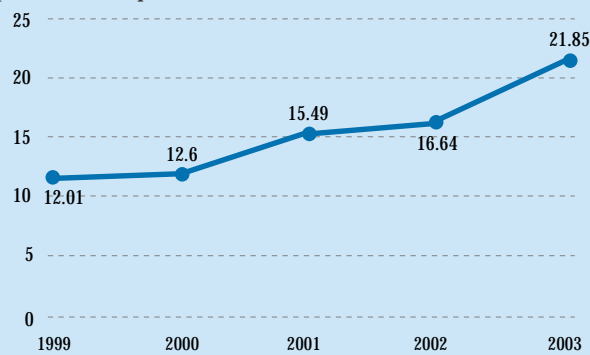
² Ministry of International Cooperation, 2005

Figure 8.4 Number of Land Line and Mobile Phone Subscribers per 1,000 People



Source: World Bank, 2005

Figure 8.5 Number of Personal Computers per 1,000 People



Source: World Bank, 2005

8.2. Major Challenges

The large volume of debt and the increase in debt service cost put pressure on Egypt's ability to benefit from international assistance and export growth. Furthermore, an increasing fraction of ODA to Egypt is in the form of loans rather than grants, and the share of debt relief is negligible.

Regional allocation of assistance is not responsive to the needs of the least developed governorates in Upper Egypt. For example, Aswan received 17 percent of ODA allocated to Upper Egypt in 2001/02 while Fayoum's share was 10 percent, despite the fact that Fayoum's HDI rank is much lower than Aswan's.

Employment and job creation, though perceived by Egypt as a national priority, does not receive enough support from international donors. ODA disbursements directed to the employment and business services sector constituted only 5 percent of the total amount disbursed in 2001/02.

With regard to trade, Egypt is facing some challenges in its efforts to actualize its export potential. These include tariffs and trade quotas imposed by a number of rich countries.

8.3. Supportive Environment

Egypt has benefited from relatively generous international development assistance. Grants and loans have been allocated to a wide variety of sectors and have satisfied diverse needs. Recently, there have been some changes in the types and allocations of ODA disbursements to Egypt in order to better conform to national priorities. Areas displaying high degrees of conformity include energy, information technology, social services, and private sector support.

The government of Egypt is embarking on a process to ensure effective utilization of development cooperation. The Ministry of International Cooperation, in collaboration with the donor community, is developing a comprehensive database for development cooperation programs and projects, as a first step towards improved management of development cooperation. It is hoped that a thorough evaluation of development cooperation in Egypt will be made possible over the coming years.

In its future plans, the government of Egypt places much emphasis on benefiting from technological advances, especially in the area of information and communication.

8.4. Priorities for Development Assistance

The following issues need more support from the international community and the more advanced countries:

- Direct more attention to the least developed regions in Upper Egypt.
- Increase ODA allocations to governorates with lower HDI values.
- Support youth employment, through investment in human capital and job creation.
- Provide access to affordable essential drugs.
- Guarantee a fair, open, non-discriminatory, and supportive trade system; provide tariff and quota-free access to markets and help build an effective transport infrastructure to access markets.
- Undertake serious measures for debt relief.
- Monitor the effectiveness of assistance allocation and use.

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Appendix

Methodological Notes and Annex Tables

A. Methodological Notes

1. Population Projection

In 2000, the Central Agency for Public Mobilization and Statistics (CAPMAS) and the Cairo Demographic Center (CDC) published a population projection for Egypt, covering a period of about twenty-five years (1996-2021), using the 1996 census as the basis. The most accurate projection method based on cohorts was used, to take into consideration future fertility and mortality trends.

The projection considered three scenarios (high, medium, low) corresponding to three assumptions regarding fertility trends. According to the high scenario, total fertility rate will gradually decrease until it reaches 2.5 children per woman in 2021. The medium scenario postulates that fertility will decrease until it reaches 2.3 children per woman in 2021. The low scenario assumes that fertility will gradually decrease to only 2.09 children per mother by 2021. This last assumption is the one targeted by the government's population policy.

When a single figure for the population number is required for 2015, the report uses the medium scenario projection.

