POPULATION SITUATION ANALYSIS

2016 EGYPT

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Abbreviations and Acronyms

4Ps	Public-Private Partnership in Population
ART	Anti-Retroviral Therapy
ASFR	Age Specific Fertility Rates
BioBSS	Biological and Behavioral Surveillance Survey
CAPMAS	Central Agency for Statistics and Public Mobilization
CBR	Crude Birth Rate
CCT	Conditional Cash Transfer
CDPA	Center for Development and Population Activities
CDR	Crude Death Rate
CEFRS	Center for Economic and Financial Research Studies
CMRS	Center for Migration and Refugee Studies
DHS	Demographic Health Survey
ECGBVS	Economic Cost of Gender-Based Violence Survey
EDHS	Egypt Demographic and Health Survey
EEE	Educate, Empower and Employ
EFPA	Egyptian Family Planning Association
EFPRHA	Egyptian Family Planning and Reproductive Health Association
ELMPS	Egypt Labor Market Panel Survey
EMR	Electronic Medical Record
ESCWA	Economic and Social Commission for Western Asia
FHI	Family Health International
FP	Family Planning
FSW	Female Sex Worker
GBD	Global Burden of Disease Project
GBV	Gender Based Violence
GIPA	Greater Involvement of PLHIV
HHs	Households
HIECS	Household Income, Expenditure and Consumption Survey
HPV	Human Papilloma Virus
HSRP	Health Sector Reform Program
ICPD	International Conference on Population and Development
IDU	Injecting Drug Users
IOM	International Organization for Migration
ISDF	Informal Settlement Development Facility
IUDs	Intrauterine Device
MARPs	Most At Risk Populations
MB	Muslim Brotherhood
MCIT	Ministry of Communication and Information Technology
MDGs	Millennium Development Goals

MIDUs	Male Injecting Drug Users
MoE,	Ministry of Education
MoF	Ministry of Finance
MoHE	Ministry of Higher Education
MoHP	Ministry of Health and Population
MoI	Ministry of Interior
MoP	Ministry of Planning
MoPMAR	Ministry of Planning, Monitoring, and Administrative Reform
MoSS	Ministry of Social Solidarity
MSM	Men who have Sex with Men
MTCT	Mother To Child Transmission
MYS	Ministry of Youth and Sports
NAHR	Network of Associations for Harm Reduction
NAP	National AIDS Program
NCCM	National Council for Childhood and Motherhood
NCW	National Council for Women
NEDSS	National Electronic Disease Surveillance System
NGOs	Non-Governmental Organization
NPC	National Population Council
PLHIV	People Living with HIV/AIDS
PPP	Purchasing Power Parity
RH	Reproductive Health
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SYPE	Surveys of Young People in Egypt
TFR	Total Fertility Rate
THO	Teaching Hospitals and Institutes Organization
THs	Teaching Hospitals
UNAIDS	UN AIDS Program
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNHCR	United Nations High Commissioner for Refugees
UNODC	United Nation Office for Drugs and Crime
UNRISD	United Nations Research Institute for Social Development
VCT	Voluntary Counseling and Testing
YFCs	Youth Friendly Clinics
YLD	Years Lived with Disability

Executive Summary

Executive Summary

The current report presents a new analysis for Egypt latest population situation. This new analysis is required, given the changes in the political, economic, social and environmental arenas occurring in the recent few years.

The report will, accordingly, serve as:

- A baseline for monitoring the implementation of the National Population Strategy;
- A source of technical inputs and recommendations for the UNFPA tenth Country Program; and
- The main UNFPA source of technical inputs and recommendations for the upcoming UNDAF.

An overview of the population status in Egypt indicates that the political instability witnessed during the period from 2011 to 2014 had its impact on health services delivery, including reproductive health and family planning, as well as on economic growth, job opportunities and poverty rates. Moreover, the lack of advocacy activities supporting the two-child policy and spacing between births, coupled with a conservative mindset, contributed to turning the stalled fertility levels between 1995 and 2005 to an increase in total fertility from 3 to 3.5 child per women in 2014. The reproductive and productive roles of women were notably competing in a society lagging behind with regard to women empowerment and gender equality.

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

Taking such challenges in consideration together with the significance of policy-making, Egypt has adopted a set of assisting policies and strategies, including the Population and Development Strategy 2015-2030 and Egypt Vision 2030. However, the review shows that objectives adopted in the planning phases were not achieved due to the lack of resources, weak coordination, discontinuity of institutional framework, centralization, and the absence of monitoring and evaluation.

Issues related to inequality are pertinent when addressing population dynamics. In Egypt, significant disparities in population and health outcomes can be explained based on poverty level and place of residence (urban versus rural areas and Upper versus Lower Egypt). This can be illustrated in Figures (1, 2 and 3) where it is evident that poverty and living in rural Upper Egypt are highly associated with large families and/or low contraceptive prevalence and fertility level. The implications of the previously stated are not only reflected in higher fertility level, but also manifested in internal and illegal migration, increasing unemployment rate and risk of political unrest. This is adversely affecting youth and creating a vicious circle, which is hard to be broken. Therefore, securing reproductive health and family planning services, especially in deprived areas and among marginalized subpopulations, should receive the highest priority. With this in mind, designed programs should be established in line with the local context and different approaches should be considered, especially in rural Upper Egypt.

Figure 1: Percent below Poverty Line by Family Size, 2015

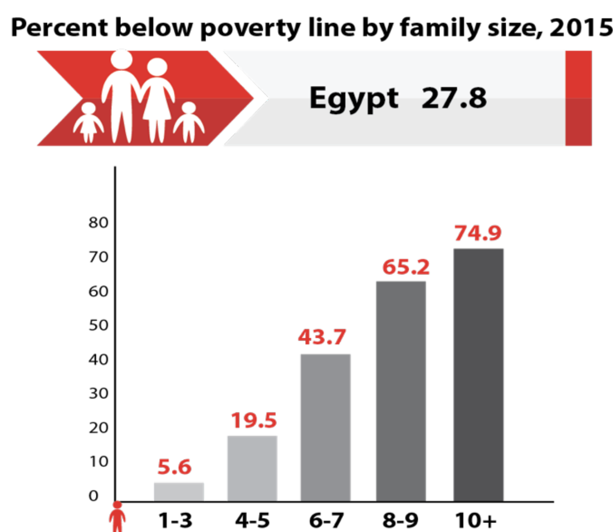


Figure 2: Contraceptive Use (among Currently Married), 2014

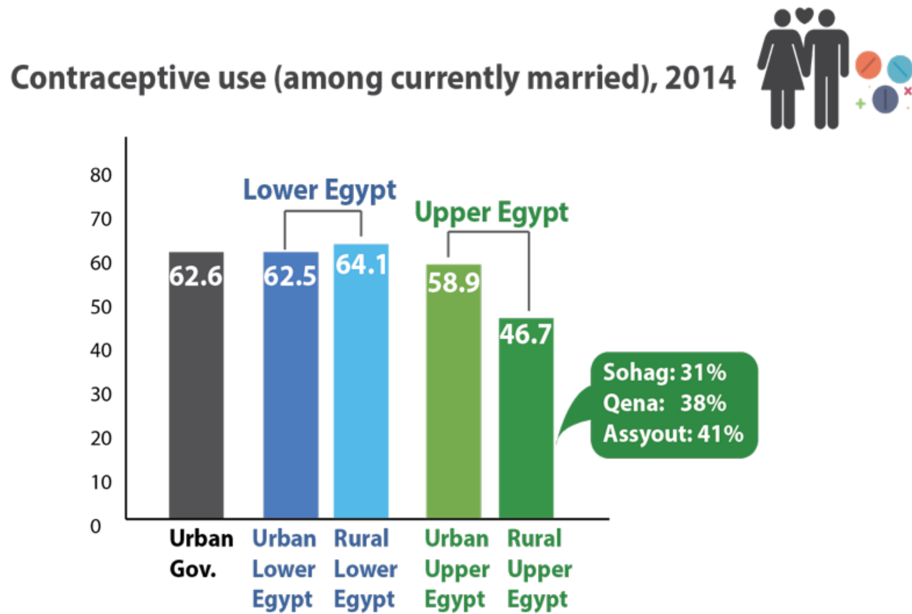
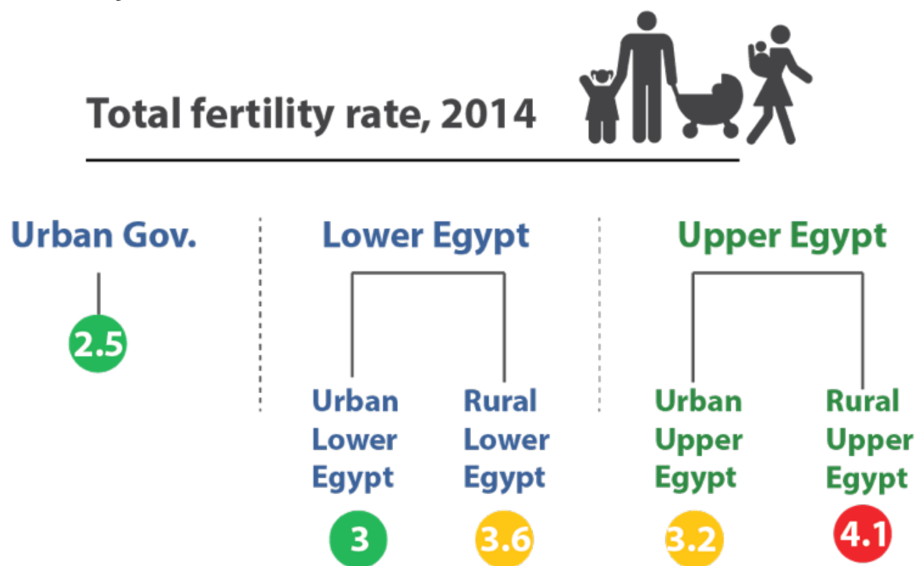


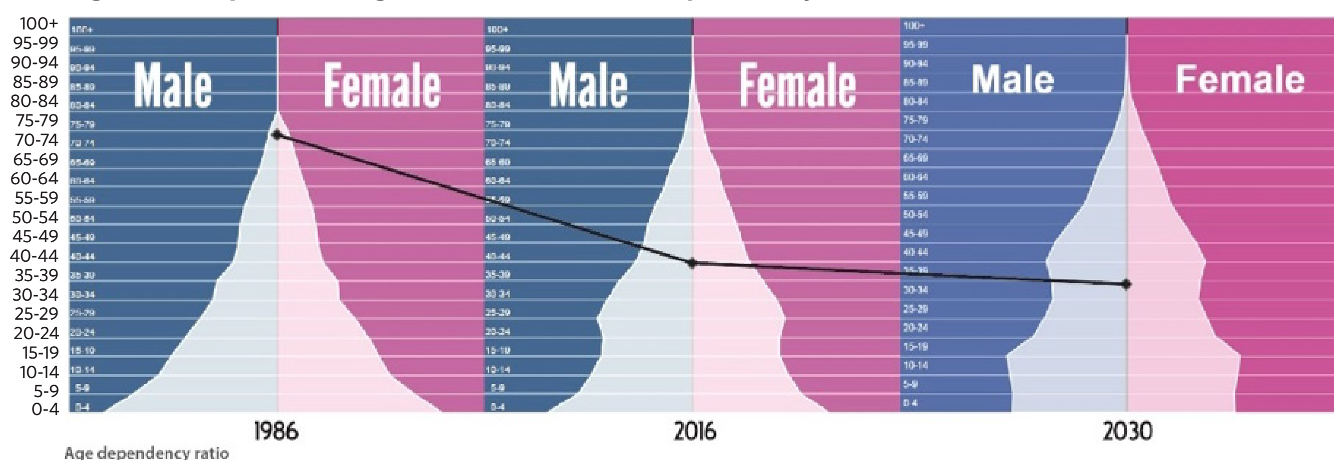
Figure 3: Total Fertility Rate, 2016



Political commitment and legislative framework offer a unique opportunity to reduce population growth rates and improve population characteristics, which in turn will improve by time the quality of life and provided opportunities. The 2014 Egyptian Constitution, new Egypt Vision 2030, Population Strategy and the SDGs provide a comprehensive approach to integrate population and development. Nevertheless, the institutional framework should be enhanced to address challenges that go beyond high fertility level and root causes should be tackled in a participatory and harmonized approach and not to be restricted to governmental organizations.

A comprehensive approach to population issues should consider the benefits of demographic dividend with regard to the significant and continuing decline in fertility rate. Demographic dividend is the economic growth potential that can result from shifts in a population's age structure, as fertility levels decrease, mainly when the share of the working-age population is larger than the non-working-age share of the population.

Figure 4: Population Age Distribution and Dependency Ratios 1986, 2016, and 2030



Age dependency ratio

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

These efforts are needed to break the vicious cycle of poverty, low level of education, early childbearing, and high fertility rate that has trapped a large segment of the Egyptian society.

In fact, demographic dividend can be addressed within the context of the SDGs. The EEE approach, namely, Educate, Empower and Employ, can also serve as a framework to make use of the demographic dividend.

Empowerment, as a keyword, can be achieved through all people access to essential health care services, especially women and girls, with special attention paid to providing them with the rights and freedom to define their lives via the protection from being exposed to harmful practices, child marriage and all forms of violence. Women in Egypt are encountering multiple forms of social, cultural, economic and political exclusion. Such forms of exclusion are caused mainly by two key factors, namely the failure of public policies to bridge the ever-expanding gender gap on several levels, and the persistence and severity of social norms hindering women economic and legal empowerment.

All and above, no demographic dividend can take place without youth empowerment. In addition to accessibility to quality education, youth political and civic participation is an essential pursuit for building a sustainable future. Comprehensive sexual education should be provided and reproductive health services should be integrated in the health system for related-risks prevention.

Together with the adoption of demographic dividend as a framework, the report outlines a set of suggestions:

Provide adequate and sustainable funding to ensure full coverage of contraceptives especially in deprived areas;

Provide capacity building in order to offer better quality reproductive health services to reduce unmet needs and dropouts;

Advocate for adopting lower fertility norms, spacing between births, and avoiding early pregnancy;

Empower women through financial inclusion, legal support and skills development to decrease unemployment rates and create job opportunities;

Empower youths through the provision of knowledge, entrepreneurship services, information and access to credit in order to create job opportunities and improve quality of life;

Encourage NGOs to play a more effective role in the provision of services, in remote areas and to marginalized subpopulations, as well as advocacy activities;

Emphasize population rights in conditional cash transfer programs, as a vehicle to enhance social transformation and improve quality of life;

Collaborate with private sector in population-oriented activities through corporate social responsibility programs; and use social media means and innovative ideas to communicate with youths.

Introduction

Introduction

Egypt witnessed several political changes during the last five years. These changes started when Egyptians took to the streets on January 25th, 2011 with specific requests "Bread, Freedom and Social Justice". These requests reflected not only the needs of Egyptians, but also a road map for a sustainable future. After a transition period, a presidential election was held by mid-2012, and the nominee of the Muslim Brotherhood, Mohamed Morsi, won the election and became the first president after the January 25th revolution. At the outset of his term, starting in June 2012, Morsi offered a package of promises, pledging to fulfill such promises in the first 100 days of his rule. By the end of the 100 days period, 78% of the Egyptians were satisfied with Morsi's performance. This high satisfaction rating soon elapsed, and the Egyptians began to set it right in response to the constitution amendment, a move that was largely perceived as a breach of the existing constitutional provisions. The satisfaction rating continued to dip, reaching 32% in late June 2013, days before the June revolution. As a result of the MB failure to meet Egyptians' expectations, Egyptians streamed into the streets demanding MB departure, and before long the army responded to the Egyptians request and deposed Morsi from power. In June 2014, another presidential election was held and Abd El-Fatah El-Sisi won. Since then Baseera polls show improvements in security and political stability, as in August 2014 around 88% of the Egyptians stated that the security has been on the march. This percentage continued at the same level, during the following two years, pinpointing the high satisfaction rate with the president's performance over this period.

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

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

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

All of the referred to facts, the emergence of new stakeholders with high impact on population growth together with the occurring cultural changes suggest the need for a new analysis to the current situation in Egypt; taking in consideration the new Egyptian population and development strategy for 2015-2030 launched in November 2014. This strategy is based on four main objectives:

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

Each of the above objectives was linked to a number of quantitative targets and a set of programs and activities. Different stakeholders have participated in developing the strategy and were committed to performing their assigned roles as well as specified targets. It is noteworthy that the implementation of such a strategy has already took place in 2015.

Monitoring and evaluation are paramount aspects in the strategy implementation in order to ensure the strategy accomplishment of final goal by 2030. The "Population Situation Analysis" report will serve as a baseline to follow up

the National Population Strategy implementation, assist in monitoring different stakeholders application of relevant procedures and activities as well as to evaluate the outcomes of applicable activities to confirm whether established targets are achieved or not.

The report will further present and address the changes taking place with regard to population and development issues in Egypt. In addition, the report will tackle programs and activities conducted to improve Egypt status and the actions needed to accomplish population and development strategy goals. Taking such points in consideration, the report will provide:

- A baseline for monitoring the implementation of the National Population Strategy;
- A source of technical inputs and recommendations for the UNFPA tenth Country Program; and
- The main UNFPA source of technical inputs and recommendations for the upcoming UNDAF.

To achieve the established objectives, the report is made of eight chapters following this introduction. Each chapter provides an overview of the latest statistics related to the topics addressed in each chapter and analyzes the differences in the values of indicators according to the specified main characteristics, whenever possible. Also, each chapter presents a set of indicators reflecting Egypt status concerning the topics discussed, with a special focus on the indicators used to set the National Population and Development Strategy goals.

Chapter One outlines the population status in Egypt including population growth, dynamics, and characteristics. The chapter sheds light on issues of marriage, fertility and mortality. It ends with an analysis of Egyptians' perceptions regarding different population issues.

Chapter Two discusses the different strategies, launched in Egypt during the last two years, aiming to improve Egyptians' lives. This chapter further pinpoints the framework needed to implement the National Strategy for Population and Development.

Chapter Three underscores issues regarding sexual and reproductive health as well as HIV/AIDS, with due attention to adolescents and youths as a priority group.

Chapter Four addresses the issue of inequality and vulnerable groups. Baseera team conducted a number of focus group discussions and in-depth interviews with Egyptians from different vulnerable groups to bridge the gap in information related to such groups.

Chapter Five focuses on women status and gender inequality, with emphasis on different issues related to women empowerment and gender-based violence.

Chapter Six tackles adolescents and youths access to sexual and reproductive health services, and early marriage together with other harmful practices against female adolescents.

To move forward towards achieving the development goals, Chapter Seven discusses the relationships connecting between population, economic situation, poverty eradication and environmental conditions. This chapter underlines the need for social protection, bearing in mind the age structure and the universal social protection approach.

Finally, Chapter Eight summarizes the main challenges facing Egypt regarding population and development issues and ends with a set of recommendations to accelerate the pace of Population and Development Strategy achievement.

Chapter 1
Egypt Population Status

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1.1 Introduction

Egypt population has been witnessing dramatic increases during the last decade. Such increases require more resources to cover the emerging population needs and achieve citizens' welfare. In fact, this depends to a great extent on population growth rate and characteristics together with citizens' perception and knowledge of population growth and relevant consequences. For more elaboration, section two of this chapter will present population size and growth; section three will shed light on population dynamics; section four will highlight population characteristics; section five will address in detail the demographic transition and dividend in Egypt; section six will underline the Egyptians knowledge of population size and natural resources limitations.

1.2 Population Size and Growth Rate

CAPMAS estimated Egypt population in November 2016 by 92 million people compared to a total of 72 million people in November 2006. In absolute terms, the population of Egypt has increased by around 20 million people in 10 years. This rise in population, during the decade 2006-2016, is almost the population size of Belgium and Sweden together as well as both Hungary and Czech Republic. Notably, Egypt population size in 2016 is almost three times the population of Malaysia, and almost the population size of Morocco, Saudi Arabia and Yemen together, and around 2.5 the population of Canada.

In 2015, the estimated global population was 7.3 billion. It is worth noting here that Egypt population accounts for almost 1.2% of such global population. With regard to population, Egypt ranked 15 globally, in 2014, according to (Info Please, 2015), as shown in Table 1.

Egypt ranked 20 back in 1950, yet since 1999 Egypt ranked 15. Egypt is the third populous country in Africa after Ethiopia, which is ranked 13, with population exceeding 96.6 million, and Nigeria which is ranked 7, with population amounting to 177 million.

Table 1: (1.1) Population Size of the 15 Most Populated Countries in the World, 2014

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

Source: Info Please, 2015

Egyptians live in one million square kilometer, with a population density of 89.2 per square kilometer, as stated in 2016. Egypt ranks 115 in population density, though Egyptians effectively live on about 8% of the estimated area. The inhabited area is concentrated along the Nile River from the south to the north. Given this extensive concentration of population on this narrow area, population density is exceedingly high if the inhabited areas only were considered. The population density in 2016 rises to almost 1136.5 persons per square kilometer, taking into account inhabited areas only. Accordingly, Egypt rank will remarkably shift from 115 to 114 globally. High population density could be related to low standards of life and low quality of services, especially if the cities are poorly structured. This asserts the significance of addressing the population distribution issue in the National Strategy for Population and Development.

The United Nations has estimated that world population growth at an annual rate of 1.23% during the period 2000-2010. The average annual growth rate for selected countries and the World is shown in Figure (1.1). China, which is the most populous country in the world, registered an annual growth rate of 0.53% during 2000-2010. India, being the second populous country, recorded an annual rate of 1.64% during the same period. Now, China growth rate is the third lowest among the ten most populous countries, after Russia and Japan and it is substantially lower than the USA (0.7%). With reference to Egypt, it is growing at a rate of 2.3%, which is a rate higher than many developing countries.

During the period 1897 to 2015, Egypt witnessed around a nine-fold population increase. Throughout the first fifty years of the past century, Egypt population doubled. However, in the latter period from 1947-2015, population rate experienced a five-fold surge, the pace of which started in the early fifties of the past century.

Figure 1: (1.1) Population Growth Rates in Selected Countries

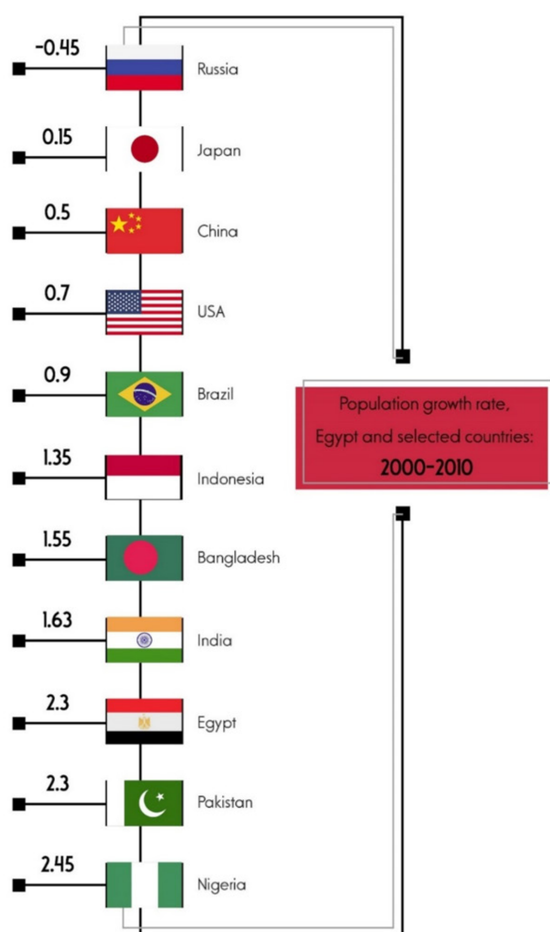


Table 2: (1.2) Egypt Population Size and Annual Growth Rate, 1897-2015

Index Number %	Annual Growth Rate (%)	Population Size (in millions)	Census Year
100		9.7	1897
115.7	1.43	11.2	1907
131.5	1.31	12.7	1917
149.6	1.10	14.2	1927
164.7	1.15	15.9	1937
196.2	1.75	18.9	1947
268.7	2.30	26.1	1960
378.8	2.12	36.6	1976
499.1	2.86	48.2	1986
613.4	2.06	59.3	1996
752.9	2.05	72.8	2006
876.2	2.30	89.6	2015

** This count excludes Egyptians not present on census reference night.*

Source: Population Censuses and Statistics Year Book 2014, CAPMAS

CAPMAS site (http://www.capmas.gov.eg/), 2015

1.3 Population Dynamics

1.3.1 Mortality Transition

The period from early 1960s until early 1990s witnessed a remarkable fall in death rate, as illustrated in Figure (1.2).

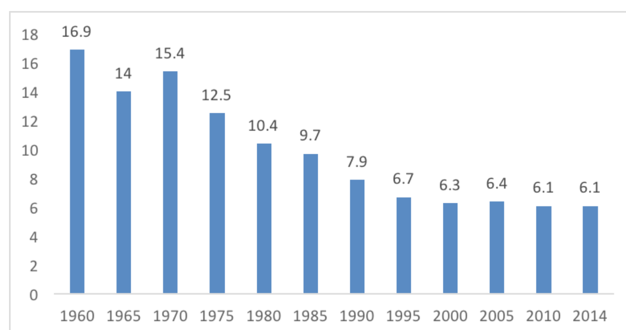
It is noticed that this rate has been dropping exceedingly slowly since early 1970s, until it reached 6.9 deaths per 1000 people in 1992.

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

Deaths are more prevalent in urban areas (8.1 deaths per 1000 people) compared to rural areas (4.7 deaths per 1000 people). The highest death

rates has been witnessed in Cairo (9 deaths per 1000 people) and Alexandria (8 deaths per 1000 people) while the least death rates are registered in the frontier governorates such as Al-Wadi Al-Gadid, Northern Sinai, and Marsa Matrouh (4.4 deaths per 1000 people). This can mainly be attributed to the high demand on the comparatively high quality health services available in Cairo and Alexandria, thus most people travel to such metropolitan areas to seek quality health services. Bearing the previously mentioned in mind, cases of death taking place in such metropolitan areas are accordingly registered there, which results in the higher death rate. It is noteworthy that males experience higher death rates (6.6 deaths per 1000 people) than females (5.6 deaths per 1000 people).

Figure 2: (1.2) Crude Death Rates in Egypt, 1960-2014



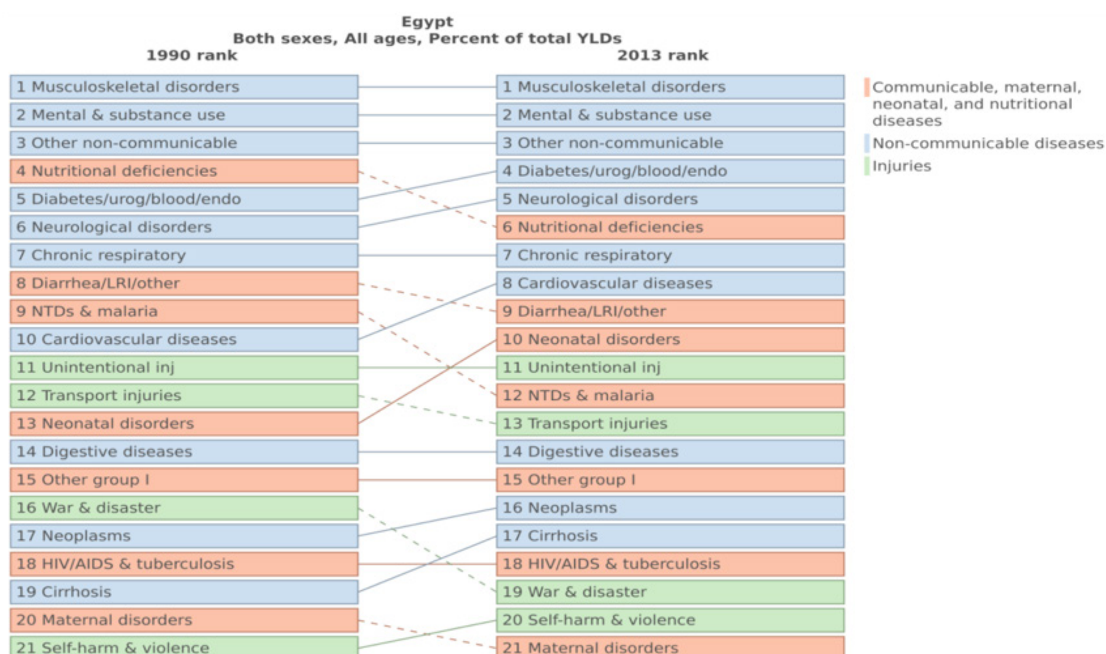
Source: Birth and Death Statistics for Several Years, CAPMAS

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

Causes of Morbidity and Mortality

One of the main outcomes of the Global Burden of Disease (GBD) project is quantifying the years lived with disability, by cause and risk factor leading to this disability. Figure (1.3) shows that between 1990 and 2013 the non-communicable diseases had precedent over the communicable ones. The ranks of diabetes, urogenital, blood and endocrine diseases together with neurological disorders rose one rank while nutritional deficiencies lost two ranks. Diarrhea, lower respiratory infections and other diseases also dropped one rank. The highest rate of rank loss was for the neglected tropical diseases and malaria, which lost three ranks from 9 to 12.

