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Millennium Development Goals
Second Country Report

EGYPT

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Prepared by the Public Administration Research & Consultation Centre (PARC)

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FOREWORD

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This is the second country report published by the United Nations and the Government of Egypt on Egypt's progress towards the Millennium Development Goals (MDGs). The eight Goals stem from the Millennium Summit held at the UN in 2000, where Heads of States from all over the world agreed to achieve tangible progress in key development areas by 2015. MDGs are about halving extreme poverty and hunger; achieving universal primary education for both girls and boys; empowering women; reducing under-five mortality and maternal mortality by two-thirds and three-quarters, respectively; reversing the spread of HIV/AIDS and other major diseases; ensuring environmental sustainability; and developing a global partnership for development.

Although not specifically included in the set of global indicators for the MDGs, economic growth is a key factor in creating a supportive environment for the achievement of the goals. Sustaining growth is of critical importance for reducing levels of poverty, as well as providing jobs for the increasing working age population. According to the World Bank, Egypt will need to achieve a sustained real GDP growth rate of at least 7 percent annually for unemployment to decline to more manageable levels. To achieve and sustain these levels of growth, the country will need to foster domestic savings and investment, increase efficiency and competition, and further improve its export performance.

The Millennium Declaration, endorsed in 2000 together with MDGs, also stressed that good governance, the rule of law and the protection of human rights are inextricably related to progress over the MDGs. In other words, realizing development objectives require the existence of a political environment that is conducive to the full exercise of peoples' rights and liberties.

In Egypt, political reform remained high on the agenda and the government confirmed its willingness to open up to greater citizen participation and advance the democratization process. The recent establishment of the National Council for Human Rights, headed by former UN Secretary General Boutros-Boutros Ghali, was considered by many a helpful step in this direction. On the other hand, the emergency law, enacted more than twenty years ago, continues to limit full popular participation in the political process.

Another major challenge facing Egypt in its efforts to achieve the MDGs is the population growth. By July 2003, Egypt's population reached 67,3 millions. Egypt ranks as the 16th most populous country in the world, and the 1st most populous among Arab countries. The annual population growth rate is around 2 percent and life expectancy at birth is 70.4 years. If this growth rate persists, Egypt's population is expected to reach 83 million by 2015. This phenomenon will obviously put a strain on the country's ability to sustain progress over the Millennium Development Goals. The population problem is all the more important, as the percentage of inhabitable and arable land has not grown at the same pace,

despite the efforts that are currently being deployed to implement land reclamation projects and reduce population pressure along the Nile valley.

The second report reveals that Egypt remains on track to achieve the expected results on the great majority of MDGs indicators. The government continued to give attention to critical areas of development, such as health and education, access to water and sanitation as well as improving the livelihood of the most deprived segments of the population. However, the pace of progress varies among the goals, fast and sustained in some areas (e.g. child and maternal mortality, water and sanitation), at acceptable levels for others (e.g. education and poverty reduction), while somewhat more slowly in others yet (e.g. women empowerment, and the environment). In addition, the country will have to increase its efforts and investments in order to keep the current rate of progress with respect to some specific indicators (e.g. in the area of poverty, mortality rates, and combating major diseases).

The present report also marks some methodological improvements with respect to the baseline study, particularly with regards to refining the methodology for designing projections, and in providing trends at the level of the 26 Governorates for a good number of the indicators. In addition, it addresses with more consistency the issue of the multiplier effect over the goals. Finally, the report attempts to monitor the country progress based on an indicators framework that is more relevant and compatible with the country realities and specificities. For the first time the report attempts to address Egypt's role in shaping a global partnership for development (i.e. MDG 8 by monitoring then most relevant targets and indicators). It is hoped that this report will facilitate a debate among different stakeholders on how to move forward this process of "localizing MDG country reports".

Like the first one, the second report was prepared by the Public Administration Research Centre at Cairo University, under the leadership of its director, Dr. Salwa Shaarawy Gomaa, and with the support of the following researchers: Dr. Botheina Mahmoud El Deeb – Deputy Minister CAPMAS/Head of Population Studies; Dr. Heba Al Laithy – Professor of Statistics, Faculty of Economic and Political Science at Cairo University; Dr. Mona El Baradai – Chair of Economic Department, Faculty of Economic and Political Science at Cairo University; Dr. Maha El Adawy - Program Officer, Reproductive Health and Rights at the Ford Foundation; Dr. Laila El Baradai – Associate Professor at the Public Administration Department, Faculty of Economics and Political Science at Cairo University; Asmaa Ramadan, Research Assistant, Cairo University.

The Central Agency for Statistics and Public Mobilization (CAPMAS) was fully involved in this exercise. CAPMAS is the source of all data provided in the report unless stated otherwise.

The team benefited from the active collaboration of the Government, namely thanks to the participation of the Policy Unit of the Ministry of Planning during the different stages of preparation. In the future, the country monitoring process can indeed become a helpful tool in supporting the national development planning process, and serve as a benchmarking instrument for locally established development targets.

The UN System in Egypt participated in the report preparation and the Office of the Resident Coordinator provided overall guidance and backstopping to the team of authors.

Acronyms & Abbreviations

ARI = Acute Respiratory Infections
BCG = Bacille Calmette Guerin (Tuberculosis Vaccination)
CAPMAS = Central Agency for Public Mobilization and Statistics
CG = Consultative Group
CPR= Contraceptive Prevalence Rates
DAG = Donors Assistance Group
DECODE = Development Cooperation Database Egypt
DOTS = Directly Observed Treatment Short Course
DPT3 = Diphtheria, Pertussis, Tetanus
EEAA = Egyptian Environmental Affairs Agency
EDHS= Egypt Demographic & Health Survey
ERSAP = Economic Reform and Structural Adjustment Program
FGM = Female Genital Mutilation
GAD= Gender & Development (A sub-group of DAG)
GALAE = General Authority for Literacy & Adult Education
GHG = Greenhouse Gases
GOE = Government of Egypt
HCV = Hepatitis C Virus
HDI = Human Development Index
HIECS = Household Income Expenditure and Consumption Survey
HIO = Health Insurance Organization
IMR = Infant Mortality Rate
IUD = Intra-uterine Device
RMR = Reproductive Mortality Rate
RNT = Reproductive & Neonatal Tetanus
MISR = Municipal Initiatives for Strategic Recovery
MOHP = Egyptian Ministry of Health & Population
NEAP = National Environmental Action Plan
NCCM = National Council for Childhood & Motherhood
NCW = National Council for Women
NTP = National Tuberculosis Program
ODA = Official Development Assistance
PHC = Primary Health Care
SFD = Social Fund for Development
STDs = Sexually Transmitted Diseases
U5MR = Under-five Mortality Rate

MDG's Status at a Glance

Goals/Targets	Will the Goal/Target Be Met				State of Supportive Environment			
	Probably	Potentially	Unlikely	Lack of Data	Strong	Fair	Weak but Improving	Weak
Eradicate Extreme Poverty & Hunger	●				●			
Achieve Universal Primary Education		●			●			
Promote Gender Equality & Empower Women		●			●			
Reduce Child Mortality	●				●			
Improve Maternal Health	●				●			
Combat HIV/AIDS & Other Major Diseases	● Malaria/ Other Diseases			● HIV/AIDS	● Malaria/ Other Diseases			● HIV/AIDS
Environmental Sustainability		●				●		
Develop a Global Partnership for Development		●				●		

The assessments of whether goals/targets will be met and of state of supportive environment in the table reflect the subjective opinion of the authors of the report.

Monitoring & Evaluation Capacity

Goal	Existing Capacity for:														
	Data Gathering Capacity			Quality of Survey Info.			Statistical Tracking			Statistical Info. Policy			Monitoring & Evaluation		
	Strong	Fair	Weak	Strong	Fair	Weak	Strong	Fair	Weak	Strong	Fair	Weak	Strong	Fair	Weak
Reduce Extreme Poverty/ Hunger	●			●			●				●			●	
Achieve Universal Primary Education		●			●			●			●			●	
Promote Gender Equality		●			●			●			●			●	
Reduce Child Mortality	●			●			●				●			●	
Improve Maternal Health	●			●			●				●			●	
Combat HIV/AIDS			●		●			●				●		●	
Combat Malaria and Other Diseases	●			●			●			●				●	
Ensure Environmental Sustainability		●				●			●		●				●
Develop a Global Partnership for Development		●		●					●			●			●

The assessments of monitoring and evaluation capacity in the table reflect the subjective opinion of the authors of the report.

1. ERADICATE EXTREME POVERTY & HUNGER

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Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than US$1 per day

Indicators: Proportion of population below lower poverty line
Poverty gap ration
Share of poorest quintile in national consumption

Target 2 : Halve, between 1990 and 2015, the proportion of people who suffer from hunger

Indicators : Prevalence of underweight children (under 5 years of age)
Proportion of population below minimum level of dietary energy consumption

1. Reducing Poverty - Status of Progress

Unlike most developing countries, Egypt experienced low level of overall income poverty incidence as well as a remarkable decline in poverty during the last decade. The Middle East and North Africa (MENA) region, using international purchasing power standards of US$1.00 or US$2.00 per day, stands out as the developing region with the lowest incidence of poverty throughout the 1990s at less than 2.5 percent of the population.

Poverty reduction was declared as one of the main objectives of the long-term development vision in Egypt, aiming at reducing poverty to 6 percent by year 2022. Several policies have been designed and implemented to help low income groups. Although there is no government entity officially responsible for planning, monitoring, and coordinating the different programs and activities addressing the poor, Egypt has engaged in multi-dimensional strategies for raising Egyptian standards of living.

In 1999/2000, overall poverty in Egypt stood at 16.7 percent, using the national lower poverty line (Table 1).[1] Thus, almost 10.7 million of the population could not obtain their basic food and non-food needs. Less than one percent of Egyptians spent less than US$1 a day - evaluated at PPP (purchasing power parity) - while 24.8 percent live on US$2 a day.

In spite of the positive poverty reduction trends (see Table 1), a study on Subjective Poverty published by UNDP in 2003[2] revelaed an increase in poverty levels (lower poverty line). The report followed the same methodology used in the Household Income Expenditure and Consumption Survey (HICES), but applied to a smaller sample.

Poverty in Egypt is shallow, with relatively low values of the distribution-sensitive measures. Using the national poverty line, the poverty gap index (P1) was 2.97 percent, implying that most of the poor were clustered just below the poverty line. This means that if there was perfect targeting of poverty-alleviating transfers (which is ad-

mittedly extremely difficult), it would have required only about LE 350 million per year (about 0.1 percent of GDP in 1999/2000) to lift everyone out of poverty.

The highest poverty incidence is in the Upper rural area (34.2 percent), followed by Upper urban Egypt (19.3 percent), while the lowest is in the Metropolitan region (5.1 percent).

Table 1: Poverty Measures for 1990/91, 1995/96, 1999/2000, and projections for 2015

	1990/1991	1995/1996	1999/2000	*2015*
National Lower Poverty Line Headcount	24.32	19.41	16.74	*10.80*
Poverty Gap	7.08	3.39	2.97	*2.06*
Poverty Line at US$1/day PPP Headcount	8.241	2.497	0.682	*0.88*
Poverty Gap	2.273	0.325	0.073	*0.20*
Poverty Line at US$2/day PPP Headcount	39.45	41.52	24.84	*16.49*
Poverty Gap	12.41	9.93	5.00	*3.33*
Food Poverty Line	8.93	3.05	2.87	*1.94*

Source: *Calculated from Household Income Expenditure and Consumption Surveys of 1990/91, 1995/96 and 1999/2000, conducted by CAPMAS.*

Though Upper Egypt represents large proportions of the population, the expenditure level there is far below the poverty line. In general, rural areas in all regions have higher poverty measures than urban areas. The picture is similar when using the upper poverty line. The greatest incidence, depth, and severity of poverty are in the Upper rural region, where 63.49 percent of the individuals are poor. This region also exhibits the highest inequality among the poor having the highest poverty gap and severity indices.

Poverty is concentrated in rural areas. As Figure 1 shows, the distribution of the poor is quite uneven across regions. Poverty, particularly extreme poverty, is relatively low in urban areas, where 41.5 percent of the population resides. In rural areas, poverty is mostly located in Upper Egypt. Almost 54.42 percent of the poor in Egypt live in the Upper rural region when using national poverty line, though its population only represents 26.67 percent of the entire Egyptian population. The metropolitan areas also have the least incidence of poverty compared to their share in population.

The poverty levels of all governorates in Upper Egypt exceed the national level, except for Giza governorate. Poverty incidence is highest in the governorate of Assiut, more than three times the national level, followed by Beni Suef and Sohag. The same pattern holds for the poverty gap and severity indices. In Lower Egypt, Menofia governorate is the only governorate where poverty measures exceed the national average (table B.1, appendix B).

The disparities between regions and governorates could be attributed to several factors including differences in educational levels, job availability, the availability of public services, roads and markets, variation in the quality of cropping patterns, and ownership of agricultural land that may contribute to wealth gap among regions.

Main Characteristics of the Poor

Large household size: Family composition is one of the most significant correlates of poverty. The number of earners and dependents has a critical impact on the family's consumption needs and ability to fulfill those needs. Families with children are worse off than families without children, and families with more children are worse off than families with few children.

High fertility rate: Fertility rates affect and are affected by the poverty status of the household. High fertility implies high dependency ratio. Moreover, poor people often want more children because they experience high replacement fertility behavior and also because children represent wealth, and provide household labor, which is a form of social security available to aging parents.

The incidence of poverty is higher among female-headed households in the Metropolitan region, Lower Urban and Border regions. Moreover, the poverty gap and severity of poverty indices are higher among female-headed households compared to male- headed households, except in the Upper rural region.

Wages are the main source of income, accounting for 42.9 percent of total income of poor individuals. Equally important for female-headed households is income from transfers, which represents 36 percent of the income of poor female-headed households in urban areas and 33 percent in rural areas.

Education of the household head has a strong influence on the household's poverty status. Those with university education are normally achieving a higher standard of living. On the other hand, it is interesting to note that a gender bias exists regardless of the household status: both in poor and in non-poor families the illiteracy rate for girls aged 11-15 is twice that of boys. It seems that high illiteracy rates of female children, in rural areas are mainly due to cultural behavior.

Child labor (and consequently lack of schooling) is obviously more prevalent in poorer households. An estimated 3.3 percent of all Egyptian children (age 6-15 years) do not attend school and are engaged in labor activities. The number of working children in households with female heads is twice that of households with male heads in urban areas, and 1.3 times that of male-headed households in rural areas.

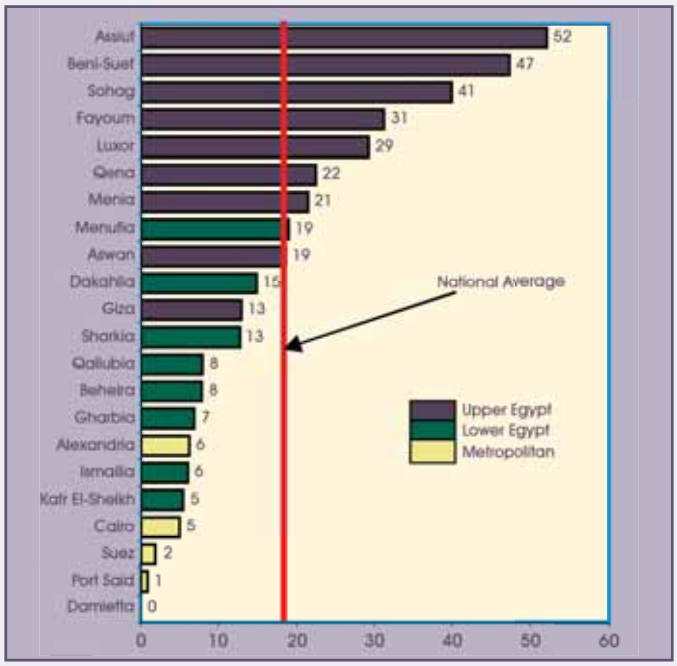
Although the poor have *lower participation rates in the labor market,* unemployment rates are not correlated with poverty for Egypt as a whole. In rural areas, being unemployed is both less likely and less of an option for the poor. Families usually engage those without work to help out in agricultural activities, often as unpaid labor.

The Evolution of Poverty

Using the results of the HIECS of 1990/91, 1995/96 and 1999/2000, a consistent[3] assessment of the evolution of poverty in Egypt is attempted. Table 2 illustrates poverty measurements at the national and regional levels, for the period 1990/91-1999/2000.

The poverty gap indices declined between 1990/91 and 1999/2000, indicating improvements in the expenditure inequality of the poor (see table B.4. appendix B).

Fig. 1: Poverty Incidence by Governorate 1999-2000



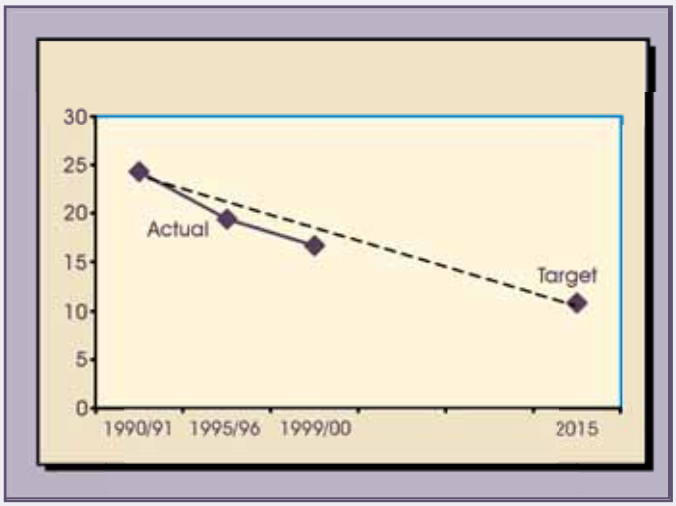
Source: *Calculated from Household Income Expenditure and Consumption Surveys of 1999/2000, conducted by CAPMAS.*

Two major trends dominated the evolution of poverty over 1990-1995: the incidence of poverty increased in Metropolitan and Lower urban regions, (by 3 and 1 percentage points, respectively) and experienced significant declines in the other three main regions.

Patterns of poverty between 1995/96 and 1999/2000 showed different stories. The incidence of poverty increased substantially in Upper Egypt over this period, from 29.3 percent to 34.2 percent in rural areas and from 10.8 percent to 19.3 percent in urban areas.

The poverty gap indices followed a similar pattern. Only the Metropolitan and Lower Egypt regions experienced declines in their poverty measurements. The decrease was substantial in the Metropolitan region going from 13.1 to 5.06 percent. In the Lower rural region poverty decreased from 21.53 to 11.83 percent. Although poverty is always higher in Upper rural areas, it changed from being a rural phenomenon during the first half of the 1990's to an Upper Egypt one in the second half of the decade.

Fig. 2: Actual and Target Poverty Measures for 1990/91, 1995/96, 1999/2000, and projections for 2015.



Source: CAPMAS

Changes in poverty patterns could be attributed to changes in the redistribution of living standards as opposed to growth in average living standards. Over the period 1995/96 to 1999/2000, growth and redistribution components worked in opposite directions in the Metropolitan region: reduction in poverty due to increased real per capita mean expenditure (-9.18 percentage points) was hampered by growing inequality (1.134 percentage points). In the Lower Egypt regions, improvements in inequality were coupled with improvements in mean expenditure, resulting in reduction in poverty levels.