2. Projection of MDG Indicators

In the first report of the MDGs at the country level, a linear projection for all millennium goals was applied depending on the guidance note. However, based on the discussion around the first MDG report and the valuable feedback from experts and resident representative of UN agencies in Egypt, it was recommended to use a more sophisticated projection (exponential method). It was also recommended to use more than two points of time (1990, 2000). Accordingly, in the current report, all available data of each measure during the period 1990-2005 were used, and the following exponential equation was applied:

$$P_t = P_0 e^{rt} \quad (1)$$

Where:

P_t : the value of the indicator in the projection year (t).

P_0 : the value of the indicator in the base year (0).

t: is the number of years, between the base year and the projection year.

r: is the annual rate of change estimated for the indicator using available trends.

Depending on the average rate of change per year, three assumptions were suggested: (high/medium/low) or (best/most likely/worst). The listed figures for projecting the MDGs up until 2015 depend on the most likely to be expected (medium) assumption.

Literacy rates for age group 15-24 in 2005 were estimated using the same rate of change of literacy rates for age group 10 years or more in the period 1996-2005. The statistics of the General Authority for Literacy and Adult Education (GALAE) were used for this purpose

3. Measuring Poverty

Defining poverty as multidimensional phenomenon raises the question of how to measure overall poverty and how to compare achievements in the different areas. One approach to addressing comparability is to define a multidimensional welfare function or a composite index. Examples for this approach are the Human Poverty Index and Human Capability Index. An alternative is to define the income poor and focus on the multiple deprivations they experience. Both approaches are valid. However, because the first MDG is concerned with income poverty, we adopt this approach here.

Data and Sampling Design

Our poverty analysis is based on Household Income, Expenditure and Consumption Surveys (HIECS) conducted by CAPMAS -- Egypt's official statistical agency. Egypt has a long history in collecting statistics, dating back to the beginning of the twentieth century. Household budget surveys were conducted since 1957/58 and the plan was to conduct these surveys every five years. However, due to shortage of funds, the surveys were not always regular. They were conducted on the following dates: 1957/58, 1964/65, 1974/75, 19981/82, 1990/91, 1995/96, 1999/2000 and 2004.

Household budget surveys present the single most important source of information for poverty analysis. They record information on household income and consumption expenditures on more than 550 items of goods and services, and are therefore a good source of information on the distribution of welfare in society. These surveys are particularly important because of their comparability, in terms of survey design and administration, and hence the opportunity they offer in making comparisons and inferences over a period that roughly coincides with the implementation of the Economic Reform and Structural Adjustment Programs (ERSAP).

Estimating Poverty Line

Most of the traditional methods (including \$1 per person per day or \$2 per person per day) suffer from one or more of three problems. (i) They are calculated for Egypt as a whole, and thereby ignore significant differences in consumption patterns and prices that exist across regions in Egypt. (ii) When using per capita poverty line, they do not account for the "basic needs" requirements of different household members (e.g. young versus old, male versus female) and hence give the same weight for every household member. For example, they set poverty threshold for a household with an adult male, an adult female and two children similar to that of a household with four adult males. (iii) They ignore the "economies of scale" within households – the fact that non-food items can be shared among household members.

The following is a new approach to estimate household region-specific poverty lines, where most of the previously mentioned drawbacks were taken into account. The availability of the raw data, for the first time in Egypt, of the most recent Households Income and Expenditure Survey (HIECS) allows the construction of poverty lines for each household depending on its size, age and gender composition as well as its place of residence. Using this method, different weights are assigned to each household member depending on his/her age and gender. Economies of scale are also taken into account. Thus, the poverty line for a household with one elderly person is different from a household with one adult male, even if they live in the same region. Besides, the poverty line of a household with two adult males is not twice as much as that of a household with one adult male, because of economies of scale.

Household Specific Poverty Lines

The report follows the cost of basic needs methodology to construct household region-specific poverty lines. The food poverty line varies for each household and for each of the seven regions. Differences in poverty lines reflect variations in the food and non-food prices across the seven regions. They also incorporate household differences in the size and age composition, and their food and non-food consumption preferences.