Figure 3: (1.3) Changes in Rank of Major Health Causes Underlying YLD, 1990-2013



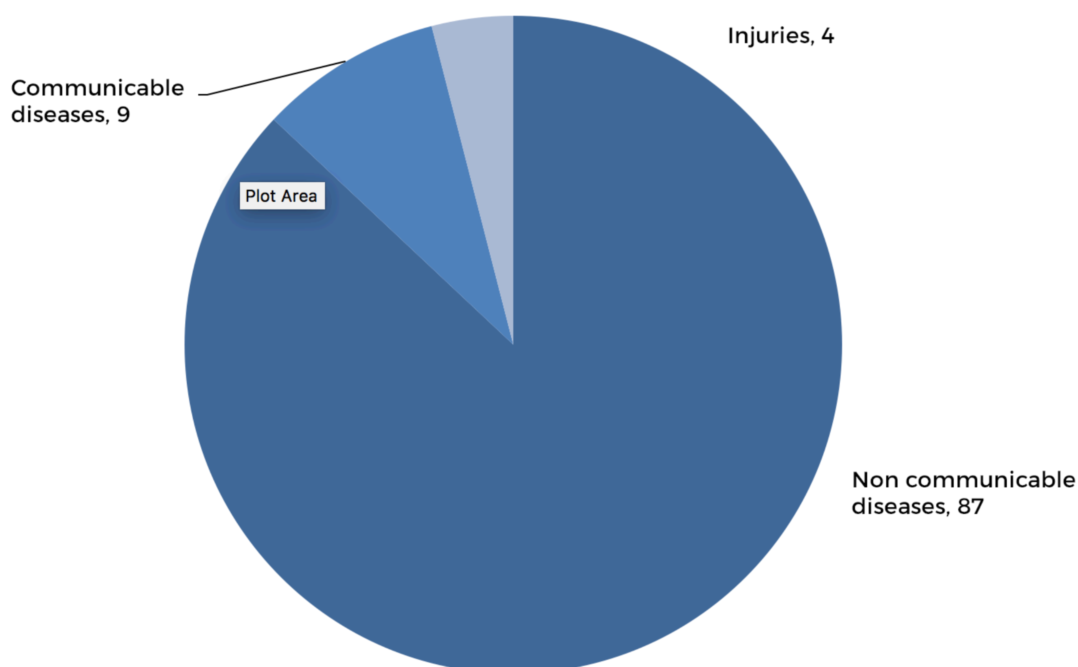
Source: Institute for Health Metric and Evaluation

According to Gayed (2014), non-communicable diseases were the leading cause of death among Egyptians, accounting for 87% of all deaths in Egypt (Figure 1.3). However, communicable diseases still maintain a significant share of deaths in Egypt, recording 9%. Injuries had the lowest share representing only 4% of all deaths.

Closely looking at the causes of death and measuring the major non-communicable diseases contribution reveal that cardiovascular diseases were the main causes of death, amounting for 43% of all deaths, followed by communicable diseases by 9%, cerebrovascular disease and malignant neoplasms by 8% and 7%, respectively (Figure 1.4). With regard to malignant neoplasm, the data showed that 22% of this category deaths were due to liver cancer. Among the juries, about 40% of the deaths were attributed to road traffic accidents.

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

Figure 4: (1.4) Major Causes of Death in Egypt, as Reported by Death Certificates, 2013



Neonatal, Infant and Under-Five Mortality

Table (1.3) presents the trend in neonatal, infant and under-five mortality in Egypt during the period 1965-2014. The trend in the three rates is going down as a result of providing better health services. For the under five years, the probability of dying in 1965 was nine times the one observed in 2014 (243 and 27 respectively). Infant mortality rate decreased six times from 141 in 1965 to 22 per 1000 live births in 2014. The decrease in neonatal deaths was much lower, almost four times, from 63 to 14 births. This clearly indicates a change in the pattern of mortality for those less than 5 years; mortality became concentrated mainly in the earliest months of life. According to EDHS 2014, around 40% of under-five deaths occurred after completing the first year in life, in 1965, compared to only 19%, in 2014.

Table 3: (1.3) Egypt Early Childhood Trends (per 1000 Live Births), 1965-2014

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

Source: EDHS 2014

Early childhood mortality is more prevalent in rural areas compared to urban areas; the difference is almost 30% higher in rural areas. Females experience higher likelihood to die than males especially those less than one year, as shown in Table (1.4). The main outcome of these findings suggests that males are still prioritized and favored even when dealing with infants, thus arises the need to further promote and raise public awareness of gender equality significance even among young children.

Table 4: (1.4) Egypt Early Childhood Mortality (per 1000 Live Births), by Residence and Gender, 2014

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

Source: EDHS 2014

Maternal Mortality

Complications of pregnancy and delivery are the leading cause of morbidity and mortality of women in reproductive age world-wide, accounting for about one fifth of the burden of disease among women in this age. Maternal mortality caused by pregnancy or childbirth is a major cause for female mortality. In 1992-1993, the Ministry of Health and Population (MoHP) conducted a study on maternal mortality ratio estimates, which showed that the ratio stood at approximately 174 per 100,000 live births. In 2000, the MoHP undertook the same study, which recorded a dramatic decline in maternal mortality ratio to 84 per 100,000 live births, with a reduction rate of 52%. The ratio decreased to 66 maternal deaths per 100,000 live births in 2010, with almost another 27% reduction in 10 years. The recent figures show a continued decrease, as the ratio reached 52.5 deaths per 100,000 live births in 2013, which indicates that Egypt has achieved the MDGs 5th goal related to improving maternal health.

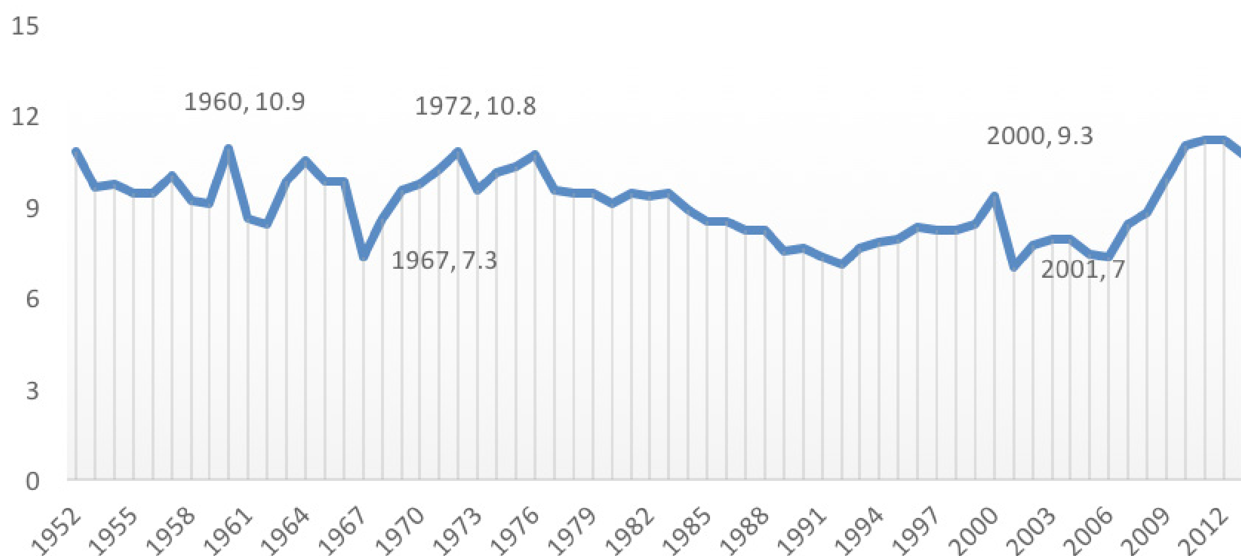
Although maternal mortality was high throughout Egypt in the early 1990s, women were more vulnerable in the less developed southern parts of the country. Women living in Upper Egypt had a more difficult time accessing high-quality maternal care; being twice more likely to die as a result of pregnancy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

1.3.2 Marriage and Family Patterns

Marriage is universal in Egypt. According to 2006 census data, three out of four females 16+ got married. The percentage increased from 11% among this age group (16-19) to 96% among the age group (30 to 39). The percentage of ever married males reached 91% among the age group (30 to 39). Among males in the age group 45+ only 1% have never married.

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

Figure 5: (1.5) Crude Marriage Rate Trend, 1952-2013



Source: CAPMAS

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

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

Table 5: (1.5) Median Age at First Marriage

	2000	2005	2008	2014
15-19	*	*	*	*
20-24	*	*	*	*
25-29	20.8	21.3	21.2	21.3
30-34	19.9	20.7	20.9	21.1
35-39	19	19.9	20.4	20.8
40-44	18.7	19.8	20	20.4
45-49	18.1	19.8	19.6	20
Total 25-49	19.5	20.4	20.6	20.8

Source: EDHS 2014

Table (1.6) shows the distribution of women (15-49 years) by their marital status, according to the 2014 demographic and health survey data. The table also highlights that early marriage is widely spreading in Egypt, since around 6% of women in the age group (15-17) are currently or ever married. Median age at first marriage reached 21 years, and gets higher among urban residents (22 years), who completed at least secondary education (22 years), and who belong to the highest wealth quintile (23 years).

Table 6: (1.6) Distribution of Women (15-49 years), by Marital Status, 2014

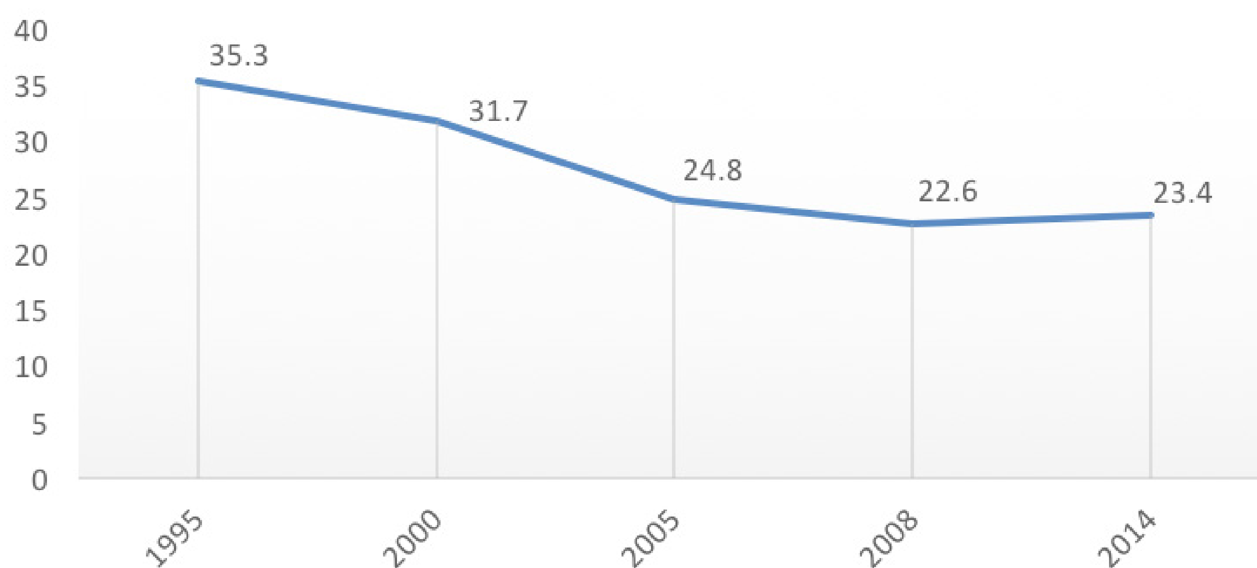
Age	Never married	married	divorced	separated	Widowed	Total
19-15	85.3	14.40	0.20	0.20	0.00	100
17-15	93.6	6.20	0.10	0.00	0.00	100
19-18	72.2	27.20	0.30	0.30	0.00	100
24-20	38.9	59.60	0.90	0.40	0.10	100
29-25	12.9	84.50	1.50	0.80	0.30	100
34-30	6.8	89.90	1.90	0.50	1.00	100
39-35	3.1	91.00	2.50	0.80	2.60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

Source: EDHS 2014

Marriage between blood relatives in Egypt is common. Almost one-third of women are married to a relative. This percentage increases to 35% in rural areas compared to 22% in urban areas. It is also more prevalent among uneducated women (37%) and those belonging to the lowest wealth quintile (43%). The highest prevalence was reflected in rural Upper Egypt, where almost half the marriages are between blood relatives.

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

Figure 6: (1.6) Percentage of Ever Married Women, Married to First or Second Cousin

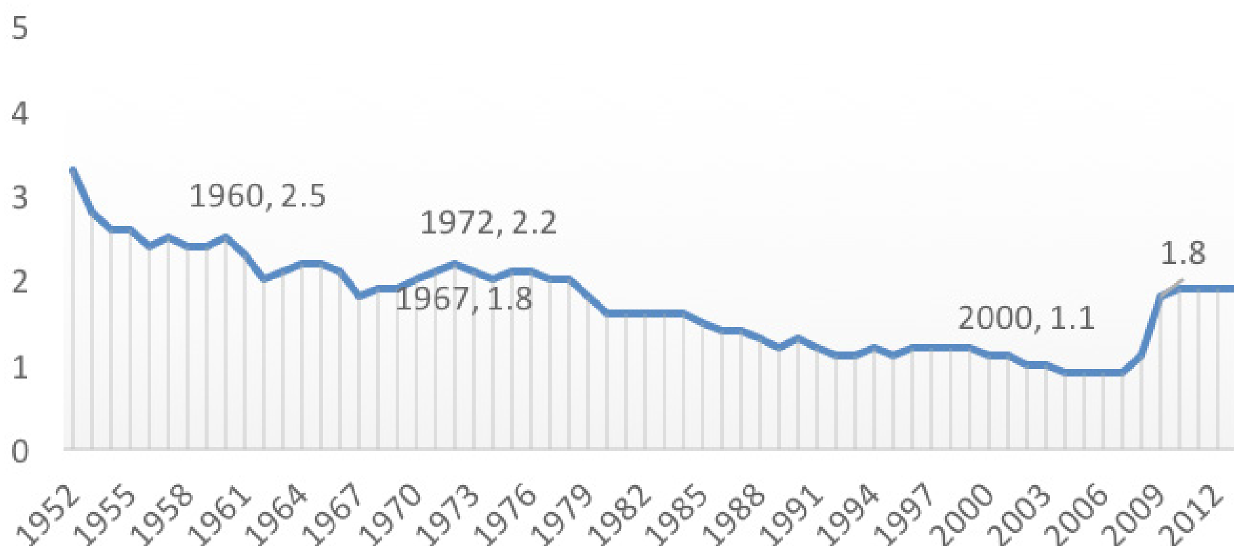


Source: EDHS 2014

CAPMAS marriage statistics show that a high percentage of women are married to men who are lower in educational level. This percentage increases from 13% among women with less than intermediate education to 23% among university graduates and 35% among those with post graduate degrees.

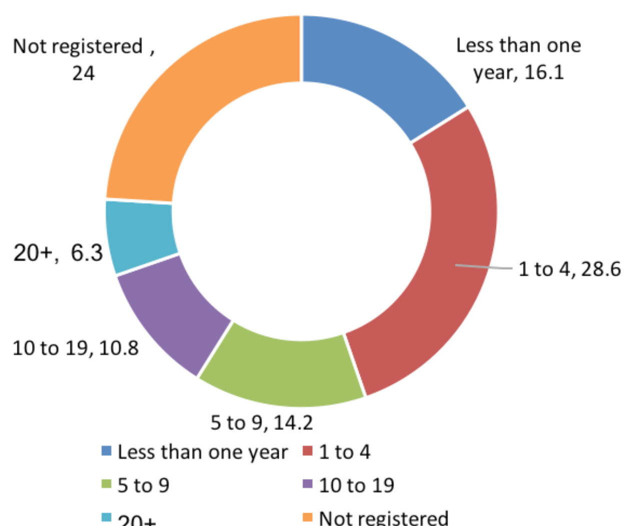
Crude divorce rate data show a decrease from 3.3 per 1000 people in 1952 to one third of such a value in 2000. It further continued at that low level till 2008, then started to increase again to reach 1.9 per 1000 people in 2009 and went on at such a level until 2013. The low level of divorce rate reflects Egyptian families' sense of stability, the matter positively reflected on children.

Figure 7: (1.7) Trend of Crude Divorce Rate, 1952-2013



In 2013, the number of divorce cases reached 162,583, 16% of which occurred during the first year of marriage, 28% between the first and fifth year and 6.3% after more than 20 years of marriage. However, the length of marriage were not registered for 24% of these cases.

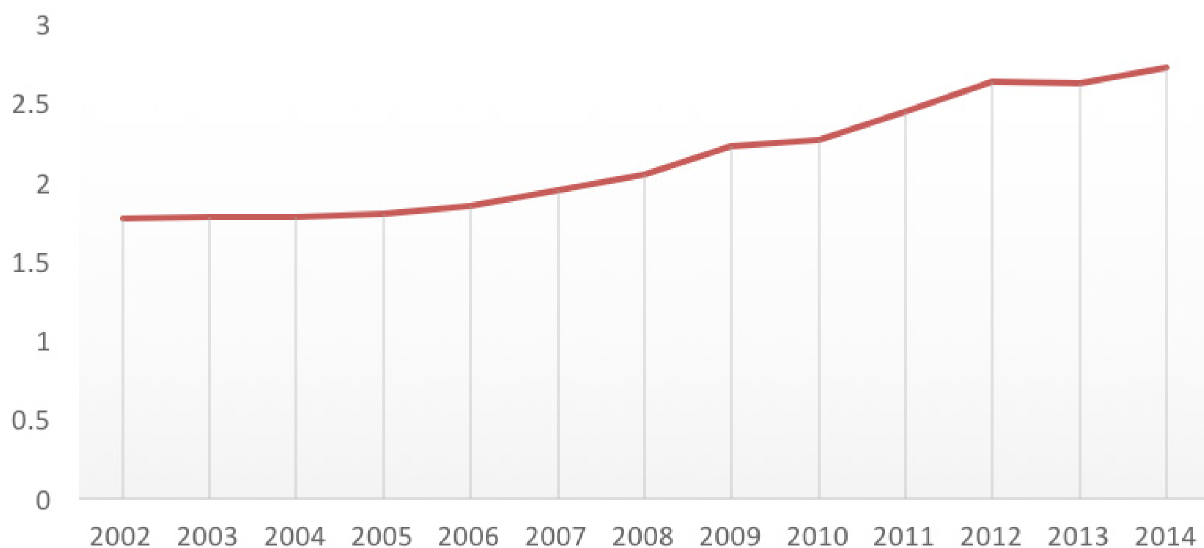
Figure 8: (1.8) Distribution of Divorce Percentage, by Marriage Duration



1.3.3 Fertility Transition

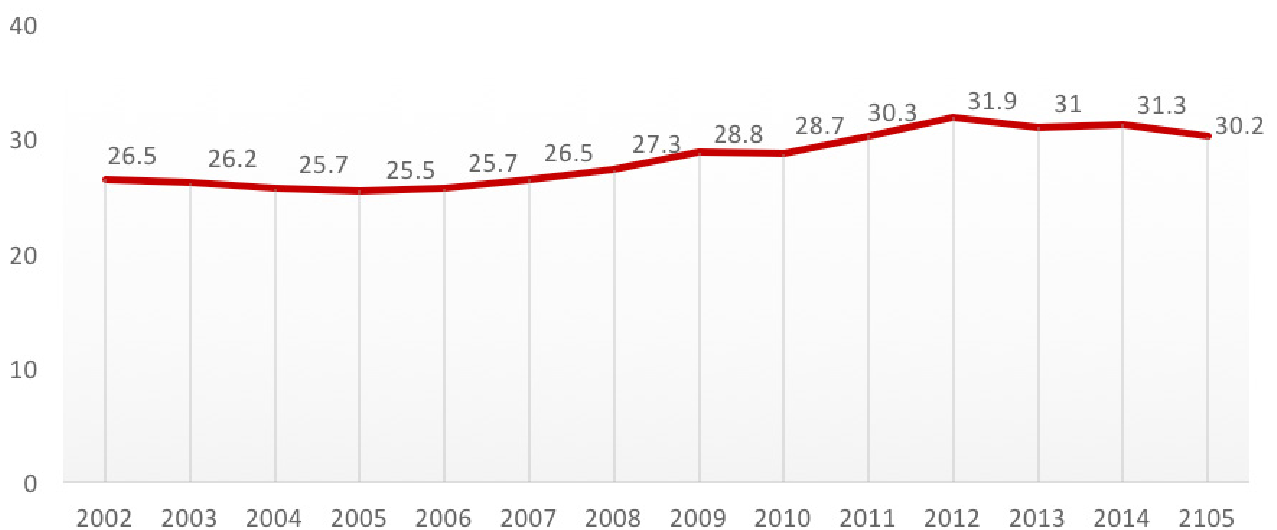
Egypt has been experiencing a rise in the annual number of live births, since early 2000s. As shown in Figure (1.9), Egypt had less than 2 million live births in 2006 (1.85 million live births). The latest key statistics figures in 2014 indicate that the number reached is almost 2.7 million live births, reflecting an increase of more than 40%. It is worth mentioning that the number of births in 2014 is more than one-half the sum of live births of the EU twenty eight countries all together, with a population size of one-half a billion people. This increase was confirmed also by the rise in crude birth rate (CBR) as shown in Figure (1.10). In 2014, CBR reached 31 live births per 1000 people, a level that was prevalent in the late 1980s and early 1990s. The low crude death rate (CDR) and the increasing CBR have resulted into a rising rate of natural increase in 2014 to 2.52% similar to rate achieved in late 1990s. In 2015, the number of births decreased by 35 thousand indicating a reduction in the CBR, for the first time in the last decade, to reach 20 live births per 1000 people.

Figure 9: (1.9) Number of Live Births, 2002-2015 (million)



Source: Births and Deaths Statistics for Several Years, CAPMAS

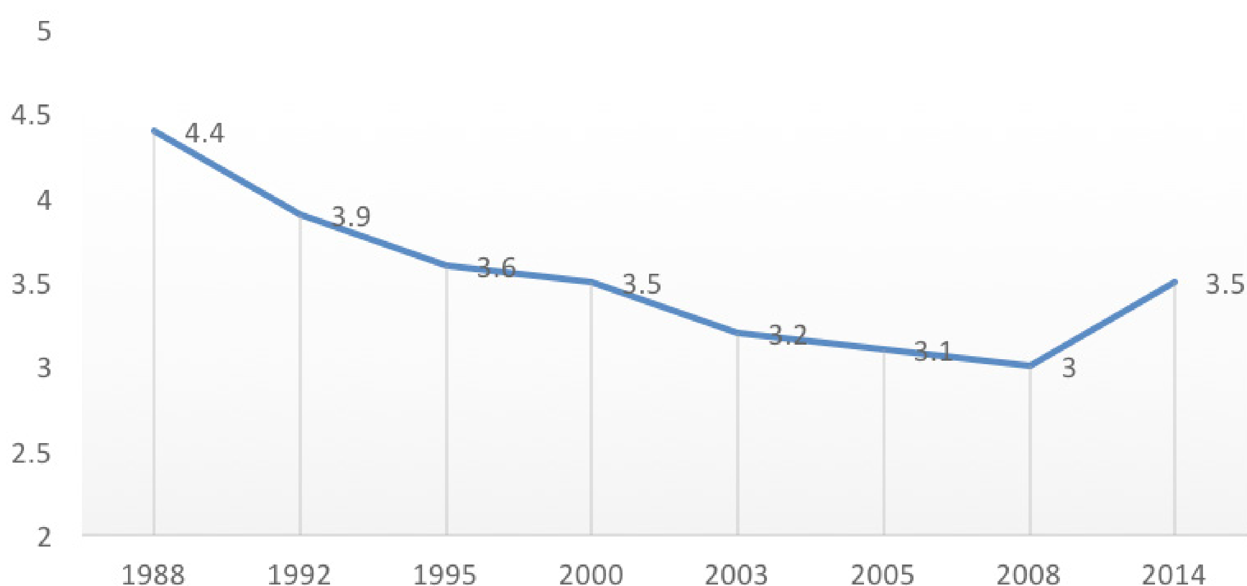
Figure 10: (1.10) Trend of CBR in Egypt, 2002–2015



Source: Births and Deaths Statistics for Several Years, CAPMAS

According to the latest Egypt Demographic and Health Survey (EDHS) conducted in 2014, the total fertility rate (TFR) reached 3.5 live births. This rate indicated an increase of 0.5 live births during 6 years since 2008 EDHS. The current rate is equivalent to the rate that was prevalent during the 1990s as shown in Figure (1.9). This upward shift in TFR confirms the increase in both CBR and the number of live births shown above. To illustrate, a study (Zaky, 2004) carried out in early 2000s has predicted the current fertility status. It predicted that one should not expect further dramatic decline in the fertility rate that was existing in the late 1990s. This was based on the fact that the relationship between female employment and fertility desires was not typical of a country at post-transitional stage of fertility. The idea of wife's opportunity cost and rational choices was not yet valid.

Figure 11: (1.11) Trends in Egypt Total Fertility Rate, 1988-2014



Source: EDHS 2014

As expected, TFR in 2014 was higher in rural areas (3.8 births per woman) than in urban ones (2.9). It is also higher among uneducated women (3.8) than among those with some primary education and higher (3.5 live births). Surprisingly, women belonging to the middle wealth quintile scored the highest in TFR (3.9 births) if compared to those belonging to the lowest and second wealth quintiles (3.6 births), and those who belong to the fourth quintile (3.5 births). Women in the highest wealth quintile had the lowest TFR of 2.8 births per woman.

The age specific fertility rates (ASFR) clearly indicates that there is a shift in the peak from the age group 25-29 to 20-24 as shown in Table (1.7). It is worth mentioning that the highest Egypt ASFR was always achieved in the age group 25-29, since Egypt Fertility Survey in late 1970s. However, the highest increase (almost 25%) in ASFR was observed in the second age group (20-24).

Table 7: (1.7) Age Specific Fertility Rates in Egypt, 2008 and 2014

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

Source: EDHS 2008, EDHS 2014

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

1.3.4 Migration

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

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

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

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

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

Syria and Libya are the countries suffering most from instability after the Arab Spring. Millions of citizens migrated to other countries through different legal and illegal channels to neighboring countries. Egypt was one of the destination countries for such migrants. CAPMAS statistics show that more than 2.3 million Syrians and Libyans came to Egypt during the period from 2011 to 2014, 70% were Libyans. Most of these migrants do not register as refugees, especially those living without formal financial aid, so as to avoid being refused when seeking visa to enter European countries later.