Table 2: Progress in Poverty Rate From 1990/91 – 1999/2000, and Projections for 2015

Year	1990/1991	1999/2000	*2015*
Average Indicator	24.32%	16.7%	*10.8%*
No. of poor, in millions	12.775	10.650	*9.018*
Most deprived region	Upper Rural	Upper Rural	*Upper Rural*
Least deprived region	Lower Urban	Metropolitan	*Lower Urban*
Most deprived governorate	Menia	Assiut	*Assiut*
Least deprived governorate	Ismailia	Damitta	*Damitta*
Ratio between poorest & richest region	6.14	6.7	*5.3*
Ratio between poorest & richest governorate	14.8	>100[4]	*>100*

Source: Table B1 & B4, and projections of Population Census; CAPMAS

The opposite trend was witnessed in Upper Egypt, where per capita expenditure decreased while inequality deteriorated. This resulted in poverty measurements confirming that growth in Lower regions were pro-poor. On the other hand, growth in the Metropolitan region was large enough to cause improvements in overall poverty levels but it was not a pro-poor growth.

Impact of Recent Price Changes on Poverty Levels

Since the implementation of the floating exchange rate system in January 2003, prices increased rapidly. These measures had negative impact on the purchasing power and consumption of households. During the period January 2003 to November 2003, it is estimated that the poverty line increased by 7 percent, indicating a decline in living standards and increase in poverty levels unless income increase with the same rate. Given that poverty in Egypt is fairly shallow, there is a chance that many of those who escaped poverty during the 1995-2000 period may have slipped back into poverty again. However this also means, that given appropriate policies, significant poverty reduction could be accomplished in the future.

Poverty Projections

Expenditure and distribution elasticities were used to predict poverty measures in various regions in 2015, using different scenarios and different poverty lines (see appendix A). Poverty projections show that Egypt could achieve its MDG on poverty if per capita expenditure will grow by 1.5 percent per annum and income inequality will continue to change with the same rate as observed in the period 1990/91-1999/2000 (increase by one percent). These rates are likely to be attained.

According to this scenario, poverty will reach 10 percent, using the lower poverty line, while the poverty rate would decline by 58 percent of the 1990/91 rate when using the poverty line of US$2 a day (see table B. 1 and table B. 4, appendix B).

The poverty rate will decline in all regions except Metropolitan and Upper Urban regions, that will not be able to attain the MDG in terms of poverty reduction. Assuit, Beni Suef and Sohag will continue to have the highest poverty rate, although lower than the 1999/2000 levels.

Alternative scenarios were performed, and their results are shown in Appendix B. Each of these scenarios is simulated by means of a simple procedure, which generates income distributions with higher means and higher inequality levels than those actually observed in 1999/2000. Growth and inequality reduction parameters are calibrated to generate all plausible (positive) combinations.

Reducing Hunger – Status of Progress

As far as caloric intake is concerned, Egypt does not generally suffer from lack of food for its population. The average calorie supply in 1999/2000 was 2960 calories per day, which is about 119 percent of the recommended requirements (see table 3).

Average caloric intake varies across regions and according to welfare levels. Rural Upper Egypt has the lowest average, and the highest percentage of persons with unsatisfied caloric requirements, in both 1990/91 and 1999/2000. Trends in percentage of persons with unsatisfied caloric requirements follow the same pattern as poverty trends, except for Metropolitan and Lower Urban regions. During the period 1990-2000, urban regions experienced increase in the percentage of persons with unsatisfied caloric requirements. This may be due to increase in food prices in urban areas as well as increase in prices of basic services forcing people to reduce their food consumption to pay for services such as health and transportation.

Children who suffer from acute (under-weight), chronic (stunting) under-nutrition or both (wasting) are usually prone to repeated infections. Studies have shown that in Egypt, girls in poor families show a higher prevalence of all types of under-nutrition and higher infant and child mortality rates, a result of gender discrimination in the family.[5] According to EIDHS 2003, the prevalence of wasting (low weight- for-height) is 4 percent at the national level and stunting (low height for age), which is an indication of a long term under nutrition is 15.6 percentage.

Table 3: Average Caloric Intake and Percentage of Persons not Obtaining their Caloric Requirements by Region[6]

	1990/1991		1999/2000	
	% of Persons not Obtaining Caloric Requirements	Average Caloric Intake	% of Persons not Obtaining Caloric Requirements	Average Caloric Intake
Metropolitan	5.29	3370.57	-	3438.41
Lower Urban	7.04	3222.72	10.65	3096.10
Lower Rural	32.09	2602.43	11.36	2985.12
Upper Urban	11.19	2972.14	18.30	2840.02
Upper Rural	45.50	2176.95	19.10	2591.04
Border Urban	15.34	3072.90	8.99	3271.67
Border Rural	44.24	2202.53	14.92	3050.77
TOTAL	25.60	2742.74	14.04	2960.25

Source: Calculated from Household Income Expenditure and Consumption Survey of 1990/91 and 1999/2000, conducted by CAPMAS.

There are clear discrepancies among regions and an indication of long-term poor nutrition in Upper Egypt where the prevalence reaches 21.8 percent in rural areas (and development activities are the least).

The trends in nutritional status are fluctuating. 1992 showed better figures than 1995 and the year 2000 better results than 2003 for acute under-nutrition. It is difficult

to provide accurate projections for the nutritional status as it depends on many factors, particularly economic status and food availability. Meanwhile, the indicators of acute under-nutrition such as low weight for both height and age have almost doubled in 2003 compared to 2000 according to EDHS. This could be due to the effect of the recent increase in prices of staple foods reducing food consumption of poor households. Further analysis of nutritional deficiencies correlated with the Human Development Index (HDI) at governorate level, as a proxy for development, shows that the two governorates with the lowest HDI have the highest levels of nutritional deficiencies (Assiut & Beni-Suef).

Table 4 shows that urban governorates that are ranked at the top in human development in Egypt have the lowest levels of protein-calorie deficiency and iron deficiency anemia. Other governorates manifest a mix of variable patterns and need to be further studied. The MOHP succeeded to improve its capacity to monitor nutritional status at primary health care level by strengthening growth monitoring services. These reached 98 percent of all children from birth to two years of age, who were brought to health centers in 2002 compared to 45 percent in the late eighties[7].

Table 4: Governorates' Classification According to the Prevalence of Both Stunting and Iron Deficiency Anemia. In Parenthesis, the Ranking of the Governorate According to its Human Development Index for Egypt[8].

Deficiency Level	High Stunting	Moderate Stunting	Low Stunting
High Level of Anemia	Beni Suef (20) Menia (18) Assiut (21) Suhag (17)	Aswan (10)	
Moderate Level of Anemia		Sharkia (13) Kafr-el-Sheikh (14) Ismailia (7) Giza (5) Fayoum (19) Qena (16)	Damietta (6) Dakahlia (12)
Low Level of Anemia	Menoufia (11)	Gharbia (8) Beheira (15)	Cairo (3) Alexandria (4) Port Said (1) Suez (2) Kalyubia (9)

STATUS AT A GLANCE

Will target be reached by 2015?
Probably Potentially Unlikely Insufficient Data

State of supportive environment
Strong Fair Weak but improving Weak

2. Major Challenges

Egypt can attain the MDG on poverty reduction if the prevailed trends on economic performance will continue. However, many challenges face Egypt's medium and long term development goals, among them: – To enhance and sustain economic growth. The prospects for the medium term GDP growth are adversely affected by: high instability in the region, which could hamper tourism receipts and FDI; the conversion of Egypt's current account balance from surplus to deficit starting in 1997/98; and the continuation of the liquidity problem. The balance of payments deficit is mainly financed by Suez Canal, tourism and workers' remittances that are vulnerable to external shocks[9].

- The outlook for job creation is unclear in the medium-term.

- The high fertility rate and high dependency ratio are affected by and affect poverty rates. The association between fertility and poverty is more prevalent among female headed households.

- Illiteracy, low school enrolment rate, and child labor are especially high among the poor, and reflect how poverty is perpetuated from one generation to another.

- Decentralization, better coordination, and increased institutional capacity of both governmental and non-governmental organizations will be critica1 to keep up to the challenge of poverty reduction.

3. Supportive Environment

Egypt has engaged in multi-dimensional strategies to raise Egyptian standards of living, including; income generation, human resources development, and safety net strategies. The Ministry of Planning draw the overall economic and social development plans for short, medium, and long terms. They are translated into plans of actions through different ministries and agencies. Poverty alleviation is pursued through various channels, including: direct assistance to the poor through the Ministry of Social Affairs, free education and literacy programs through the Ministry of Education; free health care through the local health units and the large public hospitals of the Ministry of Health; subsidies for bread, flour, sugar, and oil through Ministry of Trade and Supply; and rural development projects through the Ministry of Agriculture.

Egypt's poverty reduction strategy includes efforts on five main fronts: 1) economic growth to increase income and employment with emphasis on small and medium enterprises development and job creation initiatives; 2) skill development of the poor to raise their capability through education, health, nutrition and social interventions; 3) women's advancement and closing the gender gap in development; 4) safety net measures for the poor, especially women, against anticipated and unanticipated income/consumption shocks through targeted and other

efforts, (there are three main social safety net programs: the consumer food subsidy program, the cash transfers from the Ministry of Social Affairs, and the Social Fund for Development (SFD); 5) and participatory governance to strengthen the voice of the poor. Several programs can be mentioned in this respect: Shourok "Integrated Local Development"; Participatory Local Development Project; the Advisory Unit of the Participatory Urban Management Program, the Emergency Plan of the Ministry of Local Development; and the MISR (Municipal Initiatives for Strategic Recovery) executed by the Ministry of Planning.

Poverty reduction was declared as one of the main objectives of the Socio-Economic Development Long-term vision 2002-2022. The Ministry of Planning, supported by UN agencies and the Donor Assistance Group (DAG) is in the process of developing a Poverty Reduction Action Plan. The objective of this initiative is to ensure effective planning, implementation, and monitoring of poverty reduction policies and programs based on reliable data, in consultation with all development partners including civil society. As a first step, poverty diagnosis research was completed to identify the overall scope and distribution of the problem of poverty in its broader dimensions (income poverty, subjective poverty as well as the social capital of the poor), and devise the direction and magnitude of the work needed to reduce it.

The Government of Egypt is spending nearly US$1.4 billion towards food subsidy, which has contributed to reduction in hunger and poverty. Targeted programmes addressing hunger and poverty are, however, still needed to tackle the great regional disparity.

4. Priorities for Development Assistance

- A review of poverty reduction efforts emphasizes the importance of developing a new action plan that focuses on targeting equality, empowering the poor and generating employment, combining available and prospective resources with a sharper focus and a stronger commitment. Effective management, monitoring efficiency, and effectiveness of poverty programs are also needed.

- Government ministries, civil society, and the private sector should be brought together to coordinate their work and arrive at a division of labor, which is in the best interest of the poor. Measures are needed to ensure inclusive participation in the poverty reduction strategy and in the formulation and implementation of inclusive policies and programs. In this respect, gender needs to be a criterion of inclusion in poverty reduction. Introduction of appropriate curricula at the primary and secondary level is crucial to make students aware of the importance of participation in community activities. Awareness building should begin at an early stage of education.

- SME development should be treated as a national priority designed specially for the youth. It requires the coordination of efforts among all government and non-government actors and entities. SME development requires reforming and stimulating the financial sector to address the financial needs of SME on sound economic basis, as well as facilitating the access of poor women and men to appropriate financial services. The new SME law may represent a significant step in this direction.

- Improve the effectiveness of public expenditures to increase opportunities for human capital formation for the poor. Support for the eradication of illiteracy and drop-out rates among the poor is probably the single most important development objective. The commendable policies designed to encourage girls to join and stay in schools, taking into account the cultural and traditional barriers, should be fully and quickly implemented.

- A well designed program to improve the nutrition of vulnerable groups should be designed and implemented with emphasis on the protection of children. Some of the recommended measures are: (a) increase school feeding, as a way of targeting the poor, with the advantage of improving nutrition for children and indirectly encouraging children to enroll at schools. (b) Distribution of small quotas of necessary food items to participants in literacy classes. Sources of funding such programs could be the government in collaboration with NGO's.

- Interventions are needed to avoid high fertility rates experienced by the poor, not only by providing subsidized contraceptive methods but also by providing better access to sound health services, and offering poor households incentives to send their children to school.

- Extending infrastructure, such as safe water and sanitation, to regions in which poverty is prevalent is a reasonably efficient method for improving the individual's health status and hence reducing poverty.

- Greater decentralization should be a complementary policy to encourage a more balanced territorial development and more effective and accountable implementation of poverty alleviation programs.

5. Tracking Progress in Poverty & Hunger: Monitoring & Evaluation Environment

Elements of Monitoring Environment	Assessment		
Data Gathering Capacity	**Strong**	Fair	Weak
Quality of recent survey information	**Strong**	Fair	Weak
Statistical tracking capacities	**Strong**	Fair	Weak
Capacity to incorporate statistical analysis into policy, planning & resource allocation mechanisms	Strong	**Fair**	Weak
Monitoring & evaluation mechanisms	Strong	**Fair**	Weak

Endnotes

1 - Most poverty analysis in Egypt rely on household expenditure and income surveys conducted by CAPMAS (the official statistical agency). The recent three surveys are comparable in terms of sampling, duration, and questionnaire coverage areas.

2 - Subjective Poverty and Social Capital. Towards a Comprehensive strategy to Reduce Poverty, UNDP, April 2003

3 - Consistency requires that the poverty line is fixed in terms of the indicator of living standards used. Consistent poverty comparisons imply that two persons at the same real consumption level are deemed to be either "poor" or "not poor" irrespective of the time or place under consideration.

4 - Since the richest governorate in 1999/2000 (Damietta) had a poverty incidence close to 0, the ratio between the poorest (Assiut) and richest governorate becomes very high, indicated here as above 100.

5 - World Bank 2003.

6 - The figures refer to actual food consumption, and not to the cost of obtaining basic food requirements on which the lower poverty line is calculated. Average caloric requirement is 2300 calories a day.

7 - Ministry of Health and Population (MoHP)

8 - El-Zanaty and Associates and ORC Macro, 2003

9 - World Bank 2001.

2. ACHIEVE UNIVERSAL PRIMARY EDUCATION

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Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling

Indicators: Net enrolment ratio in primary education
Proportion of pupils starting grade 1 who reach grade 5
Literacy rate of 15-24 year olds

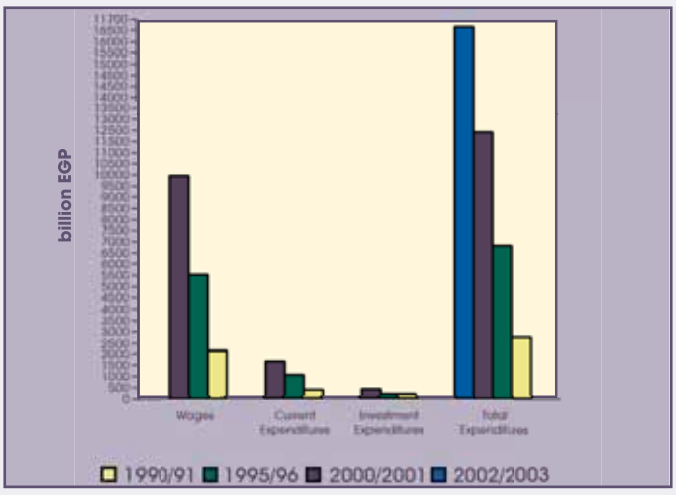
1. Status of Progress

Since the early 1990's Egypt has embarked on an ambitious and comprehensive educational reform program. The Egyptian government has demonstrated a strong commitment to prioritizing education as a key tool for development and has defined Education as the "National Project of the Nineties". Increasing amounts of resources have been allocated to education in both nominal and real terms. This increase occurred during a period of sharp fiscal contraction when the share of the budget to GDP was reduced by about one fifth.

Public expenditure on pre-university and university education (in nominal terms) increased from L.E. 4.7 billion in 1990/91 (9.5 percent of total public expenditure and 5.0 percent of GDP) to L.E. 15.08 billion in 1996/97 (22.6 percent of total public expenditure and 6.6 percent of GDP). Public expenditure on education further increased to L.E. 18.18 billion in 2000/2001 (18.1 percent of total public expenditure and 6.2 percent of GDP) and reached 24.2 billion in 2003.

Public expenditure on pre-university education (primary and secondary) increased from L.E. 8.1 billion in 1996/1997 to L.E. 11.9 billion in 2000/2001, and reached L.E 16.6 in 2002/2003 (Figure 1). Despite the fact that the Egyptian education system benefited from a significant allocation of resources since the beginning of the late 1990s, reallocation of resources is still needed to compensate the legacy of past deterioration, and to respond to the increasing population.

Fig. 1: Nominal Public Expenditures on Pre-University Education (1990/91-2002/2003)



Source: Ministry of Finance.

Enrollment rates witnessed a steady increase during the 1990s. Net enrollment rates in primary education improved between 1995 and 2002 by about 5 percentage points for boys and 9 percentage points for girls, attaining 94 percent for boys and 91 percent for girls (Table 1, Appendix C).

The illiteracy rate for children aged 12-15 years for females is almost twice that of males (15.5 and 8 percent, respectively). This regards the poor and non poor. In urban areas, male illiteracy rates are slightly lower than females within each poverty group.

Egypt could be able to achieve Universal Primary Education by 2015 at the national level. However, there would be differences at the governorate level. Lower Egypt frontiers governorates will not be able to achieve that for girls and Upper Egypt will not be able to achieve universal coverage neither for boys nor girls at the current rate of progress (see Figures 2, 3 & 4).

Fig. 2: Actual and Target of Net Enrollment Ratio in Primary Education (Males)

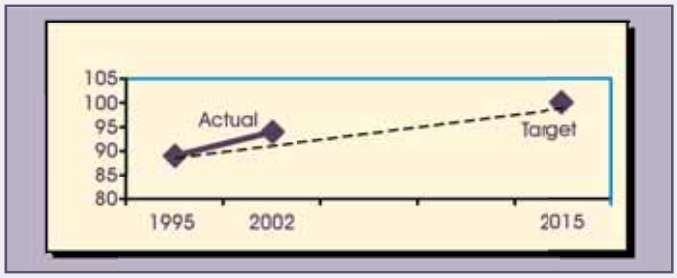
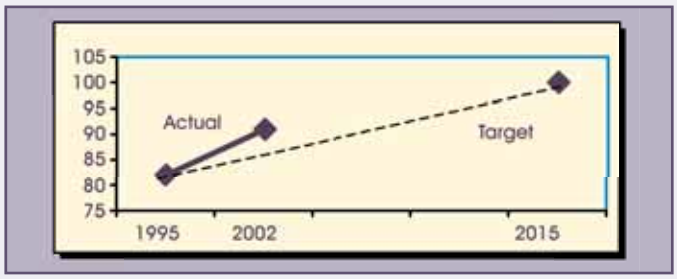


Fig. 3: Actual and Target of Net Enrollment Ratio in Primary Education (Females)



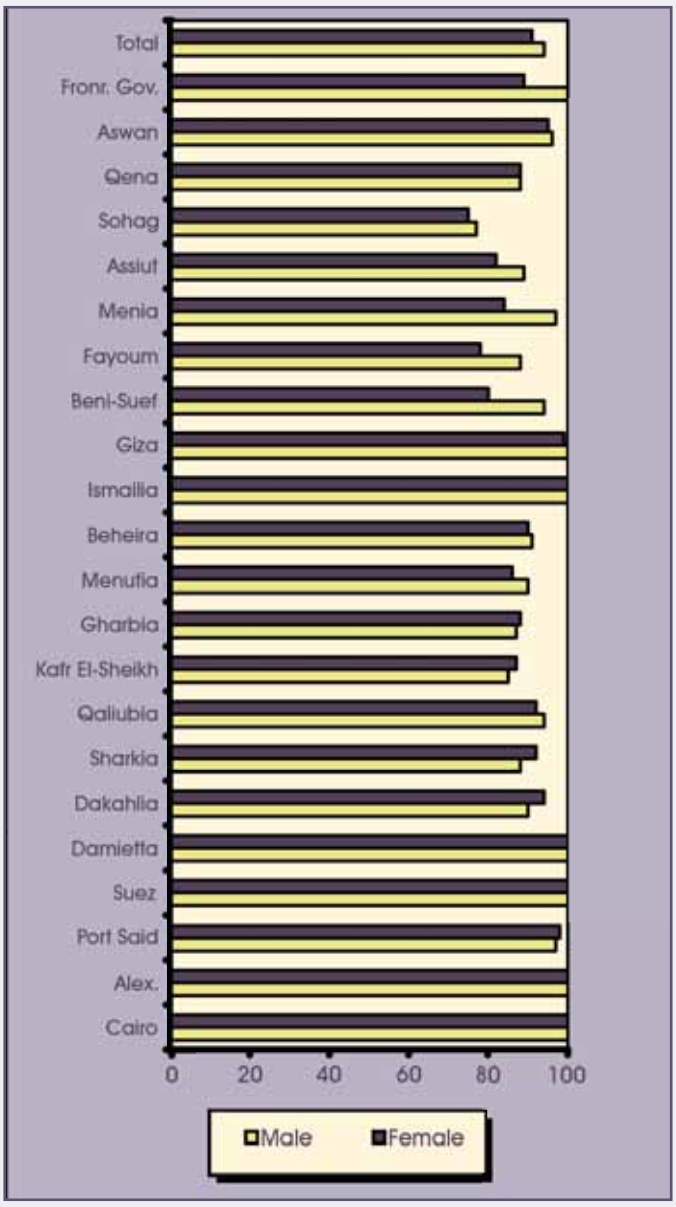
Source: CAPMAS

While some governorates have achieved universal coverage in primary education for both boys and girls (Cairo, Alexandria, Suez, Damietta, Ismailia) others lagg behind. In general, Upper Egypt governorates rank lower than Lower Egypt governorates, with Sohag coming at the bottom of the list with a rate of only 77 percent for boys and 75 percent for girls.