Stage 1: An initial step in defining the food poverty line is the construction of a minimum food basket, which can be anchored to some normative nutritional requirements. We first estimate minimum caloric requirements for different types of individuals. Using tables from the World Health Organization (WHO), caloric needs are separately specified by sex and 13 age categories for urban and rural individuals. For individuals over 18 years of age, WHO's recommended daily allowances are differentiated by weight and activity levels. The estimates used in this paper assume the average weight of individuals over 18 years of age is 70 kg for men and 60 kg for women. Urban individuals are assumed to need 1.8 times the average basal metabolic rate (BMR) and rural individuals are assumed to need 2.0 times average BMR. Thus, each household has its own caloric requirements depending on its location, age of its members and their gender composition.

Stage 2: Once the minimum caloric needs have been estimated, the next step is to determine the cost of obtaining the minimum level of calories. Cost is determined by how the calories are obtained on average by the second quintile¹, rather than by pricing out the cheapest way of obtaining the calories or following a recommended diet. For the second quintile of households ranked by nominal per capita consumption, average quantities of all food items are constructed. Total calories generated by this bundle are calculated using calories contents in every food item. These quantities represent the bundle used to estimate the food poverty lines, which reflect consumption preferences of the poor. This bundle is augmented/ deflated to meet food requirements for each household, then is priced using prices prevailing in each region to obtain household specific poverty line.

This stage can be explained mathematically as follows: let Z_r denote the actual food consumption vector of the reference group of households initially considered poor. The corresponding caloric values are represented by the vector k , and the food energy intake of the reference group is then $k \cdot Z_r = k \cdot Z_r'$. The recommended food energy intake for household h is $k \cdot h$. The reference food consumption bundle used in constructing the food poverty line for household h is then given by z_h , where z_h is obtained by multiplying every element of Z_r by the constant k_h/k_z . Thus the relative quantities in the diet of the poor are preserved in setting the poverty line.

Having selected the bundle of goods, we then value it at local prices in each region. Here, average unit values revealed by the households in the second quintile for each region, are used as estimates for local prices. Unit values are obtained by dividing the reported value by its corresponding quantity.

Food bundle includes 184 foods, allowing more than 410 grams of food-grains per person per day, plus small amounts of fresh fish, meat, eggs and a range of local vegetables, fruits, etc. Of the 2310 calories per person per day, which this bundle yielded, 60% came from cereals and grains. The average cost of 1000 calories generated by the reference food bundle ranged from LE.865 in Metropolitan, to LE.790 in Lower Rural Egypt.

Stage 3: While the cost of the minimum food bundle is derived from estimated physiological needs, there is no equivalent methodology for determining the minimum non-food bundle. Following Engel's law, food shares are regressed against logarithm of total household expenditure, logarithm of household size, share of small and older children, share of adult males and females, and share of elderly. The non-food allowance for each household can be estimated in two ways; (i) regressing the food share against total expenditures and identifying the non-food share in the expenditure distribution of households in which expenditure on food is equivalent to the food poverty line; or (ii) by identifying the share of non-food expenditure for households in which total expenditure is equivalent to the food poverty line. The former approach yields an "upper" bound of the poverty line, while the latter yields a "lower" bound or the "ultra" poverty line, since it defines the total poverty line in terms of those households, which had to displace food consumption to allow for non-food expenditures, considered to be a minimum indispensable level of non-food requirements. Absolute poverty lines have been widely used in developing countries since poverty research is dominated by the concern for the attainment of basic needs and the achievement of well-being in absolute terms. By this approach household regional specific poverty lines are estimated (households with the same gender and age composition in each region have the same poverty lines). Obviously, this approach takes into account location, age and gender composition as well as economies of scale, as food shares and hence non-food estimates vary according to household size, age and gender composition. Hence differences in food shares result from the addition of members of specific age and gender. The sharing behaviors among household members are also reflected.

To illustrate, let us examine different lower poverty lines in the Metropolitan region where, for example, the poverty line for a single male household is LE 1264. If this man got married the poverty line will be LE 2242. Obviously, the latter poverty line is less than twice the former line, reflecting that economies of scale and gender differences have been taken into account.

Stage 4: For consistent poverty comparisons, food and total poverty lines were deflated. When deflating food poverty lines, the set of prices revealed in the 1990/91 and 1995/96 HIECS surveys were used. Ravallion argued that the use of the CPI for updating the base year poverty line may generate errors in the poverty trends since the construction of the CPI includes many items that clearly fall outside the typical consumption bundle of the poor in Egypt. An alternative source of price information is the set of implicit unit-value for food in the HICES. The implicit prices are derived by dividing reported expenditures by quantities for each food item. These give the actual expenditures on a unit of consumption paid in each sector and date, and so reflect the underlying differences in prices. The implicit food prices in the HICES were used to determine the cost of the normative minimum diet in each sector and year to obtain the food consumption of the poverty line. As there unit value for non-food items could not be obtained, official CPIs were used to deflate non-food poverty line.