Table 8: (1.8) Numbers of Syrians and Libyans, Migrated to Egypt after the Arab Spring

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

Source: CAPMAS 2015

The Egyptian State does not run its own asylum system. Asylum seekers in Egypt are processed by UNHCR. Notably, the number of refugees registered by the UNHCR amounted to 140 thousand Syrians.

1. This huge number of migrants caused many challenges to Egypt, namely:
2. The demand on services and goods increased to cover the migrants' needs.
3. Migrants, especially Syrians, became competitors to Egyptians in labor market. A study by the AUC Center for Migration and Refugee Studies (CMRS) and Baseera Center revealed that nearly three quarters of the Syrian migrants households (HHs) in Egypt depend on work as a source of income and 45% work in the only source of income. Entrepreneurs consider hiring Syrians for being more committed to work and accepting lower wages than Egyptians.
4. Migrants led to an increase in the demand on housing units and pressures on Egypt infrastructure.

1.4 Population Characteristics

1.4.1 Population Age Structure

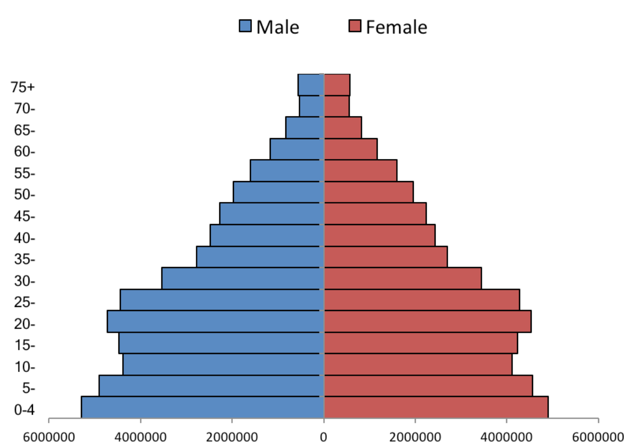
In fact, Egypt has experienced a decline in fertility rate in the 1990s and early 2000s, which led to a change in the age structure. It is clear that Egypt is a youth country with a broad base narrowing towards the top. The age structure had previously shown a diminishing base as a result of the previous decline in birth rates, and the relative importance of the young age brackets fell compared to that of the labor age group, leading to the so-called demographic window of opportunity. By all means, the recent increase in birth and fertility rates will have an impact on that age structure. Although it is not designed to answer such question, the EDHS data could shed some light on possible consequences of fertility rate on the age structure. Table (1.9) presents the trend in population distribution by broad age categories during the period 1988-2014, using the EDHS rounds during this period. The population percent distribution clearly shows that Egypt has experienced a sharp decline in the percentage of population, less than 15%, during the period from 1992 to 2005, followed by a very modest decline between 2005 and 2008. For the first time in almost 20 years, the youngest age group started to catch up again by jumping from 34% in 2008 to 35.3% in 2014. Truly, these sharp and then modest declines, followed by an increase in the share of the youngest age group, are reflected in the middle age-group (15-64). As an illustration, the age group 15-64 gained what the young age group lost during the period 1992-2008 and lost what such group regained during the period 2008-2014. These changes in the age structure caused a decrease in the age dependency ratio from 82% in 1988 to 62% in 2008, showing a great opportunity for the demographic dividend. Nevertheless, the increase in the age dependency ratio to 66%, as a result of the rise in TFR, led to the vanishing of this opportunity as will be shown in section (1.5).

Table 9: (1.9) Trends in Population Distribution, by Age in Egypt, 1988-2014

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

Source: EDHS 1988-2014

Figure 12: (1.12) Population Pyramid of 1/1/2016



Source: Egypt in Figures, 2016

1.4.2 Education and Literacy

The population educational level is among the key characteristics for having many implications on people perceptions, social and political participation, economic productivity, welfare and reproductive behavior. The EDHS-2014 shows that almost 1 in every 5 people (6 years and above) has not attended any type of education. Females are more vulnerable for illiteracy, as almost 25% of Egyptian females (6 years and above) have no access to education compared to 14% of males, as shown in Table (1.10). Although the gender gap against women gets wider in rural areas and among the lowest wealth quintiles, the likelihood of a

female (aged 6 years and above) to have no access to any education is almost double that of a male. The implications of this gap and the relatively high likelihood of illiteracy on female empowerment and accordingly fertility behavior are evident in the Egyptian literature. As the 2014 EDHS indicates, women who are less educated and less empowered are more likely to bear more children and less likely to be using contraceptives.

Table 10: (1.10) Gender Gap and Educational Attainment, 2014

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

Source: EDHS 2014

1.4.3 Labor Force and Employment

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

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

Table 11: (1.11) Market and Extended Labor Force Participation Rates, Ages 15-64, by Gender and Location, 2012

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

Source: ELMPS 2012

As indicated in the EDHS-2014, women with paid work are more likely to make enlightened choices regarding their reproductive and children health. Significantly, working women use family planning methods more than other women (67% and 57%, respectively). While the majority of women opt for modern methods, this percentage is notably higher among working

women (65.9%) than other non-working women (57.3%). Intervals between births are longer for paid working women than for other women (39.3 months and 36.5 months, respectively).

Table 12: (1.12) Antenatal Care, by Women Working Status, Age 15-49, Giving a Live Birth in the Five Years Preceding the Survey, 2014

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

Source: EDHS 2014

Procedures of pregnancy care were also more common among births to women with paid work than for other women.

Table 13: (1.13) Postnatal Care, by Women Working Status, Age 15-49, Giving Birth within Two Years of the Survey, 2014

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

Source: EDHS 2014

Mothers giving birth in the two years preceding the EDHS-2014 survey, with paid work, were somehow more likely than other mothers to have had a postnatal checkup within two days after they delivered (87.4% and 80.9% respectively), though 78% of newborns did not have a postnatal checkup at all, and only 14% were seen for the first checkup within two days following birth. The largest difference in the likelihood that a newborn receive a postnatal checkup within two days was observed by birth order, further substantiating the preference of working mothers' to limiting practices.

1.5 Demographic Dividend in Egypt

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

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

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

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

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

1.5.1 Demographic Transition in Egypt

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

As shown in Figure (1.13), the crude birth rate declined from 38.8 per thousand in 1987 to 30 per thousand in 1991. Between 1992 and 2010, the rate fluctuated around 27 per thousand, then it started to increase to reach a peak of 31.9 per thousand in 2012. A similar conclusion can be drawn from Figure (1.11), as the total fertility rates declined in the 1980s and the first half of the 1990s to reach 3.6 child per woman in 1995. A slower decline was observed in the following decade and a turnover was accentuated with an increase in TFR from 3 children per woman in 2008 to 3.5 in 2014. The trend of the TFR seems to confirm the CBR trend and is challenging the potential for a demographic dividend in the near future.

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

To show an example of the implications of the current fertility level, it is worth mentioning that the number of births increased from 1.85 million live births in 2006 to 2.6 million live births in 2012. The 40% increase in 6 years, has its tremendous impacts on quality of life and basic services including education. To respond to this surge, 40% more classes are needed by 2018, costing nearly 18 billion EGP. Such an investment was not secured and the «baby boom» cohort of 2006-2012 will accordingly face hard time to get the same level of education offered to the older cohorts, who were already not receiving the quality of education required to be prepared for labor market competition.

Figure 13: (1.13) Egypt Crude Birth Rate, 1987-2015

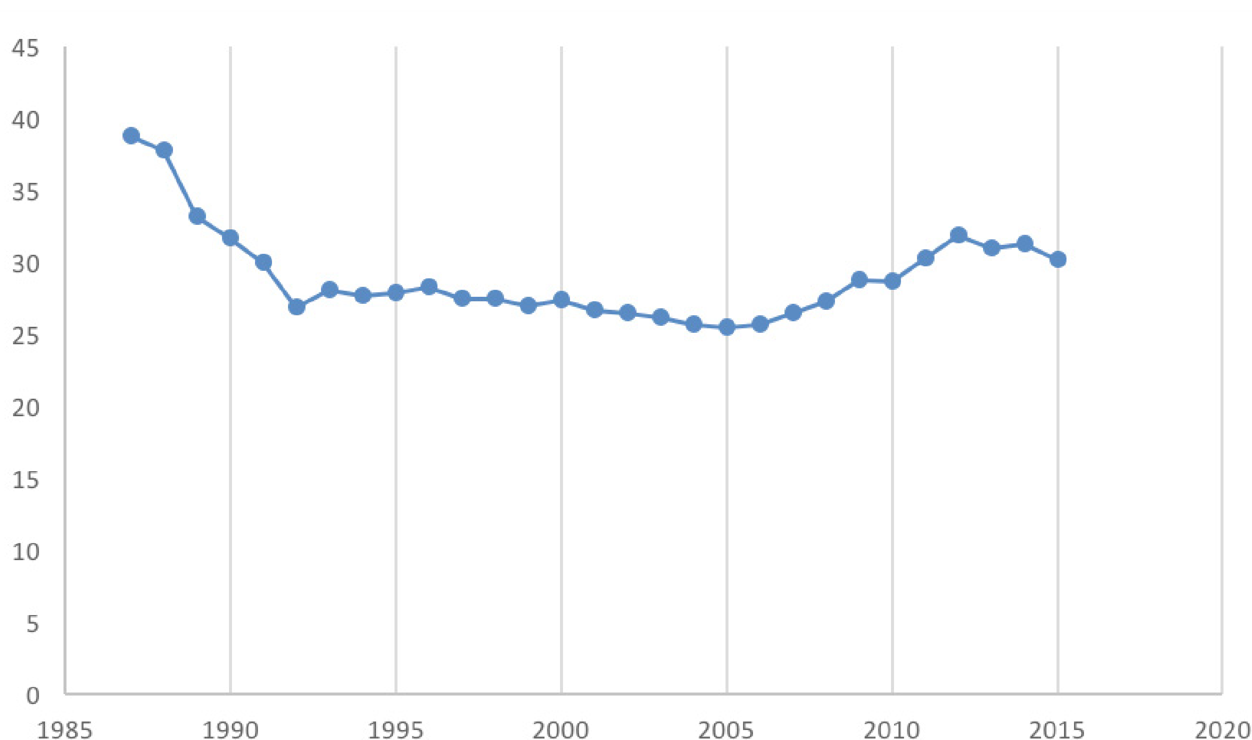


Table 14: (1.14) Crude Birth Rate, Total Fertility Rate and Population below 15 in Selected Countries, 2015

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

Source: Population Reference Bureau, 2015

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

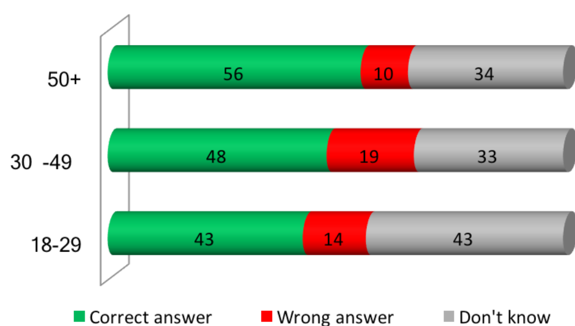
To maximize the benefits of this window of opportunity, Egypt needs to adapt their economic, social, health system and political institutions to the changes that will be brought by the unprecedented numbers of young people as they move into adulthood.

1.6 Awareness of the Population Growth Challenges

In June 2016, population size in Egypt reached 91 million, which is twice the population size in 1984 and three times in 1966. The Egyptian Center for Public Opinion Research (Baseera) conducted a poll in January 2016 to reveal Egyptians awareness of the Egyptian population size and other issues related to the population growth. The percentage of people who mentioned a population size between 85 and 95 million, which was considered a correct answer, was 49%. While 15% mentioned a size less than 85 million or more than 95 million and 36% stated that they have no idea. It is worth noting that youth (18-29 years) are more ignorant about the population size, as only 43% mentioned a correct answer compared to 56% among the age group 50 years or above. The same difference was observed between Upper Egypt, where only 42% mentioned a correct answer, and urban governorates, where 57% stated a correct answer.

Despite mentioning different figures for population size, the majority of Egyptians (58%) pinpointed that the population size is a disadvantage and only 29% mentioned that it is an advantage, 3% said it has both advantage and disadvantages, and 10% said that they have no idea.

Figure 14: (1.14) Knowledge of Population Size, by Age, 2016



Source: Egyptians' Perceptions Regarding the Population Problem, Baseera, 2016.

When asked about water security, around 45% of Egyptians said that water resources in Egypt are sufficient for all the citizens to live a healthy life, which reflects that this percentage are unaware that Egypt is under water poverty line. A close percentage (40%) knows that the available water resources are insufficient to secure Egyptians' needs and 15% said that they have no idea, whether the available resources can secure Egyptians' needs or not.

Egyptians are more aware that the agricultural production is insufficient to cover Egyptians' consumption. Around 61% of the respondents stated that the agricultural production is insufficient to cover Egyptians' consumption compared to 26% believing that it is sufficient and 13% mentioned that they have no idea.

A recent study was conducted in five governorates, namely Sharkia, Ismailia, Port-Said, Souhag and Qena in 2015 (CSSA, 2015) to explore the awareness of Egyptians about the population challenges facing Egypt. The study showed that a high percentages of the respondents recognize that the Egyptian State is incapable of providing required educational, health and service needs. This percentage ranges between 80% in Port-Said and 43% in Ismailia. Three-quarters of the sample highlighted that these sectors will significantly suffer as a result of additional increase in population. Recognizing the right of the State to intervene in fertility rate to provide better quality of life is split among the respondents and 20% either have no opinion or object the idea of family planning. Almost 60% of the sample did not identify any tools to make people aware of the population problem. All respondents stated that there are no public campaigns about population.

A poll carried out by the Egyptian Center for Public Opinion Research (Baseera) in November 2014, has uncovered that 45% of the respondents mentioned that two children is the ideal number of children for a family and 42% said that three is the ideal number. In answering the question on whether the family should have an additional birth if all births were females, 76% of the respondents answered with «No» while 18% answered with "Yes" and 6% could not decide. These results reflect people awareness and attempt to do away with some customs and traditions, already popular in Egypt years ago. Another question was asked to inquire about people perception regarding the timing when the couple decides to have

children after marriage, 31% of the sample answered that this should take place immediately after marriage, while 36% answered that this should come after one year from marriage, and a smaller percentage of 21% answered two years after marriage.

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

Chapter 2
Population and Development Strategy

Chapter 2 Population and Development Strategy

2.1 Introduction

The national strategy for population and development 2015-2030 was designed by a team of experts working under the supervision of the National Population Council (NPC). The strategy was launched in November 2014 under the auspices of the Prime Minister. By all means, the strategy and the accompanying implementation plan identified the assigned roles of all stakeholders with regard to the population issue. All and above, this Chapter will address a significant issue, which is the necessity of cooperation, with a special focus on the private sector role. As for the NGOs role, it will be highlighted in sub-section 5. Additionally, sub-section 6 will suggest other complimentary actions to encounter and overcome the population increase issue.

2.2 The National Strategy for Population and Development 2015-2030

The need to draw up a new population strategy for Egypt emanates from the current population situation in Egypt, which may place the nation at certain risk. If allowed to continue, the current population growth rates, combined with other population and development indicators, will not help in improving the country population quality of life, as illustrated in Chapter 1.

2.2.1 Why do we need a new population strategy?

Over the past few years, remarkable facts took place with regard to population and development, important of which:

1. Unemployment rates and the percentage of families living under the poverty lines rose after the 25 January 2011 revolution. On the other hand, the role of women in the workplace and production diminished in a manner that negatively affected the development rates and led to an increase in the birth rates.
2. The increase in population growth rates, coupled with the drop in economic growth rates, in comparison with the Egypt pre-revolution rates, will decrease per capita spending on health, education, and other services, while boosting the rates of unemployment and illiteracy; all of which is bound to have an adverse impact on people quality of life.
3. The heightened influence of the conservative current on the public sphere has undermined the belief in small families and having prolonged intervals between births, while encouraged antagonistic values to women empowerment; all of which led to a diminishing role of women in public life and reduced rates of women employment.
4. A new legislative reality was effectuated through the inclusion of an article in the constitution (Article 41), which highlights that the State is committed to formulating a population program that strikes a balance between population and economic growth. Simultaneous
5. The media role, in disseminating knowledge on the risks involved in population growth and family planning, has declined. Likewise, the role of civil society groups, in raising awareness and providing services related to family planning, has diminished.

The 2014 Constitution (Article 41)

"The State shall implement a population program aiming at striking a balance between population growth rates and available resources; and shall maximize investments in human resources and improve their characteristics in the framework of achieving sustainable development."

6. The disparity in population and development indicators has continued between various areas (urban vs. rural areas, north Egypt vs. south Egypt, and formal vs. informal urban areas).

7. The post 25 January 2011 phase resulted in major challenges that should be addressed, such as the irregular provision of public services including family planning services, the reduction in resources available for basic services provision and improvement, as well as the shortage in capacity building programs, monitoring and evaluation practices.

2.2.2 Strategy Objectives

The new strategy focuses on achieving a more homogenous society, balancing between population growth and available natural resources. Thus, it assists in meeting public aspirations of having better lives, offering society members equal access to basic services, improving population characteristics, and attaining higher levels of human development, social cohesion, and regional leadership.

The national strategy for population and development aims to:

1. Enhance the quality of life for all Egyptians by reducing the population growth rates and restoring the balance between economic and population growth rates;

2. Restore Egypt's regional leadership status by improving population characteristics in terms of knowledge, skills, and behaviors;

3. Redesign Egypt population map by a spatial redistribution of population, promoting Egyptian national security and accommodating national projects established needs; and

4. Promote social justice and peace by minimizing the disparities existing in development indicators among various areas.

To achieve the above objectives, the authors of the new strategy set a number of quantitative objectives, most important of which is the reduction of the total fertility rate to an average of 2.4 by 2030, compared to 3.5 at present. If the government succeeds in thus bringing down the birth rate, the population will reach 111 million by 2030. But if the current birth rates were to persist, the population will reach 119 million by 2030. For the birth rate to drop to 2.4 by 2030, the percentage of women using birth control methods must rise to 72%, from 59% at present.

The strategy encompasses a number of stakeholders including MoHP, MoE, MoP, MoF, MCIT, MYS, Parliament, National Fund for Development, CAPMAS, National Council for Women (NCW), NGOs and the private sector.

2.2.3 The Strategy Main Pillars

The strategy rests on six pillars, which are:

- More effective family planning and birth health services;
- Improved health services to young people;
- Enhancement of population characteristics;
- Raising awareness of population problem;
- Women empowerment; and
- Energetic monitoring and assessment efforts.

The strategy authors noted that the most important factor for the success of such a strategy is the firm and effective political determination to curb the population increase. It is through such a determination that all ministries and non-governmental organizations may concert efforts to carry out this strategy executive plan. President Abdel Fatah Al-Sisi and the government, therefore, showed a strong commitment to the population issue in Egypt. In 2016, the National Day of Population was declared and the year was announced to be the Year of Youths. It is further planned to announce 2017 as the Year of Egyptian Women and a new strategy for women empowerment and gender equality will be launched accordingly.

The main stakeholders of the strategy include but are not limited to the MoHP, MoP, MoE, MoI, MYS, NPC, NCCM, NCW, NGOs and the private sector.

2.3 Other Supporting Strategies:

The Egyptian government and relevant councils developed a set of strategies supporting the population and development strategy, the most important of which are the Child Strategy, Early Marriage Strategy and Egypt Sustainable Development Strategy.

2.3.1 The Child Strategy 2015-2020:

The Child Strategy was developed by the MoP and NCCM, in cooperation with the Egyptian Center for Public Opinion Research (Baseera), to cover the period from 2015 to 2020.

The vision of the Child Strategy is to ensure the improvement of children and mothers quality of life and well-being, provision of society support and protection, involvement in decision-making process and enhancement of their physical and mental health, all of which within the framework of equality and fair distribution between social groups and geographic regions.

The main objectives of the strategy are as follows:

- Provide national vision and framework for the different Strategy axes to improve children and mothers situation in Egypt;
- Ensure fair distribution of services and provision of children rights among different social groups in different geographic regions;
- Prioritize interventions, programs and policies;
- Improve networking, cooperation and coordination between the various development actors in the field of childhood and motherhood; and
- Develop a system to measure the performance and evaluate the interventions regarding childhood and motherhood.

2.3.2 The Early Marriage Strategy 2015-2020:

The vision of the Early Marriage Strategy is to create conscious society, characterized by being healthy both physically and psychologically. A society where citizens have the utmost levels of health and education; believing in the concept of a strong family, recognizing the equal rights of men and women, realizing the right of boys and girls to equally thrive, and developing the pivotal role of women.

The main objective of the Strategy is to halve the proportion of early marriages in five years, with a focus on geographical areas with high prevalence of early marriage.

2.3.3 Egypt Sustainable Development Strategy "Egypt Vision 2030":

Egypt Vision 2030 aims at maximizing the potential of Egypt competitive advantage and reviving its historic role in leading the region and improving people standards of living.

Egypt Vision objective lies in maximizing the people quality of life based on three main pillars, namely the economic pillar which aims at achieving economic development, the social pillar which aims at raising population characteristics and the environment pillar which aims at providing a better living environment. Each of these pillars has sub-issues as shown in Figure (2.1). The integration of the Population and Development Strategy and Egypt Vision will accelerate and ensure the achievement of the strategy objectives. Egypt Vision will be discussed in details in Chapter 7.

Figure 15: (2.1) Egypt Vision Pillars

2.4 The Sustainable Development Goals (SDGs)

In 2000, the United Nations proposed the Millennium Development Goals (MDGs) that were adopted by almost all the countries including Egypt. Egypt succeeded in achieving some of the goals totally or partially, while it failed in achieving others. To elaborate, Egypt was capable of achieving the targets of gender equality with regard to the enrollment in primary and secondary education, decreasing under five mortality rate, increasing the antenatal care coverage, and raising the proportion of population using an improved drinking water source. Other targets were not achieved due to many challenges that will be discussed in the next chapters.

In September 2015, countries across the world adopted the 2030 Agenda for Sustainable Development Goals (SDGs), which included 17 goals tackling the improvement of people quality of lives. Each of these goals have certain targets with a total of 169 targets. These SDGs covered the areas already highlighted by the MDGs, in addition to new ones.

Egypt has a strict commitment to the SDGs. As part of its commitment to the SDGs, a Presidential Decree was issued forming a national committee to follow up the implementation of the SDGs. The committee is headed by the Prime Minister and encompasses 12 ministries and governmental entities. In each ministry a monitoring and evaluation unit has been established. Moreover, the Central Authority for Public Mobilization and Statistics (CAPMAS) established a Sustainable Development Unit to be responsible for providing data and information related to the SDGs indicators.

The Sustainable Development Strategy (Egypt Vision 2030) integrated most of the SDGs, as part of its pillars, in order to guarantee the harmonization between the SDGs and the National Strategy.

Box 1: Sustainable Development Strategies (SDGs)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.5 Social Protection Program

Social protection targets the improvement of vulnerable groups' life conditions. Social protection schemes minimize risks affecting living conditions and quality of life. This includes reducing poverty and inequality.

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

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

Universal social protection helps achieving the following:

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

This approach focuses on 3 main pillars; social insurance, social assistance and labor market standards. Social insurance is represented in the programs targeting the protection of employees via contributions from employers and employees, based on earnings. While social assistance

is manifested in programs of money transfers to vulnerable households, with heads incapable of working. Labor market policies aim at ensuring decent jobs for those capable and ready to work.

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

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

With reference to Egypt, it is on the track of universal social protection. The SDGs, as discussed above, head to cater for universal social protection. With this in mind, the following sections will present some of the social protection policies and programs.

Poor Households

The MoSS provides monthly pensions for poor households having children in primary, preparatory or intermediate schools. The pension ranges between 40 and 200 EGP.

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

Till December 2016, Takafol and Karama program provided 4.6 billion EGP to more than 5.4 million beneficiaries.

Children Protection

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

The Child Strategy 2015-2020 paid due attention to child protection, with a special focus on prevention and protection from violence, exploitation and abuse. It addressed each of the aforementioned risks in detail. The Strategy suggested the following:

- Reforming the Committee for Child rescue line and activate its role;
- Preparing and activating case management system within the child protection committees and the concerned ministries;
- Linking child rescue line and the protection committees;
- Preparing a national program for parents to encourage positive upbringing of children;
- Developing information management systems for child protection;
- Activating national protection mechanisms;
- Providing the institutional framework and human and financial resources necessary for the implementation of policies and legislation for child protection;
- Paying special attention to the activities of all domains related to marginalized groups of children in remote areas, border and poor areas, slums, as well as children with disabilities, and street children; and
- Including civil society organizations in child protection activities, and providing the necessary training for the capacity building of such organizations' members.

In addition, the MoSS provides monthly pension for children in unusual circumstances, including the following groups:

- Orphans and children of unknown parents or fathers;
- Children of divorced women, if they married, imprisoned or died; and
- Children of imprisoned parents for a period not less than three years.

This pension is provided to children under 18, lacking any other sources of income, in addition to the monthly pension for those attending school regularly, up to a maximum of 200 EGP per month, for a period of 8 months from October to May of each academic year.

2.6 What else to do?

Though being multi-faceted and comprehensive, the National Strategy for Population and Development overlooked significant factors:

Firstly: the Strategy and its executive plan missed to mention the need to invest in the large number of young people in the country. Because of the rising population in recent years, the number of young people has significantly maximized, to the point where the young people constitute one-third of the population. Employing young people in development projects could give a momentous boost to the economy. But for this to take place, the young people must undergo training activities to become more creative and innovative, as many young people are unqualified to join the labor market and compete for jobs due to their low levels of education, skills, and motivation.

Secondly: despite the large number of parties in Egypt, the strategy did not involve these parties to any extent. This may be due to the low popularity of the parties or the lack of public interest in such parties. Opinion polls indicate that most Egyptians have minor knowledge of parties or their programs. Still, the country political parties have resources that can be used in addressing the population problem, including the parties offices spreading across the country and members having unhampered access to the rest of the population.

Public sympathy and enthusiasm are crucial factors to the success of any strategy. The National Population Strategy will only succeed if families started to think not only in terms of what is good for them, but also of what is good for their country.

Thirdly: there is a dire need to more data and information, in order to monitor the implementation of the above mentioned national strategies. Most of the indicators that are related to RH and fertility are driven from surveys conducted with wide time spaces and had sample sizes disallowing the calculation of indicators on small administrative units level. Thus, it is suggested to build an observatory for population related data and indicators. The observatory should be designed to:

- Collect and harmonize the available data and indicators: Egypt produces hundreds of indicators each year, but there is no unique portal to collect and organize these indicators in a way useful to plan, monitor and evaluate the strategy. Collecting these indicators, defining and even unifying the methodologies of calculations and providing them to researchers and decision makers would help in improving the performance of the stakeholders.
- Assess and bridge the information gaps: the observatory may help in assessing the information gap to be bridged by new surveys or other research methods. This includes designing and carrying out surveys to fill in the information gaps, and utilizing new methodologies to collect the needed data such as crowdsourcing and big data methodologies.

It is suggested that such an observatory should prioritize the provision of indicators, to be used in monitoring and evaluating the implementation of the National Strategy for Population and Development according to the needed periodicity.

Chapter 3
Sexual and Reproductive Health

Chapter 3 Sexual and Reproductive Health

3.1 Introduction

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

As mentioned in Chapter 1, Egypt population is increasing rapidly. Such a rapid population growth is practicing pressure on the country economy and environment and threatening people health and well-being. As a result, the Egyptian government is facing challenges in cater for basic needs, including education, health care, work opportunities, housing and sanitation.