The proportion of pupils starting grade 1 who reach grade 8 increased for both boys and girls, which means that dropout rates have decreased.

Thus, dropout rates decreased from 16.11 percent for the cohort of pupils starting grade 1 in 1991/92 and reaching grade 8 in 1998/99, to 13.23 percent for the cohort of pupils starting grade 1 in 1992/93 and reaching grade 8 in 1999/2000. The fall in the dropout rate for girls was faster (3.02 percent) than that for boys (2.75 percent) during this period. (Tables 4 & 5, Appendix C)

Fig. 4: Net Enrollment Rates in Primary Education by Governorates and Gender in 2002.



Source: CAPMAS

Literacy rates for males (15-24) improved by about twelve percentage points between 1996 and 2001, while that of females in this age group improved by about 25.1 percentage points (Table 2, Appendix C). This is due to the great efforts exerted for promoting gender equality in the field of education.

In spite of the above, there are still large differences in adult literacy among regions, with Upper Egypt ranking at the bottom of the list for both males and females espe-

cially in the governorates of Beni-Suef, Fayoum, Menia, Assyout, and Sohag.

STATUS AT A GLANCE

Will target be reached by 2015?
Probably Potentially Unlikely Insufficient Data

State of supportive environment
Strong Fair Weak but improving Weak

The estimated illiteracy rate for the entire population (15+) only dropped from 25.7 percent in 2000 to 24.3 percent in 2003. Female illiteracy stood at 31.6 percent, while the illiteracy rate for males were 17.4 percent in 2003.

Egypt will probably not be able to eradicate illiteracy among youth (15-24 years) completely by 2015 (Table 3, Appendix C).

2. Major Challenges

Two major challenges – which are interlinked – are now facing the Egyptian education system: Attain high quality standards of education and increase the accessibility of the poor to education.

2.1. The Need to Improve the Quality of Education

Despite the government efforts to improve the quality of education since the mid 1990s, improvements are still needed in order for the education system to become more flexible, diversified and relevant to the economic and social needs of the country.

Three important determinants of education quality are the school environment (where students are taught), learning processes (how students are taught), and learning contents (what students are taught).

Concerning the school environment, a Survey of Public Preparatory Schools in 1999[1] indicated that despite improvements, upgrading school facilities remains an issue.

Many school buildings remain unfit for use, and although triple shifting has been eliminated, a number of double shift schools, particularly at the preparatory and secondary levels continue to operate. Classroom crowding is also a particular concern in some governorates.

The 1999 survey further pointed to the importance of school sanitation facilities and classroom cleanliness. The lack of appropriate medical facilities was another concern raised by the study. As for learning processes, classroom observations undertaken as part of the survey suggested that Egyptian students have relatively few opportunities to actively participate in the learning process. At the same time, only 24 percent of teachers in the sample used lesson time efficiently. Another survey[2] indicated that many Egyptian teachers continue to resort to corporal punishment in the classroom.

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

2.2. Increasing the Poor's Access to Education

The second major challenge facing the Egyptian educational system is the inequality of access to education among income groups and the low educational attainment of the poor. There is a correlation in Egypt between education and poverty, illiteracy being concentrated among the poor (according to the recent report on poverty in Egypt)[4]. The proportion of illiterate individuals (aged ten and above) in the total population of Egypt was 31.3 percent, while the proportion was 45.7 percent among the poor and 28.4 percent among the non-poor. Large inequalities in educational attainments emerge also among the literate: poverty was inversely correlated with educational attainment. Thus, the majority of the poor has only basic education or no education at all. However, there are great regional variations in educational attainment and its correlation to poverty. The most significant feature that emerges from the regional educational profile is the low educational attainment in Upper Egypt and the highest rate of illiteracy among the poor (52.07 percent) as well as the non-poor (46.27 percent).

There is also inequality in school enrollment especially in basic education. Enrollment of children aged 6 – 15 years in basic education in 1999/2000 was 84.18 percent (Table 1). Enrollment of poor children accounted for 76.87 percent only compared to 86.35 percent for non-poor children. This means that about 23.13 percent of poor children were out of school in 1999/2000.

Table 1: School Enrollment of Egyptian Children Aged 6-15 Years by Poverty Status, 1999/2000 (percent)

	Enrolled	Not Enrolled
Non-poor	86.35	13.65
Poor	76.87	23.13
All	84.18	15.82

Source: The World Bank (2002a).

Disaggregation by region shows that the highest proportion of children not enrolled in basic education among the poor is in rural Upper Egypt (24.70 percent) followed by poor children in rural Lower Egypt (20.97 percent).

The lower access of poor people to education could be attributed – besides the financing shortage and the distributional pattern of public educational expenditures – to the declining demand of the poor to education.

There are two major reasons behind this declining demand. The first is the low quality of education and the second is the increasing household cost of education (including the opportunity cost of education). The low quality of education has been a "push factor" for the poor. A CAPMAS Survey on the Educational Characteristics of the Egyptian Society[5] showed that repeated failure (an aspect of poor quality) constituted 92.5 percent of the reasons for dropping out of the poor.

Low quality and low achievement among the poor produce limited learning and thus limited expected economic returns, especially when compared to the rising household cost of education.

During the period 1990/91 – 1995/96, in both urban and rural areas, and for the poor and the non-poor alike, education was the expenditure category that witnessed the highest increase in real terms[6].

During the period 1995/96-1999/2000, the increase in the cost of education to the household amounted to 70 percent for basic education, 196 percent for secondary education and 18 percent for university education[7].

In terms of expenditure shares, the most important expenditure item for both poor and non-poor was private tutoring.

3. Supportive Environment

The Egyptian government is strongly committed to improve access, equity and quality of education. Education was also identified as a mechanism for sustaining national security.

Government allocations to education during the 1990's witnessed unprecedented increases. Consequently, the number of schools and classrooms increased, and facilitated enrollment growth. By 1997 a household survey showed that 99 percent of all villages in Egypt had access to primary education, and 92 percent had access to preparatory education[8].

Since 1996, the government has developed a comprehensive strategy of educational development covering all levels of education. At the basic education level, an "Education Enhancement Project" supported by the World Bank and the European Union was designed and approved to address not only the increase of access but also the improvement of equity and quality in education.

"Education for All" was the goal Egypt adopted during the 1990's. Since then, Egypt has identified Excellence For All, as a goal for educational reform. The government is attempting to strike a balance between the challenges of quality and quantity. The Ministry of Education initiated a long term plan (2002/2003- 2015/2016) to implement "the Education For All" initiative.

4. Priorities for Development Assistance

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

-Supporting the government's efforts in improving the quality of teachers and introducing new technologies.

-Assisting the government's and NGO's efforts in literacy classes, one-classroom schools and community schools.

-Regarding equity issues, development assistance could focus on awareness campaigns for deprived and out of school children as well as targeted subsidies program in the community to help decrease the household cost of education for poor families.

5. Tracking Progress in Promoting Universal Education: Monitoring & Evaluation Environment

Elements of Monitoring Environmental	Assessment		
Data gathering capacity	Strong	**Fair**	Weak
Quality of recent survey information	Strong	**Fair**	Weak
Statistical tracking capacities	Strong	**Fair**	Weak
Capacity to incorporate statistical analysis into policy, planning & resource allocation mechanisms	Strong	**Fair**	Weak
Monitoring & evaluation mechanisms	Strong	**Fair**	Weak

Endnotes

1 - El Tawila and Others, 2000

2 - Ibrahim and Others, 1997

3 - UNICEF, 2002a

4 - World Bank, 2002a

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

6 - El Laithy and others 1997

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

8 - World Bank 2002b

3. PROMOTE GENDER EQUALITY & EMPOWER WOMEN

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Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015

Indicators: Ratio of boys to girls in primary, secondary, & tertiary education
Ratio of literate females to males of 15-24 year old
Share of women in wage employment in the non-agricultural sector
Proportion of seats held by women in national parliament

1. Status of Progress

Gender disparities in education have been persistent in Egypt. However, they are improving rapidly due to considerable efforts exerted by the government over the last fifteen years.

The ratio of females to males in primary education increased from 79.7 percent in 1990/91 to 84.5 percent in 1999/2000. In secondary education, the pace of increase was faster: the ratio of females to males increased from 77.0 percent to 99.7 percent during the period. This ratio improved also for technical education, from 74.1 percent in 1990/91 to 84.9 percent in 1999/2000 (Fig. 1). These improvements are connected to the growing access of girls to education.

Significant progress has been achieved in school enrollment over the past few decades. Net enrollment rate in primary education (Table 1, Appendix C) witnessed an observed improvement. However, there are still more girls than boys out of school. The net enrollment rate in primary education for girls (91 percent) was still three percentage points less than that for boys (94 percent).

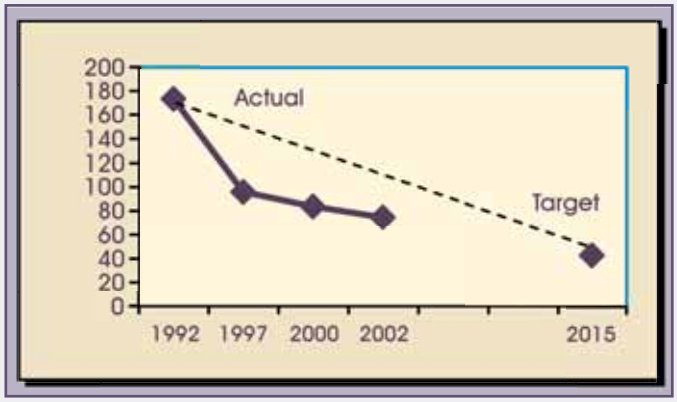
Fig. 1: Ratio of Females to Males in Primary, Secondary and Technical* Education

(*) Include Gender Primary and Al-Azhar Education.

Source: Statistical Year Book 1997, 2001.

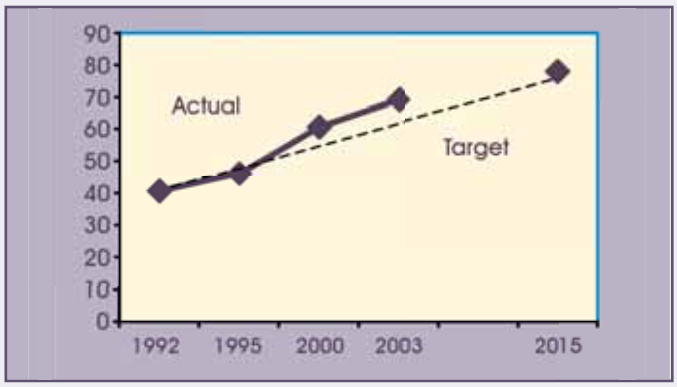
It is probable that Egypt will be able to eliminate gender disparity in secondary education by 2005 (Table 1). Though efforts are being made to address the problem, the target might not be met at all levels of education and in all regions by 2015.

Fig. 2: Actual and Target Females to Males in Primary Education



Source: CAPMAS

Fig. 3: Actual and Target Females to Males in Secondary Education



Source: CAPMAS

Table 1: Projection of the Ratio of Females to Males in Primary, Secondary and Technical Education, for 2015

Assumptions	Primary	Secondary	Technical
Low	92.2	100.0	92.5
Medium	93.5	100.0	100.0
High	100.0	100.0	100.0

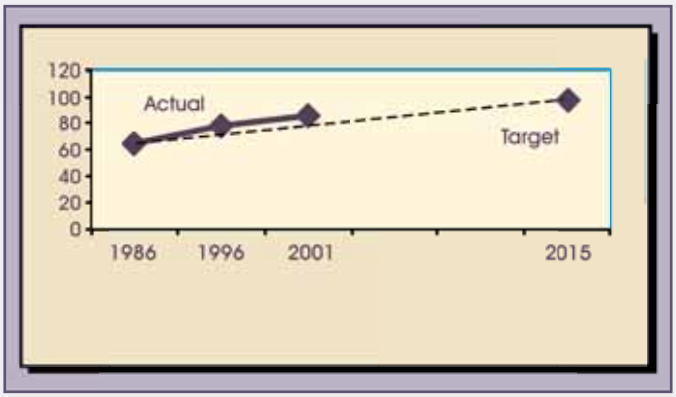
Source: Population Census & Housing in 1986, 1996 & estimates for 2001 projected using exponential method.

The literacy rate of 15 – 24 year-olds increased from 71.2 percent for males and 51.3 percent for females in 1986 to 83.2 percent for males and 76.4 percent for females in 2001. However, there are still great differences among governorates in the ratio of literate females to males in the age group 15-24.

In 2001, this ratio fluctuated between 57.9 percent in Fayoum governorate and 100 percent in both Suez and Damietta governorates, averaging 85.5 percent for total Egypt (Table 6, Appendix C).

Egypt will be able to reach the goal at the national level (Fig. 4). However, it is probable that it will not be able to eliminate gender disparity on this indicator in Upper Egypt and Frontiers governorates. This is because of the problems still encountered in girls education especially in rural and poor areas, despite the efforts of the government in this respect.

Fig.4: Actual and Targeted Ratio of Literate Females to Males (15-24)



Source: CAPMAS-Table (6) of appendix

Between 1976 and 1996 the female share in the Egyptian labor force (15-64 years) increased from 7.26 percent to 15.28 percent. The average rate of growth of the female labor force amounted to 7.19 percent during 1976-1986 (against 2.43 percent for males) and to 6.48 percent during 1986-1996 (against 2.45 percent for males).

An important factor behind this gender-based shift in the labor force structure is the increase of educated females. This led to higher rates of employment of females holding secondary and above intermediate education certificates. It is also attributed to more employment of married females in the age of 30 years and above[1]. The gender composition of the labor force in 2001 is more balanced in urban than in rural areas as the ratio of Female/Male in the former is higher. If compared with 1990 and 1995, it is evident that the gender gap is shrinking in both rural and urban areas (Table 1, Appendix D).

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

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

similar for both urban and rural areas (Table 2, Appendix D).

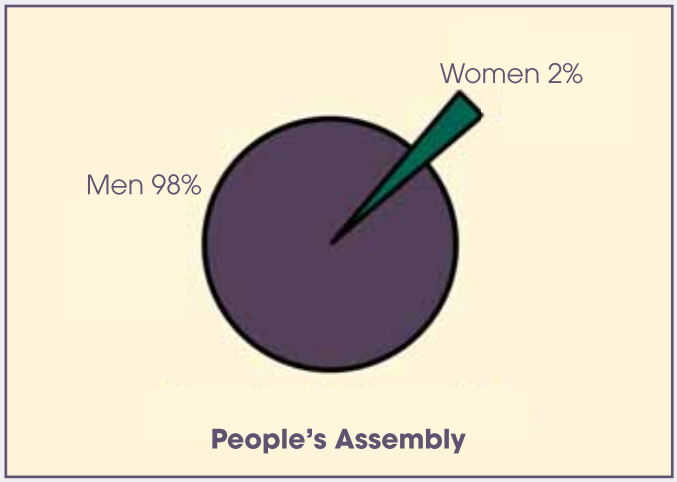
This has a significant impact on the development indicators as women are more likely than men to use their incomes to improve their children's nutrition, health care and schooling[2].

Table 2: Share of Females in Wages Employment in Non Agriculture Sector by Region in 1990, 1995 and 2001,

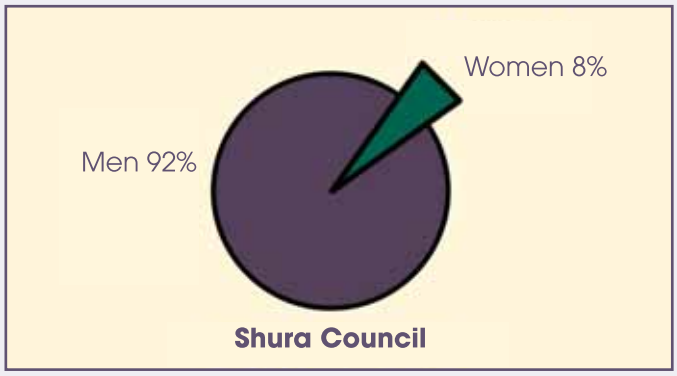
Region		1990	1995	2001
Urban Governorates		22.0	19.5	22.6
Lower Egypt Govs.		19.0	19.3	22.2
Upper Egypt Govs.		15.9	17.5	14.6
Frontier Governorates		25.9	25.4	22.4
Total Egypt	Urban	22.2	22.3	24.6
	Rural	13.6	13.0	15.1
Total		**19.2**	**18.9**	**20.6**

Source: Labor Force Sample Survey (1990 – 2001).

Fig. 5: Women Participation in People's Assembly and Al-Shura Council



Source: CAPMAS



Source: CAPMAS

Achieving gender equality and empowerment of women is even more difficult on the political front. Egyptian women still occupy an insignificant number of seats in parliament. There are 2.4 percent women in the People Assembly and 8 percent in the Shura Council, following the recent appointments by the President. Although they are small in number, women are active participants in the parliamentary debates and discussions. There are governmental and non-governmental ongoing efforts to enhance women political participation and to ensure a representation that reflects their weight in the society. The National Council for Women (NCW) is in the process of creating a Center for Political Training to upgrade women's political skills and creating a pool of potential candidates that can run for the 2005 parliamentary elections. The NCW is also coordinating with the political parties to ensure that these are committed to bring women to decision making posts within the party machinery. Voter sensitization programs focusing on women are also being implemented.

The political leadership has stated that enhancing women participation in the political life is part and parcel of the political reform currently taking part in the country.

2. Major Challenges

Poverty is the major challenge that faces the Egyptian government in closing the gender gap in primary and secondary education, and in reducing the gender gap in literacy among 15–24 year olds. Gender inequality, while limited among the rich, is quite large among the poor, and poverty exacerbates gender disparities in education[3].