Poverty Measures

It has become standard practice in poverty comparisons to use the Foster-Greer-Thorbecke class of decomposable poverty measurements. It is given by:

$$p = 1/n \sum_{i=1}^q (z - y_i) / z \quad (2)$$

where y_i denotes income or expenditure of the i -th poor individual, Z is the poverty line, Q is the number of individuals whose consumption or income is less than the poverty line, and N is the population size, $q = 0, 1$ or 2 depends on which poverty measure is used. These include three indices: the head count, the poverty gap and the poverty severity indices.

The *head count index* (P0) is a measure of the prevalence of poverty. It denotes the percentage of households who are poor - as defined by the poverty line - as a proportion of total population. This measure however, is insensitive to the distribution of the poor below the poverty line. This is captured by the following two indices, P1 and P2. The *poverty gap index* (P1), is a measure of the depth of poverty and it denotes the gap between the observed expenditure levels of poor households and the poverty line. Assuming perfect targeting, the poverty gap index indicates the amount of resources (transfers) needed to bring all households in poverty up to the poverty line. The *poverty severity index* (P2) measures the degree of inequality in distribution below the poverty line and it gives greater weight to households at the bottom of the income (or expenditure) distribution.

To illustrate, suppose that, as a result of a policy change, 10 percent of income is redistributed from a poor household whose income level places it at 30 percent below the poverty line, to a household placed at 50 percent below the poverty line. The head count index in this case would not change, since the size of the redistribution does not allow either household to move up to the poverty line. The poverty gap index would not change either, since the redistribution occurred at levels below the poverty line. The effect of this redistribution policy will be captured by the P2 index, as the position of the lower level household in the distribution would improve.

¹ All previous estimates of the percentage of the poor ranged from 20-40 percent. It is reasonable to consider that the expenditure pattern of the second quintile corresponds to the expenditure pattern experienced by the poor.

Poverty Projections

The first step in poverty projections is to estimate the percentage change in poverty measures, resulting from changes in different factors affecting poverty, that is the elasticity of poverty. Here, we assume that the changes in mean expenditure and in the level of inequality are the main factors contributing to changes in poverty levels.

Elasticity of poverty measures to changes in the mean expenditure and inequality were estimated. Indeed, the elasticity of poverty measures to the mean expenditure and to the inequality index were the least (in absolute term) for Rural Upper Egypt followed by the Urban Upper Egypt, where poverty was highest, while elasticity was the highest for the Rural Lower Egypt where poverty and inequality were low (Table AA.1). The Upper Egypt regions had the lowest elasticity for both the headcount and poverty gap indices, with respect to mean expenditure, implying that the impact of growth in expenditure or improvement in inequality were small compared to other regions. The same applies to the poverty gap index, although the magnitude of change was much greater. That is, for every percentage growth in mean expenditure, the headcount index would decline by only 2.7 percent in Upper Rural and by 3.2 percent in Upper Urban region, as opposed to 5.8 percent in Lower Urban. This may explain, to some extent, change in poverty between 1995/96 and 1999/2000.

Region		Consumption Elasticity	Gini Index Elasticity
Metropolitan	P0	-5.67153	12.16966
	P1	-6.80346	17.74424
	P2	-7.25491	21.85869
Urban Lower Egypt	P0	-5.82759	6.45804
	P1	-5.76357	8.49529
	P2	-5.06005	9.82384
Rural Lower Egypt	P0	-5.91886	3.69503
	P1	-7.04383	6.02161
	P2	-7.30733	7.81038
Urban Upper Egypt	P0	-3.23797	3.33996
	P1	-4.24356	6.40871
	P2	-4.7725	8.98581
Rural Upper Egypt	P0	-2.89425	0.91316
	P1	-4.27326	2.66375
	P2	-5.24449	4.28569