3.2 SRH Services

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

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

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

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

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

Regarding the evolution witnessed by the percentage of women in the reproductive age (15-49) receiving any antenatal care, it is obvious that such a percentage significantly surged during the last 30 years from only 57% in 1988 to 90% in 2014. Recently, positive trends within categories of educational status and socioeconomic class were revealed; as the percentage of women in the reproductive age (15-49) receiving any kind of antenatal care rose from 80% for women who have never been to school to 94% for women who at least finished high school, and from 83% for the lowest socioeconomic level to 90% for the highest one. There are also differences according to place of residence, as it is 94% for women living in Lower Egypt and 85% for women living in Upper Egypt.

Medically-assisted deliveries witnessed a great change from late 1980s till 2014 as the percentage of births delivered by skilled medical

service provider increased from only 35% in 1988 to 92% in 2014, according to DSH. However, this high percentage still did not have fair share for the different socioeconomic levels, as it is 82% for the lowest socioeconomic level while reaches 99% for the highest level. In addition to socioeconomic level, it is clear that the educational level of mothers has a significant effect on the referred to percentage, as it tends to increase when the educational level of mothers increases, namely from 79% for women who have never been to school to 96% for women who at least finished high school. The same applies when comparing such a percentage in terms of different places of residence, as it is 97% for women living in urban governorates and 95% for women living in Lower Egypt, and decreases to reach the lowest level in Upper Egypt with a percentage of 86%.

The percentage of women receiving first postnatal checkup from a trained medical service provider reached 82% in 2014. This percentage differs significantly when it is compared in terms of different places of residence and socioeconomic levels, as it amounts to 94% for women living in urban governorates, but this percentage decreases to 86% for women living in Lower Egypt and 74% for women living in Upper Egypt. Similarly, when comparing this percentage for different socioeconomic levels, it increases from 70% for the lowest level to 95% for the highest one. Moreover, it is obvious that the percentage of women receiving the first postnatal checkup from a trained medical has a positive relationship with the educational level of mothers, as it is estimated by 66% for women who have never been to school while it is 86% for women whose educational level is high school or above.

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

- Provide high quality family planning services including counseling, offering advice, focusing on young and poor population and highlighting the effectiveness of long term modern contraceptive methods;
- Train and retrain health providers to provide better counselling and services;
- Increase the national budget allocated to contraceptives procurement;
- Promote different kinds of long term contraceptives such as sub-dermal implants;
- Link post-partum and post-abortion care to family planning; and
- Raise community awareness of birth spacing and immediate post-partum contraceptives importance.

3.3 SRH, Health Systems and Service Delivery:

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

A major concern expressed by key informants was that public health facilities are not considered responsive to patients' needs, thus leading patients to resort to paid private sector care. Inequalities persist by income across governorates, and by gender. Supply-side payment mechanisms along with low wages for physicians and other health staff provide little incentives for better performance. Dual practice remains a pressing problem, as the vast majority of physicians work in both public and private sectors.

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

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

3.4 Health Sector Reform Program (HSRP):

As key informants suggested, the health system has apparent strengths and weaknesses emanating from ongoing changes. The system encounters many challenges in improving and ensuring the health and well-being of the Egyptian people, as it faces not only the burden of combating illnesses associated with poverty and lack of education, but also responds to the emerging diseases and illnesses. The MoHP and key partners have identified fragmentation in health services delivery, excessive reliance on specialist care and low quality of primary care service as the main constraints to achieving universal coverage. Therefore, the Government of Egypt has embarked on a major restructuring of the health sector. The ultimate goal of health sector reform initiatives is to improve population health status, including reducing infant, under-five and maternal mortality rates, decreasing population growth rates and alleviating infectious diseases burden.

The overall aim of the HSRP is twofold. Firstly, it yearns to introduce a quality basic package of primary health care services, contribute to the establishment of a decentralized (district) service system and improve the availability and use of health services. Secondly, it aspires to introduce institutional structural reform, based on the concept of splitting purchasing in providing the regulatory functions of the MoHP.

A poll conducted by Baseera on "the role of the Egyptian State in basic services provision" showed that 34% of Egyptians seek health care services from public health facilities. Among the people using public health facilities services only 36% are satisfied with the provided services. Ill-treatment from staff is the main reason for dissatisfaction (41%) followed by unavailability of medications (22%) and lack of equipment and crowd (13%).

As currently shown, Egypt has achieved remarkable progress with respect to its national health indicators over the past decades. Availability of basic health services is almost universal. 95% of the population is now living within 5km of primary health centers.

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

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

- Providing an integrated package of family health services;
- Emphasizing on health system accountability;
- Ensuring the adoption of quality assurance and quality control measurement;
- Necessitating equal distribution of services and dealing with health care system bias to urban areas; and
- Guaranteeing ongoing capacity building of staff, especially through on job training.

Box 2: ICPD Recommendations for Adolescent Reproductive Health Services

ICPD Recommendations for Adolescent Reproductive Health Services

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

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

Table 15: (3.1) Number and Percentage of Youths to Total Population, 1975-2015

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

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

3.5 Reproductive Health Services for Young People:

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

Table 16: (3.2) Age Specific Fertility Rates among Females, Age 15-29, 2000-2014

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

Source: EDHS 2014

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

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

In Egypt, there are approximately 30 youth friendly clinics[1] in Cairo and Upper and Lower Egypt providing the following services at subsidized prices:

(1) Premarital counseling/examination;

(2) Counseling, examination, and treatment/referral for STIs;

(3) Counseling, examination, and treatment of pubertal disorders;

(4) Counseling and provision of contraceptives for married youth;

(5) Antenatal and postnatal care;

(6) Counseling lab services.

According to MoHP policies, such service providers can only give information and counseling and are not allowed to conduct physical examinations to unmarried youth. Cases that require medical treatment would be referred to specialists (El Damanhoury, and Abdel Hameed, 2013; Roudi-Fahimi and El-Fiki, 2011).

Box 3: Sustainable Development Goals and Adolescent Reproductive and Sexual Health

Sustainable Development Goals and Adolescent Reproductive and Sexual Health

Increased investment in sexual and reproductive health services, specifically for adolescents, will push Egypt forward to reaching the proposed specific SDGs applicable targets. Health targets for SDG 3 highlight ensuring sexual and reproductive health care services for all, promoting the rapid reduction in fertility level through exclusively voluntary means, and achieving universal quality health coverage, including the prevention and treatment of communicable and non-communicable diseases, the provision of sexual and reproductive health, family planning, routine immunization, and mental health services as per basic health care priorities.

3.6 How Reproductive Health and Reducing Unwanted Births Contribute to Poverty Reduction

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

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

The National Strategy for Population and Development aims at reaching a CPR of 71.6% and unfulfilled needs of 6%.

The increasing number of births in the last 8 years, from 1.85 million in 2006 to 2.7 million in 2015, will increase the burden of public services provision for the additional 0.85 million births. For example, the enrollment of such births in education needs an allocation of 18 billion EGP to build new classes.

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

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

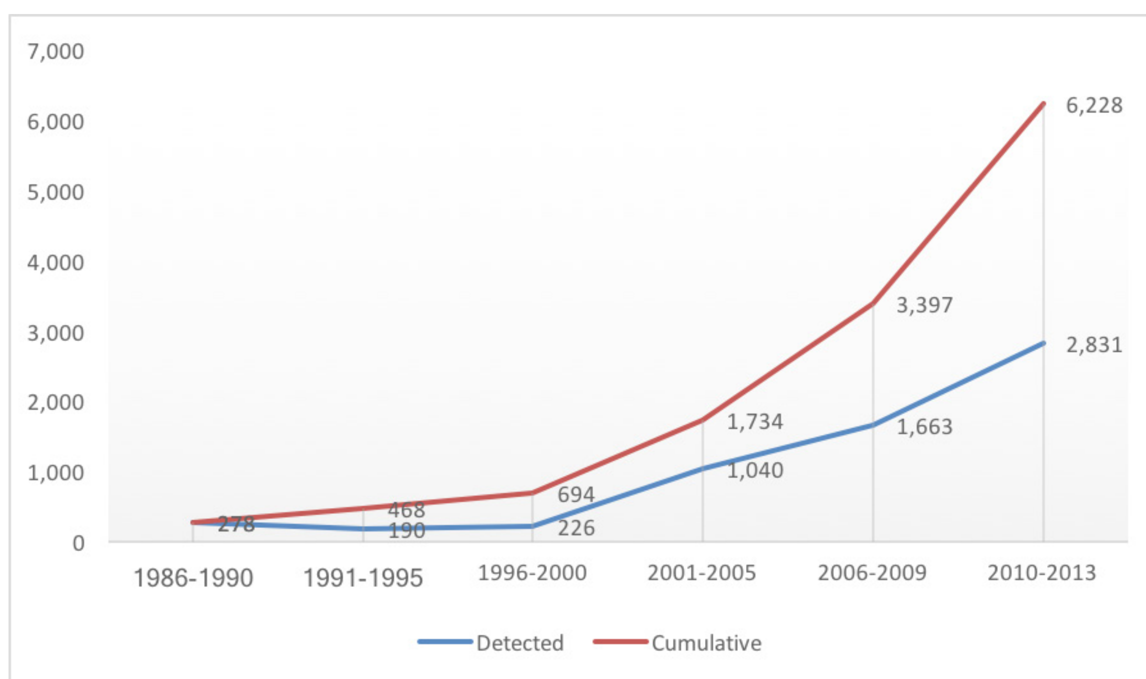
3.7 HIV/AIDS and STIs Situation and Trend

3.7.1 HIV/AIDS Status and Trend

Egypt first HIV/AIDS case was declared in 1986, since then, there is an incessant rise in the number of HIV/AIDS detected cases (Figure 3.1). The perceived increase in the number of detected HIV cases can be partially explained by the epidemic growth but more plausibly by the incessant efforts of the National AIDS Program (NAP) to improve HIV/AIDS testing and reporting.

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

Figure 16: (3.1) Number of HIV/AIDS Reported Cases in Egypt, 1986-2013



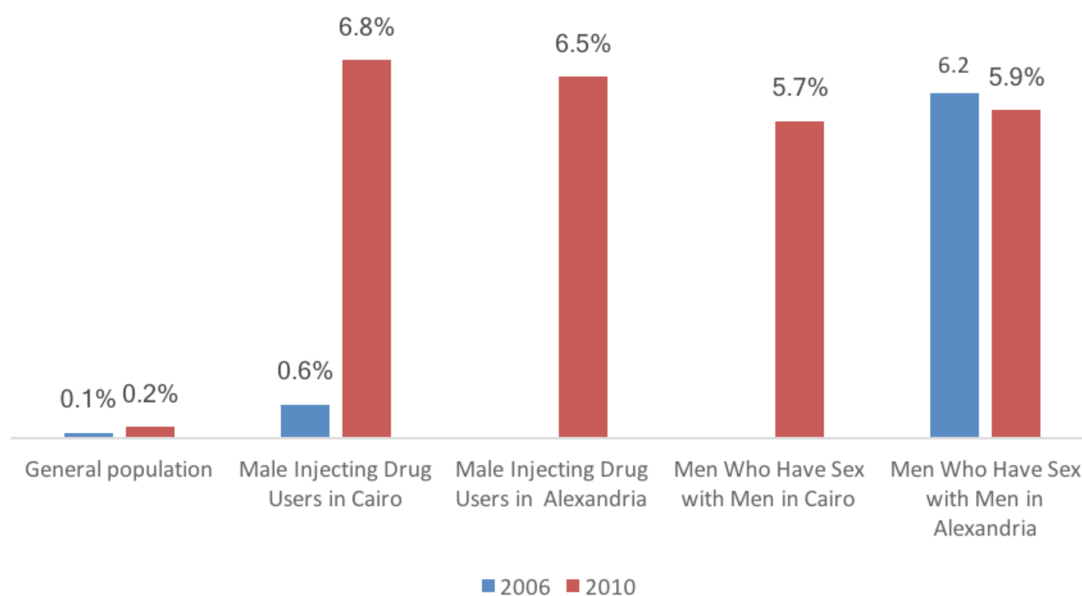
The estimates of the UNAIDS shown that the number of PLHIV nearly doubled from 3,200 (2,200-5,800) in 2005 to 7,400 (4,800-12,000) in 2013, and the deaths from AIDS-related illnesses tripled from 0.2% to 0.6% of HIV cases over the same period. The underestimation in the national statistics is attributed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

The estimates of the UNAIDS shown that the number of PLHIV nearly doubled from 3,200 (2,200-5,800) in 2005 to 7,400 (4,800-12,000) in 2013

Despite that the HIV epidemic is not considered a serious health threat in Egypt, there is emerging evidence that the epidemic is escalating (Figure 3.2). The UNAIDS estimates an increase in prevalence from <0.1% in the gen-

eral population in 2005 to 0.2% in 2013. Several pockets have been identified in IDUs and MSM. In 2006, the first round of Biological and Behavioral Surveillance Survey (BioBSS), raised many doubts about the potential concentration of the HIV epidemic in MSM with a population estimate prevalence of 6.2%. By that time, the population estimate of HIV prevalence in Male Injecting Drug Users (MIDUs) was 0.6%. These doubts were settled four years later with the second BioBSS, which confirmed the concentration of the epidemic in MSM and highlighted its concentration in MIDUs. According to the 2010 BioBSS, the population estimates of the HIV prevalence among MSM in Cairo was 5.7% and in Alexandria was 5.9%. In the four years period, MIDUs showed a rapidly increasing HIV prevalence that reached 6.8% in Cairo and 6.5% in Alexandria. These signals have marked that Egypt is no more in the low prevalence era and has stepped to an HIV concentrated epidemic.

Figure 17: (3.2) Trend in HIV Prevalence in the General Population and the Most at Risk Populations in Egypt



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

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

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

The HIV epidemic in Egypt has a male dominance, yet the years have shown an increase in women's share representing around one quarter of HIV cases. The growth of the epidem-

ic in the country puts both men and women in the path of the HIV infection through their own or their partner high risk behaviors. In addition, poverty and unemployment were identified as potential catalyst for the growth of the epidemic. Furthermore, Egypt hosts plenty of heterogeneous groups, who are vulnerable to HIV infection as street children, young people and prisoners. It is noteworthy that the country has provided shelter to many migrants, asylum seekers, and others who have moved-in over the past half-decade as a result of the political instability in the region.

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

The intimate relation between HIV and hepatitis B virus (HBV) and hepatitis C virus (HCV) should not be neglected. HBV and HCV are among the major health threats and leading causes of death in Egypt. Both viruses share with HIV many common characteristics. Like HIV, they have similar modes of transmission, do not have an effective treatment to date and cause inescapable death. The fact that HBV and HCV found route in Egypt and score high prevalence puts the country at high risk of HIV transmission and indicates that Egypt is not out of the beaten path of the HIV epidemic.

In spite of the incessant NAP efforts to reduce HIV transmission, comprehensive HIV knowledge remains insufficient among population, especially youths and females. Abstinence and condom use are the least to be recognized as prevention measures. Several misconceptions exist and comprehensive HIV knowledge show no remarkable improvement. There is limited information on the condom use among MARPs, as insufficient HIV knowledge and practice of unprotected sex among MARPs were noted among FSWs, IDUs and MSM.

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

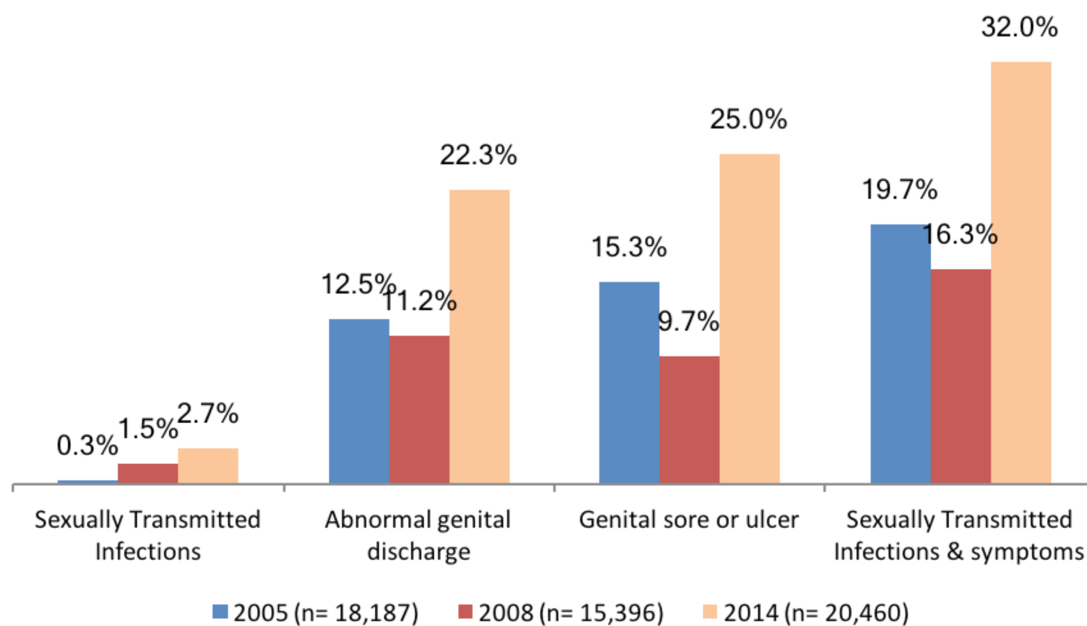
3.7.2 Sexually Transmitted Infections

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

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

The demographic and health surveys have started collecting information on STIs in Egypt since 2005. These information were restricted to married women 15-49 years old. In 2005, self-reported STI prevalence was 0.3% in married women 15-49 years old, yet over the past decade it has increased around 10 folds. Over the years, there was, also, an apparent rise in the self-reported STI symptoms including abnormal genital discharge and genital sore or ulcer (Figure 3.3).

Figure 18: (3.3) Trend in Self-Reported Sexually Transmitted Infections and Symptoms (Abnormal Discharge, Genital Sore or Ulcer) in Married Women, Age 15-49 years, in Egypt



Source: EDHS 2005, 2008, 2014

The latest available information, in 2014, document numerous disparities in self-reported STIs and STIs symptoms in married women 15-49 years old. Self-reported symptoms highlighted the emergency of STIs in several population subgroups notably youths, rural residents, Upper Egypt people and the poorest social groups. STI knowledge was apparently low and lack of information on treatment coverage or cure rate was evident.

3.7.3 Adolescents and Youth as a Priority Group in Relation to HIV/AIDS and STIs

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

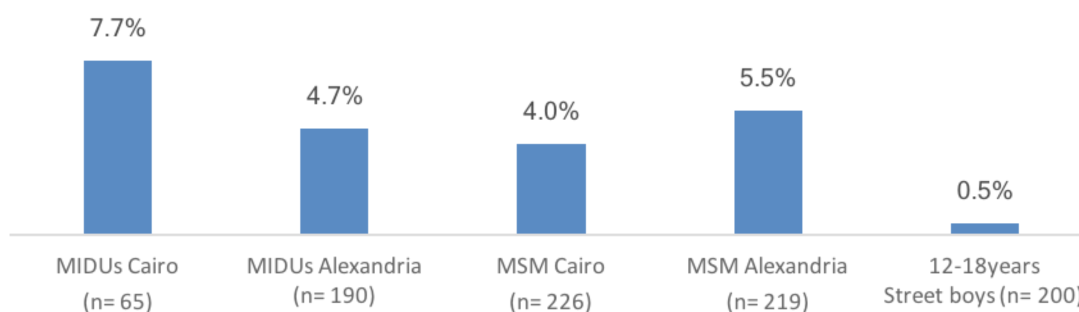
Egypt is relatively a young nation with around 40% of its population in the age group 10-29 years. The few data on risk behavior of Egyptian youths show that some may be indulged in drug abuse, and start sexual activity at an early age with very low condom use and presence of premarital sex, including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

There is dearth of information on youth HIV infections in Egypt. Nevertheless, it is clear from the reported cases, that there is an annual expansion of the youth epidemic. In Egypt, the UNAIDS has estimated HIV prevalence in youth 15-24 years to be <0.1%, while the UNICEF estimated adolescents (10-19 years) share of HIV cases by 7%. The latest available national statistics for youth in 2009 revealed that they amount to 29.2% of HIV cases, with a female dominance notably in the age group 20-29 years. This draws the attention to the risk of unperceived HIV infection spread in young sexually active girls, in the childbearing period, and from them to their offspring. MTCT is already evident in Egypt and was declared in

15 infants below one year of age and 53 children under-five years. UNAIDS estimated that the new HIV infections in 0-14 years children, in Egypt, has increased from 40 (30-70) in 2009 to <100 (<100-<100) in 2013.

The BioBSS data in 2010 was another source documenting the HIV infection in youth (Figure 3.4). From all MARPs under the age of 30 years tested for HIV, the infection was detected in 5.7% of the MIDUs and 4.7% of the MSM. Street children were another group found to be vulnerable to HIV infection as 0.5% of street boys between 12-18 years were HIV positive. Street children in Egypt are a matter of concern, their actual number in the country is still unknown. Some estimated their figure to exceed one million, while others reported the number to be in thousands. Nevertheless, they lack economic security and protection under law, as they do not have access to education and many practice several income generating activities. They are at great risk of spreading HIV as they inject drugs and are forced either by fear or poverty to practice several risk behaviors, as unsafe sex and MSM activity.

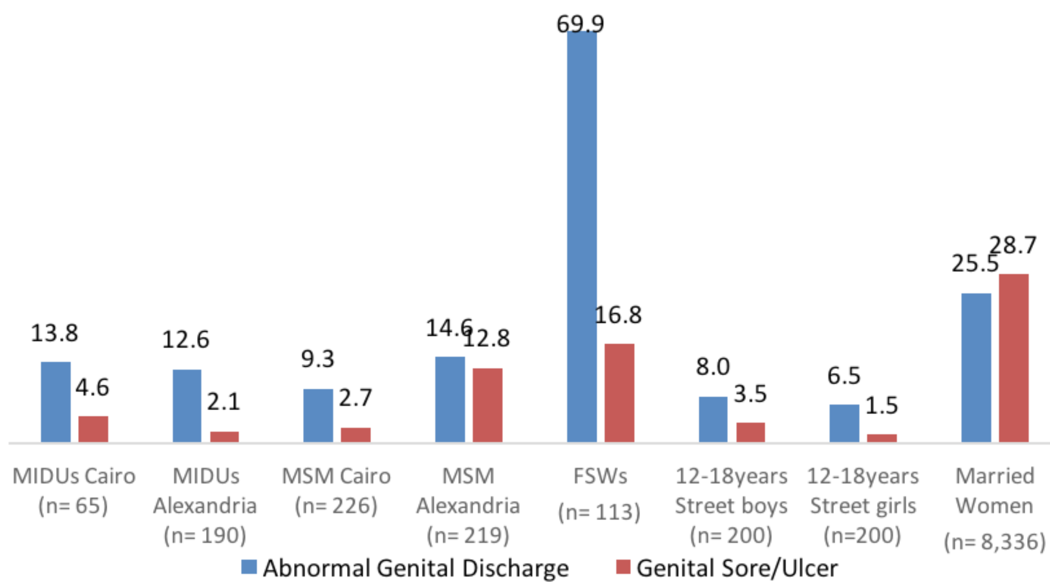
Figure 19: (3.4) HIV Prevalence among MARPs, under 30 Years, in Egypt



Source: BioBSS Data, 2010

There is hardly information on STIs in youth. However, with the growth of the HIV epidemic in those below 30 years of age, it became evident that STIs other than HIV may be existing early in life. The few information available from the BioBSS and the Demographic and Health Survey (DHS) provided evidence on self-reported STI symptoms in young MARPs and vulnerable populations. STI symptoms were reported by at least 70% of young FSWs and at least one quarter of young married women under 30 years. Moreover, STI symptoms were also reported by street boys and girls 12-18 years, as well as young MIDUs and MSM (Figure 3.5).

Figure 20: (3.5) STIs Symptoms Including Abnormal Genital Discharge and Genital Sore or Ulcer, in MARPs and Vulnerable Populations, under 30 Years, in Egypt



The practice of risk behaviors among youths has also been documented. There is a growing reliance on drug abuse and addiction by adolescents and youths, with a decrease in the mean age of drug use onset. The rate of drug addiction, among adolescents under the age of 20 years, is almost 9.5% of the total drug addicts' number. Despite the prevalence of addiction in males more than females, there is a rise in the rate of addiction among girls, where the average age has fallen at the first drug use to11 years.

Further to the high risk behaviors, both girls and boys may be subject to several social determinants, which expose them to HIV infection and other STIs throughout their lives. In childhood, boys and girls survive in a conflicting environment, as since birth children live with their parents or guardians, who avoid talks on sexual and reproductive health believing that children should not be exposed to such information. There is a wide spread resistance to sexual and reproductive health messages. HIV awareness campaigns are unwelcomed to be aired in TV programs or produced as sex education programs in schools. However, with the technology advancement and the open sky era, children are liberally exposed to all sort of risk behaviors that they watch on the internet, social media or television. They seek further knowledge from their immature peers, who are left over with numerous misconceptions and risk behaviors. Furthermore, health promotion and prevention services focus mainly on two age extremes, children up to 5 years and married youth at least 18 years old. Therefore, there are no such services for the age group 5 to 18 years. Accordingly, children find no assistance in understanding the biological changes they face during puberty or responding to the many pending questions they have. All these factors combined constitute a fertile milieu for risk behaviors to flourish early in life.

As they grow up, adolescents are bounded by the cultural norms, which uphold the institution of marriage as the only legitimate context for sexual relations. Early marriage is encouraged, sexual relations outside marriage are prohibited and sex education is a sensitive issue. These cultural norms are further translated into gender roles. On one hand, the ideals of premarital chastity and lifelong fidelity make women face steep barriers to accessing accurate information about STIs in general and HIV in specific, as well as having a proactive role in negotiating safer sex, as they are not expected to be sexually experienced. On the other hand, the prevailing norms of masculinity provide men with more privileges and freedoms. Men multiple experiences and partners are often tolerated as part of the masculine ideals, the matter putting them at risk of practicing risk behaviors, as their masculine image prevent them from seeking accurate information or admitting their lack of knowledge about sexuality and risk reduction. These normative societal

ideals increase both women and men transmission risk and impact the ability of those infected to have access to care services. Cultural norms and gender roles subordinating women and trapping men in damaging patterns of risk behaviors are increasingly recognized as fundamental forces that increase population health vulnerabilities, and Egypt is no exception.

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

The current situation in Egypt is even worsened by the political instability in the region over the past years. The country has become the haven for many migrants with a heightened number of unaccompanied children, a pattern known as "child on the move". According to recent reports of the Italian Government, Egypt occupies the second position in terms of the number of unaccompanied children refugees. While the law imposes HIV mandatory testing for non-nationals, refugees and persons of concern to United Nations High Commissioner for Refugees (UNHCR) are exempted from this mandatory testing for their residency needs. Moreover, the UNHCR and the government concerted efforts resulted in a reduced expulsion of refugees, who are HIV-positive. But still, fear of deportation restrains such children from accessing HIV testing and treatment. All these circumstances create a hub of children at risk of capturing HIV and STIs.

3.7.4 National Efforts to Halt HIV/AIDS and STIs

3.7.4.1 National Response to HIV/AIDS and STIs

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

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

The NAP strategy has built a multi-sector national response to halt the HIV epidemic and STIs with special focus on PLHIV, MARPs and other vulnerable groups.

In the initial phase, the NAP efforts focused on reporting HIV detected cases through passive surveillance mechanism. Since 2004, screening of blood and blood products through strict infection control measures became mandatory in the country. Several blood banks throughout the country were renovated, and a national blood donor tracking system was established to ensure safe voluntary blood donors attraction and retention. Blood units are screened for blood-borne diseases prior to transfusion. The MoHP has called for the establishment of an infection control committee in all hospitals and the application of infection control measures in renal dialysis units and blood banks. The HIV screening has also been extended to foreigners residing in Egypt for education or work purposes, and Egyptians studying or working abroad in countries applying HIV-travel restrictions, in addition to those seeking voluntary testing.