Poverty was also among the principal reasons for dropping out of school[4] while traditions and cultural factors constitute an additional constraint to girls' education in Egypt[5].

Regarding women employment, the major challenge is constituted by the economic conditions and the expected rate of growth in the near future. It is therefore uncertain weather there will be new job opportunities created for women.

As regards women's greater political participation, the notion that women's traditional role in the private domain (as wives and mothers) still represents a major obstacle.

3. Supportive Environment

- The Egyptian government is drafting a new election law and there is an opportunity to include measures to ensure larger number of women in the parliament.

- Some Arab countries managed to increase the representation of their female Member of Parliaments (MPs) by enforcing a quota system.

- Egyptian women managed to gain very important achievements such as the appointment of a female judge

for the first time and the right to pass their nationality to their children.

- In addition to increasing the number of schools, the government is conducting an "Awareness Campaign with Subsidy Program" that is successfully raising girls' enrollment in basic education. Under this pilot project, the government provides L.E. 50 to 12,000 children respectively. The subsidy is used to cover the private cost of education.

- Egypt was among the first countries to respond to the UN Secretary General's Education Initiative and Commit to the Dakar Declaration on Education for All. This was manifested in the Egyptian Girls' Education Initiative (2002/2003 – 2006/2007). The most important goals of the initiative are a) Placing girls' education as a top priority on the five – year national agenda for development (2002/2003 – 2006/2007). b) The commitment of the government to eliminate gender disparities by the year 2007. c) Achieving gender equality and enrollment of all girls in a high quality educational system by the year 2015.

STATUS AT A GLANCE

Will target be reached by 2015?
Probably **Potentially** Unlikely Insufficient Data

State of supportive environment
Strong Fair Weak but improving Weak

The Alexandria Declaration adopted at the Fourth National Conference of the Council for Women, outlines a number of future actions addressing gender equality, such as: promote gender equality in primary and secondary education, work towards the integration of women in the labour market and ensure their access to social security; promote greater representation of women in legislative councils and parliament; and revise articles in the penal law that discriminate against women.

4. Priorities for Development Assistance

- International development assistance could be a source for promoting girls' education by improving access of poor girls to education. This could be done by expanding the awareness campaigns and the targeted subsidy programs, and finance the on-going girl's education initiatives, which is facing funding shortages. This program should also be expanded to early childhood education.

- Preparing a National Strategy to enhance women's participation in political life and in general increase efforts promoting women empowerment and their more active participation in socio-economic and political life, supplemented by concrete measures (e.g. affordable and safe nurseries, etc.).

5. Tracking Progress in Promoting Gender Equality and Empowering Women : Monitoring & Evaluation Environment

Elements of Monitoring Environmental	Assessment		
Data gathering capacity	Strong	**Fair**	Weak
Quality of recent survey information	Strong	**Fair**	Weak
Statistical tracking capacities	Strong	**Fair**	Weak
Capacity to incorporate statistical analysis into policy, planning & resource allocation mechanisms	Strong	**Fair**	Weak
Monitoring & evaluation mechanisms	Strong	**Fair**	Weak

Endnotes

1 - El Ehwany, 2002

2 - World Bank 2001, World Bank 2002

3 - El Baradei, 2002

4 - Third World Forum, 1994; Bibars, 1999

5 - El Baradei, 2002

4. REDUCE CHILD MORTALITY

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Target 5: Reduce by 2/3, between 1990 and 2015, the under-five mortality rate
Indicators: Under five mortality rate
Infant mortality rate
Proportion of one year old children immunized against measles

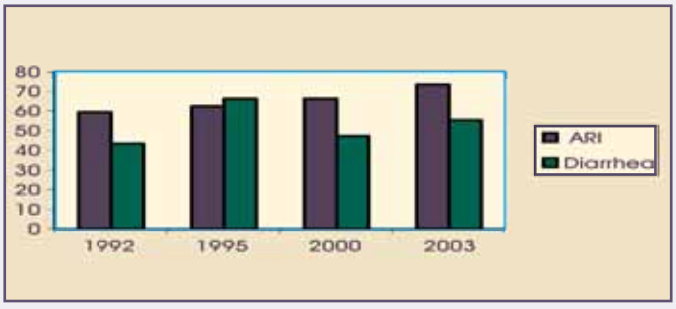
1. Status of Progress

The infant and child mortality rates are considered two of the most complex indicators in development. They reflect both the efficiency of the heath system and the influence of socio-economic and cultural factors on child survival. During the last 20 years, the Egyptian Ministry of Health and Population (MOHP) has focused on strengthening vertical programs with direct impact on improving infant and child mortality indicators. These include control of diarrhoeal diseases and acute respiratory infections (ARI), the expanded program of immunization, and growth monitoring. There was a shift towards an integrated approach to child health as of the mid nineties.

Diarrhoeal diseases are still considerably prevalent among children below five years of age. However, mortality from diarrhoeal diseases dropped markedly due to the efforts of the national program, although it remains the second cause of infant death responsible for around 16 percent of total infant mortality in 1999[1]. ARI is the leading cause of infant and childhood mortality, responsible for almost 30 percent of total deaths[2]. The EDHS data from 1992 to 2003 for the proper management of diarrhoea and ARI show fluctuations in the household response to childhood diarrhoea and improvement in seeking care for ARI (Fig.1).

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

Fig.1: Percentage of Proper Management of Diarrhoea & ARI



Source: *EDHS 1992, 1995, 2000 & 2003.*

An important factor contributing to infant and child mortality is malnutrition. Protein-calorie (energy) deficiency that is usually attributed to household poverty is discussed in goal one. Micronutrient deficiency, particularly iron, vitamin A, and iodine have negative implications on the child's growth, health status, immune response, and school performance. Iron deficiency anemia in children has its highest prevalence and is most severe in governorates that have the lowest rank using the Human Development Index[3].

The Egyptian government is targeting other causes of infant and child illness through strengthening the Primary Health Care system and improving health education. Some of the programs include family planning to space pregnancy, educating mothers on the benefits of exclusive breastfeeding for the first six months, improving maternal nutrition through iron supplements during pregnancy, improving the quality of ante-natal care and immunizing pregnant mothers with tetanus toxoid to prevent neo-natal tetanus.

Egypt is on track to achieve the MDG of reducing infant mortality by two-thirds of the 1990 value (76/1000 live births), and reach an Infant Mortality Rate of 25/1000 by 2015 at the national level, if the current rate of progress continues (see tables 1 and 1A). It is estimated that all regions will achieve a target below 21.3/1000 live births. Rural Upper Egypt, however, is estimated to remain at around 30.1 per 1000 at the current rate of progress. As for the under five mortality rate, the goal of 35 per 1000 live births would be achieved by 2015 at the current rate of decline and child mortality is expected to reach 24/1000. The best case scenario, which assumes scaling-up of efforts to reduce infant mortality rate and under five mortality rate, will accelerate achievements and estimates that all governorates and settings will reach the targets including rural Upper Egypt.

Table 1: Infant (IMR) and Under Five Mortality Rate (U5M) per 1000 live births by Place of Residence

Region	1992		2000		2003	
	IMR	U5M	IMR	U5M	IMR	U5M
Urban Governorates	45	49	30	35	26.3	33.5
Lower Egypt	58	77	36	46	41.3	49.2
Urban	46	57	32	41	33.4	40.8
Rural	62	84	38	47	44.3	52.5
Upper Egypt	90	110	57	70	54.8	68.8
Urban	53	70	44	51	45.1	56.3
Rural	106	129	62	77	58.3	73.4
Front Governorates	-	-	30	36	-	-
Total	**68**	**85**	**44**	**54**	**38**	**45.7**

Source: *EDHS 1992, 2000, 2003.*

The national figures for infant mortality and under five mortality rates per 1000 live births will be 12.2 and 13.4, respectively. Figures 2 and 3 show current levels of infant mortality and under five mortality rates by governorate, based on MOHP data. It is clear from both figures that all Upper Egypt governorates, except Giza, have higher Infant Mortality Rate and under five mortality rates than Urban and Lower Egypt governorates. Not surprisingly, the governorates with high levels of infant and child mortality such as Assyout, Beni-Suef and Suhag are also poorly ranked on the Human Development Index scale for Egypt. The goals for infant and under-five child mortality are the most difficult and slowest to show progress as they require systemic improvements in the health care delivery system particularly at the primary care level in addition to overall socio-economic development of the community. They also require targeted efforts to reduce neonatal mortality rate which contributes to almost 55 percent of total infant mortality rate[4].

Table 1A: Targets at Current Rate of Progress and with Accelerated Efforts to Achieve Goals of Infant (IMR) and Under-five Mortality Rate (U5MR)

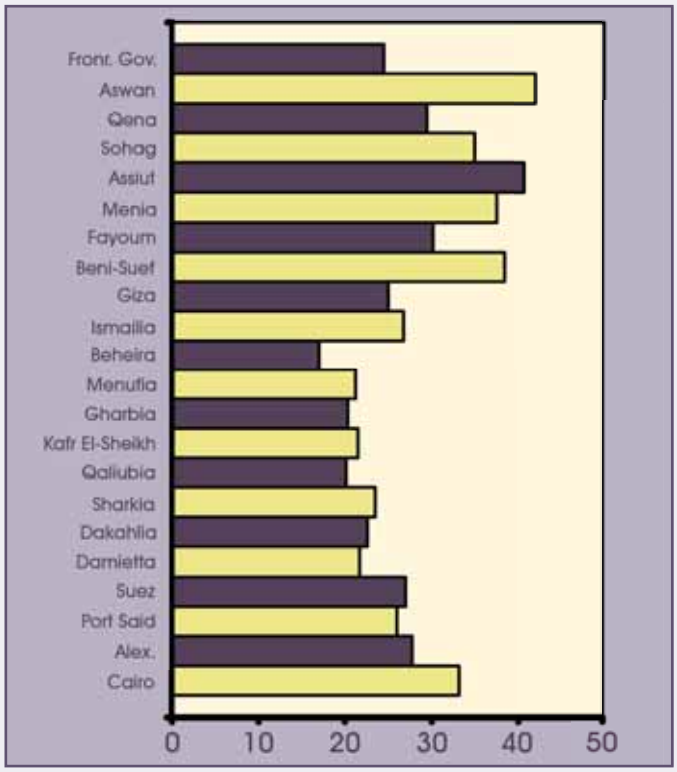
Region	2015 current	2015 current	2015 accel.	2015 accel.
	IMR	U5MR	IMR	U5MR
Urban	14.6	15.8	8.3	8.7
Lower Gover.	17.6	20.5	10.1	11.3
Lower Urban	15.7	18.2	9.0	10.1
Lower Rural	18.3	21.3	10.5	11.8
Upper Gover.	27.7	31.4	15.9	17.4
Upper Urban	21.1	22.9	12.1	12.6
Upper Rural	30.1	34.5	17.2	19.1
Total	**21.3**	**24.3**	**12.2**	**13.4**

Measles and its complications, particularly diarrhoea and pneumonia, are the main causes of childhood mortality. It is therefore no surprise that the proportion of children immunized against measles is one of the indicators for the goal of reducing child mortality. There has been noticeable progress in immunization coverage for measles. It increased from 89 percent in 1995 to 97 percent in 2000. The proportion of children 12-23 months receiving measles vaccine is higher than that of children who are fully immunized (table 2A).

Historically, Egyptian mothers have been aware of the negative effects of measles on child health and survival. In the 2003 Egypt Interim Demographic and Health Survey (EIDHS), vaccination againt measles reached 95.6 percent, slightly less than the 2000 EDHS figure. It is expected that Egypt achieves the goal of full measles immunization by 2015 if the rate of progress remains the same as that between 1995 and 2000 (see table 2B). It should be noted that the MDG for measles vaccination coverage is targeting children aged 0-12 months. The

expanded program of immunization in Egypt recommends measles vaccination at the age of nine months but some recommend postponing vaccination till the age of 12-15 months to ensure complete waning of maternally acquired immunity. Table 2B shows trends in measles vaccination by region from 1992 to 2003 and targets for 2015 at the current rate of progress.

Fig. 2: Infant Mortality in Egypt EDHS 2000 by Governorates in 2001



Source: *CAPMAS*

STATUS AT A GLANCE

Will target be reached by 2015?
Probably Potentially Unlikely Insufficient Data

State of supportive environment
Strong Fair Weak but improving Weak

Table 2A: Percentage of Children 12-23 months fully immunized and those receiving only measles vaccines by place of residence

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

Source: *EDHS 2003.*

Table 2B shows trends in measles vaccination by region from 1992 to 2003 and targets for 2015 at the current rate of progress. Figure 4 shows the target for measles immunization by 2015.

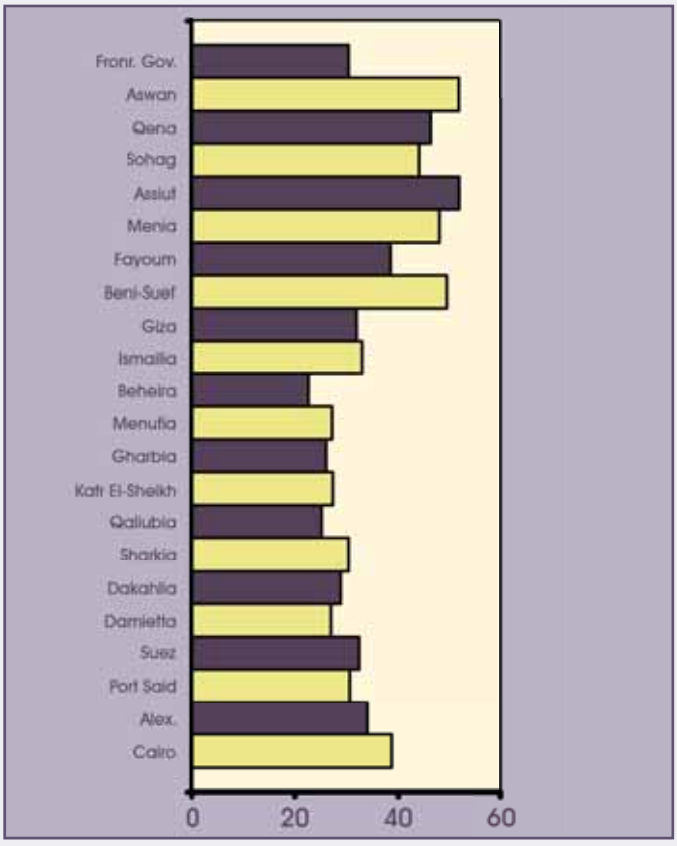
The MOHP is conducting regular campaigns and is providing a fourth dose of the Polio vaccine to help eliminate the infection. To ensure wider coverage and more effective vaccination, 65.5 percent of targeted children received the extra dose. According to EIDHS 2003, coverage in Upper Egypt seems to be higher than in Lower Egypt. This is possibly a result of efforts over the past years to target Upper Egypt in order to decrease the gaps between geographical areas.

Table 2B: Trend in Measles Vaccination among 12-23 Month Old Children in the Years 1992, 1995, 2000 & 2003, & 2015 Targets

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

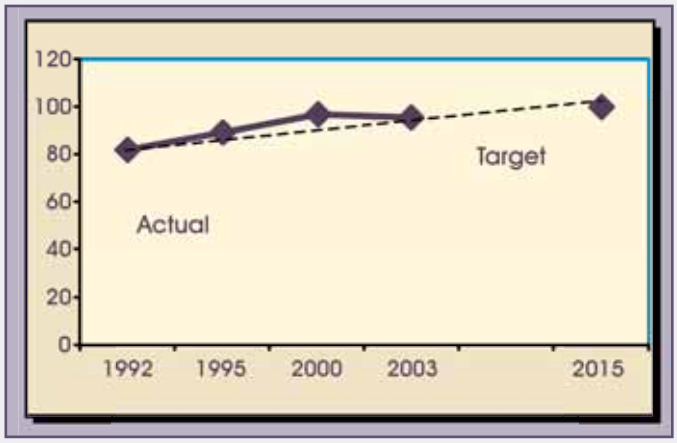
Source: *EDHS 1992, 1995, 2000 & 2003.*

Fig 3: Under Five Mortality Rate by Governorates in 2001



Source: *CAPMAS.*

Fig. 4: Actual and Target of Proportion of 12-23 Months Old Children Immunized Against measles



Source: *CAPMAS*

2. Major Challenges

Discrepancies in performance indicators between geographic areas remain a challenge to the health system. Upper Egypt, especially rural areas, shows lower performance than all other geographic areas of the country. Rural Upper Egypt is expected to remain the only geographic area that does not reach the national target for infant mortality rate. Several factors are responsible for this slow improvement including socio-economic and cultural factors. In addition, rural Upper Egypt has the poorest development indicators compared to the rest of the country. Discrepancies also result from inequitable distribution of trained human resources as well as financial allocations to health services in the governorates. Physicians tend to concentrate in urban areas and a rapid turn over of personnel is usually noticed in rural areas. Gender gaps were also recorded in under-five mortality rate as a result of some cultural preferences for boys particularly noticed in poor families. Other challenges related to the health care delivery system include poor supervision of service delivery and the sub-standard level of care provided.

Another challenge is the availability of reliable data on infant and child mortality and on childhood diseases. Collecting reliable information on the number of infant deaths is not easy. Improving data collection through MOHP facilities at a decentralized level is essential to identify causes of death by governorate and plan accordingly. Health care providers are not well trained to collect data in proper forms nor do they value the importance of information gathered at the level of service provision. In addition, there are several forms that providers are required to complete creating an added burden to the many tasks they have to carry out. Currently there are different sources of data on infant and under five-child mortality at the national level. The two most reliable are those of the MOHP and the Egypt Demographic and Health Survey[5].

Acute Respiratory Infections (ARI) that have now shifted from being the second to become the first cause of IMR and U5MR need to be particularly targeted. Enhancing access to information about home management, sources of treatment and ensuring the continuous availability of low cost effective drugs are essential measures to reduce their complications. Diarrhoeal diseases are still a major problem for child morbidity and sustaining the achievements of reducing their contribution to IMR and U5MR requires a continuation of the past efforts of increasing knowledge and use of Oral Rehydration Therapy (ORT). This is particularly important as some studies have shown a decline in the use of ORT.

Although Egypt has achieved good progress in terms of measles vaccination coverage, the Expanded Program of Immunization still faces major challenges. Eradication of poliomyelitis is one of them. Although the government is committed to reach 100 percent coverage of all children below 24 months with the Polio vaccine in order to achieve other universally declared health goals, the rapid population growth coupled with the poor sanitary conditions seem to be an obstacle. A case of Acute Flaccid Paralysis resulting from poliomyelitis was recorded in 2003.

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

3. Supportive Environment

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

The Diarrhoeal Disease Control Program and components of the Child Survival Project started as donor funded programs but became fully institutionalized in the Ministry and were integrated with other activities such as those mentioned above. Other programs such as family planning, antenatal care, and immunization of pregnant mothers against neonatal tetanus play a major role in lowering neonatal mortality.

MOHP is now supporting programs for emergency obstetric care and neonatal units and linking those pro-

grams to Primary Health Care and Maternal and Child Health services. Such programs contribute to the reduction of neonatal mortality.

The "Healthy Mother, Healthy Child" project is focusing on Upper Egypt. Providing neonatal and maternal care, it positively affects neonatal and maternal mortality rates. Neonatal mortality accounts for more than half of IMR – curbing this line will therefore lead to a significant decline in the total IMR. Nutritional programs such as iron supplements for pregnant mothers, fortifying subsidized bread with iron, iodization of salt and breastfeeding programs are improving the nutritional status and reduce nutritional deficiencies. Still, they do not fully address the problem of under weight and wasting, which contribute to ill health and repeated infections. Such problems could be captured with better implementation of growth monitoring activities.