Source: Calculated from Household Income Expenditure and Consumption Surveys

B. Annex Tables

Empowering the Poor Through A New Social Contract and Employment Creation
{equivalent to Goal 1. Eradicate Extreme Poverty and Hunger}

Table A1.1 Poverty Incidence for 1990/91, and 2004 and Projections for 2015, Using National Poverty Line

Governorate	1990/91	2004	2015	Governorate	1990/91	2004	2015
Cairo	6.41	4.32	7.57	Behera	31.99	21.07	5.19
Alexandria	16.21	9.35	9.44	Ismailia	3.12	12.6	3.99
Port Said	5.10	8.75	1.37	Giza	19.15	14.02	9.91
Suez	18.23	8.36	2.89	Beni Suef	41.54	43.65	36.33
Damietta	8.08	4.39	0.04	Fayoum	40.47	15.12	23.97
Dakahlia	18.48	7.47	9.85	Menya	46.27	38.2	16.46
Sharkia	29.71	28.78	8.40	Assuit	40.64	61.04	40.04
kalyubia	13.39	9.5	5.25	Souhag	40.32	45.79	30.66
Kafr El-Sheikh	18.44	9.91	3.59	Qena	28.05	33.04	17.27
Gharbia	18.66	4.46	4.53	Aswan	21.18	27.36	14.31
Menoufia	26.89	15	12.55	Luxor		12.52	22.44
				Total	24.32	20.16	10.80

Source: Calculated from Household Income Expenditure and Consumption Surveys of 1990/91 and 2004, conducted by CAPMAS.

Table A1.2 Cumulative Percentage of Total Expenditures by Deciles

Population deciles	Metropolitan		Urban Lower Egypt		Rural Lower Egypt		Urban Lower Egypt		Rural Lower Egypt		All Egypt	
	2004	2000	2004	2000	2004	2000	2004	2000	2004	2000	2004	2000
10	3.05	3.39	3.90	5.06	4.99	5.53	3.07	3.70	4.48	5.09	3.51	4.11
20	7.17	8.15	8.91	11.29	11.26	12.24	7.26	8.75	10.33	11.37	8.27	9.41
30	11.99	13.76	14.70	18.38	18.36	19.76	12.31	14.57	17.04	18.55	13.87	15.46
40	17.57	20.12	21.26	26.21	26.17	27.98	18.19	21.24	24.61	26.39	20.26	22.28
50	24.01	27.31	28.75	34.79	34.76	36.87	24.85	28.73	33.00	34.95	27.43	29.85
60	31.48	35.43	37.17	44.24	44.16	46.44	32.50	37.06	42.32	44.31	35.55	38.29
70	40.41	44.85	46.69	54.66	54.52	56.93	41.43	46.43	52.75	54.64	44.85	47.90
80	51.65	56.20	58.04	66.36	66.13	68.63	51.96	57.33	64.55	66.11	55.74	59.01
90	67.61	70.88	72.67	80.02	79.64	81.97	65.77	70.85	78.70	79.42	69.65	72.77
100	100	100	100	100	100	100	100	100	100	100	100	100
Gini Coefficient	0.399	0.348	0.323	0.222	0.225	0.191	0.398	0.333	0.249	0.223	0.352	0.310

Table A1.3 Trends in Nutritional Status of Children Under-Five by Place of Residence 1992-2003

Region	1992			1995			2000			2003		
	Ht. for Age	Wt. for Ht.	Wt. for Age	Ht. for Age	Wt. for Ht.	Wt. for Age	Ht. for Age	Wt. for Ht.	Wt. for Age	Ht. for Age	Wt. for Ht.	Wt. for Age
Urban Gov.	16.8	4.5	7.4	18.4	5.4	9.1	8.5	1.8	2.5	15.6	3.1	5.7
Lower Egypt	27.0	2.6	7.7	28.0	3.0	9.6	16.0	3.1	2.6	10.9	3.1	6.2
Urban	20.5	2.3	4.4	25.6	2.4	8.8	13.7	3.3	1.9	10.0	2.2	4.8
Rural	29.1	2.7	8.8	28.8	3.2	9.9	16.8	3.1	2.8	11.3	3.4	6.8
Upper Egypt	28.7	3.7	11.4	36.4	5.2	16.0	25.8	2.2	6.3	20.4	5.3	11.9
Urban	24.6	2.8	8.3	27.2	4.7	11.0	21.9	2.3	5.0	16.7	6.3	10.5
Rural	30.0	4.0	12.4	39.7	5.3	17.8	27.2	2.2	6.8	21.8	4.9	12.4
Frontier Gov.	Na	Na	Na	32.5	26.1	35.2	16.7	0.8	2.3	Na	Na	Na
Total	26.0	3.4	9.9	29.8	4.6	12.5	18.7	2.5	4.0	15.6	4.0	8.6