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

In 2005 a "Youth Train" traveled from north to south Egypt carrying students, and in every stop national seminars and music concerts were held to this end. Peer support programs in schools and youth clubs were also established with support of various CSOs. This included peer education programs led by youths and student groups such as the student-led "Anti-AIDS" clubs in high schools, awareness activities in faculties of medicine, peer education among scouts, and outreach to refugees. Programs addressing vulnerable groups and MARPs (FSWs, MSM and IDUs) and prison inmates have been also initiated. The NAP has worked in close collaboration with the MoE and MoHE to include HIV information in the educational curriculum.

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

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

In 2004, the NAP outlined a national HIV surveillance plan for monitoring the HIV epidemic. A National Electronic Disease Surveillance System (NEDSS) was put in place serving at least 13 governorates to collect and analyze data on 26 priority infectious diseases including HIV. Few serological and behavioral surveys have been conducted on MARPs, but were made on an ad hoc basis and failed to produce disease trend information or risk behavior pattern in the country. In the same year, the MoH in collaboration with UNAIDS and UNODC conducted a behavioral survey on IDUs in Cairo. While in 2008, the MoH along with the UNICEF and the Population Council ran a behavioral survey among street children in Cairo and Alexandria. In 2006, the MoH, in collaboration with FHI360 and USAID, conducted the first round of BioBSS, the first of its kind in the region, collecting data on risk behaviors and STIs, and assessing HIV prevalence among street children, FSWs, MSM and IDUs. In 2010, the MoH, together with FHI360 and Global Fund, conducted the second round of BioBSS to monitor HIV prevalence trend and risk behaviors.

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

Sustainable Development Goals and Adolescent Reproductive and Sexual Health

Increased investment in sexual and reproductive health services, specifically for adolescents, will push Egypt forward to reaching the proposed specific SDGs applicable targets. Health targets for SDG 3 highlight ensuring sexual and reproductive health care services for all, promoting the rapid reduction in fertility level through exclusively voluntary means, and achieving universal quality health coverage, including the prevention and treatment of communicable and non-communicable diseases, the provision of sexual and reproductive health, family planning, routine immunization, and mental health services as per basic health care priorities.

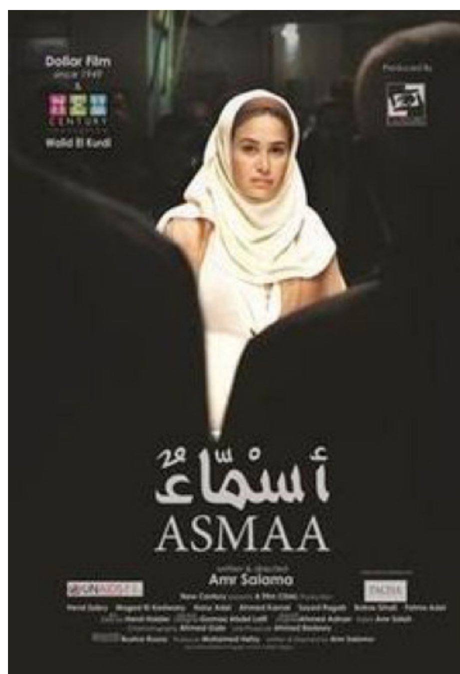
The NAP has trained physicians and nurses all over the country on HIV care and support provision in collaboration with the MoSS. It is also worth noting that Egypt already has in place a network of motherhood and childhood care centers at governorate level, providing care for abandoned children.

In 2013, with the technical assistance of FHI360, funding from Dross and FORD Foundation and support from UN agencies, the NAP worked with the CSOs and established the Network of Associations for Harm Reduction (NAHR). NAHR is the first locally owned network aiming to unify, strengthen and sustain efforts invested in harm reduction for all key populations in Egypt. It works on strengthening the capacity and enhancing the collaboration among CSOs to share the goal of reducing stigma, promoting behavior change and expanding the harm reduction services available to MARPs. It provides wide range of services including the provision of HIV voluntary counselling and testing, STIs and other illnesses detection and treatment clinics, syringes, condoms, information, education and communication services, support groups, peer education, and referral services to provide beneficiaries with access to rehabilitation and ART. NAHR members work in diverse governorates, have access to a large number of beneficiaries, and employ outreach teams capable of targeting a greater number of people.

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

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

Despite Egypt concrete HIV strategy and programs, the STIs efforts are less evident. There is no clear strategy in place and the services mainly focus on case management. However, the MoH has taken gigantic strides in upgrading services for the detection and treatment of STIs, through the provision of laboratory diagnosis and treatment services along the private and public sectors. The MoH has implemented the syndromic approach for STI case management and has also carried out etiological studies to validate the WHO flowcharts relating to the syndromic approach. Notably, Egypt is among the six countries, with regard to EMR, providing special STIs services for MARPs in the form of outreach and peers education program among FSWs, and offering special consultation and treatment services for this group.



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

3.7.4.2 National Regulations Related to HIV and STIs

The NAP efforts are founded on solid national environment. The 2014 Egyptian Constitution, in addition to previous constitutions, value health and the right to health care for all citizens and prohibit all sorts of discrimination. Egypt is a signatory to the Millennium De-

velopment Goals (MDGs), the Declaration of Commitment on HIV/AIDS and the Sustainable Development Goals (SDGs), together with all international human rights treaties.

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

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

In Egypt social solidarity pension can be dispensed to PLHIV similar to that being dispensed for people with disabilities, if they are unable to work.

3.7.5 Child Protection Regulations Related to HIV and STIs

A set of child protection policies have been developed to protect the right of children to health and well-being, which are further reflected on their HIV and STI vulnerabilities. A wide range of protection initiatives exist in the country, aiming to address such diverse problems, namely age at marriage, citizenship rights, female genital mutilation/cutting (FGM/C), violence against children and child labor. Egypt has recently revisited the laws to provide greater legal protection to children, and currently being implemented. These include, the Child Law 12/1996 as amended by Law 126/2008, and the relevant articles of the Penal Code. The Child Law has for the first time criminalized some practices injurious to child well-being, such as FGM/C and trafficking in persons. It, also, led to the amendment of the Civil Status Law raising the age of marriage to 18 years for both males and females.

Egypt signed a number of international conventions and was one of the first countries ratifying the Convention on the Rights of the Child (CRC). Also, it was one of the founding countries for the Children World Summit initiative held in 1990.

The 2014 Egyptian constitution has stressed on child rights and confirmed commitment to the ratified agreements and international conventions, coming into force under Article 93 of the Constitution, including the CRC and ACRWC in 2001, and other related conventions and treaties. All and above, Egypt has issued the first decade document in 1989-1999 and the second decade document in 2000 – 2010, on the protection and care of the Egyptian Child.

Finally, the NCCM has developed the Childhood Strategy 2017-2022 to ensure child protection, health and right to health. The strategy aims to translate the provisions on the rights of the child stipulated in the Egyptian Constitution, and address the numerous social, economic and security challenges facing children and mothers. The strategy represents a unified framework for all governmental and non-governmental institutions concerned with childhood and motherhood issues in Egypt. The strategy was prepared in consultation with all stakeholders, including groups representing Egypt children. Taking the previously mentioned in consideration, the strategy came to reflect the aspirations of the new generation, in order to promote child protection, health and access to knowledge and healthcare services.

The NCCM has developed the Childhood Strategy 2017-2022 to ensure child protection, health and right to health. The strategy aims to translate the provisions on the rights of the child stipulated in the Egyptian Constitution, and address the numerous social, economic and security challenges facing children and mothers.

Chapter 4
Inequalities and Exercising Rights

Chapter 4 Inequalities and Exercising Rights

4.1 Introduction

Vulnerability is the degree to which a population, individual or organization is unable to anticipate, cope with, resist and recover from the impacts of disasters. (Environmental Health in Emergencies and Disasters: Practical Guide) (WHO, 2002).

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

Previous reports on population status discussed the aging issues[2]. In addition to the aforementioned, this chapter concentrates on slum areas, street children and fishermen in Egypt.

Although there are many definitions of poverty, the United Nation definition encompasses all the poverty factors and consequences. The UN defines poverty as the inability of having choices and getting opportunities. In other words, this means lack of enough food or clothes to cater for family needs (food), lack of school (education) or clinic facilities (health), lack of lands to grow or job to earn a living (income) and lack of access to credit. The consequences of lacking these factors would lead to insecurity, powerlessness, exclusion and marginalization.

As there are numerous definitions of poverty, there are also multiple methods for measuring poverty. Money metric poverty, Expenditure-based methods, Gini index and multidimensional poverty indices are the most used poverty indicators.

One of the money metric poverty measures is based on the purchasing power parity (PPP) related to poverty lines. This measurement relies on a $1.25 PPP as a reference threshold to measure poverty across the world based on a "welfare consistent" approach. People earning (or spending) less than $1.25 PPP are considered unable to meet basic survival needs, in monetary terms, anywhere in the world. The PPP represents comparable income (expenditure) across nations to purchase certain minimum needs (World Bank, 2013). However, whether or not the $1.25 PPP line allows meaningful comparison of poverty across countries, or the PPP$ based poverty line can meaningfully represent poverty at the national level, remain a matter of contention.

Another money metric approach is based on the national lower and upper poverty lines. Such an approach establishes the lower and upper poverty lines based on the expenditure surveys identifying poor and vulnerable population.

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

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

Number of poor people more than doubled between 1999/2000 and 2015 from 11 million to 25 million people.

The latest Egypt Household Income, Expenditure and Consumption Survey (HIECS 2015) shows swelling poverty in Egypt. The percentage of population under the national pover-

2- Population Status in Egypt: A Way forward, UNFPA, Egypt 2012.

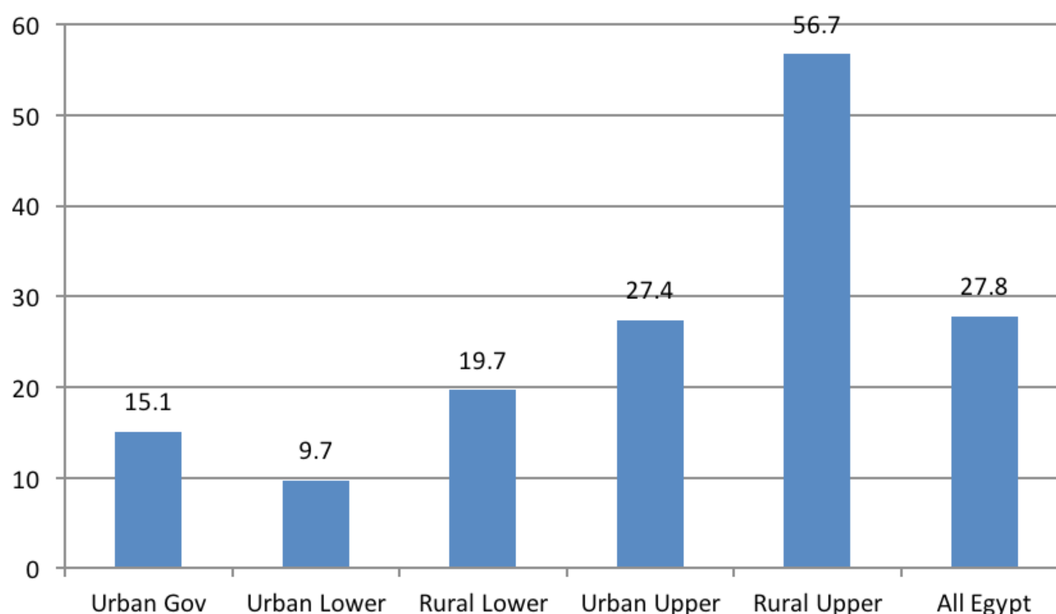
ty line increased from 16.7% in 1999/2000, to 26.3% in 2012/2013, with a 58% rate of change. During this period the number of poor people was almost doubled from around 11 million to around 22 million. Sub-section 2 of this chapter will briefly describe the population inequalities by poverty, highlighting intergenerational transmitted poverty, health and educational inequalities, in addition to other religious and cultural characteristics.

With regard to sub-section 3, it concentrates on slum areas, street children and fishermen in Egypt.

4.2 Population Inequality by Poverty

In 2015, the poverty rate, in rural areas, was higher compared to urban areas. In particular, the poverty rate in rural Upper Egypt reached around 57% compared to around 20% in rural Lower Egypt Figure (4.1). On the other hand, poverty rate in urban Upper Egypt was higher than all other urban areas in Egypt. More than one quarter of population in urban Upper Egypt are poor (30%), compared to 15% in urban governorates, and 12% in urban Lower Egypt.

Figure 21: (4.1) Poverty Rates, in Egypt (2015) by Region, HIECS (2015)



Source: HIECS 2015

To address the problem of higher poverty at rural areas in Egypt, the small-area estimation technique was adopted. The idea of the small area technique is to combine the abundant information on household income and expenditure available from the HIECS and the complete coverage of the census data, in order to estimate poverty rates for all locality-level in Egypt. Accordingly, the 5000 villages of Egypt are sorted by poverty rates. Table (4.1) presents the distribution of the villages by centiles of poverty rate and region. The first centile includes the poorest 10% villages and the second centile includes 10% of the second poorest villages. The tenth centile includes the richest 10% villages.

The results of Table (4.1) document the fact that poverty is concentrated in Upper Egypt. More than 80% of the poorest 20% villages are located in rural Upper Egypt. Around 778 villages of the poorest 1000 villages are located in Upper Egypt. This number of villages accounts for more than one third of Upper Egypt villages.

Furthermore, the findings presented in Table (4.2) document the fact that the poorest villages are less educated and less developed.

- The percentage of households with sewage facilities exceeds not 5% in the poorest 10% villages, while it reaches 100% in some of the richest 10% villages;

- The percentage of households with water networks ranges between 51% and 100% in the poorest 10% villages compared to 99% and 100% in the richest 10% villages;
- The illiteracy rate among population (10+) ranges between 18% and 79% in the poorest 10% villages, compared to 10% and 53% in the richest 10% villages; and
- The average number of persons per household ranges between 3.81 and 5.83 in the poorest 10% villages, compared to 3.33 and 4.55 in the richest 10% villages.

Table 17: (4-1) Distribution of Villages, by Poverty Rates, Centiles and Region (2012/2013)*

			Centiles										Total
			Poorest	20%	30%	40%	50%	60%	70%	80%	90%	Richest	
Region	Lower Egypt	Count	6	19	124	267	333	333	334	349	444	457	2666
		% within Centiles	1.28%	4.03%	26.33%	56.69%	70.70%	70.70%	70.91%	74.10%	94.27%	97.23%	56.63%
	Upper Egypt	Count	375	403	309	175	124	119	124	97	7	3	1736
		% within Centiles	79.79%	85.56%	65.61%	37.15%	26.33%	25.27%	26.33%	20.59%	1.49%	0.64%	36.87%
	Frontier	Count	89	49	38	29	14	19	13	25	20	10	306
		% within Centiles	18.94%	10.40%	8.07%	6.16%	2.97%	4.03%	2.76%	5.31%	4.25%	2.13%	6.50%
Total		Count	470	471	471	471	471	471	471	471	471	470	4708
		% within Centiles	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Calculated by the author

Table 18: (4-2) Some Characteristics of Villages in Egypt, by Poverty Rates, Centiles and Region (2012/2013)*

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

Calculated by the author

4.2.1 Intergenerational Transmitted Poverty

The poor children are more likely to be poor adults, yet this is not always the case. The household characteristics affect people well-being over the life-course. In this sub-section some of these characteristics will be addressed. The data used here depends on calculating the likelihood of the household being poor from EDHS (2014), based on the Poverty Progress Index. Table (4.3) represents the distribution of households by size and poverty as calculated by the author from EDHS (2014). The poor household size is around two members more than the non-poor. The higher household size will lead to high dependency ratio, which in turn can contribute to the intergenerational transmission of poverty by limiting children human development, socialization and subsequent earnings. The costs of education, health care and food may be enough to ensure persistent severe poverty in high dependency ratio households. With this in mind, children are less likely to be well fed and to complete secondary school.

Table 19: (4.3) Distribution of Households, by Size and Poverty

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

Source: Calculated from EDHS 2014 data

The household possessions and access to services can influence income, investment, savings, consumption, nutrition, health, education, and indirectly leading to a chronically poor individual. Tables (4.4), (4.5) and (4.6) present the distribution of EDHS households by access to drinking water and sanitation as well as the material of floor, for poor and non-poor. The poor household is less likely to have access to drinking water piped into dwelling (87% compared to 91%), less likely to have a toilet flush connected to piped sewer system (45% compared to 65%), and more likely to have earth/sand floor (10% compared to 3%).

Table 20: (4.4) Source of Drinking Water among Poor and Non-Poor

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

Source: Calculated from EDHS 2014 data

Table 21: (4.5) Type of Toilet Facility among Poor and Non-Poor

	Poor	Non poor	Total
Flush to piped sewer system	45.0	65.5	60.0
Flush to septic tank	23.4	15.9	17.9
Flush to somewhere else	.1	.1	.1
Flush, don›t know where	.1	.1	.1
Flush to vault (Bayara)	22.3	11.9	14.7
Flush to pipe connected to canal	8.8	6.5	7.1
Flush to pipe connected to ground water	.0	.0	.0
Ventilated Improved Pit latrine (VIP)	.0	.0	.0
Pit latrine with slab	.0	.0	.0
Pit latrine without slab/open pit	.0	.0	.0
No facility/bush/field	.2	.0	.1
Bucket toilet	.1	.0	.0
Other	.1	.0	.0
Total	100.0	100.0	100.0
	7570	20532	28161

Source: Calculated from EDHS 2014 data

Table 22: (4.6) Main Floor Material among Poor and Non-Poor

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

Source: Calculated from EDHS 2014 data

4.2.2 Health Inequalities

Child and maternal nutrition together with health status are often cited as the critical factors determining the irreversibility of poverty transfers. Maternal malnutrition contributes to higher rates of maternal, infant and under five mortality. Poor in utero nutrition also leads to low birth weight babies, with higher risk of children being stunted, and experiencing a permanent limit to physical and cognitive

development, which in turn affects schooling performance and completion. These problems affect a very large number of children: over 200 million children are stunted worldwide; more than 150 million of pre-school children are underweight. Stunting and wasting have long term repercussions, which could influence a child likelihood of becoming a poor adult. Malnutrition reflected in low weight-for-age, contributes greatly to child mortality, as it increases the risk of death from common illnesses. Table 4.7 documents the fact that poor children are more likely to be under weight and stunted relative to non-poor.

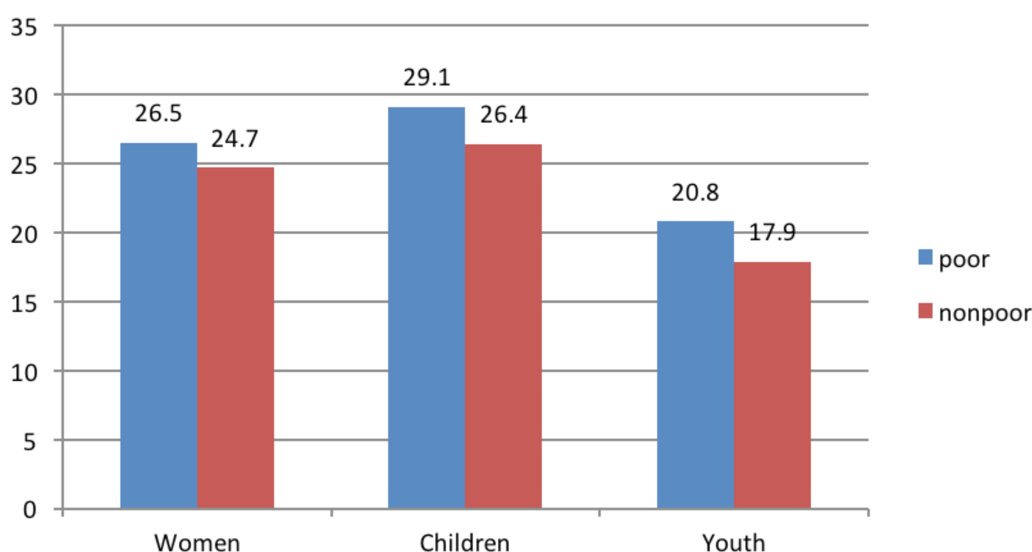
Table 23: (4.7) Children under 5, Weight for Age Standard Deviation and Height for Age

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

Source: Calculated from EDHS 2014 data

In addition, Figure (4.2) shows that the prevalence of anemia was higher among women, youths and children of poor households compared to non-poor households.

Figure 22: (4.2) Prevalence of Anemia among Women, Children and Youths, by Poverty



Source: Calculated from EDHS 2014 data

4.2.3 Educational Inequalities

The education differentials are very clear among poor and non-poor individuals in the age group 10 years and above. According to the EDHS 2014 data, 57% of poor population have not been to school or did not complete primary stage, compared to 45% of non-poor. On the other hand, only 5% of poor compared to 14% of non-poor people completed higher education (Table 4.8).

Table 24: (4.8) Distribution of Individuals (10 years and above), by Educational Level Attained and Poverty (EDHS, 2014)

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

Source: Calculated from EDHS 2014

The inequalities in education level is clearer among poor and non-poor ever married women (15-49 years). Table (4.9) indicates that around half of the poor ever married women have not attended school or have not completed the primary stage, compared to one fifth of the non-poor woman. The percentage of non-poor women attained higher education is three times the corresponding percentage of poor women (18 % and 6% respectively).

Table 25: (4.9) Distribution of Ever Married Women (15-49 years), by Educational Level Attained and Poverty (EDHS, 2014)

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

Source: Calculated from EDHS 2014

In 2011, a household survey was conducted in the poorest rural areas of Upper Egypt (in Assuit and Suhag), based on Conditional Cash Transfer (CCT). The average number of school years of children no longer in school, whether dropped out or graduated according to the CCT survey is presented in Table (4.10). The mean number of educational years among children 8-17 years in rural Upper Egypt is approximately 5.4 years as per the CCT. The average number of school years for female 8-17 years is slightly higher than males regardless of wealth as presented in the CCT results (5.67 years and 5.25 years respectively)

Table 26: (4.10) Mean Number of Educational Years among Children (age 8-17) not in School

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

Source: Calculated from the findings of CCT surveys

4.3 Slum Areas, Street Children, and Fishermen

4.3.1 Slums

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

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

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

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

Slums in Egypt are considered ticking time bombs waiting to go off at any minute. The statistics provide conflicting numbers of slum areas and their populations. A study conducted by CAPMAS stated that the number of slums in Egypt amounted to 1,221 areas, 20 of which 20 are to be removed for being inadequate for development. However, the Cabinet Informa-

tion and Decision Support Centre estimated the number of slums by nearly 1,034, while the National Planning Institute confirmed the existence of over 1,109 slums covering 20 governorates.

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

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

The discussion showed that slum areas encounter numerous problems include the lack of services, especially education and health services, poor quality of available services, and lack of safety due to the absence of police and security that threaten the lives of people living in such areas.

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

Work

One of the males owns a local café, he assumed his income is quite good for his living. The other male works as a carpenter and receives a small retirement allowance, which he believed cannot be sufficient for a living as he said: "What can 380 EGP do us?!"

On the other hand, all female participants were unemployed housewives and they had concerns about their family income. Some of them complained from their husbands' seasonal work which does not guarantee a stable income: "When he goes to work, we are fine. But there is no work in winter. All I want for him is to have a stable job".

Moreover, another female participant complained saying that her husband salary does not cover the whole monthly needs.

Access to Public Services

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

Moreover, participants asserted the lack of natural gas in their residence area. They use LPG gas tanks instead. They even suffer from shortage in LPG gas tanks during winter, as one of the females said: "It becomes expensive in winter and we don't even find it".

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

Education

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

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

Health

Some of the participants highlighted the availability of a health unit in the area, which is newly constructed. One of the females stated that the service quality in this unit is good as her child was vaccinated there, she also added: "My sister has been examined there, and they gave her medicine as well."

Beside the health unit, participants referred to the presence of two hospitals, existing outside their residence area, which are not considered far from their place, as they easily use means of transportation to reach them.

Transportation

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

Safety

The majority of participants stated that their girls, as well as all family members, can wander in the area without any fears day and night. One of the males said: "I think everyone can move freely; as we are all known to each other. Daughters, sons and wives".

On contrary, only one female complained that her girls cannot walk in the streets safely because of the harassments that they might be exposed to.

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

Meanwhile, participants mentioned that there might be some "small thefts", as they described it. In addition, all participants stated that the area witness numerous fights either because of financial issues or social ones (i.e. shared toilets... etc.). They also agreed that the area had no longer witness any bullying practices as one of them said: "That happened in the past, but now they're dead and the area is clear from such bullying".

Security

The majority of respondents argued that the police forces are always late to show up as one of them said: "They only come by the end of the fight."

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

Problems

Respondents listed many problems, from which they suffer as a result of living in slums. One of these problems is the lack of bakeries in their residence area, which requires women to go outside the area to buy bread to cater for their food needs. Moreover, some respondents showed resentment about the new system of the ration cards, which combined bread with the rest of food supplements; as one of them said: *"It is unfair! I, for example, don't have a ration card, so I don't get bread. One day I don't buy bread, another day I pay 10 EGP for the bakery. This is truly unfair"*

The majority of respondents complained about the roads contraventions, hindering people from walking around easily in the streets. Many of them, also, demanded a quick governmental intervention to solve this issue.

The problem most commonly reported was the dilapidated buildings, affecting people sense of safety, as one of the respondents said: *"A 70-year-old slum, you can see through the cracks of the walls while you pass by"*.

The second commonly stated problem was the narrow residences which are, mostly, rooms

with shared toilets. Meanwhile, respondents agreed that it is, almost, impossible to obtain one of the flats offered by the government; as one of them said: *"People who already lost their homes have been waiting for 7 to 8 years to receive a flat and they get nothing until now. So, if I applied for any of these flats, and even before my home collapses, I will get nothing. They definitely have the priority"*.

On the same context, one of the respondents complained about the poor service in the area as he said: *"People are nearly buried alive, for being extremely narrow slums that barely allow a couple of individuals to walk"*.

Support and Aid

All respondents denied that they had received any aid or support either from the governmental agencies or from private sector organizations. Meanwhile, they admitted the role of the NGOs in the area by offering some aid to the orphans. On the hand, respondents demanded such organizations to serve people without favoritism, as one of them said: *"They only help their relatives"*.

As for the private sector, participants' most prominent demand was to establish projects in order to employ youths and help them do away with drugs. Also, participants agreed on being neglected by the government. They further stated that developing and reconditioning buildings in addition to constructing schools are their key demands from the government.

Finally, when asked whether mentioning their residence place embarrasses them or not, the answer came out clear that they do feel embarrassed; as people usually act offensive when they mention Ezbet Abu Hashish. A participant stated that he was once rejected from a job when the employer knew where he lives. Another participant added: *"Schools outside always reject children from here, they don't accept students from Ezbet Abu Hashish"*.

Individual Requests

Participants emphasized their desire to live in Ezbet Abu Hashish after being developed; as they are already attached to the place. They, all, had the same wish of having a proper flat to live in. In addition, female participants expressed their wish for their children to join any of these good schools that refused to enroll them, or only accepted students after paying bribes as one of the respondents said: "I knew someone who paid 500 EGP in order to enroll her son in the school."

4.3.2 Street Children

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

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

Definition and Causes

First of all, the interviewee was asked about the definition of street children from his association perspective, he answered: "A less than 8 year child, male or female, who abandoned his/her family and took the streets as a shelter; meaning that if a child works in streets but returns back to his family at the end of the day, he is not a street child for us".

In addition, the respondent reported that 85% to 90% of families, from which street children come, are poor families. He, further, listed the causes of street children phenomenon, namely family disintegration (for which he gave the highest share of the responsibility), poverty, negligence and cruelly treating children. The respondent emphasized that the problem usually results as a combination of two or more from the previous causes.