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

4. Priorities for Development Assistance

- Improve access to quality health care services and support initiatives to build capacities for health planning and financing at the decentralized district level.

- Strengthen the identified weak points of the health system to combat childhood illness and consolidate the gains achieved.

- Develop public/private partnerships and strengthen NGOs to provide basic child health services and contribute to raising health awareness in the community.

- Identify methods of increasing community involvement in funding and regulating service provision at the local level.

5. Tracking in Reducing Child Mortality: Monitoring and Evaluation

Elements of Monitoring Environment	Assessment		
Data gathering capacity	**Strong**	Fair	Weak
Quality of recent survey information	**Strong**	Fair	Weak
Statistical tracking capacities	**Strong**	Fair	Weak
Capacity to incorporate statistical analysis into policy, planning & resource allocation mechanisms	Strong	**Fair**	Weak
Monitoring & evaluation mechanisms	Strong	**Fair**	Weak

Endnotes

1 - UNICEF

2 - UNICEF and CAPMAS, 1999

3 - El- Zanaty and Associates and ORC Macro,2003

4 - UNICEF, Egypt, and CAPMAS

5 - Their difference in figures is mainly due to the method of data collection. EDHS capturing more accurately the neo natal mortality rate (mortality of infants less than one month of age), since the survey is conducted at the household level, and includes those infants who die early in life before they are issued a birth certificate. These deaths are therefore missing from official birth and death registration data.

5. IMPROVE MATERNAL HEALTH

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Target 6: Reduce by 3/4 , between 1990 and 2015, the maternal mortality ratio
Indicators: Maternal mortality ratio
Proportion of births attended by skilled health personnel
Contraceptive prevalence rate

1. Status of Progress

Egypt was host to the 1994 International Conference on Population and Development and committed itself to an agenda for a holistic approach to reproductive health in a primary care setting. Egypt's goals are to reduce the Total Fertility Rate (TFR), reduce maternal mortality ratio and improve pregnancy outcomes through increased number of regular ante-natal care visits and the proportion of births attended by skilled personnel.

Although the total fertility rate and Contraceptive Prevalence Rate (CPR) are not part of the globally agreed indicators, Egypt emphasizes progress in those two indicators as priority to implement its national policy of reducing population growth. In addition, reduction of total fertility and the use of contraceptives to space births have a positive effect on maternal health and contribute to the reduction of maternal mortality. They also reflect the quality of reproductive health services in the primary care setting. Since 1990, the TFR has been slowly declining from 4.1 in 1990 to 3.5 in 2000. Additional decline in TFR to 3.2 was shown by EIDHS 2003.

Egypt's target is to reach TFR of 2.1 in 2017. This requires accelerated efforts to increase contraceptive prevalence and reduce total fertility. The contraceptive prevalence rate is currently at 60 percent (56.6 percent modern methods) of married women. This is below the target required for a decline in population growth. The surveys of 1992, 1995 and 2000 likewise showed that almost 29 percent of women discontinue the use of a modern method within 12 months of marriage, mostly due to reasons that could be avoided by proper counseling. The table shows a leveling in CPR between 1991 and 1995 and a noticeable but relatively slow improvement between 1995, 2000 and 2003.

Table 1: Trends in CPR and TFR and target for 2017

Year	CPR	TFR
1991	47.6	4.1
1992	47.1	3.9
1995	47.9	3.6
2000	56.1	3.5
2003	60	3.2
2017	*72*	*2.1*

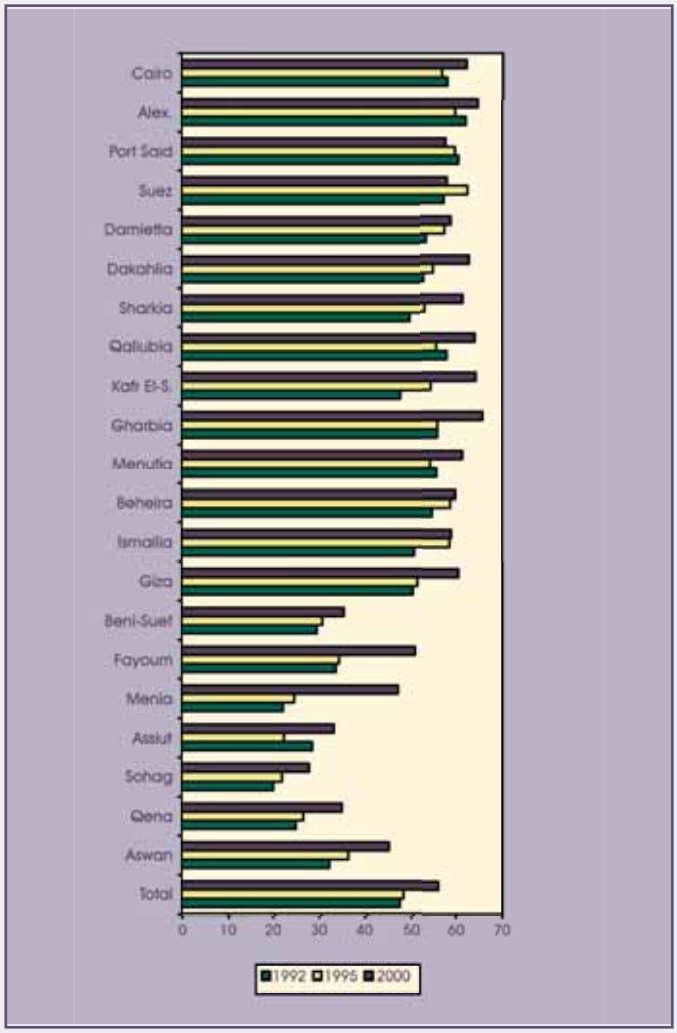
Source: *EDHS 1991- 2003*

There are large gaps in CPR between governorates. All Upper Egypt governorates have lower CPR than the national

average, especially the governorates of Suhag, Assiut, and Quena. This could be connected to less resources, both technical and financial, lower female literacy, and participation in the formal labor sector, and the prevalence of the cultural norm of having many children.

Figure (1) shows that all Lower Egypt governorates exceed the national average indicating better quality of health services and higher female education than Upper Egypt. Still, all governorates without exception have seen improved access to family planning services, including the least performing governorate of Suhag, which improved in CPR by almost 6 percent between 1995 and 2000.

Fig. 1: Percentage of Currently Married Women of Reproductive Age, Using Family Planning Method by Governorate in 1992, 1995 and 2000



Source: *EDHS 1992, 1995 &2000.*

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

Egypt has to accelerate its family planning program to reduce population growth and its negative impact on socio-economic indicators. A focus on Upper Egypt is essential to achieve such a goal aiming at improving CPR to as close as possible to current national figures. In this case the national level of CPR could reach 70 percent. Egypt conducted two national studies to measure maternal mortality in the years 1992/93 and 2000, respectively. The National Maternal Mortality survey of 1992/93 showed the maternal mortality ratio (MMR) in Egypt to be 174 maternal deaths per 100,000 live births. In the year 2000, the National Maternal Mortality Study showed a dramatic decrease in the ratio reaching 84 maternal deaths per 100,000 live births. In 2002 the MOHP data showed a further decline to 75/100,000 live births, less than 50 percent below the previous findings in the 1992 survey.

Maternal death was found to occur more commonly within 24 hours of delivery (49 percent of cases) and was caused primarily by preventable factors (92 percent in 1992 and 81 percent in 2000). Substandard care provided by obstetricians was the most commonly reported factor in the two studies (47 percent and 43 percent respectively) followed by delay in seeking professional care (42 percent and 30 percent) and unavailability of blood for transfusion (6 percent and 16 percent). Some governorates, such as Suez, Aswan, and Assiut, which were studied in the two surveys showed marked improvements in maternal mortality ratio reaching to almost 70 percent, 50 percent, and 90 percent reductions, respectively. Such achievements raise hopes that Egypt can reach the MMR goal of 43.5/100,000 by the year 2015. Table 2 shows MMR by region for the years 1992/93, 1997, and 2000.

The MMR will be expected to reach 43/100,000 live births in the year 2015 if the rate of decline remains as constant as the rate between 1997 and 2000. This figure is just barely below the 3/4 reduction (43.5/100,000) of the 1992 figure and hence the goal for MMR would be achieved.

Provided that the health system continues to provide quality maternal health services such as increased utilization rates for antenatal care and increased number of births attended by skilled health professionals (69 percent), it is estimated that the maternal mortality ratio will continue to decline and be below 43.5 - and the MDG target will be achieved.

An increase in the use of contraceptives will also reduce maternal mortality rate from induced abortions, reducing unwanted pregnancies, and pregnancies after the third child which will all positively impact mothers' health. If we assume even better performance, Egypt will reach MMR of 40/100,000 and hence, well exceed the targeted indicator. Table 2 shows trends and projections for maternal mortality ratio.

Egypt Development and Health Survey data show that only 22.5 percent and 36.7 percent of pregnant women in 1992 and 2000, respectively, attended an adequate number of ante-natal care visits. This number reached 56 percent in 2003 (Egypt Interim EDHS) with an observed increase in visits to government facilities. This reflects the efforts of MOHP in upgrading service delivery and improving quality. Ante-natal care is essential for early detection of complication while it reduces complications at delivery and both neonatal and maternal mortality.

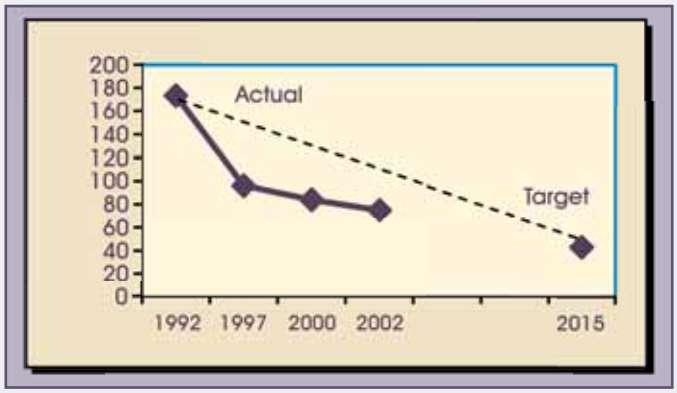
Table 2 : Maternal Mortality Ratio by Region in 1992/93,1997, 2000, 2002, and Projections for 2015

Region	92/93	1997	2000	2002*	2015	
					**	***
Urban Governorate	233	122	48			
Lower Egypt	132	91	93			
Upper Egypt	217	92	89			
Frontier	n/a	n/a	120			
Total	**174**	**96**	**84**	**75**	***43***	***40***

Source: *1992/93: National Maternal Mortality Survey; 1997 and 2002: MOHP; 2000: National Maternal Mortality Study*
** Data only available at national level*
*** Current rate of progress*
****Accelerated progress*

The proportion of births attended by skilled personnel has increased over the years, as shown by EIDHS data for the regions and governorates. Table 3 shows the proportion of births attended by skilled health care personnel by region for the latest rounds of EDHS. The rise in this proportion reflects improvement in health service provision and an increased awareness in the community of the high risks associated with births in inappropriate environment or in the absence of trained midwives, nurses or physicians.

Fig. 2: Actual and Target Maternal Mortality ratio



Source: *CAPMAS*

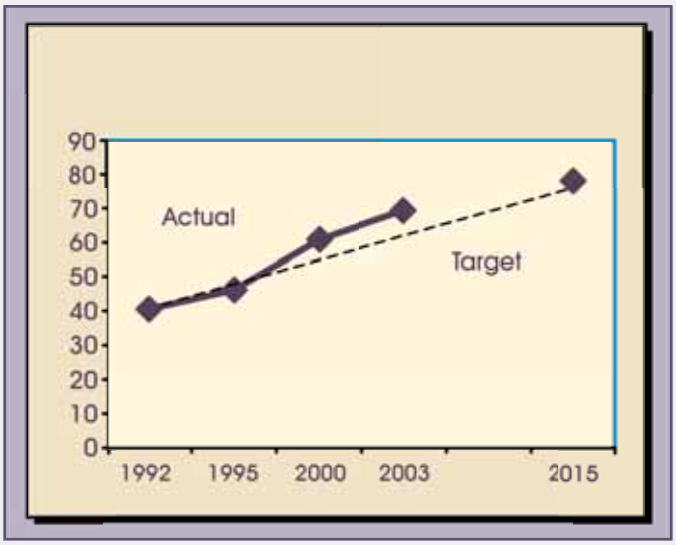
Table 3 shows an increased trend in seeking professional assistance during delivery in all regions of the country and the rural/ urban divisions. Fewer women in rural Upper Egypt seek professional help compared to the rest of the country including the culturally conservative Frontier governorates. Assuming that seeking the care of skilled health personnel during birth remains at current levels it would be expected that in 2015 coverage could reach 100 percent in urban governorates and urban Lower Egypt and almost 96 percent in urban Upper Egypt.

Table 3: Proportion of Births Attended by Skilled Personnel in 1992, 1995, 2000, 2003 and Projections for 2015 at Current and Accelerated Rate of Progress

Region	1992	1995	2000	2003	2015 *current*	2015 *accelerated*
Urban Governorate	68.3	69.2	83.7	90.2	*100*	*100*
Lower Egypt	39.7	51.4	65.1	76.5		
Urban	62.9	75.1	84.7	91.0	*100*	*100*
Rural	32.5	43.9	58.1	70.9	*74.5*	*81.3*
Upper Egypt	29.7	32.2	47.8	55.3		
Urban	51.8	59.6	74.7	77.4	*96*	*100*
Rural	23.0	22.9	38.2	47.6	*49*	*53.4*
Frontier	n/a	59.3	60.4	n/a	*77.5*	*84.5*
Total	**40.7**	**46.3**	**60.9**	**69.4**	***80***	***84***

Source: *EDHS.*

Fig. 3 Actual and Target of Proportion of Births Attended by Skilled Health Personnel



Source: *CAPMAS*

Meanwhile, seeking professional assistance during delivery in rural areas of both Lower and Upper Egypt, and the frontier governorates would be only 74.5 percent, 49 percent and 77.5 percent, respectively. It would be necessary to hasten the pace in rural Upper Egypt by introducing quality services that cater to the cultural needs. With a strengthened approach to maternal health that leads to a better performance, it is possible to achieve 100 percent coverage of all urban areas and 81.3 percent, 53.4 percent and 84.5 percent coverage in Lower, Upper rural and Frontiers, respectively. Rural Upper Egypt would not be able to fulfill the goal by 2015. Figure (3) shows trends in

the proportion of births attended by skilled personnel and target for 2015.

STATUS AT A GLANCE
Will target be reached by 2015?
Probably Potentially Unlikely Insufficient Data
State of supportive environment
Strong Fair Weak but improving Weak

2. Major Challenges

Several challenges to improving maternal health are attributed to non-health related elements particularly cultural attitudes encouraging early marriage, early pregnancy, and short spacing between pregnancies. Couples, particularly in rural areas of Upper Egypt, seldom respect the two-years spacing that is advocated for by the family planning program. Almost 25 percent of pregnancies occur before the 24 months period recommended for spacing.

Preference for boys contributes to an increased number of repeated un-spaced pregnancies. Several other indicators related to the use of family planning services raise concerns, particularly the very slow decline in the proportion of women with unmet needs, which fell from 16 percent in 1995 to almost 12 percent in 2000. Also, the EDHS showed that 18.4 percent of births were not wanted at the time of conception. The rate of discontinuation of a method within a 12 months period of beginning use is very high and almost constant since 1992 (29 percent) indicating the need for a new approach to service provision. Discontinuation rate was 29.5 percent in 2000 and 29.8 percent in 1995.

Although the MOHP ensures continuous supply and provision of contraceptives through MCH and PHC centers, the availability of Intra-Uterine Device (IUD), which is the most commonly used method in Egypt, still relies on donor's funding for continuous availability.

It should be noted that tackling population policies and strategies is multi-disciplinary and requires the mobilization of several Ministries and community based organizations in order to have a more integrated and sustainable approach to the issue. Funding of family planning programs must be secured from national resources and health providers must be trained to provide quality services to attract and retain clients.

Another challenge is the quality of the training of medical professionals and their ability to follow guidelines in service delivery. Programming must target priority areas where interventions can yield quick results.

Religious figures and community leaders play an important role in shaping people's perceptions of family planning and the use of modern contraceptives. Female illiteracy is another factor influencing women's access to health care and their ability to make decisions. However, EDHS showed that decisions related to the use of family planning are usually joint decisions of man and wife.

3. Supportive Environment

Improved attendance in ante-natal care in the public sector and the increased proportion of births attended by skilled health personnel in all geographic areas reflect an improvement in the quality of services in government health facilities and a commitment to achieve the goals.

Reduction of population growth is the priority policy issue for GoE as it impacts all developmental efforts in the social and economic fields. The Government of Egypt and NGOs are playing a key role in pushing forward the agenda for reproductive health, family planning and reproductive rights.

The National Council for Women (NCW) is playing a role in ensuring gender equity in access to health care. The National Council for Childhood and Motherhood (NCCM) led Girls Education Initiative will help girls and women to improve their access to information and their decision-making power. Many NGOs are providing reproductive health services and are working with the National Council for Childhood and Motherhood to eliminate female genital mutilation (FGM).

The MOHP is currently implementing and testing several programs on emergency and essential obstetric care in many governorates particularly in Upper Egypt. MOHP is also ensuring that maternal care remained an essential component of the basic benefits package of services developed for the health sector reform initiative.

4. Priorities for Development Assistance

- Develop the capacity of the health team and expand the programs on emergency and essential obstetric care to reduce maternal mortality.

- Target groups with highest needs for family planning and improve the quality of service delivery particularly counseling programs to reduce high discontinuation rates within the first twelve months of use.

- Develop media campaigns to specifically target rural Upper Egypt from a culturally sensitive approach to family planning.

- Improve maternal health services and develop models to test several packages of maternal and reproductive health and scale-up successful models of the "Healthy Mother, Healthy Child" project in Upper Egypt.

5. Tracking in Maternal Health: Monitoring and Evaluation

Elements of Monitoring Environmental	Assessment		
Data gathering capacity	Strong	**Fair**	Weak
Quality of recent survey information	Strong	**Fair**	Weak
Statistical tracking capacities	Strong	**Fair**	Weak
Capacity to incorporate statistical analysis into policy, planning & re-source allocation mechanisms	Strong	**Fair**	Weak
Monitoring & evaluation mechanisms	Strong	**Fair**	Weak

6. COMBAT HIV/AIDS, Malaria & Other Major Diseases

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Target 7: Have halted by 2015, and begin to reverse, the spread of HIV/AIDS
Indicators: HIV prevalence among 15-24 year old pregnant women
Condom use rate of the Contraceptive Prevalence Rate
Number of Children Orphaned by HIV/AIDS

Target 8: Have halted by 2015 and begun to reverse the incidence of Malaria and other major diseases
Indicators: Prevalence of Malaria
Prevalence of tuberculosis and proportion of cases detected and cured under DOTS (Directly Observed Treatment Short Course)

1. Status of Progress

Efforts towards the eradication of Malaria and Tuberculosis, two of the major health challenges for the Millennium, are showing good progress in Egypt. Malaria has been well controlled over the past ten years. The incidence declined from four cases to almost zero per thousand population between the years 1990 and 2000. WHO reported 87 percent Directly Observed Treatment Short Course (DOTS) treatment success in Egypt for 1999 and 2000, which is a higher proportion than the target of 85 percent. Egypt has also achieved 63 percent case detection of the sputum positive cases and has a strategy to reach 70 percent. Prevalence of TB in the population is currently at around 32 cases per 100,000 inhabitants and Egypt's goal is to reach 22 cases per 100,000 inhabitants.