Ht. = Height and Wt. = Weight

Sources: El Zanaty et al., 1993, 1996; El Zanaty and Way, 2001, 2004

Table A2.1 Net Enrollment Rates in Primary Education by Sex and Governorate in 1995, 2002 and 2005*

Governorate	1995			2002			2005		
	M	F	Total	M	F	Total	M	F	Total
Cairo	100	100	100	100	100	100	128	128	128
Alexandria	100	100	100	100	100	100	119	123	121
Port said	95	99	97	97	98	97.5	104	104	104
Suez	100	100	100	100	100	100	108	109	108.5
Damietta	100	100	100	100	100	100	98	101	99.5
Dakahlia	92	95	93.5	90	94	92	91	97	94
Sharkia	83	81	82	88	92	90	83	91	87
Kalyubia	88	85	86.5	94	92	93	98	99	98.5
Kafr El-Sheikh	85	84	84.5	85	87	86	77	81	79
Gharbia	87	89	88	87	88	87.5	86	89	87.5
Menoufia	96	92	94	90	86	88	93	92	92.5
Behera	91	80	85.5	91	90	90.5	85	88	86.5
Ismailia	99	97	98	100	100	100	107	109	108
Giza	97	89	93	100	99	99.5	107	110	108.5
Beni Suef	78	56	67	94	80	87	95	91	93
Fayoum	80	59	69.5	88	78	83	84	81	82.5
Menya	80	55	67.5	97	84	90.5	91	88	89.5
Assiut	79	63	71	89	82	85.5	84	83	83.5
Souhag	71	59	65	77	75	76	71	73	72
Qena	83	77	80	88	88	88	78	82	80
Aswan	100	94	97	96	95	95.5	87	89	88
Frontier Gov.	91	79	85	100	89	94.5	89	86	87.5
Egypt	89	82	85.5	94	91	92.5	93	95	94

Source: Ministry of Education, General Department of Information and Computer.

*The net enrollment ratio is greater than 100 for some governorates because of internal migration, particularly to urban governorates and governorates with more opportunities for work.

Table A2.2 Number of Pupils in Grade 1 in 1991/92 Who Reach Grade 8 in 1998/99 and the Number and Ratio of Dropouts

	Boys	Girls	Total
Number of Pupils in Grade 1 in 1991/92	716341	607014	1323355
Number of Pupils in Grade 8 in 1998/99	681356	587036	1268392
Number of Dropouts	131712	81536	213248
Ratio of Dropouts to the Pupils entered in Grade 1 in 1991/92	18.39%	13.43%	16.11%

Source: Ministry of Education, General Department for Information and Computers, 2000

Table A2.3 Number of Pupils in Grade 1 in 1992/93 Who Reach Grade 8 in 1999/2000 and the Number and Ratio of Dropouts

	Boys	Girls	Total
Number of Pupils in Grade 1 in 1992/93	759423	650947	1410370
Number of Pupils in Grade 8 in 1999/2000	730443	638960	1369403
Number of Dropouts	118791	67795	186586
Ratio of Dropouts to the Pupils entered in Grade 1 in 1992/93	15.64%	10.41%	13.23%

Source: Ministry of Education, General Department for Information and Computers, 2000