All and above, when he was asked about the places where street children are most found, he mentioned many districts like Al-Sayeda Zeinab, Al-Hossain, Al-Agouza, shooting club, Ramsis, Shoubra Al-Khaima, Helwan, Maadi and Ahmed Helmy. He, also, added that Lower Egypt is the most populated with street children. The respondent illustrated that street children usually take some places as their inconstant shelter according to the availability of their needs; they might gather around malls, restaurants and jammed streets until someone dismiss them in a way or another, saying that: "Their main reason to inhabit a certain place is the opportunity to practice any work that will provide them with some money accompanied with a place to sleep in peacefully".

He, also, highlighted that a street child could be a male or a female with a ratio of 4 to 1, but a female child needs to be treated quite differently as he said: "Girls would be more aggressive than boys. They need a special way of treatment. For example, if a male and female street children were sexually abused, you can treat the boy by psychological sessions. But girls are hard to be treated from such incidents. Their problems are much more complicated than boys".

Street Children Community

The respondent pinpointed that, from his experience, street children often construct a community of their own with certain systems, rules, incentives and even languages as he said: "In one of our researches, we have studied their language and we have found 400 vocabularies only they can relate to. There is a language developed in this community. They have their own behaviors, morals and laws. They have their own community in our community inside our streets".

He added that they usually have a leader among them; someone to plan, regulate and control. This leader, as he mentioned, is not just the older among them, but also the most skilled or experienced. He, also, confirmed that they often compete with each other to prove who deserves this title. This competition, often, consists of dangerous actions. He added that this leader could be a girl in some groups.

Problems of Street Children

Another point of concern is the problems street children face. The respondent reported that street children encounter physical problems from headache to cancer, besides psychological illnesses, which are widely spreading among street children. He reported that dental diseases are the one common among street children, followed by scabies and skin diseases. He, also, asserted that cold and flu arise among them in winter, in addition to, burns from fire used to keep warm at night.

On the other hand, the interviewee stated how psychological issues and persistent comparison with other society members affect street children and induce significant violence easily reflected on the society. The respondent said: "From the psychological side, I can say that we work with shreds; Psychological Shreds. That child is probably in the streets because of a family fault. A violent mother and/or father or school could be the reason behind leaving such children homeless and finding themselves facing an ever crueler violence. The child, becomes absolutely devastated, suffering from a psychological messed up structure".

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

Governmental and Non-Governmental Responses to Help Street Children

The respondent stated that he has worked with several governmental agencies over the years; from which he listed MoSS, MoI and NCCM.

He highlighted that the government can effectively contribute in confronting the street children problem.

The private sector role towards the cause is quite limited and needs to expand by cooperating with the community development associations in Egypt. He, further, commented on the charities role that he considered quite

limited, as well. He said: "The role of charities is quite inadequate. We have around 22000 associations in Egypt, from which only 7000 work with children in general and only 12 or 13 work with street children in particular. Notably, very few of such 12 or 13 associations actually".

The respondent gave international organizations, a medium rank with regard their performance, allocating their role mainly in offering funds.

The interviewee expressed his dissatisfaction with the policies dealing with the phenomenon. He admitted the dereliction of several entities working on such issue, as they could not assimilate those children or take enough prevention actions.

Obstacles Facing Street Children Issue Settlement

The respondent considered unemployment and poverty as the main obstacles encountering the obliteration of street children issue, as he said: "The father of such kind of child, who already has 12 brothers, won't accept his/her return back to his/her family, as he cannot afford his/her expenses anymore".

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

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

Suggestions to Confront the Phenomenon

The interviewee suggested the integration between governmental and the civil society organizations, as the pillar for solving such a problem.

He, also, pinpointed the importance of changing the private sector mentality in dealing with the several social causes. He stated that there should be awareness raising campaigns to sensitize the private sector in order to support in overcoming the existing social challenges.

Regarding the community development associations, he recommended the application of specializations in the different scopes of work, namely each association should be specialized in one of the social causes (i.e. street children, disabled, handicapped, addicts... etc.), supported by the government and encouraged by society.

Moreover, he suggested that the international organizations and donors could limit intervening in the strategies, on which the community associations actually work in relation to social causes.

4.3.3 Fishermen

Fishermen in Egypt are facing a variety of problems, especially concerning the policies of the draining lakes that led to the decrease in El Manzala fishing area from 750 thousand feddans in 1956 to 190 thousand feddans in 1982 and only 125 thousand feddans in 1994. Large areas of these lakes are also being rented by big businessmen, who prevent fishermen from fishing in such areas. In addition, the fish catch has decreased in the last few years due to the increasing pollution caused by dumping industrial and domestic wastes in the sea. Boatmen have to compete with bigger boats, the matter that raised the number of fishermen, who lack licenses or take fishing as a hobby. The prices of fishing nets have also escalated, multiplying the prices of fish. Without any intervention from the government, the decrease in tourism and the inflation in the food market are exposing fishermen economic livelihoods to risk.

Three in depth interviews took place in Lake Burullus, Kafr El-Sheikh, with three fishermen, two of them were 53 years old, and the other one was 35 years old. The three fishermen had suffered, mostly, of the same problems, that is favoritism, corruption and venality. Moreover, they agreed on the weak, and sometimes corrupted role of Fishermen Association that does not respond to their demands and have no positive impact on their problems.

One of the fishermen referred to his daily struggle with Water Police in order to fish in the lake. The man admitted that he, as well as other fishermen, sometimes use a slight illegal dragnets and do not have licenses, which always put them under pressure.

Another respondent stated that he cannot practice his work freely, as he too faces many pressures in issuing the needed license earn his living. Besides having five sons that he cannot afford their living, this man has a transplanted kidney and lives on medication. He had tried several times to get an exception based on his health conditions, but he could not reach someone to help him. He also mentioned being obliged to pay bribes, sometimes, to continue fishing in the lake.

The interviewees stressed on the necessity to have new laws to regulate fishing. They underscored their association weakness and incapability to solve their daily problems.

Chapter 5
Women Status in Egypt

Chapter 5 Women Status in Egypt

5.1 Introduction

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

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

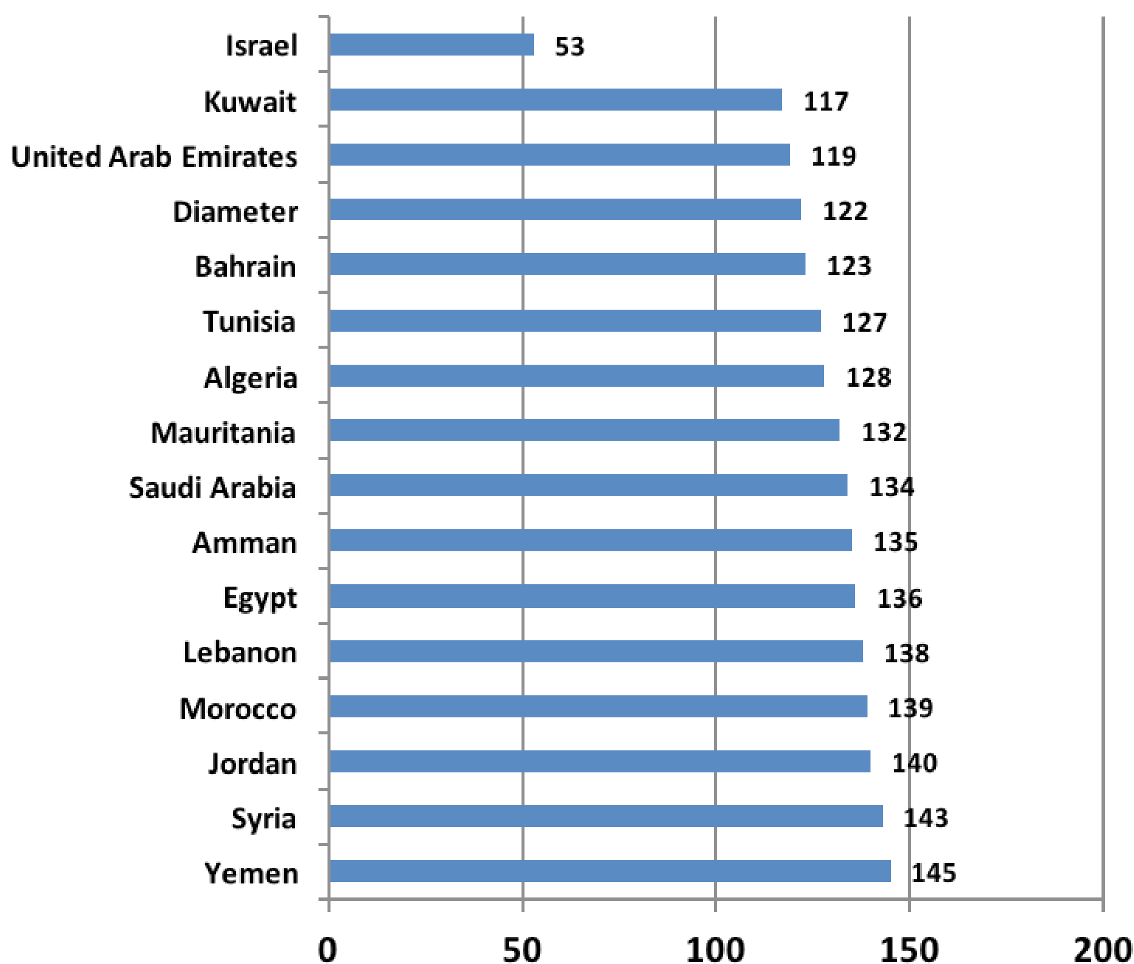
It is truly ironic, and indicative of the breadth of this gap of modernity, that the demands for freedom and social justice promoted by the revolutionary protests of January 25th, 2011 led to no tangible improvement in the situation of women over the past five years, not to mention the persistent gender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

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

5.2 Overview of Gender Gap

Available data indicates that Egypt is still facing difficulties in achieving the MDGs, with regard to the promotion of gender equality and the empowerment of women. This is particularly the case when it comes to education and participation in paid employment, as well as political participation. Notably, the World Economic Forum Gender Gap Index reflects the gap between females and males in different dimensions including education, health, economic participation and political participation. The higher the index value, the narrower the gap is. In 2015, the World Economic Forum Gender Gap Index ranked Egypt, with a score of 0.599, 136 among 145 countries globally, and 11 among 16 countries in the MENA region, lagging behind other countries such as Israel, most of Arabian Gulf countries, Tunisia, Algeria and Mauritania.

Figure 23: (5.1) Egypt Ranking in the Gender Gap Index, in MENA Region, 2015



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

Table (5.1) shows a general trend of improvement in gender gap with a score increase of 0.020 between 2006 and 2015. Amid the wave of economic, social and political turmoil that Egypt has witnessed following the outbreak of the 2011 protests, improvements in the gender gap index have become fractional and fluctuating from one year to the next. The year 2014 represented the highest level of improvement, with the gender gap increasing once more in 2015, almost reaching the same levels of 2010 and 2012.

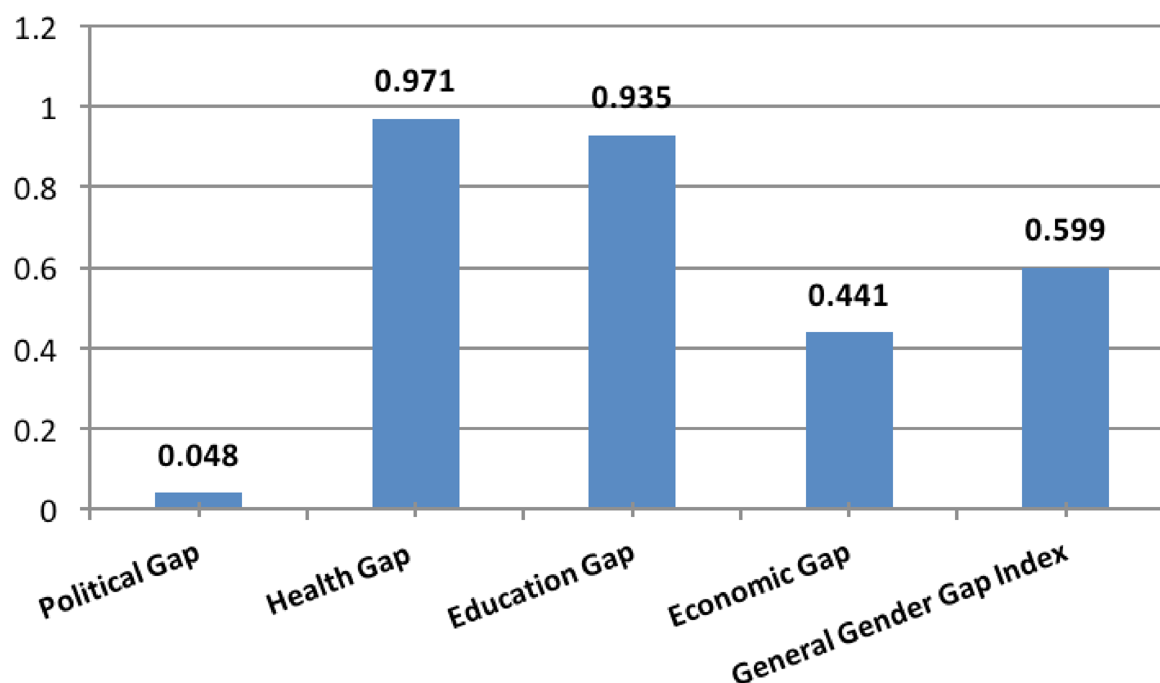
Table 27: (5.1) Egypt Gender Gap Index Scores, 2006 - 2015

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

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

The low score of the current Gender Gap Index in Egypt could be attributed to the widening gap between males and females in economic and political indicators in particular. Figure (5.2) shows a widening gender gap in the economic sphere recording a score of 0.441, with Egypt ranking 135 globally in the economic participation index. In the political sphere, the gender gap reached a maximum of 0.048 in favor of males, with Egypt ranking 136 globally in the political empowerment index. On the other side, the gender gap witnessed substantial improvement in the fields of health and education; Egypt ranked 97 globally in health and survival index with a score of 0.971, and 112 in the education Gender Gap Index with a score of 0.935.

Figure 24: (5.2) Components of Gender Gap Index in Egypt, 2015



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

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

Gender Gap in Educational Attainment

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

Table 28: (5.2) Egypt Gender Gap Index Score, Educational Attainment, 2006-2015

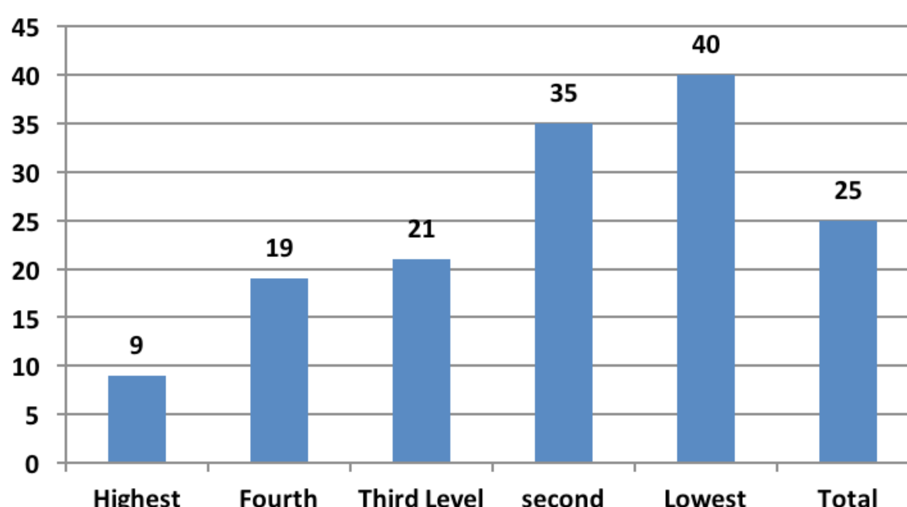
Year	Number of Countries	Ranking	Score
2015	145	115	0,935
2014	142	109	0,947
2013	136	108	0,920
2012	135	110	0,925
2011	135	110	0,908
2010	134	110	0,899
2009	134	107	0,900
2008	130	105	0,902
2007	128	101	0,909
2006	115	90	0,903
Change between 2015-2006			0.032

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

Out-of-School Females

Despite government efforts to accommodate all school-age population within the different stages of educational system, females still make up the majority of the population deprived of access to education. The non-enrollment percentage for the 6-18 age group is 7% among females, compared to 5% among males. An obvious correlation exists between household economic status and non-enrollment of females in schools. Data from the EDHS 2014, as shown in Figure (5.3), reveals that non-enrollment among females from households in the lowest and second lowest economic levels reached 40% and 35%, respectively. The percentage of non-enrolled females decreases gradually by the increase in economic level, with a 9% in the highest economic level. This shows a strong linkage between poverty and lower levels of education among women.

Figure 25: (5.3) Non-Enrollment, by Economic Level



Source: Population Health Survey, 2014.

Table 29: (5.3) 2015 Egypt Gender Gap Sub-Indexes, Education

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

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

Data from the 2015 Gender Gap Report, as shown in Table (5.3), indicates that three quarters of out-of-school children, in the age of primary school, are females. Despite the drop in general illiteracy rates from 30% to 26% between 2007 and 2013, women still make up the bulk of the illiterate population, with 34% illiteracy rate among females, compared to 19% among males in 2013. Official data, as shown in Table (5.4), indicates a lower percentage of female dropouts in the 6-18 age group with 2%, in comparison to 3% among males.

Table (5.5) also pinpoints that male dropout rates remain higher than female dropout rates in primary and preparatory education between 2004/2005 and 2010/2011, which means that females having access to education are more serious and diligent with respect to completing their education than males. However, the percentage of female dropouts is on the rise over the years, and increases from one stage of education to the next, due to social and cultural constraints, which undermine the importance of education for girls, connecting their future to early marriage prospects, especially in rural areas.

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

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

Rising Illiteracy Rates

The 2015 Gender Gap Report shows a severe gap in literacy rates between males and females, estimated at 65% versus 82% for males, with Egypt scoring 0.80 in the literacy Gender Gap Index, and very poorly ranking 123 globally; last among countries of the Arab World and of the MENA region. The high illiteracy rates among females could be attributed to the lack of serious governmental and social efforts to better the status of female education and combat female illiteracy, especially in rural and poor areas.

Table 30: (5.4) Dropout Rates, for 6-18 Age Group, 2006 Census

Enrolled and Dropped out	Enrolled and Did not Dropout	Never Enrolled	Population 18-6	Gender
3	93	5	9084697	Male
2	91	7	8500384	Female
2	92	6	17585081	Total

Source: CAPMAS, September 2015

Gender disparity in enrollment clearly varies for different types of education. Remarkably, gender disparity in public schools' enrollment is less than other types of schools. The difference in enrollment between males and females in public schools is 6%, increasing in private schools to 8% and nearly doubled in Azhar education to reach 14%. This reflects significant improvement in female access to public schools, and relatively lower access to private schools.

The fact that males have higher enrollment rates in private schools can be explained by the tendency of some middle-class families to direct their spending on private schools to male children. This is ascribed to the prevailing values justifying such a behavior, as males are expected to bear heavier future burdens, compared to females, in the context of marriage and family-making; the matter entailing more investment in male children.

As for the severe disparity favoring males in Azhar education, it is evident in all stages of education and increases drastically in Azhar tertiary education, with males and females recording 61% and 39% respectively. This disproportionate distribution is related to the prevalence of patriarchal values in regions where religious education is generally on demand. Also, religious education has traditionally been more common among males for a very long time, with a general perception that males are better suited for this type of education. Therefore, female access to religious education is a new phenomenon to religious institutions of this kind. Moreover, the nature of religious educational institutions is marked by a general tendency in favor of severe gender disparity and strict separation, justified by interpretations of religious texts, between male and female students and teaching staff.

Table 31: (5.5) Gender Distribution of Dropout Rates in Primary and Preparatory Education, 2004/2005 versus 2011/2012

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

Source: CAPMAS 2014

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

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

Table 32: (5.6) Distribution of Enrolled Students in Different Stages of Education, by Gender (2013/2014)

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

Table 33: (5.7) Enrolment Rates for Male and Female Students in Various Stages of Education, According to Census

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

Source: EDHS 2014

The enrollment rates in various stages of education according to the EDHS 2014, compiled in Table (5.7), point to a gender gap at the various levels of education. In primary education, the rates of enrollment of girls is 116% compared to 93% for boys, which indicates a sizeable gender gap of 23 points in favor of girls. The gender gap continues to favor girls in preparatory education by 7%. At the higher levels of education, the gap is reversed in favor of boys, accounting for 2% in high school and 5% in university. This situation shows a remarkable progress in the opportunities of female education in the early stages of education, albeit males have a better chance of completing high school and being enrolled in university.

Comparing changes in enrollment rates in primary education across three time points (years 2003/2004, 2007/2008 and 2012/2013), as shown in Table (5.8), highlights a relative improvement in female enrollment rates in primary education going up from 87% in 2003/2004 to 97.2% in 2012/2013, despite the drop witnessed in 2007/2008.

Data for female enrollment in the preparatory stage points to a decrease from 99% in 2003/2004 to 93% in 2007/2008 followed by an increase to 95% in 2012/2013, with noticeable improvement in female enrollment rates compared to male enrollment rates particularly in 2012/2013.

The overall trend shows a diminishing gender gap for basic education as a whole, which is attributed to tangible success of government efforts granting females better opportunities to attain primary education on the one hand, and the positive change

in the society outlook on female primary education, on the other hand. The majority of Egyptian families now view primary education as an essential component of a girl rearing process, and a necessity to improve girls options in life, even if to get married at an early age as the case in poor rural areas.

Table 34: (5.8) Developments in Enrollment Rates in Different Stages of Education, by Gender

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

Source: CAPMAS 2014

Females in Secondary Education: Gender-Just Decline

Starting from preparatory education, a decline in female access to education can be detected along with an increase in equal opportunities among males and females in secondary education. According to data shown in Table (5-8), a sharp decline can be noticed in female enrollment rates from 81% in 2003/2004 to 66.3% in 2012/2013. Nevertheless, the gender gap is shown to diminish consistently from 5% in 2003/2004 to 0.5% in 2012/2013, meaning that the decline in female access goes hand in hand with more gender-just opportunities in secondary education. Thus, the Gender Gap Index in secondary education falls to a score of 1.0.

Low Levels of Female University Education

Female enrollment rate in higher education reaches 31% compared to 35% for male enrollment. With this disparity, the Gender Gap Index for higher education falls to 0.89, thereby placing Egypt in the 108 rank among 141 countries worldwide. Although access to higher education is not as socially significant as pre-university education, according to welfare programs in many countries, Egypt still fares quite poorly in the Arab world and the Middle East region, where many countries lead this index including Qatar, Kuwait, Bahrain, Tunisia, Algeria, Oman, and Israel.

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

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

Table 35: (5.9) Enrollment in STEM (Science, Technology, Engineering, and Mathematics) and Non-STEM Programs, by Gender, 2013/14

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

Source: CAPMAS, September 2015

Data shows a clear imbalance in the distribution of students according to specializations in university. Nearly 78% of university students study humanities, while only 22% study sciences. About 51% of students, studying humanities, are females. While the percentage of students studying sciences is 48%. Still, there is a gender gap even within some branches of humanities. Female students are reluctant to join several faculties that are quite popular among males. So, female students represent 27% in physical education, 39% in law, and 39% in business. The Faculty of Art Education is remarkably popular among female students (86.6%). In science faculties, most of the students are males, with the exception of the Faculty of Fine Arts, and the Faculty of Nursing, which have female student percentage of 76% and 75% respectively. Data points to a massive gender gap in the fields of science, technology, engineering, and mathematics, with young women constituting only 32%, leaving 68% to male students.

The official figures for graduate studies in 2013, compiled in Table (5.10), indicate that there are less women with post-graduate degrees (48%) than men (52%). Still, women lag behind men by only 1% in master and doctoral degrees. Figures for 2015, compiled in Table (5.10), indicate that women are ahead (55%) of men (45%) in the case of doctoral degrees. This accordingly shows show that, given half a chance, women can excel despite the discrimination.

Table 36: (5.10) Holders of Post-Graduate Degrees, by Gender, 2013

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

Source: CAPMAS, 2015.

5.3 The Gender Gap in Labor Market

The 2015 labor market gender gap data, for the past ten years, points to an improvement in five of these years and a deterioration in the other five. As we can see from Table (5-11), the gender gap for economic participation and life opportunities, of which work is an important factor, recorded 0.416 in 2006, putting Egypt in the 108 ranking among world nations. In the following three years, the gap narrowed gradually, to reach 0.450. Then, with the exception of 2011 and 2014, the gender gap gradually grew between 2010 and 2015, to reach 0.441 in 2015, placing Egypt in the 135 rank among world nations. The general trend of the past ten years underscores an increase in the economic gender gap by 0.025. Knowing the economic difficulties of the past few years, it is safe to assume that these difficulties left an unfavorable impact on the labor gender gap. This assumption seems to be in harmony with some of the sub-indexes of the labor gender gap, as we shall see in the course of the following analysis.

Table 37: (5.11) Labor Gender Gap Index in Egypt, 2006-2015

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

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

5.3.1 Participation in the workforce

Table (5-12) shows a relative increase in the gender gap regarding workforce participation in labor market, showing 26% for women and 79% for men. In other words, the rate of participation in labor market for men is three times that of women; putting the gender gap in 2015 at 0.33. This places Egypt in a low ranking (139 worldwide) lagging behind other Arab and MENA countries including Israel, Qatar, Kuwait, the UAE, Bahrain, Turkey, Mauritania, Tunisia, Oman, and Morocco.

Table 38: (5.12) Sub-Indexes for Labor Market Gender Gap in Egypt, 2015

Indicator	Rank	Score	Male	Female	Proportion of Females to Males
Participation in the workforce	139	0.33	79	26	0.33
High-level and technical professions	104	0.55	64	36	0.55
Legislators and managerial positions	121	0.08	93	7	0.08
Percentage of workers in the accounting sector to the total	-	-	18	9	-
Percentage of workers in the informal sector	-	-	93	7	-
Unemployment rates	-	-	9.9	24.2	-
Equality of payment for similar job	24	0.75	-	-	0.75
Estimated income in dollar purchasing power parity ($PPP)	133	0.30	17,353	5,218	0.30
Total gender gap in economy and opportunity	135	0.441	-	-	-

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

Because the percentage of men in the labor market is three times greater than that of women, unemployment among women is particularly rampant. The total unemployment rate of women in the labor force is more than double that of men. The official figures for participation in the labor force – compiled in Table (5.13) – show a decline in women participation in all age groups between 1995 and 2013, which is particularly pronounced among the young category, although women in older age groups, from 30 to 60 years, experienced a slight increase in participation in the labor market. This reflects women late entry to the labor market and the diminishment of women economic role in society. The highest rate of women participation was just over one-third in the (20-24) age group in 1995, compared to 32% in the (25-29) age group in 2013.

EDHS 2014 shows that only 16% of women are working, with the higher percentage (23%) in the (45-49) age group. Unemployment among women, at 84%, is highest among young women, married women, and women from rural or low-income backgrounds. The ratio of unemployment is 87% among women in the (25-29) age group and 85% among married women. Although the unemployment ratio of women is high across the board, it is higher (86%) in the bottom income bracket than in the top income bracket (77%).

Figures from the survey of young people (Sype 2009) show that women participation in workforce is influenced by the level of education and marital status. About 82% of women, who did not attend school, are not working, compared to only 13.6% of men who did not attend school. In other words, there are nearly 5.6 million women

who are neither studying nor working. Still, the higher the level of women education the more likely they are to have a job. Just under 10% of women with a secondary education have jobs, but among those with a technical school degree the same ratio climbs to 18%. Nearly 32% of women with above-intermediate technical education and 47% of women with university degrees have jobs.