Egypt, on the other hand, is facing an epidemic of Hepatitis C. The exact prevalence rate is not known but the MOHP estimates, based on national survey results, that 7 to 9 percent of the population are carriers (Hepatitis C antibody positive)[1]. Surveys in Luxor, Qena and Sharkia showed prevalence between 50 to 57 percent in a number of villages. Hepatitis C is a blood borne pathogen of high virulence and has the ability to survive on contaminated instruments for long periods. It shares with HIV/AIDS many of the modes of transmission. Like HIV/AIDS, it does not have an effective treatment and causes death due to liver failure or hepatic cancer. The high prevalence of Hepatitis C and the fact that it shares some modes of transmission similar to HIV indicates that the risk of uncontrollable epidemic of HIV/AIDS might be possible if its prevalence in the population rises.

Achieving the goal of reducing the prevalence of Hepatitis C and reversing its spread requires several coordinated efforts including raising public awareness and a strong infection control program at the national level. Such efforts are still being piloted and need the development and continuous review of infection control guidelines suited to all levels of health service delivery in addition

to strengthening the capacity of health care providers. It is difficult to assess progress to date or provide estimates for the situation in 2015.

The incidence of Hepatitis B is decreasing as a result of including the anti-Hepatitis B vaccine in the expanded program of immunization for children in addition to making it available for high risk groups and the public in general.

Schistosomiasis, another commonly prevalent disease in Egypt, which causes severe complications including urinary bladder cancer, is now declining as a result of the efforts of MOHP over the past years in particular the generalization of the one dose oral treatment. The one dose treatment shows high effectiveness with urinary schistosomiasis (90 percent) and lower effectiveness with the intestinal type (60-70 percent). The MOHP reports a decline in the prevalence of schistosomiasis, which is now only found in scattered areas of some governorates and is no longer a threat to public health. According to MOHP the prevalence of intestinal schistosomiasis dropped from 14.8 per 100 population to 2.7 between 1990 and 2000. Similarly, the prevalence of urinary schistosomiasis dropped from 6.6 to 1.9 over the same period. Those figures, however, reflect the number of patients seeking care in public facilities and are not validated by independent research. The epidemiological pattern of schistosomiasis has changed and it now appears in small scattered foci. In addition, research has showed that since 1997 intestinal schistosomiasis, which was only found in the Delta, now also seems to be appearing in Upper Egypt in the governorates of Giza, Menya, and Assiut as a result of the changed irrigation system.

Egypt remains a low prevalence country for HIV/AIDS. Since the establishment of the National AIDS Program (NAP) in 1986 as a unit in the Ministry of Health (now Ministry of Health and Population "MOHP"), less than two thousand persons were diagnosed as HIV positive or AIDS cases, including 574 foreigners[2]. UNAIDS estimated that there were 12,000 cases by the end of 2003, a prevalence rate below 0.01 percent of the population. In spite of the low prevalence, public awareness about the problem is still considered to be insufficient.

Although there is no institutionalized surveillance system to continuously monitor the incidence and prevalence of HIV/AIDS, the central laboratories of MOHP annually examine around 150,000 individuals for both HIV and Hepatitis, a requirement to apply for work permits abroad. In addition, around 6,000- 10,000 persons undertake voluntary testing every year.

HIV/AIDS infections in Egypt are mostly of type I. They result from sexual transmission in 65 percent cases. 81 percent of all infections and cases identified to date are male. Mother to child transmission is still very rare (less than ten cases) and no cases were detected in the year 2003. Past efforts were made to test women attending ante-natal care but the lack of prevalence among them, at the time, made the efforts very costly and ineffective in detecting cases in the community at large. If the low prevalence among pregnant mothers continues, the Millennium indicators of HIV prevalence among 15-24 year old pregnant women and the number of children orphaned by HIV/AIDS would not be significant in the Egyptian context.

Governorate level data are not readily available. Many governorates identified their first HIV/AIDS cases following outbreaks in renal dialysis units. Each of the 26 governorates and Luxor have a part-time local manager for the HIV/AIDS program under the supervision of the director of the National AIDS Program (NAP). An assessment study conducted by NAP in 2002 found that technical and administrative capacities of governorate level managers vary widely.

In spite of the fact that the majority of cases are sexually transmitted, the use of condom as a method of prevention is still insignificant. Prevention strategies, including condom programs, need to be fostered, while taking fully into account the local and cultural context. Surveillance for sexually transmitted diseases (STDs), a common risk factor for HIV/AIDS transmission, is weak and true figures for their prevalence are not available at the central or governorate levels. Most patients of STDs prefer to seek care in the private sector to ensure privacy and confidentiality. Condom use as a contraceptive in the family planning program is negligible and is declining dramatically (table 1). Cultural and religious norms restrict the distribution of condoms to only married women, who request them. There is no data on condom use in non-marital relations or among youth. Condoms are mainly imported by the private sector and the MOHP. Around 5 million condoms were distributed to pharmacies and health facilities in the year 2003 but data on their utilization or the type of clients who buy condoms is not available.

Table 1: Trends in the Prevalence of Condom Use Among Married Couples.

Year	1992	1995	2000	2003
% Condoms	4.2	2.9	1.7	0.9

Source: *EDHS 1992 –2003.*

2. Major Challenges

The challenge with Hepatitis C is its high prevalence and underestimation of its true magnitude. Many carriers of Hepatitis C live normally without any symptoms - while being capable of transmitting the infection. Almost 30 percent of the infection occurs at the community level, making it a disease that needs a communication strategy

for behavioral change. In addition, the cost of testing for Hepatitis C is very high making continuous community-based surveys very expensive to conduct.

The current system for measuring the prevalence of schistosomiasis is focusing on some areas of identified risk and neglecting others. Surveillance is not enforced particularly with the low reported prevalence rates. Egypt should work to prevent the re-emergence of schistosomiasis by enforcing treatment protocols and follow-up and strengthening surveillance in endemically infected areas.

Although Egypt managed to eliminate Malaria it is geographically close to countries where Malaria is still endemic and must therefore remain alert to prevent the entrance of infected individuals. Efforts are required to continuously control the mosquito breeding areas and to cover all areas of the country with a good sewage system.

The goals for Tuberculosis can be achieved but challenges related to individual behavior such as smoking and sharing shisha (traditional water pipe) need to be changed. Over-crowding, poor ventilation in houses, and poor nutrition also increase the chances of infection.

The very low prevalence of HIV/AIDS somehow reduces the urgency to prioritize prevention and control programs. The NAP also needs to strengthen its capacity in data collection and analysis, policy formulation, strategic planning and program implementation at the governorate level.

An assessment of the situation and the current response, conducted by the UN Expanded Theme Group on HIV/AIDS and the NAP during 2003, confirmed that regardless of the current low prevalence, Egypt presents risk factors that must be adequately addressed in order to prevent any possible outburst in the future.

Focused policies and strategies are therefore needed to provide care for affected individuals and counseling to their families, and to reach high risk groups such as commercial sex workers, intravenous drug users, and men who have sex with men. Outreach and counseling to HIV positive individuals should also be fostered.

Because of the cultural traditions of the Egyptian society, HIV/AIDS is considered to be a very sensitive issue and it is therefore difficult to raise awareness about it among the population. Important target groups, such as youths and high-risk groups are often not adequately reached. Treatment of affected individuals is limited to the opportunistic infections, and antiretroviral therapy remains largely unavailable. Efforts to negotiate the purchase of low-cost anti-retroviral therapies should become part of the priorities of the NAP.

Systematic surveillance to identify cases and contacts at early stages do not function well yet. Many individuals with sexually transmitted infections, associated with an increased risk of HIV/AIDS, currently seek care in the private sector and these cases are neither reported nor followed-up.

Voluntary counseling and testing services are still in the development stage. A system for ensuring anonymous testing is necessary to build trust of the clients. The prevention of HIV/AIDS requires an integrated approach and the collective efforts of other line Ministries such as Education, Interior, Youth, and Information. Also, identifying sources of financing the program from MOHP resources is essential to sustain and expand the effectiveness of the program.

The development and strict application of infection control guidelines form a major challenge for preventing the spread of Hepatitis C, HIV/AIDS and other communicable diseases in health care settings, such as dialysis units. Implementation of such guidelines will require intensive training of health care providers and introduction of the guidelines in undergraduate curricula and at all levels of providers' training.

3. Supportive Environment

STATUS AT A GLANCE

Will target be reached by 2015?
Probably* Potentially Unlikely **Insufficient Data****

State of supportive environment
Strong* Fair **Weak but improving**** Weak

Malaria, TB, and schistosomiasis.
****HIV/AIDS, Hepatitis C***

The MOHP ensures testing of all blood and its products for HIV and Hepatitis B and C, which improved blood safety. An infection control unit was established within MOHP and is now in the process of developing national guidelines which when implemented will reduce the risk of transmission of blood borne pathogens such as HIV/AIDS and Hepatitis.

Egypt has committed to all the international agreements pertaining to HIV/AIDS such as achieving the MDG and the declaration of commitment against AIDS[3].

The MOHP also supports media messages to raise awareness of the population on modes of transmission and prevention of blood borne pathogens and HIV/AIDS.

The UN is currently supporting the National AIDS Program in formulating a National Strategic Plan.

An AIDS hotline functions 12-hours a day, providing assistance to individuals of all age groups and backgrounds. The staff of the hotline are well trained and their services are accessed by many callers inside Egypt and in the Arab world.

Religious leaders in Egypt, as in the rest of the Arab region, are starting to pay more attention to HIV/AIDS and its implications, in order to support current efforts to increase public awareness, while promoting the local culture and traditions.

Treatment for Schistosomiasis and Tuberculosis is available and widely accessible to all patients.

Egypt continues to ensure that it remains a Malaria free zone.

4. Priorities for Development Assistance

- Establish functioning surveillance systems for HIV/AIDS, Hepatitis C and other STDs

- Strengthen the capacity of the NAP at the central and governorate level in policy formulation, planning and program implementation.

- Promote a multi-sectoral approach to HIV/AIDS.

- Raise public awareness and adopt communication strategies for behavioral change to lower the incidence of Hepatitis C infection and maintain HIV/AIDS at current low levels.

- Support NGOs and expand their role in raising awareness for the prevention of HIV and reduce stigma and discrimination.

- Develop and strengthen the capacity of service providers, both public and private, to diagnose, report and manage sexually transmitted infections.

- Continue the initiated efforts to develop infection control guidelines and follow-up on their implementation.

- Pilot services for voluntary counseling and testing.

5. Tracking Progress in Malaria, Tuberculosis and Schistosomiasis & HIV/AIDS and Hepatitis B & C Spread: Monitoring and Evaluation

Elements of Monitoring Environmental	Assessment		
Data gathering capacity	**Strong**	Fair	**Weak**
Quality of recent survey information	**Strong**	**Fair**	Weak
Statistical tracking capacities	**Strong**	Fair	**Weak**
Capacity to incorporate statistical analysis into policy, planning & resource allocation mechanisms	**Strong**	Fair	**Weak**
Monitoring & evaluation mechanisms	Strong	**Fair**	Weak

***Blue**: Malaria, Tuberculosis and Schistosomiasis*
***Red**: HIV/AIDS and Hepatitis B & C Spread*

Endnotes

1 - MOHP" Ministry of Health and Population".

2 - To date, 1343 HIV/AIDS cases has been reported. NAP, 31.3.2004

3 - UNGASS (United Nation General Assembly Special Session on HIV/AIDS), June 2001

7. ENSURE ENVIRONMENTAL SUSTAINABILITY

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Target 9: **Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources**

Indicators: *Proportion of land area covered by forest*
Land area protected to maintain biological diversity
GDP per unit of energy use (as proxy for energy efficiency)
CO2 emissions (per capita) (+2 figures of global atmospheric pollution ozone depletion and the accumulation of global warming gases)

Target 10: **Halve, by 2015, the proportion of people without sustainable access to safe drinking water**

Indicator: *Proportion of population with sustainable access to an improved water source*

Target 11: **By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers**

Indicators: *Proportion of people with access to improved sanitation & secure tenure*

1. Status of Progress

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

The most significant impacts on health and quality of life are caused by urban air pollution, especially in Cairo, followed by diarrhoeal diseases leading to mortality. The latter primarily affects children, and is caused by lack of access to safe water and sanitation, inadequate domestic personnel, and bad food hygiene.

The National Environmental Action Plan 2002/2017 recognizes the gravity of Egypt's multifaceted environmental problems, and emphasizes the changes needed in areas of water, sanitation, energy and biodiversity. The National Plan of 1997-2017 states that the ultimate goal is "attaining development that is economically, politically, and environmentally sustainable". The Ministry of Environmental Affairs seeks integrating the environmental dimension in all national policies, plans, and programs relevant to the protection of human health and management of national resources.

It aims to preserve the national resource base, national heritage, and biodiversity within context of sustainable development. Also, the Ministry aims to reduce current

pollution levels and thereby minimize health hazards and improve the quality of life.

Yet, the impact of the government's efforts to address these problems have had limited impact so far.

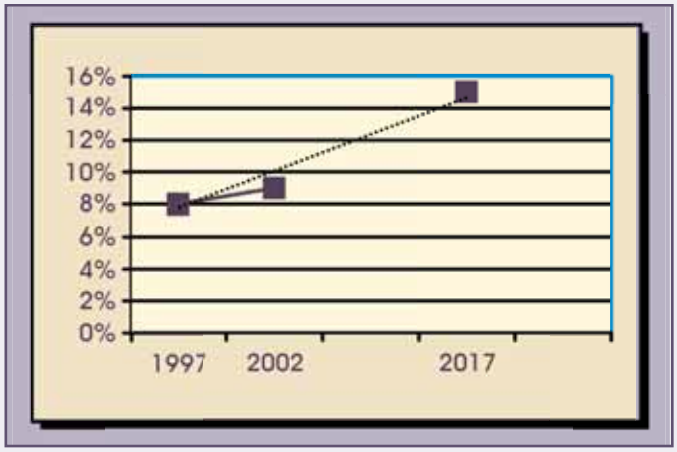
Natural protectorates: Egypt is endowed with a rich natural heritage, which the government of Egypt seeks to conserve for the benefit of present and future generations. At present, there are 23 protectorates covering about 9 percent of the country's total territory[2].

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

Climate change: In 2000/2001 CO2 emissions per capita reached 1.7 tons compared to 2 tons in 1999 and 1.1 tons in 1980. Egypt is 92 percent dependent on fossil fuels. GDP per unit of energy is currently at 6.33 Kgoe (Kilogram Oil Equivalent) compared to 4.8 Kgoe in 2000 and 3.9 Kgoe in 1990. The main source of GHG emissions is fuel combustion in the energy sector (22 percent), in industry (21 percent), in the transport sector (18 percent), and in the agricultural sector (15 percent)[3].

Compared to industrialized countries Egypt's CO2 emissions are still considered low, and are insignificant on a global level. At the same time, Egypt is one of the countries to which the global climate change represents a real threat due to Egypt's densely populated areas. Further development of projects to reduce the GHG emissions would offer an opportunity for Egypt to upgrade the country's energy, transportation, and industrial sectors. One such project has been Carbon Dioxide Sink actions - planting trees and thereby increasing the country's CO2 absorptive capacity.

Fig. 1: Percentage of Area Covered by Natural Protectorates and Government Target for 2017



Source: *The Egyptian National Environmental Action Plan 2002/2003.*

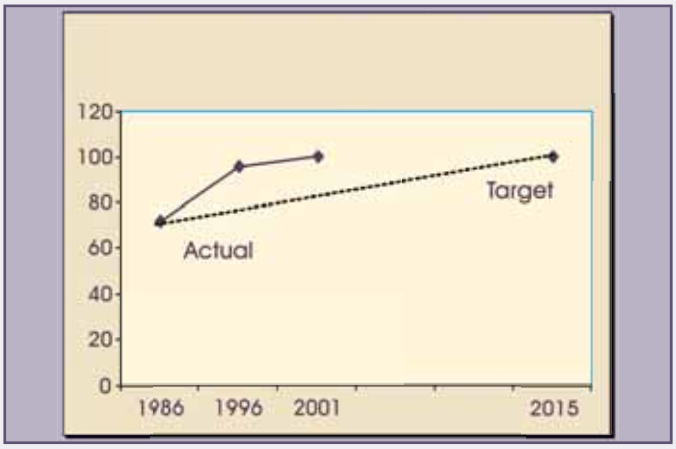
In the last 10 years around 2200 feddans were cultivated as forests. Most of these forests are located in Upper Egypt (Qena, Luxor, and Idfu) and in the New Valley. The proportion of land area covered by forest is still very limited in comparison to the inhabitable area of Egypt (9 KM2: 400,000 KM2)

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

Population Growth: The environmental situation is worsened by the rapid population growth, which puts a strain on Egypt's natural resources. Egypt relies on the Nile for 97 percent of its water resources in addition to 1.4 billion cu.m rainwater. There has been a rapid decline in the per capita share of water in light of Egypt's fixed Nile water quota, which is currently 55.5 billion cu.m annually. Average annual per capita share, which was almost 1000 cu.m in the early 90s, will reach 600 cu.m in 2020, and decline to 400 cu.m by 2030 if the current birth rate continues.

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

Fig. 2: Actual and Target percentage of Population with Access to Piped Water



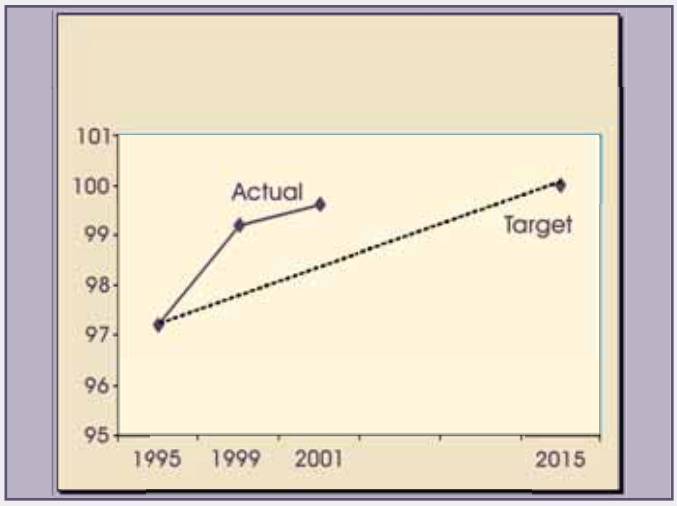
Source: *CAPMAS*

Access to water and sanitation: The Egyptian Government general policy has been to increase the efficiency of water utilities and implement a National Water Quality Management Program. Approximately 99 percent of urban population and 96 percent of the rural population

of Egypt relies on piped water supply. However, these figures do not reveal the disparities that exist between the governorates.

With regard to the status of water and sanitation on the governorate level, the proportion of households with sustainable access to an improved water source has increased over the years 1986, 1996, and 2001 for all governorates. As of 2001 the best governorates were Port-Said, Suez, Damietta, Kafr El-Sheikh, Giza, Fayoum, and Aswan at 100 percent. The worst were Menia 60.7 percent and Suhag 71.9 percent. The 2015 projection shows that most Egyptian governorates will reach full access to improved water sources 100 percent, with the exception of Cairo, Kalyoubia, Menoufia, Beni-Suef, Menia, and Frontier governorates. The proportion of urban people with access to improved sanitation has increased over the period 1995, 1999, and 2001 in all the governorates. As of 2001 the best governorates were Port-Said, Suez, Damietta, Dakahlia, Kalyoubia, and Ismailia at 100 percent. The worst were Suhag (92.4 percent), and South Sinai (92.5 percent). The 2015 projection for all governorates is 100 percent.