Table A2.4 Literacy Rate (15-24) by Governorate and Sex in 1986, 1996 and 2005

Governorate	1986			1996			2005		
	M	F	Total	M	F	Total	M	F	Total
Cairo	83.6	76.9	80.25	87.4	85.9	86.2	92.6	89.4	91
Alexandria	81.1	74.6	77.85	86.3	84.5	85.4	93.0	89.2	91.1
Port said	84.2	80.8	82.5	89.9	89.7	89.8	97.0	94.6	95.8
Suez	85.1	73.2	79.15	90.3	86.0	88.15	100.0	94.1	97.05
Damietta	65.0	65.1	65.05	77.1	83.9	80.5	93.8	95.9	94.85
Dakahlia	71.2	54.2	62.7	80.3	75.9	78.1	90.9	80.1	85.5
Sharkia	69.9	45.8	57.85	76.1	65.2	70.65	91.7	78.1	84.9
Kalyubia	79.6	53.5	66.55	80.6	72.6	76.6	91.1	79.5	85.3
Kafr El-Sheikh	62.8	37.0	49.9	75.6	62.2	68.9	94.7	69.9	82.3
Gharbia	74.8	52.6	63.7	85.2	76.9	81.05	98.6	81.5	90.05
Menoufia	77.2	53.9	65.55	82.7	72.7	77.7	98.3	81.3	89.8
Behera	66.0	39.5	52.75	73.5	55.2	64.35	89.0	65.2	77.1
Ismailia	80.7	61.6	71.15	83.6	77.7	80.65	100.0	100.0	100.0
Giza	72.7	53.5	63.1	80.7	69.1	74.9	87.8	79.2	83.5
Beni Suef	58.7	31.3	45	68.9	44.0	56.45	85	60.7	80.35
Fayoum	50.5	29.8	40.15	62.1	41.6	51.85	84.3	62.8	73.55
Menya	59.0	31.0	45	70.5	42.7	56.6	88.8	62.7	75.75
Assiut	62.9	34.5	48.7	72.2	48.8	60.5	84.8	69.1	76.95
Souhag	62.3	31.2	46.75	74.2	47.7	60.95	91.6	64.6	78.1
Qena	65.9	29.3	47.6	79.2	53.3	66.25	91.5	72.8	82.15
Aswan	81.3	55.7	68.5	89.4	79.1	84.25	100.0	100.0	100.0
Frontier Gov.	73.6	47.5	60.6	84.4	66.4	75.4	96	92.2	94.1
EGYPT	71.2	51.3	61.2	79	66.9	73	92.7	80.1	86.8

Source: Calculated from Population Census and Housing, 1986, 1996 and estimates for 2005, from GALAE Statistics, 2005.

Table A3.1 Unemployment Rate by Sex and Region 1990, 1995 and 2001

Region	1990*			1995*			2001**		
	M	F	T	M	F	T	M	F	T
Urban Governorates	7.1	23.7	10.7	6.3	21.5	9.1	4.5	17.7	7.1
Urban Lower Egypt	7.3	27.4	12.5	8.2	32.4	14.1	6.6	26.2	11.9
Rural Lower Egypt	5.2	10.3	6.9	8.5	25.1	12.6	5.9	23.5	10
Urban Upper Egypt	5.9	23	10	8.8	29.1	13.5	6.6	26.4	11
Rural Upper Egypt	3.7	5.6	4.2	5.6	13.6	7.3	5	18.9	6.9
Urban Frontier Egypt	6.2	15.4	8.3	12.3	30.4	16.7	6.9	23.2	11
Rural Frontier Egypt	3.9	37.3	10.3	15.2	31.8	18.9	9.6	31.5	13.7
Total Urban	6.9	24.6	11	7.6	27.6	11.9	5.7	23.1	9.7
Total Rural	4.6	8.8	5.9	7.3	21	10.5	5.5	22.1	8.9
All Egypt	5.6	14.4	8.1	7.4	23.8	11.1	5.6	22.6	9.2

* Unemployment rate for ages (12 - 64).

** Unemployment rate for ages (15 - 64).

Source: Calculated from Labor Force Sample Surveys 1990, 1995 and 2001.

Table A4.1 Neonatal, Post-Neonatal, Infant and Under-Five Mortality Rates for the Five Year Periods Preceding the Surveys

Approximate Midpoint of Calendar Period	Survey	Neonatal Mortality	Post-Neonatal Mortality	Infant Mortality	Under 5 Mortality
1977	EFS 1980 ⁽¹⁾	59	74	132	191
1986	EDHS 1988 ⁽²⁾	38.5	34.5	73.1	102.0
1990	EDHS 1992 ⁽³⁾	32.8	28.7	61.5	84.8
1993	EDHS 1995 ⁽⁴⁾	30.4	32.2	62.6	80.6
1998	EDHS 2000 ⁽⁵⁾	24.0	19.6	43.5	54.3
2001	EIDHS 2003 ⁽⁶⁾	22.9	15.1	38.0	45.7

Sources: (1) Hallouda et al., 1983 (2) Sayed et al., 1989 (3) El Zanaty et al., 1993 (4) El Zanaty et al., 1996 (5) El Zanaty and Way 2001 (6) El Zanaty and Way 2004.