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

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

Table 39: (5.13) Rates of Participation in Workforce, by Age (15-64) and Gender, 1995-2013

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

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

5.3.2 Gender Disparity in Wages

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

When we tackle the distribution of income according to gender, we find that the total income for all women is about one-third that of all men. In Egypt, women make generally 30%

of what men make, the matter placing Egypt in a rank of 133 among world nations. Discrimination in wages among men and women performing similar jobs, however, seems to be less pronounced in Egypt. According to a survey of several countries including Egypt, the gender gap of wage equality is slight. Egypt scored 5.22 on that index, with women lagging behind men by 0.75, which places Egypt at a relatively good ranking (24) worldwide, even ahead of other Middle East countries that strenuously attempted to reduce the other indexes of the gender gap, including Kuwait, Tunisia, Turkey, Lebanon, Israel, Algeria and Saudi Arabia. It is worth noting that this is considered an aspect of success in women struggle for wage equity in Egypt labor market.

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

5.3.3 Social Protection and Women Mobility for Work

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

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

5.4 Empowering Women

The current state of women empowerment can be assessed through various indicators including: difference in income between spouses, wife ownership of immovable assets, decisions related to the expenditures of husband

and wife incomes, and wife participation in family issues decision making process. Table (5.14), compiled from the data of the EDHS 2014, indicates that only 15% of all married women work for wages. Among women of 35 years and above, the proportion is even higher, for one out of five women in such an age group said she works for wages. Generally speaking, working women receive wages. More than 8 out of 10 working women reported having a wage. Women aged 20-24 years are the least likely to receive a wage for their work. Only 5% of previously married women aged 15-29 years own a home, and only about 2% own a land.

Table 40: (5.14) Comparison between Wife and Husband Incomes, Wife Ownership of Assets

Women working for wage	Comparison between Husband and Wife Income %			Ownership of Assets	
	Higher income	Lower income	Same income	Doesn't own a home	Doesn't own a land
15.4	9.1	62	23	95.2	98.2

Source: EDHS 2014

What Table (5.15) shows is that most married women having income do make decisions related to the manner of spending. About 29% of such women make financial decisions on their own and 63% make such decisions in collaboration with their husbands. The more women are making as much money as the husbands, the more likely they are to make decisions on financial matters. Available data also suggests that three-quarters of women participate in making decisions about their husbands' income, while 6% take sole charge of deciding how the husband income is spent. About 23% of women said that their husbands do not consult them on how to spend their income. In general, the closer the income of both spouses, the more chances of women to decide on the manner of spending the husband income.

Table 41: (5.15) Comparison between Spouses Role in Financial Decisions, Manner of being Affected by their Relative Incomes

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

Source: EDHS 2014

According to the EDHS 2014, most married women participate in making numerous decisions regarding personal life. More than 80% of married women make decisions related to their health care. In fact, about 15% said they make such decisions alone and 64% said they take decisions in consultation with their husbands. Figures also show that three-quarters of women make decisions to visit friends or family, either alone (11%) or in consultation with their husbands (64%). Women participate less when it comes to basic family purchases. But even in such decisions, about two-thirds of women said that they make such decisions,

either alone (6%) or in consultation with their husbands (51%). As for the level of participation by wives in decision making (regarding health care, purchases, and visits), 59% of women participated in such three categories of decisions, 19% in two categories, 12% in only one category, with about 10% of women took no part in any of such decisions. This seems to suggest that there is a considerable level of women empowerment within family life, in a manner exceeding that of women empowerment in public life.

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

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

The main aim of Niqdar Nisharek was to empower women, socially and economically, through providing women with work skills, helping them in finding jobs or starting their own business, offering basic life skills that help them understand their rights and responsibilities as citizens. The project also aimed to enhance societal acceptance of women work and the integration of women in public life and social activities in Upper Egypt impoverished rural areas. The program, which targeted 4,500 young women aged 16-29 years, in 30 villages in Fayoum, Qena, and Suhag governorates, lasted for three years, from September 2011 till December 2014.

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

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

One of the remarkable achievements of Ishraq is that it reached out to 3,321 girls in 54 villages in five governorates. An empirical study assessing the social impact of Ishraq concluded that the program helped the girls improve their knowledge and ability to read and write. Nearly 88% of the participants, who took the literacy exams passed them successfully, and 52% of those enrolled in schools. Ishraq raised

the participants' awareness about reproductive health, marriage, and female circumcision, as well as gender roles. The study noted a change in the participants' view about marriage, with 85% of the girls favoring a delay of marriage and many adopting a positive view of birth control after marriage, voicing desire to have less children and rejecting the practice of female circumcision in the future.

In terms of life skills, Ishraq instructed the girls on the basics of project planning and the best health practices. The study found that 82% of participants became more inclined to seek medical help for health problems, compared to 60% among non-participants. The program offered girls a chance to learn physical sports and engage in sports activities, activities that were previously confined to boys. The program also boosted the ability of girls to move around, develop social relations, have access to safe venues, and broaden the circle of their social acquaintances. Some of the participants in Ishraq said that the skills they gained in the program improved their status in the family and gave them a voice in decision making.

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

5.5 Violence against Women

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

With regard to the habitual exposure of women to violence, data shows that 18% of women reported seeing their fathers beat their mothers, 9% of women expressed constant fear of their husbands, and 36% of women approved husbands beating their wives. Most of women approving wife beating are young, rural, impoverished, and under educated. Conversely, older women tend to reject wife beating. This suggests a link between the acceptance of wife beating and the low quality of life among women. The justification cited for the acceptance of wife beating varied, with 7% of women citing negligence in preparing food as a reason, 13% citing "talking back" to husbands, 20% referred to refusing sexual intercourse, 24% stated neglecting children, and 26% pinpointed leaving the house without permission.

Available data suggests that the prominent types of violence against women are five: circumcision practices, limiting women freedom, physical, sexual, and psychological violence. These types are tackled below in detail.

5.5.1 Female circumcision

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

is likely to take place in rural areas, especially in south Egypt. Still, among educated mothers and high-income families, the percentage of circumcised girls is likely to drop in the future.

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

5.5.2 Limiting Women Freedom

Husbands place social limitations on their wives freedom, including jealousy and expressing extreme anger when their wives speak to another man. About 73% of women, most of young age and have small number of children, reported such behavior; a sign to the fact that jealousy could be more pronounced in the early years of marriage. Unusually, however, jealousy and anger of husband were even more frequent among women with higher education than with low education, the matter emphasizing that education per se does not have a positive impact on the women freedom constraints. About 36% of women, most of young and low income, reported that their husbands insist on knowing their daily movements.

5.5.3 Physical Violence

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

5.5.4 Sexual Violence

Sexual violence against women is less common than physical violence. About 4% of women said that their husbands forced them to have sexual intercourse or engage in certain sexual acts against their will. There is no clear difference in this respect among various demographic categories, although previously-married women seem to be more likely to face sexual violence than women in their first marriage. Sex sometimes seemed to be used as means to alleviate marital disputes, but it can also exacerbate the daily conflict between the spouses, especially in ill-matched marriages.

5.5.5 Psychological Violence

Available data shows that 19% of women have been exposed to a form of psychological violence by their husbands. About 13% of women reported recent incidents of psychological violence, most of them are poor and under educated. Most divorced women further reported various forms of psychological violence. Psychological violence, in its various forms, includes exposing wives to humiliation, sadness, and shame, which was reported by 16% of women. About 11% of women stated that they were subject to words or deeds by their husbands to insult or humiliate them. About 5% mentioned that they were exposed to abuse or beating in front of relatives or friends, for humiliation purposes. The daily life of Egyptian

women seems to be filled with forms of indirect psychological violence that women may not always find it easy to describe. This includes forms of sexual harassment within family and at school, work, street, and public places. There are no accurate or up-to-date data on the scale of this phenomenon and its social impact on women empowerment. A recent study indicated women concern about sexual harassment, fear of neglecting home and children, complications associated with the segregation of sexes and the patriarchal bias against women in the workplace; all these were cited by women as impediments to women work.

5.6 Cultural Constraints on Women Empowerment

There is a wide-spread belief in Egypt that the right place for a woman is at home with her family and children, regardless of any educational or practical advantage she may have otherwise. Women educational and practical achievements are often seen as matters that would help them succeed in their family life, especially in taking caring of their children and raising a good generation embracing the right social values and identity. Religious discourse often glamorizes women only within the framework of home responsibilities. The message that resonates in this discourse is that the home is the "kingdom" or "crown" or the sanctuary for women dignity, chastity, and beauty.

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

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

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

Although women are one half of society, their participation in the workforce is lower than men, and lower also than women in more advanced countries. A study on the aspirations of Egyptian women mentioned that most women justify their lack of pursuit of a career by saying that their role is in the home, and that working outside the home is a man responsibility. They are also convinced that women are not fit for working outside the home or that workplaces fail to offer women the right working conditions.

Despite these restrictions, working and non-working women alike have career aspirations, which are often undermined by the restrictions their families impose and the social constraints of feeling insecure and unappreciated. Within the family, most women admit

that the main motive for women to work is the need for an income. Even though some women may not agree that women place is necessarily at home with their children, they regard home making as their most valued endeavor and accordingly willing to sacrifice their salaried jobs if they were to conflict with their obligations toward their families. Besides, women sense of insecurity often imposes restrictions on their daily lives. A large percentage of women cannot leave any of their children at home alone, not even for a short time. Others cannot stay at home alone at night or avoid daily errands or visits to relatives because of their feelings of insecurity.

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

Chapter 6
Youths and Adolescents
Emerging Issues

Chapter 6 Youths and Adolescents Emerging Issues

Introduction

Egypt is a young population; one quarter of the population is between 12 and 22 years and another quarter is between 23 and 39 years old. Youths and adolescents face issues similar to that of all Egyptian citizens, in addition to some youth-specific issues related to their lives and roles in society. This Chapter mainly focuses on youths and adolescents related issues. Sub-section 2 discusses the gender based violence among female adolescents and Sub-section 3 focuses on youth access to sexual and reproductive health services. As for Sub-section 4, it tackles youth civic engagement and political participation.

6.2 Gender Based Violence among Female Adolescents

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

Physical violence includes slapping, pushing or shoving, fist striking, kicking, dragging, threatening with weapon and using weapon. The most recent data reveals that less than one fifth of women aged 18-64 years have ever experienced physical violence (17%; ECGBVS, 2015). The 2015 Egypt Economic Cost of Gender-Based Violence Survey shows a 19.5% of young women, who have ever experienced violence perpetrated by family members or persons in close relation and within surrounding environment, are aged 18-19 years, 19.7% among the age group 20-24 years and 18.9% among the age group 25-29 years. The most recent data also shows that this percentage exceeded one third among ever married women aged 15-49 years (35.5%; EDHS, 2014). The EDHS 2014 reveals that 35.5% of ever married young women, who have ever experienced physical violence perpetrated by any individual are aged 15-19 years, 39.9% at the age 20-24 years and 35.3% at the age 25-29 years.

Table (6.1) shows the percentage of ever-married women aged 15-29 years, who have ever experienced physical violence perpetrated by any individual since age 15, Egypt, 2014. It also pinpoints the percentage of women aged 18-64 years, who have ever experienced violence perpetrated by family members or persons in close relation and within surrounding environment since age 18, Egypt, 2015.

Table 42: (6.1) Percentage of Ever Married Women Aged 15-29, Experienced Physical Violence

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

Source: EDHS 2014/ ECGBV 2015

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

Among SYPE respondents, who experienced sexual harassment, only one third (35%) to someone about being exposed to harassment. Younger females were more likely than older females to tell someone about their experience; 44% of females aged 15-17 years told someone, while only 27% of those aged 25-29 years did. Fewer females living in rural areas told someone than females living in urban or informal urban areas. Among SYPE respondents, who experienced sexual harassment, 23% told one of their parents, 15% told a friend, and 3% told another relative. Almost no one reported to the police or doctor (0.2%).

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

Psychological or emotional violence includes insulting, humiliating or belittling in front of others, intimidating or scaring, threatening and controlling behavior.

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

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

Table 43: (6-2) Percentage of Ever Married Women Aged 15-29 Years, Experienced Emotional Violence Committed by Husband

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

Source: EDHS 2014/ ECGBV 2015

Female Genital Mutilation is another type of gender based violence against female youths. The practice of FGM has been a tradition in Egypt, and adherence to such a custom remains although the government has banned the practice (El Zanaty and Way, 2015). 92% of the ever-married women aged 15-49 years in EDHS 2014 were circumcised and virtually all of were circumcised before the age of 15.

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

In Egypt, the EDHS estimated total proportion of daughters aged 0-19 years, who are circumcised, by 21%, and the proportion expected to be circumcised by 56%. Looking at the variations, by place of residence, the expected prevalence of circumcision records lowest percentage in urban governorates (31%) and highest in rural Upper Egypt (75%).

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

Child marriage is considered a violation to human rights. Despite the laws banning such a practice, it still widely exists, in part because of the persistent poverty and the low level of educational attainment. According to the latest figures in developing countries, one in every three girls is married before reaching the age of 18, and one in every nine is married under the age of 15 (UNFPA). Girls forced to early marriage often become pregnant while still adolescents, increasing the risk of complications in pregnancy or childbirth. These complications are leading causes of death among older adolescents in developing countries.

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

The EDHS 2014 pinpoints that married women aged 15-17 years account for 6%, while divorced women at the same age record 0.1%. The percentage of married women aged 18-19 years represents 27%, divorced women 0.3% and separated women 0.3%. About 7% of ever-married women in the age group 15-19 have alive children, and 4% were pregnant in their first child. About 7% of those who aged 20-24 years had their first child before reaching 19 years old.

The ECGBVS 2015 examines the proportions of ever-married young women, who did not express free consent to marry their current or most recent husbands (i.e. forced to marry their husbands). The findings clearly indicate an apparent association between prevalence of forced marriage and age; where older women are more likely to be forced to marry. To enumerate, the percentages are as follows: 4% of ever-married women aged 18-19 years, 5.3% of those aged 20-24 years and 4.6% of those 25-29 years compared to 22% for the oldest age category 60-64 years.

6.3 Youth Access to Sexual and Reproductive Health Information

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

6.3.1 Establishment of Youth Friendly Clinics

In 2003, Egypt embarked on the establishment of Youth Friendly Clinics (YFCs), in government-affiliated teaching hospitals, nationwide. YFCs in Egypt started through a joint project between UNFPA and the EFPRHA, called "Meeting Adolescents' Reproductive Health Needs in Egypt." Under this project, the MoHP established nine YFCs in government-affiliated teaching hospitals in six governorates across Egypt. By 2014, Egypt had 25 YFCs in 14 governorates, managed by either MoHP or EFPRHA, and serving both married and unmarried youths.

Initially, the establishment of these clinics within the government-affiliated teaching hospitals was mainly to take advantage of such hospitals' prime location in areas heavily crowded, in order to ensure accessibility to the general population.

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

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

- Discussions with service providers revealed that client flow in the beginning was much higher due to the promotional campaign for the clinics in schools and universities. However, when this campaign was interrupted, client flow was negatively impacted.

- Internal staff at the THs were unaware of the existing YFCs or their services. Others perceived them as FP or sexology clinics, and the majority believed that the clinics were specialized in premarital counseling and examination. The staff of the THs expressed a missed opportunity in terms of such clinics promotion.

- Having physicians of the same sex as patients contributes to a feeling of ease between patient and physician. A factor of making services youth friendly that was mentioned by all physicians in the in-depth interview.

- Issues with the lack of required equipment, such as ultrasound devices, were stated. These equipment are needed to check males and females, instead being referred to the radiology department, as such would boost client flow.

6.3.2 Access to Comprehensive Sexuality Education

The WHO recommends to provide SRH education within the context of school programs and health promotional activities. Moreover, the UNFPA has worked with various governments to implement comprehensive sexuality education, both in schools and through community-based training and outreach. A wide scope of scientific research in both developed and developing countries has shown that SRH education programs have improved the overall wellbeing of young people.

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

In 2011, after the January 25 Revolution and the subsequent political instability, the newly appointed Minister ordered to remove these topics, along with family planning methods, from the 12 grade curriculum, as a means of shortening the curriculum content.

The most notable provision of SRH services, mandated by the MoHP, are in the form of pre-marital counseling, which provide youths with reproductive health information. This pre-marital counseling and testing were made mandatory on 12 June 2008, as per a Presidential Decree regarding the Child Law. Furthermore, the minimum age of marriage for males and females was increased to 18 years, and premarital testing and counselling were identified as preconditions to issue a marriage certificate.

Some programs such as the Youth Hotline and the websites www.shababna.org and www.Ma3looma.net, offer information services on

sexuality to young people aged 15-24. Naturally, other health concerns besides sexuality, such as nutrition or smoking, are included in these initiatives. However, in reflection of lacking a national policy on youth sexual and reproductive health and rights, targeting the different population segments, the number of young people exposed to available sexuality education programs in Egypt is fairly limited.

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

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

The survey continued with a series of questions asking young people aged 13-35 their opinions regarding the appropriate age, if ever, to talk to adolescents about puberty. The largest percentage of respondents (38%) believed that this discussion should take place at the onset of menstruation/puberty. The second most common response (15%) was that no one should talk to youths about puberty; more young men than women gave this answer. Furthermore, 11% of respondents believed that this conversation is best had at marriage. Finally, 11% of the sample was unsure of the best age to discuss puberty issues.

All the surveyed SYPE 2014 respondents were asked if they had ever heard of sexually transmitted infections (STIs). Just over half of the sample (54%) had, with substantially more male respondents (60%) having heard of STIs than their female counterparts (48%). Altogether, those who indicated that they had heard of HIV/AIDS comprised 73% of the total sample. While the data reveals that a notable percentage, aware of HIV/AIDS, did not identify it as a sexually transmitted infection; as 43% of the SYPE respondents, who indicated that they had no idea of any sexually transmitted infections, have heard of “AIDS.”

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

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

Despite the many efforts exerted and initiatives launched to increase the general public awareness of the numerous health damages caused by FGM/C, it remains widely practiced due to the strong religious debates on its necessity. The fact that six out of ten young people believe the practice is necessary calls for interventions targeting young people (both male and female), early enough to help them question their beliefs and conceptions before getting married and exposing their daughters to this practice.

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

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

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

6.4 Youth Political and Civic Participation

Political and civic participation is essential for youth to successfully move forward to meaningful adult roles, in which they can participate fully in society and contribute to community and national development. Egypt 2014 Constitution contained a significant number of articles encouraging Egyptians political participation.

Although youths were the ones who lit the torch of the January 25 Revolution, several evidences on youth low political participation after the revolution were observed. The presidential elections exit polls conducted by the Egyptian Center for Public Opinion Research "Baseera" revealed that despite the percentage of youths (18-30 years) among eligible voters (37%), their percentage among the actual voters was 27%. The same pattern was observed in 2015 parliamentary election.

The «Political participation in Egypt: Perceptions and Practice» poll conducted by Baseera, as part of Masar project, showed that only 23% of youths (18-29 years) have ever voted before 2011. This percentage increased to 75% after January 25 Revolution.

From Mubarak's ouster till Mohamed Morsi presidency election in June 2012, the percentage of youth taking part in protests or demonstrations reached 17%. The overall level of participation reached its highest level (19.3%) during the period of Mohamed Morsi's presidency, till he was overthrown following the demonstrations of June 30, 2013.

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

Table 44: (6-3) Participation in Protests or Demonstrations during each of the Following Periods, among Youth (18 to under 30 years of age), 2014

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

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

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

Table 45: (6.4) Notions towards Arab Revolution among Youth (18 -29 years), 2014

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

Source: Social and Political Transition in the Arab Countries Survey, Baseera, 2014

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

Table 46: (6.5) Self-Reported Political Actions of Youth (18 -29 years), 2014

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

Source: Social and Political Transition in the Arab Countries Survey, Baseera, 2014

Directly following the January 25 Revolution and the June 30 Movement, Egyptians held a greater sense of duty to be civically engaged and help in changing the direction taken by the nation. The importance of youth in igniting change in their communities through civil engagement has been highlighted time and time again. However, data collected by Baseera in the «Social and Political Transition in the Arab Countries Survey" in November 2014, reveals notably low self-reported membership in civic establishments among youth. The highest reported percentage of civic participation among youth from 18 to 29 years of age was through professional association/trade union (5.1%), followed by youth/cultural/sports organization (2.1%), and charitable organizations (2.1%). A single respondent under 30 years of age reported being a member of a political party.

Table 47: (6.6) Self-Reported Civic Engagement of Youth (18 -29 years), 2014

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

Source: Social and Political Transition in the Arab Countries Survey, Baseera, 2014

Chapter 7
Public Policies and Population Program Management

Chapter 7 Public Policies and Population Program Management

7.1 Introduction

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

7.2 Interdependence of Demographic Changes and Economic, Social, and Environmental Developments

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

Egypt population characteristics lack many desired factors. To illustrated, our human capital is impaired, with productivity below average, and women participation in economic activities is fairly low. A low household income and dwindling market would lead to reduced State revenues, thus making it harder to finance basic services. The failure to provide such services, in return, undermines the country human capital. We are thus caught in a vicious circle, where low demographic characteristics impede our quest for development.

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

In the last three decades of the 20th century, Egypt witnessed a remarkable improvement in school enrollment, especially for females. Between 2005 and 2014, the percentage of people aged 15-19, who never attended school, dropped from 4.4% to 2.6% among males, and from 12.8% to 3.9% among females. But over the same period, the dropout rate climbed, with the percentage of those who did not finish elementary school in the age group 15-19 rising from 5.2% to 7.1% for males and from 4.2% to 4.6% for females. This phenomena question the ability of the country to educate all of the children, when the population keeps growing in the manner described above. If poverty persists, the invisible cost of free education may drive the children of low-income families out of school.

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

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

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

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

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

In the light of the above mentioned, one must never examine population issues in isolation from economic and social factors, nor should one focus on population growth alone, or handle it as a mere health issue. There is a need to forge a multi-faceted approach to this complex issue that poses undeniable peril to the future of this country. One must, however, note that the health-dominated approach had some successes in the 1980s. But in the absence of a more comprehensive approach, Egypt efforts to strike a balance between population and resources eventually failed. Since 1996, Egypt has grown by over 30 million people, a 50% increase over two decades.

Cost Benefit Analysis of SRH Programs

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

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

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

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

7.3 Sustainable Development Strategy: Egypt Vision 2030

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

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

There are several matters that may impede the transition to sustainable development, especially in developing countries. These include the absence of genuine participation by all stakeholders, corruption, political instability, lack of security, internal and external turbulence, high public indebtedness, and lack of adequate resources to finance the sustainable development programs and projects. Other impediments to sustainable development comprised the lack of an effective system for governance, transparency, and accountability, as well as population increase and the inability to create enough jobs for young people trying to join the workforce.

In the light of the aforementioned, Egypt Ministry of Planning, Monitoring, and Administrative Reform (MoPMAR) led a multi-agency quest to create "Sustainable Development Strategy: Egypt Vision 2030," a document widely seen as a recipe for utilizing available

resources, improving competitiveness, restoring Egypt historical role as a regional leader, and providing a decent life for its people.

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

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

While formulating Vision 2030, each and every effort was made to benefit from the strategies and initiatives previously prepared in the past by government, civil society, and business institutions, as well as strategies that were implemented successfully in other countries. In other words, Vision 2030 is an inclusive framework that brings together all previous efforts, while developing an integrated approach, one that includes specific ways of addressing Egypt main problems, taking into account various risks that may surface on the world arena in the next few years.

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

Figure 26: (7.1) Main Goals of the "Sustainable Development Strategy: Egypt Vision 2030"

- Formulating a cohesive long-term political, economic, and social vision to serve as a reference point for medium and short-term development plans on the national, local, and sectorial levels;

- Turning Egypt into an effective player in a dynamic and fast-paced international environment;

- Meeting the aspirations of the Egyptian people, improving their standards of living, and boosting the efficiency of services impacting their daily life;

- Enabling civil society and the Parliament to follow-up and evaluate the implementation of Vision 2030 by setting and implementing clear objectives, performance indicators, quantitative goals, programs, and projects, within a well-defined timeframe; and

- Acting in line with the UN post-2015 SDGs and Africa Agenda 2063.

Figure 27: (7.2) Comparing Current Situation with the Goals of Egypt Vision 2013

Components of the Sustainable Development Strategy, Egypt Vision 2030

Egypt Vision presents a framework for improving the Egyptians quality of life. It also supports the main objectives of Population and Development Strategy 2015-2030 as shown in the following table.

Table 48: (7.1) Population Strategy and Egypt Strategy 2030

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

Institutional Framework

Now, we will tackle the institutional framework obstructing the efficiency and effectiveness of the Egyptian population program.

1) Limited Achievements

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

The outcome of previous efforts must not be disassociated from the general performance of cash-strapped government institutions. Due to inadequate, or total lack, of resources, successive strategies launched in the past two decades failed to bear fruit.

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

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

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

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

The lack of resources is, however, not the only problem. Despite the oversized government apparatus, there is a shortage of health personnel trained to provide reproductive health services and encourage women to use various methods of birth control. In particular, there is a shortage of female doctors and nurses in conservative areas, where women tend to feel awkward resorting to male doctors.

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

2) Coordination Problems

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

suited to a development vision that places people at the heart of development efforts. To reiterate, we need to have a greater level of integration among government ministries and institutions.

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

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

Aside from the challenges facing coordination among government institutions, other problems exist when it comes to coordination among government agencies and NGOs. For starters, government agencies – which are considered as constitutionally responsible for providing such services – are averse to collaboration with NGOs. The lack of trust between the two sides undermines cooperation accentuating rivalries in a manner that undermines the common goal of serving the public. This problem is compounded by the lack of adequate finance for civil society organizations, which hampers the sustainability of efforts and further discourages government agencies, with few exceptions, to forge partnerships with CSOs.

3) Problems of Follow up and Evaluation

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

Administratively speaking, the NPC is the agency in charge of following up and evaluating various components of all the Egyptian population program components. And yet the follow up and evaluation procedure leaves much to be desired, which may actually explain part of previous failures. Consequently, the current follow-up and evaluation mechanism needs to be revisited using the following steps:

- Improving the follow up and evaluation tools, including the indicators to be used on the local level, and the methods of collecting data in a neutral and credible manner;
- Linking the follow up and evaluation tools with accountability on the local and national levels; and
- Integrating the follow up and evaluation outcomes in local and national decision-making process, especially insofar as resources allocation and prioritization are concerned.

4) Funding Problems

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

Nevertheless, the budgets allocated to family planning programs in the last two decades did not seem to take this issue into account, a matter that led to an increase in the number of births and more pressure on education, health, and food supply systems, not to mention the long-term impact on the infrastructure, housing, water, energy, agricultural land, and food sufficiency. The allocation of adequate funds to ensure the supply of family planning is thus needed to meet current and future demand. To reduce the number of births, however, the demand on family planning services needs

to rise beforehand. In other words, we need to change the public perception with regard to planned parenthood by boosting the idea of small family and the spacing of births. So, we need to spend more on campaigns aiming to change the public perception of contraceptives and the side-effects for their use. In short, there is a need to increase demand on family planning, while dedicating resources to meet that demand.

7.4 Toward a More Efficient and Effective Management of the Population Program

The interdependence of population issues with economic and social developments, coupled with the ambitious development objectives stated in Vision 2030, call for a more effective and efficient management of the population program. But to increase the efficiency and effectiveness of the population program, we must recognize the current problems; namely, the modest achievements of previous efforts, ineffective mechanisms of coordination on the central and local levels, absence of a well-managed follow up and evaluation system, and inadequate finance.

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

7.4.1 Political Commitment

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

7.4.2 Institutional Framework

Egypt has explored different ways of running its population program. At times, a specific ministry was entrusted to carry out such an effort, and at other times the task was given to an independent council. The powers of the NPC also shifted over time. Being authorized to plan, coordinate, follow up and evaluate, the Council was placed in charge of providing family planning services. Debating which institutional framework is best is a moot point, as neither alternative (ministry or council) seem to have a track record of consistent success to be accordingly recommended. In short, the existence or lack of an independent ministry in charge of the population program is not the deciding factor as far as success is concerned.