Fig. 3: Actual and Target Percentage of Urban People with Access to Sanitation



Source: *CAPMAS*

STATUS AT A GLANCE

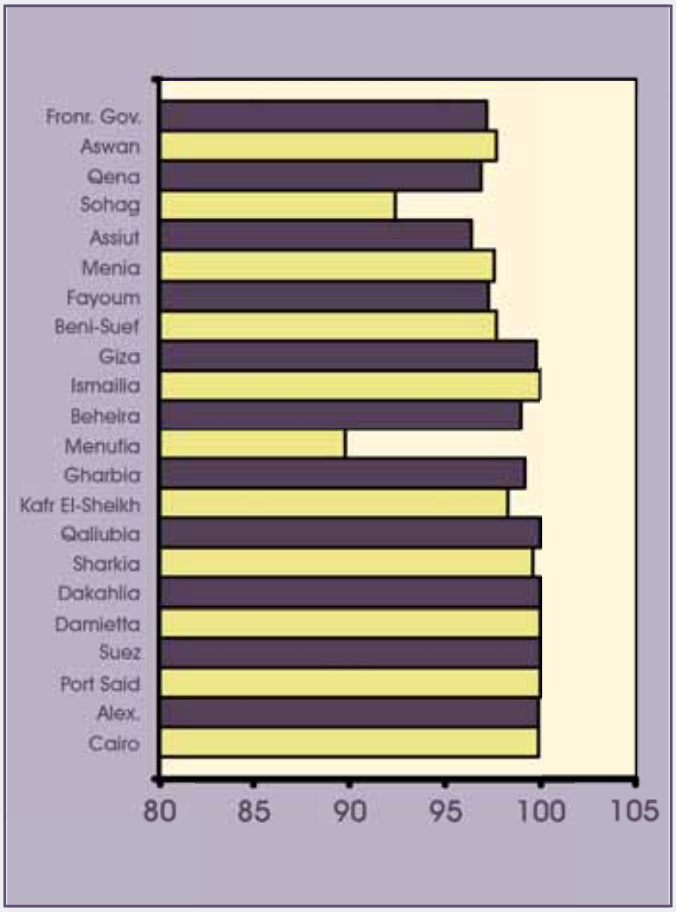
Will target be reached by 2015?
Probably **Potentially** Unlikely Insufficient Data

State of supportive environment
Strong **Fair** Weak but improving Weak

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

Slum areas: Egypt's slum dwellers are negatively affected in terms of access to education, health services, water, and their well-being. According to CAPMAS (June 2000) Egypt contains 909 slum dwelling areas inhabited by more than 5.5 million people. Poor people and those living in slum areas need access to better education and health services, including reproductive health, to improve their well-being and bring down birth rates. Several social problems seriously impact the lives of the most vulnerable groups, especially women. Overcrowding affects their health and self-esteem, while large family size limits their participation in the labor force and is an impediment to reproductive health privacy. The unavailability of transportation makes access to health services restricted and poverty makes working opportunities limited.

Fig. 4: Percentage of Urban People with Access to Sanitation by Governorates in 2001



Source: *CAPMAS*

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

The government has embarked on several projects to improve the living conditions in these areas. In order to address this problem adequately, reliable data is, however, still needed, for instance through establishing urban observatories to report on slum conditions.

2. Major Challenges

Despite the government's investments and actions, the problem of ensuring environmental sustainability remains severe.

- The conditions of women and youth in slum areas are a major social component of Egypt's future. This calls for the need to invest in improving their conditions as a source of community development. They are not only a reproductive elements but also as a productive power of change of the society's economic, social, and political situation. Policy makers should be convinced that poor people are not only part of the problem, but also part of the solution.

- Strengthening environmental institutions and enforcing a sound environmental behavior.

- The major challenge is to curb the population problem and the increasing demand for natural resources.

- Absence of consistent monitoring system of environment health indicators.

- Environmental education and awareness activities have had little impact on environmental friendly behavior of citizens.

3. Supportive Environment

The Egyptian government is aware of the problem and is taking steps towards achieving the target goal.

- Egypt has invested heavily in the water sector, through major irrigation projects, drinking water supply, and sanitation infrastructure. Egypt has played a central role in cooperating with other Nile riparian countries on its trans-boundary surface and groundwater resources, and has been involved with all major international agencies in the water sector.

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

- The Ministry of State and Environmental Affairs is implementing the Green Belt project around Greater Cairo in order to improve the air quality and reduce dust and sand levels.

- Strong donor-government cooperation, such as: Development projects of protectorates in South Sinai implemented in collaboration with the European Union, in the Red Sea Governorate in cooperation with USAID, in El-Fayoum with the support of the Italian Government, and in North Sinai in cooperation with the UNDP. The project of Sustainable Use of and Conservation of Medical Plants in Arid and Semi-arid Lands is being implemented in collaboration with the UNDP during the next five years.

4. Priorities for Development Assistance

In order to ensure environmental sustainability, the following issues should be supported by the international community:

- Capacity building for environmental planning and management as a tool to achieve sustainable development.

- Bridging geographical disparities and guaranteeing equal access to resources and services. Increasing the level of environmental awareness through the encouragement of consumer awareness initiatives and community based environmental intervention.

- Further develop alternative sources of energy, especially solar.

- Increase efforts on water demand management

- Curbing the population growth

- Implementing Urban Observatories to report on slum conditions and manage policy related to water, sanitation as well as housing and land tenure.

- Implement urban development strategies to guide local action.

- Monitor national participatory policy implementation in urban and environmental development efforts.

5. Tracking Progress in Environmental Sustainability – Monitoring and Evaluation

Elements of Monitoring Environmental	Assessment		
Data gathering capacity	Strong	**Fair**	Weak
Quality of recent survey information	Strong	Fair	**Weak**
Statistical tracking capacities	Strong	Fair	**Weak**
Capacity to incorporate statistical analysis into policy, planning & resource allocation mechanisms	Strong	**Fair**	Weak
Monitoring & evaluation mechanisms	Strong	Fair	**Weak**

Endnotes

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

2 - The Egyptian National Environmental Action Plan 2002/2003. Since the report, two more areas have been declared protected, making the total number 23.

3 - Egypt's national Strategy Study on the Clean Development Mechanism, Egyptian Environmental Affairs Agency, Cairo 2003

8. DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

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Target 12[1]: Develop further an open trading and financial system that includes a commitment to good governance, development and poverty reduction – nationally and internationally.

Indicators: Total ODA (official development Assistance) disbursements in 2002.
Proportion of ODA allocated to basic services (basic education, primary health care, nutrition, safe water and sanitation)
Proportion of Egyptian exports admitted free of duties.
Proportion of ODA provided to help build trade capacity

Target 15: Deal comprehensively with developing countries debt problems.

Indicators: Debt relief and debt swap arrangements Debt service as a percentage of exports of goods and services.

Target 17: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries.

Indicators: Proportion of population with access to affordable essential drugs on a sustainable basis

Target 18: In cooperation with the private sector, make available the benefits of new technologies – especially information and communications technologies.

Indicators: Telephone lines and cellular subscribers per 100 population Personal computers in use per 100 population and internet users per 100 population

1. Status of Progress

The MDG 8 agreed at the Millennium Summit represents the commitments of the developed countries towards the developing world, and faces critical aspects such as aid, trade and debt.

The MDG Country Report 2004 attempts to provide some insights on how Egypt is benefiting from the Global Partnerships for Development

The main features of Official Development Assistance (ODA) in Egypt as per 2002 figures are as follows:

- Total volume of disbursements by donors in 2001 amounted to approximately US$1.6 billion and assistance per capita equaled approximately US$24[2].

- Nearly 41 donor organizations provided assistance to Egypt, both bilateral and multilateral.

- 70 percent of Official Development Assistance (ODA) disbursements were made by bilateral donors, 26 percent by non UN multilateral donors, and 4 percent by the UN.

-USAID is the major donor responsible for nearly 48 percent of all ODA disbursements to Egypt.

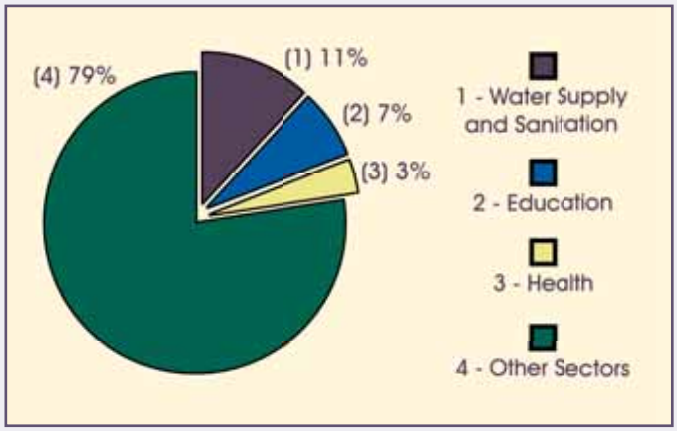
- 2001 classification of ODA disbursements by type of assistance shows that 50 percent is in the form of investment project assistance, 20 percent is in the form of programme budgetary aid or balance of payment support, 29 percent in the form of technical cooperation, and 1 percent in the form of food aid.

- The allocation of ODA disbursements according to sectors reveals that the five sectors that received 65 percent of allocation were in descending order as follows: banking and financial services (15 percent), agriculture (18 percent), water supply and sanitation (9.5 percent), industry (14 percent), and trade (9 percent).

The second group of sectors that received 25.5 percent of total ODA disbursements was in descending order as follows: education (7.5 percent); energy (7 percent); multi-sector/cross- cutting (4 percent); transportation (4 percent); other social infrastructure (3 percent).

66 percent of projects target the national level. 8 percent focus on Cairo governorate, and 26 percent directly support the remaining 25 governorates and the city of Luxor. 12 percent of the total is allocated to Upper Egypt directly.

ODA Disbursements allocated to Social Services in 2001



Source: *DECODE, UNDP 2003*

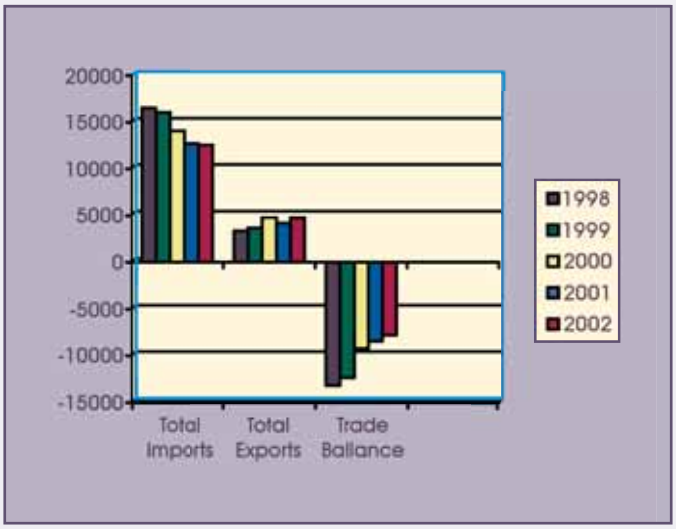
Although the governorates of Fayoum, Minia and Sohag have the lowest Human Development Indicator values, their share of ODA disbursements in 2001 is respectively only 10 percent, 10 percent, and 13 percent among Upper Egypt governorates. Meanwhile, Aswan with the highest value of HDI 0.691 in Upper Egypt, receives 17 percent of ODA disbursements to Upper Egypt. For greater congruence, perhaps more resources should be directed to the governorates with the lowest HDI values.

The amount of external resources allocated to basic education, health, water and sanitation, and emergency food aid amounts to nearly 18 percent of total ODA disbursed during that year.

Despite a number of measures taken to improve the export capacity of the country, Egypt is still not utilizing its significant export potential. A number of bilateral trade agreements, the EU partnership agreement, and the future prospect of a free trade area with the United States provide in principle great opportunities to expand trade.

Development cooperation should contribute to a more open trading and financial system in Egypt. Total exports portray an increasing trend that was reflected in a decreasing deficit in the balance of trade over the period from 1998 -2002.

Fig 1: Egypt Trade Balance 1998-2002 (value in Million USD)



Source: *CAPMAS, as published in the Consolidated Foreign Trade Report, Ministry of Foreign Trade, May 2003, Volume 2, Issue 10, p. 13.*

While Egyptian exports are diversified among a large group of export markets, there are quotas imposed on exports from a number of countries, including the European Union, the United States and Turkey.

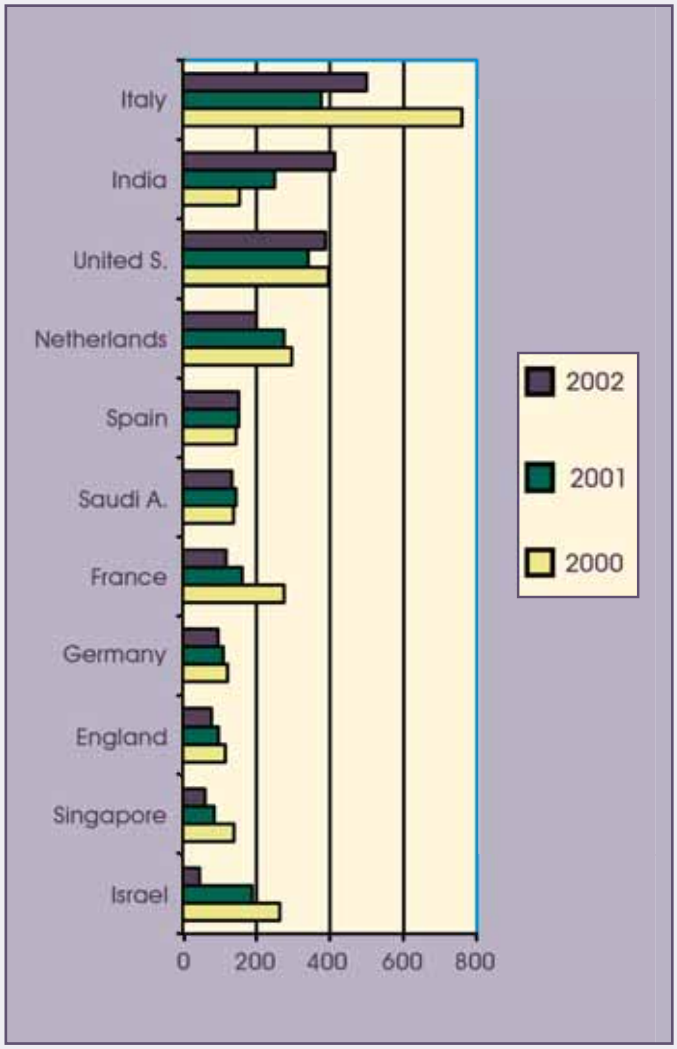
According to the World Bank estimates, the debt situation in Egypt in 2001 was as follows: Total debt/GDP: 28.6 percent Interest payments/GDP: 0.79 percent[3].

The total debt stock in 2000 was US$ 28,957 Millions. 86 percent of the total debt was long-term debt, of which 13 percent was multilateral, 80 percent was bilateral and 4 percent was private organizations[4].

According to the DECODE findings in 2001, ODA disbursements, when classified in terms of assistance, reveal that 73 percent was in the form of grants, 25 percent in the

form of concessionary loans, and only 0.5 percent in the form of debt swaps.

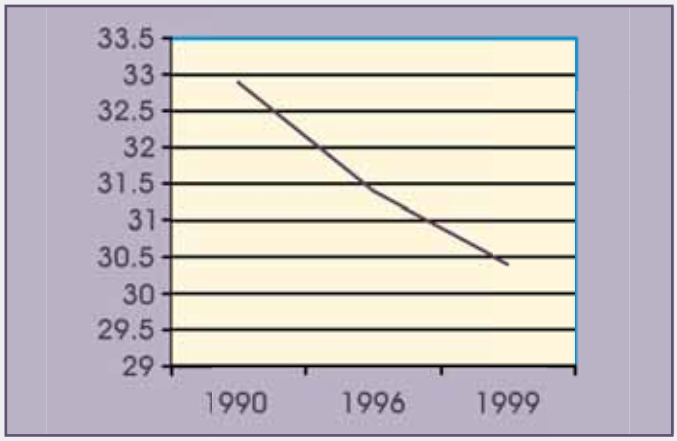
Fig 2: Egypt's Main Export Markets 2000-2002



Source: *CAPMAS & International Trade Point, as published in The Consolidated Foreign Trade Report, Ministry of Foreign Trade, May 2003, Volume 2, Issue 10, p.23.*

The following figures show the development in the total volume of debt over the years.

Fig 3: Egypt's total external debt (billion USD)

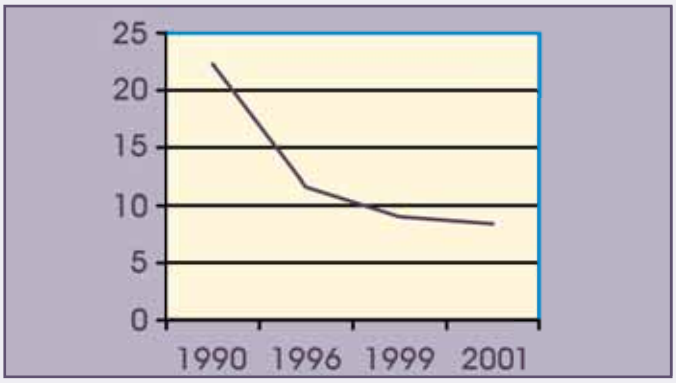


Source: *World Development Indicators, 1995 and 2001.*

It is noted that there is a decreasing trend manifested in the total volume of debt over the years.

Figure 4 demonstrates the decrease in the debt service as a percentage of exports of goods and services in 1990, 1996, 1999 and 2001.

Fig 4: Development of Egypt's Debt Service (percentage of exports of goods and services)

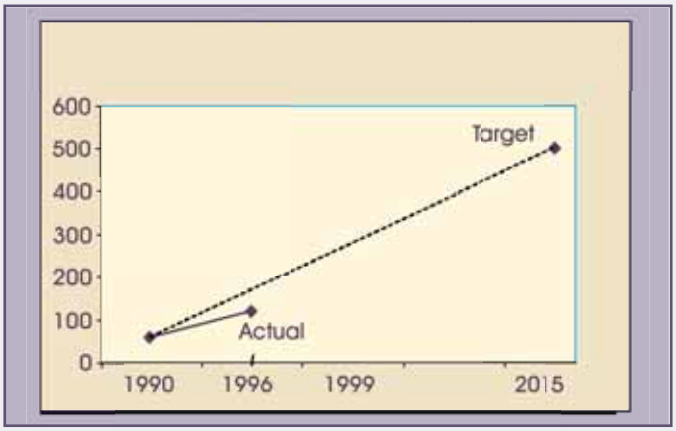


Source: *World Development Indicators, 1995 & 2000; "Egypt, Arab Republic at a Glance".*

Development cooperation should improve Egypt's access to information and communication technology. Despite the variety of projects and programs supported by donors in the field of ICT, DECODE findings show that only 2 percent of the total value of ODA disbursements in 2001 deal with Information Systems and Communication Technology.

The use of personal computers and telephone mainlines is on the increase, yet the use of telephone lines and personal computers is well beyond the indicators.

Fig 5: Actual and Target Personal Computers per 1000 People



Source: *World Bank Development Indicators 1998-2001 Using Exponential Method*

2. Major Challenges

It is critical to improve the effectiveness of aid monitoring as a means of providing timely information for decision making.

There is a need to devote more attention to assessing the impact of development cooperation efforts, specifically in the area of good governance, productive work for youth, access to essential drugs, etc.