Table A4.2 Neonatal, Post-Neonatal, Infant and Under-Five Mortality Rates form Vital Statistics

Years	Neonatal Mortality	Post-Neonatal Mortality	Infant Mortality	Under 5 Mortality
1977	14.8	70.5	85.3	140.7
1986	13.1	34	47.1	69.6
1990	9.4	28.4	37.8	56.0
1993	8.9	22.9	31.8	45.7
1998	11.4	17.7	29.1	39.0
2001	15.6	12.6	28.2	35.4

Sources: Calculated from Births and Deaths Statistics 1977, 1986, 1990, 1993, 1998 and 2001.

List of Acronyms & Abbreviations

ARI	Acute Respiratory Infections	MISR	Municipal Initiatives for Strategic Recovery
BMR	Basal Metabolic Rate	MMR	Maternal Mortality Rate
CAPMAS	Central Agency for Public Mobilization and Statistics	MOALR	Ministry of Agriculture and Land Reclamation
CCA	Common Country Assessment	MOE	Ministry of Education
CCIMD	Center for Curriculum and Instructional Materials Development	MOHP	Egyptian Ministry of Health and Population
CFC	Chlorofluorocarbons	MOI	Ministry of Investment
CPI	Consumer Price Index	MOISA	Ministry of Insurance and Social Affairs
CPR	Contraceptive Prevalence Rates	MOIWR	Ministry of Irrigation and Water Resources
DAC	Development Assistance Committee	MOP	Ministry of Planning
DAG	Donors Assistance Group	MOSEA	Ministry of State for Environmental Affairs
DOTS	Directly Observed Treatment Short Course	MP	Member of Parliament
EDHS	Egypt Demographic and Health Survey	NAP	National AIDS Program
EEAA	Egyptian Environmental Affairs Agency	NCCM	National Council for Childhood and Motherhood
EFS	Egyptian Fertility Survey	NCW	National Council for Women
EIDHS	Egypt Interim Demographic and Health Survey	NDP	National Democratic Party
EOC	Essential Obstetric Care	NEAP	National Environmental Action Plan
ERF	Economic Research Forum	NGO	Non-Governmental Organization
ERSAP	Economic Reform and Structural Adjustment Program	NSB	Nasser Social Bank
EU	European Union	ODA	Official Development Assistance
FDI	Foreign Direct Investment	ODP	Ozone-Depleting Potential
GAD	Gender and Development (A sub-group of DAG)	OECD	Organization for Economic Co-operation and Development
GALAE	General Authorities for Literacy and Adult Education	ORT	Oral Dehydration Therapy
GDP	Gross Domestic Product	PARC	Public Administration Research Center
GHG	Greenhouse Gas	PHC	Primary Health Care
GNI	Gross National Income	PPP	Purchasing Power Parity
GOE	Government of Egypt	SFD	Social Fund for Development
HDI	Human Development Index	SME	Small and Medium Enterprises
HIECS	Household Income Expenditure and Consumption Survey	SRC	Social Research Center
HIPC	Heavily Indebted Poor Country	STDs	Sexually Transmitted Diseases
IDSC	Information and Decision Support Center	TFR	Total Fertility Rate
IMCI	Integrated Management of Childhood Illness	TT	Tetanus Toxoid
IMR	Infant Mortality Rate	U5MR	Under 5 Mortality Rate
INP	Institute of National Planning	UN	United Nations
IUD	Intra-uterine Device	UNAIDS	Joint United Nations Programme on HIV/AIDS
Kgoe	Kilogram Oil Equivalent	UNCT	United Nations Country Team
LDC	Least Developed Country	UNDP	United Nations Development Programme
MCH	Maternal and Child Health	UNICEF	United Nations Children's Fund
MDG	Millennium Development Goal	USAID	United States Agency for International Development
MENA	Middle East and North Africa	WHO	World Health Organization