7.4.3 Planning on the Central and Local Levels

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

7.4.4 Incorporating the Population Aspect in Development Programs

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

7.4.5 Follow up and Evaluation

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

7.4.6 Funding

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

7.4.7 Public-Private Partnership in Population (4Ps)

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

After the January 25 Revolution, businessmen became more convinced about population quality of life impact on the success and stability of their businesses, which encouraged them to be more involved in corporate social responsibilities activities.

In-depth study of the Population and Development Strategy and its implementation plan suggests three areas for Public-Private Partnership in Population issues:

Strengthening FP & RH on Ground

One of the obstacles facing the achievement of the Population and Development Strategy is the under coverage of family planning and reproductive health services and contraceptives. DHS 2014 shows that the unmet need for contraceptives reached 12.6%, with a 1% increase if compared to 2008 level. Around 9.7% of mothers, who got pregnant during the 5 years prior to the survey, did not receive any pre-natal care.

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

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

Advocacy and Mass Media/ Communication

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

- Generating updated evidence based content/messages related to population issues;

- Producing segmented media materials (age, residence, educational level.);
- Ensuring airing during peak times;
- Producing drama that promote positive messages: limiting number of children to two and spacing between births;
- Using social media (22 million users on Facebook) to change attitudes of youth and to provide information related reproductive health; and
- Producing related innovative products.

Information, Research, Monitoring and Evaluation

Lack of monitoring and evaluation of the Egyptian government policies and programs, in general, is one of the relevant inefficiency factors. It is worth noting that the success of monitoring and evaluation systems depends on the availability of information. Egypt 2014 Constitution included an article that guarantee freedom of information and obligate different authorities to produce and disclose information.

However, the production of the information needed to monitor and evaluate the implementation and achievement of the Population Strategy needs huge financial resources. Private sector could play a pivotal role in securing such financial resources, in order to produce information and build computer systems required to organize and utilize the input of monitoring and evaluation processes.

7.4.8 Governmental and Non-Governmental Partnership

NGOs role in the implementation of the Population Strategy emerges from the spread of the NGOs across Egyptian governorates. Also, most of the Egyptian NGOs have volunteers dedicating time and effort to their community. These two advantages qualify NGOs to handle the following:

- Monitoring and Evaluation of Strategy Implementation

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

- Raise Society Awareness on Population and Development Issues

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

Chapter 8
Challenges and Recommendations

Chapter 8 Challenges and Recommenda-tions

8.1 Introduction

The report presented in the previous chapters the population status in Egypt and discussed the issues related to development and improving the quality of Egyptians' lives. This Chapter will present the most important challenges, building on what has been discussed in the report previous chapters, and will end by a map to the way forward.

8.2 Challenges

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

8.2.1 Population Growth

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

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

The IOM and ESCWA report on international migration released in 2015 estimates the number of Egyptian migrants by 3.47 million. In fact, migration is selective, as the hosting countries usually host migrants in the working age groups and having distinguished skills. Thus, migration effect negatively the characteristics of population and the ability to innovate and produce. On the other hand, more than 2.3 million Syrians and Libyans came to Egypt during the period from 2011 to 2014. Most of those migrants do not register as refugees. This huge number of migrants caused many challenges to Egypt; including the provision of more services and goods to cover the migrants' needs, the high competition between migrants and Egyptians in labor market, the rise in demand on housing units, and the pressure on the infrastructure in Egypt.

8.2.2 Population Characteristics

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

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

The unemployment rate increased from 9% in 2010 to 13% in 2014. This rate was 9.6% among males compared to 24% among females in 2014. Data on women participation

in labor force shows low participation of women in the Egyptian labor market over time and across the different economic sectors. Working women use family planning methods more than other women (67% and 57%, respectively) and intervals between their births are longer, the matter decreasing their TFR.

8.2.3 Sexual and Reproductive Health

- Although Egypt is exerting strenuous efforts to halt HIV epidemic and control STIs, these infections constitute a threat to population. The information presented in this Chapter shows that the burden of HIV in Egypt is on rise. The country has stepped towards a concentrated epidemic in MIDUs and MSM. In the early stages of the HIV epidemic, most PLHIV were MARPs, but now transmission routes are varied. Transmission through injecting drugs and MSM activity accounted for around half of the cases, while heterosexual transmission represented a significant proportion of infections accounting for the remaining half. In addition, women and children became part of the HIV epidemic.
- Furthermore, STIs incidence cannot be neglected. A variety of STIs caused by a number of pathogens affect both men and women in the country. STIs go beyond being a health threat to being a catalyst for the spread of the HIV infection in the country.
- Adolescents and youth have emerged as a priority vulnerable group for HIV and other STIs. The experiences early in life influence young people health status and quality of life. Adolescents and youth, particularly the unmarried young people, remain highly neglected in terms of access to promotion and prevention health services, in general, and sexual and reproductive health services, in particular. Moreover, the lack of a life-cycle approach from early childhood to post-reproductive stage of life is evident. With this in mind, it is evident that there is a dire need for health services to cope with the many adolescents and youth health requirements. Health promotion early in life and building awareness on the biological changes that occur to girls and boys during puberty are cornerstones for healthcare, but are missed in the country healthcare services.
- Culture norms and gender roles affect people vulnerability to HIV and STIs. The stigma and discrimination is a shared experience for MARPS, PLHIV and people harboring STIs. Also, conflicts occurring in the region expose Egypt to massive forced displacements from surrounding countries, which strain the capacity of the health system to respond and create numerous vulnerabilities for HIV and STIs. A major issue that appeared was the disparities in HIV and STIs status and knowledge, including the experiences of poverty, illiteracy, unemployment and rural residence. These different experiences in the life paths expose the population to numerous vulnerabilities. They highlight the need for directing programs to identify people requirements and ensure that such programs are inclusive. There is also a need for strengthening the inter-sectorial approach and social participation engaging the various stakeholders in the control of HIV and STIs through relevant health policies.
- Egypt response to HIV/AIDS involves a wide array of policies, strategies and regulations with several organizations and communities significantly involved. There is an HIV strategy in place, in addition networks and organizations are becoming more dynamic in this regard. However, such efforts are still not enough to halt the epidemic. Furthermore, STIs remain a neglected area with no clear strategy in place and no comprehensive national response. This underlines the need for strengthening the national health system efforts to put an end to the HIV epidemic and STIs.

8.2.4 Morbidity and Mortality in Egypt

- While life expectancy at birth in Egypt increased by 4 years over the period 1990 to 2013, women and men in Egypt lose 11 and 9 years, respectively, of their lives for disability and premature death.

- Evidence from analyzing both the cause of death and the Global Burden of Disease project indicates that people loss of life years was attributed to a combination of communicable and non-communicable diseases.

- Hypertension and diabetes were the most prevalent chronic diseases in Egypt. Disparities in their prevalence were strongly related to vulnerable social categories among women, but not among men.

- Risk factors of both hypertension and diabetes showed different direction, by social groups. While overweight and obesity were more prevalent among the privileged social groups, smoking was more prevalent among vulnerable groups.

- Egypt had the highest rates of Hepatitis C infection and experienced significant increase in mortality levels because of liver diseases.

- Disparities in the prevalence of HCV indicates that vulnerable social groups are commonly overburdened with this infection.

- All evidences refer to iatrogenic transmission in formal and informal health care. Vertical transmission was largely responsible for infection among children <5 years

- Enduring efforts on behalf of the Egyptian government, NGOs and WHO in tackling HCV, securing and locally manufacturing effective medication paid off in significant success against the HCV battle and the prevalence declined from 14.7% in 2008 to 7% in 2014.

- Comorbidity accounts for less than 5% in the population. However, vulnerable groups are more likely to suffer compared to other social groups.

- Data on health issues are significantly limited and outdated. Most of this profile is based on EDHS 2008, more than 8 years old. Unfortunately, other sources of data are minimal in size or unrepresentative of population. There is a significant need for data to monitor and evaluate the real situation of population health. Health surveillance has already become part of the MoHP activities and has many potentials in securing health information. Essentially, it should become fully activated and offer relevant data for researchers, to highlight areas for policy interventions and assess impacts on real grounds.

- Inequalities, as the available data prove, are hardly hitting the vulnerable population. While improving the average health is of substantial importance, it is even more important to monitor these inequalities. The increasing gap between the vulnerable and the privileged population calls for policy intervention to address the pitfalls, through which such vulnerable social categories fall in heavy burden of diseases. Furthermore, special tailored program for such social groups should be established, whether through universal health coverage or targeted health promotion.

8.2.5 Inequalities and Vulnerable Groups

Poor Households

During this period the number of poor people was almost doubled from around 11 million to around 22 million. More than 80% of the poorest 20% villages are located in rural Upper Egypt. To enumerate, around 778 villages of the poorest 1000 villages are located in Upper Egypt.

The poor household size is around two members more than the non-poor. The larger household size will lead to high dependency ratio, which in turn can contribute to the intergenerational transmission of poverty, thus limiting children human development, socialization and subsequent earnings. The costs of education, health care and food could be enough to ensure persistent severe poverty in high dependency ratio households. Notably, children are less likely to be well fed and to complete secondary school.

Poor children are more likely to be under weight and stunted relative to non-poor. The

prevalence of anemia was higher among women, youth and children of poor households compared to non-poor households.

The education differentials are very clear among poor and non-poor individuals. 57% of poor population have not been to school or did not complete primary stage compared to 45% of non-poor. Only 5% of poor compared to 14% of non-poor people completed higher education.

Slum Areas

Slum areas face a set of problems include the shortage in services, especially education and health services, the poor quality of available services and lack of safety due to the unsafe buildings threatening the lives of residents and the absence of police and security.

The most stated problem, by slums respondents, is the narrow residences, which are, mostly, rooms with shared toilets. Meanwhile, respondents agreed that it is, almost, impossible to obtain one of the flats offered by the government. Another problem mentioned was the contraventions in the roads; the matter that hinders people easy movement in streets.

Street Children

Street children usually come from poor families. They often construct a community of their own with specific systems, rules, incentives and even languages, with a leader among them; someone to plan, regulate and control. Physical issues, from headache to cancer, and psychological illnesses are the most common among street children. Also, the commonly spreading diseases among street children are dental, followed by scabies and skin diseases.

Street children were found to be vulnerable to HIV infection, as 0.5% of street boys between 12-18 years were HIV positive. They lack economic security and protection under law, in addition they do not enjoy access to education and many practice several income generating activities. They are at great risk of contracting and spreading HIV, as they inject drugs and are forced either by fear or poverty to practice several risk behaviors as unsafe sex and MSM activity.

Fishermen

Fishermen in Egypt encounter numerous problems, especially the draining of lakes policies that for instance led to the decrease in lake area. Large areas of these lakes are also being rented by big businessmen, who accordingly prevent fishermen from fishing in such lakes.

8.2.6 Gender Inequalities

- Available data indicates that Egypt is still facing difficulties in achieving the MDGs with regard to the promotion of gender equality and empowerment of women. This is particularly the case when it comes to education and participation in paid employment, as well as political participation.
- The 2015 Gender Gap Report shows a severe gap in literacy rates between males and females, estimated by 65% versus 82% for males. Data shows that the non-enrollment percentage for the 6-18 age group is 7% among females, compared to 5% among males. The percentage of non-enrolled females decreases gradually with the increase in economic level. Females, who have access to education, are more serious and diligent than males with respect to completing their education. However, the percentage of female dropouts is on the rise over the years, and increases from one stage of education to the next, due to social and cultural constraints.
- Female enrollment rate in higher education reaches 31% compared to 35% for male. Most of the 23 government-run universities are located in Greater Cairo and Delta, the capacity of which falls short with regard to the national demand for higher education. In Upper Egypt, families refuse to allow their girls to travel for long distances or live in other cities for the sake of education. So, female students have difficulties leaving their home to pursue higher education in far-off governorates. Moreover, the opportunity cost for particular specializations in higher education (joining private universities) is prohibitive for low-income families. Data shows a clear imbalance in the distribution of students by age and specializations in university.

- Available data on the gender gap in wages indicates that the proportion of women working for cash wages is 39% compared to 57% for men. Over one-fourth of women perform unpaid family tasks, compared to 5% of men. In Egypt, women make generally 30% of what men make. The gender-based discrepancies in wages are not mainly due to the differences in education, absenteeism nor performance of women, but to the number of working hours.
- According to a certain study, there is a gender gap that allows men working in private sector to have 10% better terms than women in job contracts and health insurance. The gender gap in social insurance is also more favorable to men than women by about 3.5%. Conversely, women who work for the public sector and the government have a better opportunity for social protection.

8.2.7 Empowering Women

Available data reveals that most married women, who have income do make decisions related to the manner of spending their income, and three-quarters of women participate in making decisions about their husbands' income. More than 80% of married women make decisions related to their health care. Women participate less when it comes to the basic purchases of the family, as about two-thirds of women stated that they make these decisions, while most of them do in consultation with their husbands.

8.2.8 Violence against Women

Available data suggest that 92% of previously married women aged 15-49 years are circumcised. Of every five women under 19, one has been circumcised. There are several misconceptions among many women about circumcision; 62% of women consider such a practice a religious duty, 50% believe that men approve circumcision and desire to marry circumcised women, 46.3% perceive that circumcision is a bulwark against adultery.

Three in every four women report that their husbands place social limitations on their wives' freedom, including jealousy and expression of extreme anger when their wives speak to another man.

About 25% of ever-married women were subject to physical violence at least once by their husbands. The most common incidents involve slapping (22%), forceful pushing (17%), and arm twisting (12%). Sexual violence against women is less common than physical violence, reported by only 4% of ever-married women.

8.2.9 Child Marriage

Despite laws banning child marriage, the practice widely spreads, in part because of the persistent poverty and low educational attainment. Around 6% of females aged (15-17) are ever-married. This percentage reaches 27% among females aged (18-19).

8.2.10 Youth Political Participation

Egypt 2014 Constitution contained a significant number of articles that encourage Egyptians political participation including Articles 73 and 74. However, youth political participation is low. This was observed in the 2014 Presidential Elections and the Parliamentary Elections. Youth participation in informal political participation forms is low too.

8.3 The Way Forward

In addition to the institutional aspects discussed in Chapter 7, the following should be taken into consideration:

1- The National Strategy for Population and Development 2015-2030 was developed by a team of experts working under the supervision of NPC. The Strategy was launched in November 2014 under the auspicious of the Prime Minister.

The National Strategy for Population and Development aspires to:

- Enhance the quality of life for all Egyptians through reducing population growth rates and restoring the balance between economic and population growth rates;
- Restore Egypt regional leadership through improving population characteristics in terms of knowledge, skills, and behavior;
- Redraw Egypt population map through a spatial redistribution of population promoting Egyptian national security and accommodating the needs of planned national projects; and
- Promote social justice and peace through reducing disparities existing in development indicators among various areas.

All and above, the starting point is to bring down the birthrate. Therefore, a successful population strategy needs to increase demand on reproductive health and family planning services and also to improve and stabilize the quality of such services. One of the opportunities that Egypt should not overlook is that the unmet need reaches 12.6%, and around 16% of births in the five-year preceding the EDHS 2014 were unwanted, while half were unwanted at all. This clearly call for immediate interventions to assist families to achieve their desires. This requires to train public health service providers on good service delivery and provide public health facilities with the needed equipment and medication

2- Egypt can harness its demographic dividend through investments that would improve health, education, economic policy, and governance—and ultimately slow population growth. These efforts are needed to break the vicious cycle of poverty, low education, early childbearing, and high fertility that trapped a large segment of the Egyptian society. International experiences have shown that the most effective investments are those focusing on improving the health and wellbeing of girls and women, including their sexual and reproductive health[3].

Demographic dividend can be addressed within the context of the SDGs. The triple E's, namely, Educate, Empower and Employ can serve as a framework for not missing the demographic dividend[4]:

- Educate (SDG4): A demographic dividend depends on people generating and capitalizing on new opportunities and new information-based economies. The fulfilment of SDG4 is essential to ensure lifelong access to universal and high quality education.
- Empower (SDG3 and SDG5): All people need access to essential health care services, and women and girls must be assured the rights and freedom to decide when and whom to marry, and when to start a family. Ensuring that all young women have the freedom to define their lives also demands to be protected from harmful practices such as FGM and child marriage, and all forms of violence.
- Employ (SDG8): A demographic dividend can only be realized if education and skills are deployed in productive activity, enabling all persons to contribute to the economy through decent work.

On the national level, the Sustainable Development Strategy 2030, is the road map adopted by the Government of Egypt. The Strategy, which was developed in a participatory way, is fully synchronized with the SDGs. In addition, sectorial strategies for population and early marriage have been launched in 2014 and 2015 to guide the way for a demographic dividend[5] . Such a strong framework needs to be complemented with political will, on all levels, monitoring and evaluation mechanisms coupled with accountability on the central and local levels.

3- Success in family planning can only be achieved through the provision of adequate and sustainable funding needed to provide contraceptives, train healthcare team entrusted with the family planning and reproductive health services, launch awareness campaigns aiming to keep the rates of population growth in check and inform the public about the availability of contraceptives.

3- Yousef, H., Osman, M. & Roudi, N. (2014) Responding to Rapid Population Growth in Egypt, Population Reference Bureau.
4- UNFPA (2016) Monitoring Progress towards a Demographic Dividend.
5- A strategy for women empowerment is expected to be launched in 2017.

4- Egypt has a large number of NGOs and political parties that have a pool of volunteers and members. Also, many private sector firms allocate a significant percentage of their income to social corporate responsibilities (SCR). Coordination between governmental organizations, NGOs, political parties and private sector to provide RH services and awareness campaigns will accelerate the pace of achieving the national population and development strategies goals.

5- The Government of Egypt has embarked on a major restructuring process for the health sector. The ultimate goal of health sector reform initiatives is to improve the health status of the population. These initiatives resulted in a decline in mortality levels. The trend in neonatal, infant and under-five mortality is going down due to the improvements made in health services and vaccinations. However, recent surveys show that health services, both governmental and private, need to be more improved so as to match the expectations of Egyptians.

6- Political discourse in Egypt always reflects the Egyptian Government clear commitment to improving the status of women and achieving women empowerment on all social, economic, cultural and political levels. For more than half a century, the situation of Egyptian women has witnessed great changes, in conjunction with relative improvement in opportunities for women education, employment, participation in public affairs, and appointment to senior posts. However, women continue to endure multiple forms of social, cultural, economic and political exclusion caused mainly by two important factors. The first factor is the failure of public and social policies for more than half a century to bridge the gender gap which is ever-expanding on several levels. As for the second factor, it is the persistence and severity of social and cultural constraints facing any genuine efforts to provide women with liberty and equality. There is a great need to change the society values regarding women and eradicate the negative images and stereotypes of women, which are still existing to this day.

7- Some development projects for women, had positive impact on the lives of targeted women in poor and conservative rural areas in Upper Egypt. Two projects that were particularly successful in empowering women, especially young women, socially and economically, are worth noting here. The first is called Niqdar Nisharek (We can participate) and the other is called Ishraq (Dawn). Repeating these projects and extending them may bring out unexpected successes.

8- In 2003, Egypt embarked on the establishment of YFCs within government affiliated teaching hospitals nationwide. The objective of establishing the YFCs was the provision of comprehensive RH services, including information and counseling to young people in need, regardless of gender, economic status, religion, disability, or any other factor. By 2014, Egypt had 25 YFCs in 14 governorates run by either the MoHP or EFPRHA, serving both married and unmarried youth. The increase in young people number, who benefit from the YFCs, requires increasing the number of the YFCs and encouraging youths to visit such clinics through a promotional campaign for the YFCs in schools and universities and in different mass media means.

9- Egypt has reduced the maternal mortality ratio from 120 per 100,000 births in 1990 to 45 in 2013; a reduction percentage of 62.5%. The decline in maternal mortality is likely associated with high rates of family planning use, antenatal care and skilled birth attendance. The coverage of maternal health services has expanded substantially. The percentage of medically assisted births tripled from 35 % in 1988 to 92 % in 2014. According to the EDHS 2014, 90 % of mothers received antenatal care by trained service providers. However, the last 6 years witnessed a decrease in CPR, which resulted in an increase in TFR and CBR. In-spite of the achieved success, there is a need to reduce maternal mortality more through:

- Promoting community participation in pregnant women care provision. This require greater use of media means and community outreach (Raedat Rifiat).

- Educating women and communities about the importance of antenatal care, delivery by skilled health personnel in health facilities and receiving postnatal care.

10- Egypt have succeeded in tackling most of the major communicable diseases. The only exception is HCV infection and related complications. A study by WHO pointed out that a high percentage of those registered on the NCCHV portal to get the treatment do not show up in successive treatment stages, which requires a new strategy to guarantee the commitment of patients with the treatment course.

11- Since the detection of the first AIDS case, MoHP established the NAP for controlling the HIV epidemic in the country. The NAP strategy has built on multi-sector national response to halt the HIV epidemic and STIs. It is evident that the available national statistics are far from depicting the HIV epidemic in the country. STIs are not believed to be high in Egypt and little information are available on their magnitude in population. A key theme that emerged is the insufficiency or lack of information on HIV and STIs. Statistics are only obtained through passive surveillance and the BioBSS data needs to be updated. There is very limited STIs information to portrait the burden of such infections in the country. Furthermore, HIV and STIs research is very limited and there is rarely solid evidence to guide policies. Thus, there is a need for strengthening the HIV and STIs information and conducting regular MARPs surveys, in addition to making use of the available DHS activities for monitoring HIV and STIs status and knowledge in the country.

12- It is suggested to build an observatory for population related data and indicators. The observatory should be designed to collect and harmonize the available data and indicators, assess and bridge the information gap. The NPC started building an information system to monitor the progress in a set of indicators on different administrative levels. However, the system depends on the available data, which is limited if compared to the required data to monitor the progress of the different Population and Development Strategy pillars.

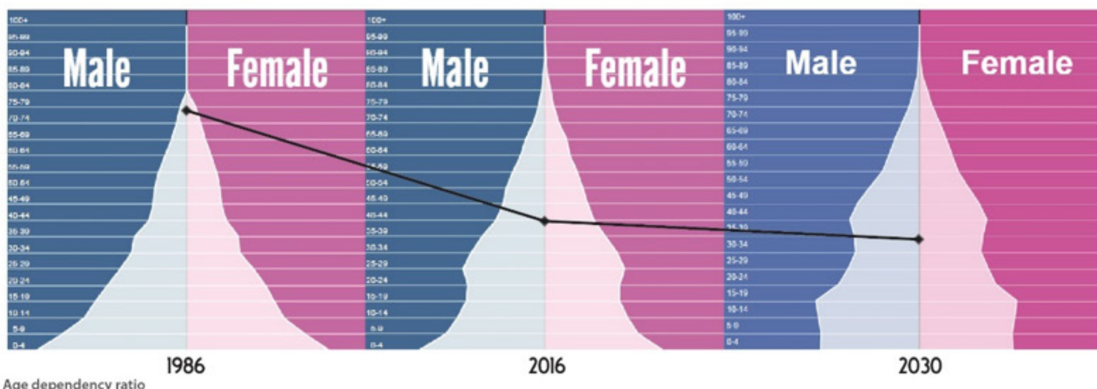
Annex

Annex 1: Demographic Dividend

Egypt

Demographic Dividend Profile

Population



— Age dependency ratio

Empowerment

Freedom from early and forced marriage
Access to family planning
Freedom from early childbearing
Safe childbirth
Confident in health and wellbeing
Healthy work-life balance

Child Marriage 2015

Percentage of women20-24 who got married before age 18, by residence, education and wealth index

National 22; Rural 45, Urban 26; No education 38, Secondary 33; Poorest 22, Richest 4

Early childbearing 2014

Percentage of Girls Ages 15 to 19 Who Have Begun Childbearing, Egypt, 2014

National 6; Rural 8, Urban 2

Health and Wellbeing 2015

Under -five mortality rate per 1000 live births

females; males: 85.8, 86.1, 48.1, 44.8, 30.6, 27.4, 25.4, 22.5 (1990, 2000, 2010, 2015)

Family planning 2014

Unmet need of family planning ,currently married/in union women age 15-19 and 20-24 , by residence, education and wealth index

National Age 15-19: 9; Rural 13, Urban 12; No education 14, Secondary 12; National Age 20-24: 3

Safe children 2015

Maternal mortality rate per 100,000 live births

Year	1990	1995	2000	2005	2010	2015
Rate	106	83	63	52	40	33

Work -life balance 2015

Average daily (24 hours) spent on unpaid domestic and care work

Women 4.57; Men 0.42

Education

Secondary school enrolment, gross percent of secondary school-age children, 2014

Girls 64.9; Boys 64.3

Percent of population age (25-29) completed secondary school or higher, 2014

Girls 66.3; Boys 65.9

Employment

Employment to population ratio; ages 15-24 2014

Girls 7; Boys 31.9

Employment to population ratio; ages +15

Girls 17.2; Boys 68.6

Labor force participation 2014

Girls 25; Boys 75

Economy

GNI per capita; PPP (US dollar)

1990: 2240; 2000: 3710; 2010: 6030; 2014: 10260

GINI Index

1992, 1996, 2000, 2008

Empowerment Policy Situation Analysis

	Policy Outcome Indicator	Narrative
Freedom from early and forced marriage	Minimum legal age for marriage with parental consent - **Girls: 18** **Boys: 18**	**Law number 31 (bis) of the Child law No. 126 of 2008 states that:** It is illegal to issue marriage contract for those who did not reach eighteen years old.
Access to family planning	Number of Clinics providing contraceptive methods in 2016: **5600**	**Article (41) of the Constitution of The Arab Republic of Egypt 2014:** The State shall implement a population program aiming at striking a balance between population growth rates and available resources; and shall maximize investments in human resources and improve their characteristics in the framework of achieving sustainable development.
Freedom from early childbearing	PUBLIC expenditure ON EDUCATION; TOTAL (% OF GDP) IN EGYPT: **4%**	**Article (19) of the Constitution of The Arab Republic of Egypt 2014:** The State shall allocate a percentage of government spending to education equivalent to at least 4% of the Gross National Product (GNP), which shall gradually increase to comply with international standards.
Safe childbirth	A doctor or trained nurse/midwife assisted at the delivery of 92 percent of all births in the five-year period before the 2014 with 87 percent occurring in a health facility	
Confident in health and wellbeing	a percentage of government spending to health equivalent to at least 3% of Gross National Product (GNP)	**Article (18) of the Constitution of The Arab Republic of Egypt 2014:** The State shall allocate a percentage of government spending to health equivalent to at least 3% of Gross National Product (GNP), which shall gradually increase to comply with international standards.
Healthy work-life balance	• promulgated and enforced lawas against workplace discrimination against women –yes • facilitating compatibility between labour force participation and parental responsibilities- yes • promulgated and enforced laws that enable marernity leave- No • promulgated and forced laws that enable paternity leave -Yes	

Education and Employment Policy Situation Analysis

Education

Egypt vision 2030 included a pillar for education . It's objectives are :

• A high quality education and training system available to all, without discrimination within an efficient, just, sustainable and flexible institutional framework.

• Providing the necessary skills to students and trainees to think creatively, and empower them technically and technologically.

Contributing to the development of a proud , creative ,responsible, and competitive citizen who accepts diversity and differences, and is proud of his country's history.

Targets :

• Illiteracy rate (15 -35 years old) reaches 7% (absolute zero) in 2030.

• Egypt's rank in primary education quality index reaches 30 or less in 2030.

Employment

• By 2030, the Egyptian economy is a balanced, knowledge-based, competitive, diversified, market economy, characterized by a stable macroeconomic environment, capable of achieving sustainable inclusive a growth. An active global player responding to international developments, maximizing value added, generating decent and productive jobs, and a real GDP per capita reaching high-middle income countries level.

Tragets:

• Unemployment rate reaches 5% in 2030.

• Female labor force participation reaches 35% in 2030.

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