Policy changes are required in donor countries regarding: aid volume, aid allocation, aid tying, transparency, technology and pharmaceuticals patents, rich country tariffs and trade quotas, aid practices harmonization, and reduction of administrative barriers for developing countries.

3. Supportive Environment

Positive steps undertaken by the GOE:
Reorganization of the Ministry of International Cooperation for better coordination and management of development cooperation.

In cooperation with the donor community, development of a comprehensive database for development cooperation programs and projects. The intention is to manage and update the database annually by the Ministry of International Cooperation. More accurate analysis of development cooperation in Egypt will be made possible over the coming years.

New international cooperation policies articulated by the government aiming at increasing the effectiveness of development cooperation.

Greater GOE commitment towards a more effective utilization of development cooperation resources. Currently a study is being carried out to establish actual utilization rates as a prelude to identifying major causes of underutilization.

Positive Steps by the Donor Community:
Official development assistance received by Egypt has resulted in many beneficial projects and development activities. In general the resources have been allocated among a wide variety of sectors and have satisfied diverse needs. The 2001 and 2002 ODA disbursements to Egypt are perceived to conform with national priorities and objectives, but with varying degrees of conformance.

Areas where there were high degrees of conformance included the assertion of the role of the private sector in the development process and the assertion on the importance of social services as stated in the Five Year Development Plan. Meanwhile, the area of employment and job creation, showed moderate conformance with national priorities. Although it was perceived as a vital priority in the Socio Economic Development Long Term Vision and in the Five Year Plan, we find that ODA disbursements directed to the Employment and Business Services Sector make up only 5 percent of the total amount disbursed during 2001.

4. Priorities for Development Assistance

More congruence to be realized between ODA objectives and national priorities and needs, such as in the area of job creation.

Despite the diverse projects and programs supported by donors in the field of ICT, Egypt's use of telephone lines and personal computers is way below target. Accordingly, more assistance is recommended to the ICT field in general.

More resources should be directed to support Egypt in building an efficient transport infrastructure to access international markets. For example, Egypt would like to participate in building a rail network linking it to Europe through its western neighbors: Tunisia, Libya, Morocco, and to Spain through Gibraltar[5].

5. Tracking Progress in Developing Global Partnership – Monitoring and Evaluation:

Elements of Monitoring Environmental	Assessment		
Data gathering capacity	Strong	**Fair**	Weak
Quality of recent survey information	Strong	**Fair**	Weak
Statistical tracking capacities	Strong	Fair	**Weak**
Capacity to incorporate statistical analysis into policy, planning & resource allocation mechanisms	Strong	Fair	**Weak**
Monitoring & evaluation mechanisms	Strong	Fair	**Weak**

Endnotes

1 - Only targets relevant to the Egyptian context are mentioned

2 - Note that the focus for analysis here is on disbursements in 2001 only. Commitments by donors exceed the amounts disbursed by far, but are divided over a number of years.

3 - "Egypt, Arab Republic at a Glance" - http://www.worldbank.org/data/countrydata/countrydata.html

4 - World Bank Statistics on External Debt - http://www.worldbank.org/data

5 - Specific request mentioned by the representatives of the Arab Republic of Egypt during the United Nations Conference on Trade and Development, 23 August, 2001

APPENDICES

Appendix A
Methodological Notes

1-Methodology of population projection:

In 2000, CAPMAS and the Cairo Demographic Center published a population projection covering a period of about twenty-five years (1996-2021). The best for such population projection was the 1996 census. The most accurate projection method, the projection component method, was used. It takes into consideration future fertility and mortality trends.

Three assumption levels of fertility were used (high, medium, and low). The high assumption level considers that fertility will gradually decrease till it reaches 2.5 children/ mother by 2021. The medium level assumption supposes that fertility will decrease till it reaches 2.3 children/mother by 2021. The low level assumption considers that fertility will gradually decrease to only 2.09 children/mother by 2021. This last assumption is the one targeted by the government's population policy.

In most cases, when only one figure for population projection is used. Hence, in Egypt's Millennium Development Goals Report we used an estimated population figure in 2015 which corresponded to the medium assumption of fertility.

More specifically, the evaluation used to estimate the population in any year is:

$$P_t = P_o e^{rt}$$

Where:

P_t : the value of the measure in year (t).
P_o : the value of the measure in year (o).
t : the number of years.
R : Rate of change.

2- Methodology of MDG projection uptill 2015 rather than population projection:

In the first report of the Millennium Development Goals at the country level, the liner projection for all millennium goals was applied depending on the guidance note. However, according to the discussion held for the first report of MDG and the valuable feedback from experts and resident representative of UN Agencies in Egypt, it was recommended that more sophisticated projection (exponential method) and more than two points of time (1990, 2000) should be used. Accordingly, all available data of each measure during 1990-2000 were used and the following exponential equation was applied:

$$P_t = P_o e^{rt}$$

Where:

P_t : the value of the measure in year (t).
P_o : the value of the measure in year (o).
t : is the number of years, between the base year & comparable year.
R : Rate of change.

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

Methodology for measuring poverty

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

A.1 Data and sampling design

Our poverty analysis is based on Household income, Expenditure and Consumption Surveys (HIECS) conducted by the Central Agency for Public Mobilization and Statistics (CAPMAS)- Egypt's official statistical agency. Egypt has a long history in collecting statistics, dating back to the beginning of the twentieth century. Household budget surveys were conducted since 1957/58 and it was planned to conduct these surveys every five years. However, due to shortage of funds , the surveys stopped for some time. Dates for these surveys are 1957/58, 1964/65, 1974/75, 19981/82, 1990/91, 1995/96 and 1999/2000.

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

A.2 Estimating poverty line:

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

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

Household specific poverty lines:

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

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

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

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

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

Table A.1: Quantities and calories generated by the reference food bundle

	Daily calories intake	Quantity in KG	% of total calories
Cereals and starches	1327.12	0.41	57.57
Pulses	54.18	0.02	2.35
Vegetables	104.29	0.24	4.52
Fruits	61.26	0.09	2.66
Meat and poultry	137.35	0.12	5.96
Fish	27.00	0.02	1.17
Eggs	21.10	0.21	0.92
Milk & milk products	62.38	0.07	2.71
Oil & butter	271.87	0.03	11.79
Sugar	203.45	0.05	8.83
Others	30.95	0.02	1.34
Tea & coffee drinks	1.59	0.01	0.07
Soft drinks	2.83	0.00	0.12
alcholic drinks	0.00	0.00	0.00
Total food	**2305.38**		**100**

Source: Calculated from Household Income Expenditure and Consumption Survey of 1999/2000, conducted by CAPMAS.

Table A.2: Cost of 1000 calories by region

Region	Cost of 1000 calories
Metropolitan	0.865142
Lower Urban	0.806268
Lower Rural	0.790086
Upper Urban	0.826337
Upper Rural	0.807851
Border Urban	0.765684
Border Rural	0.849175

Source: Calculated from Household Income Expenditure and Consumption Survey 1999/2000, conducted by CAPMAS.

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

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

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

Poverty measurements

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

$$P_\alpha = 1/n \sum_{i=1}^{q} [(z - y)/z]^\alpha \qquad (2)$$

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

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

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

Factors contributing to changes in poverty:

In understanding the evolution of poverty over time, it is necessary to distinguish between the factors that contribute to observed changes in poverty. Contributions to changes in poverty measures are typically decomposed into growth and redistribution factors.

It is important to understand how much of any observed change in poverty could be attributed to changes in the *redistribution* of living standards as distinct from *growth* in average living standards. In other words, the growth component is the difference between the two poverty indices of the two periods if the parameters of Lorenz curve have not been changed and the change would therefore be attributed to shifts in the mean per capita expenditure, μ. Conversely, the redistribution component is the difference between poverty indices of the two periods if the mean, μ , had not changed and hence, changes would be due to shifts in the parameters of the Lorenz curve.

The growth component is given by:

$$G(1,2)=P(Z,\mu_2,L_1)- P(Z,\mu_2,L_1)$$

and the redistribution component is given by:

$$D(1,2)=P(Z,\mu_1,L_2)-P(Z,\mu_1,L_1).$$

Table A.3 presents the results of the decomposition of poverty changes into growth and redistribution components, at regional level.

Table A.3: Growth and redistribution decomposition for poverty changes between 1996 and 2000 by region

	Percentage change in incidence of poverty between 1996-2000		
Regions	**Growth**	**Redistribution**	**Actual Change**
Metropolitan	-9.178	1.134	-8.044
Lower Urban	-0.611	-1.557	-2.168
Lower Rural	-4.449	-5.254	-9.704
Upper Urban	1.294	7.153	8.448
Upper Rural	3.552	1.281	4.833
Border Urban	6.836	-8.771	-1.934
Border Rural	29.055	-24.572	4.483
Total	**-1.723**	**-0.954**	**-2.677**

Source: *Calculated from Household Income Expenditure and Consumption Surveys of 1995/96 and 1999/2000, conducted by CAPMAS.*

Poverty Projections:

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

E***lasticity of poverty measures to changes in the mean expenditure and inequality*** were estimated. Indeed, the elasticity of poverty measures to the mean expenditure and to the inequality index were least (in absolute term) for the Upper Rural followed by the Upper Urban regions, where poverty was highest, while elasticity was the highest for the Lower Rural region where poverty and inequality were low (Table A.4). The Upper Egypt regions had the lowest elasticity for both the headcount and poverty gap indices, with respect to mean expenditure, implying that the impact of growth in expenditure or improvement in inequality were the smallest compared to other regions. The same applies to the poverty gap index, although the magnitude of change was much greater. That is, for every percentage growth in mean expenditure, the headcount index would decline by only 2.7 percent in Upper Rural and by 3.2 percent in Upper Urban region, as opposed to 5.8 percent in Lower Urban. This may explain, to some extent, change in poverty between 1995/96 and 1999/2000.

Table A.4 : Elasticity of poverty measures to mean consumption and inequality, 1999/2000

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

Source: *Calculated from Household Income Expenditure and Consumption Surveys of 1999/2000, conducted by CAPMAS.*

Appendix B
Eradicate Extreme Poverty & Hunger

Annex Tables

Table B.1: Poverty Measures for 1990/91, and 1999/2000 and Projections for 2015, Using Lower Poverty Line

	1990/91			*1999/2000*			*projections for 2015*		
GOV	**P0**	**P1**	**P2**	**P0**	**P1**	**P2**	**P0**	**P1**	**P2**
Cairo	6.41	1.20	0.34	5.01	0.96	0.29	7.57	2.39	1.11
Alexandria	16.21	4.16	1.46	6.24	1.02	0.27	9.44	2.53	1.03
Port Said	5.10	0.63	0.08	0.90	0.09	0.02	1.37	0.23	0.06
Suez	18.23	2.31	0.50	1.91	0.19	0.03	2.89	0.48	0.13
Damitta	8.08	2.17	1.15	0.07	0.00	0.00	0.04	0.00	0.00
Dakhlia	18.48	4.52	1.79	14.88	1.94	0.40	9.85	1.73	0.50
Sharkia	29.71	8.41	3.71	12.70	1.70	0.37	8.40	1.52	0.46
Qalubia	13.39	3.52	1.36	7.94	1.25	0.30	5.25	1.12	0.38
Kafr Elsheikh	18.44	5.55	2.48	5.42	0.64	0.14	3.59	0.57	0.17
Garbia	18.66	5.26	2.31	6.85	1.00	0.22	4.53	0.89	0.28
Menofia	26.89	8.33	3.92	18.96	2.54	0.52	12.55	2.28	0.65
Behera	31.99	8.82	3.63	7.85	1.04	0.23	5.19	0.93	0.29
Ismailia	3.12	0.22	0.02	6.02	0.78	0.17	3.99	0.70	0.22
Giza	19.15	4.95	2.21	12.89	1.98	0.48	9.91	1.87	0.58
Beni-Suef	41.54	11.57	4.50	47.26	9.87	2.90	36.33	9.29	3.47
Fayoum	40.47	11.86	5.24	31.18	5.79	1.48	23.97	5.45	1.77
Menia	46.27	15.22	6.91	21.41	3.20	0.75	16.46	3.01	0.90
Assuit	40.64	13.81	6.70	52.08	11.79	3.66	40.04	11.10	4.37
Sohag	40.32	13.62	6.39	39.88	8.04	2.36	30.66	7.56	2.82
Qena	28.05	8.76	4.06	22.46	4.05	1.05	17.27	3.81	1.25
Aswan	21.18	6.00	2.70	18.61	3.32	0.83	14.31	3.13	0.99
Luxor				29.20	6.37	1.98	22.44	6.00	2.37
Red Sea	15.27	4.83	1.90	9.52	1.22	0.28	10.13	1.86	0.59
New Valley	20.59	6.15	3.11	7.36	1.07	0.20	7.83	1.64	0.43
Matrouh	16.56	2.47	0.47	14.13	2.29	0.53	15.04	3.50	1.15
North Sinai	21.64	8.74	4.07	16.17	2.65	0.57	17.21	4.05	1.22
South Sinai				1.16	0.02	0.00	1.23	0.03	0.00
Total	**24.32**	**7.08**	**3.10**	**16.74**	**2.97**	**0.80**	**10.80**	**2.06**	**0.65**

Source: *Calculated from Household Income Expenditure and Consumption Surveys of 1990/91 and 1999/2000, conducted by CAPMAS.*

Table B.2: Poverty Measures for 1990/91, and 1999/2000 and Projections for 2015, Using One US$ a Day Poverty Line

	1990/91			*1999/2000*			*projections for 2015*		
GOV	**P0**	**P1**	**P2**	**P0**	**P1**	**P2**	**P0**	**P1**	**P2**
Cairo	0.91	0.11	0.02	0.15	0.01	0.00	2.05	0.20	0.05
Alexandria	4.52	0.96	0.33	0.16	0.02	0.00	2.23	0.30	0.07
Port Said	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Suez	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Damitta	1.91	0.82	0.54	0.00	0.00	0.00	0.00	0.00	0.00
Dakhlia	5.82	2.10	1.15	0.26	0.01	0.00	0.51	0.02	0.00
Sharkia	10.71	3.30	1.71	0.24	0.02	0.00	0.46	0.06	0.01
Qalubia	4.61	1.05	0.43	0.16	0.02	0.00	0.30	0.05	0.01
Kafr Elsheikh	5.58	1.77	0.74	0.08	0.02	0.01	0.16	0.05	0.02
Garbia	7.83	2.07	0.85	0.08	0.00	0.00	0.15	0.01	0.00
Menofia	12.67	4.38	1.93	0.00	0.00	0.00	0.00	0.00	0.00
Behera	10.71	2.61	0.94	0.19	0.04	0.01	0.38	0.10	0.05
Ismailia	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Giza	4.84	1.24	0.55	0.14	0.02	0.00	0.32	0.05	0.01
Beni-Suef	13.16	2.68	0.97	3.13	0.34	0.05	7.25	1.10	0.23
Fayoum	14.86	3.62	1.79	0.76	0.10	0.01	1.76	0.31	0.06
Menia	18.39	4.78	2.12	0.50	0.04	0.00	1.16	0.12	0.02
Assuit	17.39	5.13	2.28	4.22	0.49	0.10	9.76	1.60	0.46
Sohag	17.44	4.63	1.78	2.46	0.28	0.05	5.70	0.91	0.20
Qena	9.91	3.35	1.81	0.98	0.04	0.00	2.27	0.13	0.01
Aswan	6.15	1.94	0.85	0.77	0.07	0.01	1.79	0.23	0.03
Luxor				2.79	0.36	0.09	6.45	1.16	0.39
Red Sea	4.73	1.08	0.26	0.00	0.00	0.00	0.00	0.00	0.00
New Valley	12.17	3.68	1.27	0.00	0.00	0.00	0.00	0.00	0.00
Matrouh	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
North Sinai	16.67	3.30	0.92	0.00	0.00	0.00	0.00	0.00	0.00
South Sinai				0.00	0.00	0.00	0.00	0.00	0.00
Total	**8.24**	**2.27**	**1.00**	**0.68**	**0.07**	**0.01**	**0.88**	**0.20**	**0.11**

Source: *Calculated from Household Income Expenditure and Consumption Surveys of 1990/91and 1999/2000, conducted by CAPMAS.*

Table B.3: Poverty Measures for 1990/91, and 1999/2000 and Projections for 2015, Using Two US$ a Day Poverty Line

	1990/91			*1999/2000*			*projections for 2015*		
GOV	**P0**	**P1**	**P2**	**P0**	**P1**	**P2**	**P0**	**P1**	**P2**
Cairo	18.11	3.86	1.23	4.83	0.88	0.25	7.12	2.13	0.95
Alexandria	30.60	8.80	3.72	5.95	0.97	0.26	8.78	2.34	0.97
Port Said	8.38	1.80	0.47	1.70	0.12	0.01	2.51	0.29	0.05
Suez	35.59	7.05	1.98	2.47	0.22	0.04	3.64	0.52	0.15
Damitta	19.48	4.75	2.03	0.07	0.01	0.00	0.04	0.01	0.00
Dakhlia	32.98	10.09	4.67	25.20	3.95	0.94	15.25	3.01	0.97
Sharkia	47.54	15.67	7.48	24.46	3.48	0.78	14.80	2.65	0.80
Qalubia	31.49	8.09	3.34	12.82	2.24	0.59	7.75	1.71	0.61
Kafr Elsheikh	39.46	10.79	4.55	10.47	1.46	0.34	6.34	1.11	0.34
Garbia	33.24	10.16	4.72	13.47	2.11	0.51	8.15	1.61	0.52
Menofia	46.31	16.34	8.30	31.67	5.24	1.26	19.16	4.00	1.29
Behera	52.29	16.67	7.37	15.42	2.11	0.49	9.33	1.61	0.50
Ismailia	9.23	1.48	0.31	8.71	1.28	0.29	5.27	0.98	0.30
Giza	28.63	8.03	3.43	17.74	3.29	0.89	13.31	2.89	0.95
Beni-Suef	54.12	19.13	8.76	60.29	15.57	5.29	45.24	13.66	5.65
Fayoum	58.99	20.63	9.75	46.23	9.60	2.84	34.68	8.42	3.03
Menia	66.49	23.90	11.67	36.08	6.58	1.79	27.07	5.77	1.91
Assuit	59.15	21.89	10.93	65.02	17.74	6.30	48.79	15.56	6.73
Sohag	60.41	21.06	10.27	56.54	13.29	4.36	42.42	11.66	4.66
Qena	46.38	15.16	7.30	37.41	7.41	2.18	28.07	6.50	2.33
Aswan	44.40	12.07	5.13	25.11	4.78	1.34	18.84	4.19	1.43
Luxor				38.10	9.67	3.33	28.58	8.49	3.56
Red Sea	32.73	9.79	4.27	10.23	1.60	0.40	9.36	2.07	0.73
New Valley	41.25	13.55	6.55	11.40	1.69	0.34	10.43	2.19	0.62
Matrouh	40.00	8.35	2.22	15.44	2.37	0.60	14.12	3.08	1.10
North Sinai	41.51	15.64	7.96	18.77	3.44	0.80	17.17	4.47	1.46
South Sinai				2.32	0.13	0.01	2.12	0.17	0.01
Total	**39.45**	**12.41**	**5.69**	**24.84**	**5.00**	**1.49**	**16.49**	**3.33**	**1.07**

Source: *Calculated from Household Income Expenditure and Consumption Surveys of 1990/91 and 1999/2000, conducted by CAPMAS.*

Table B.4: Poverty Measures for 1990/91,1995/96 and 1999/2000 and Projections for 2015, assuming GDP per Capita Growth of 1.5 percent, and Increase in Inequality 1 percent

	1990/91			1995/96			1999/2000			2015		
	P0	P1	P2	P0	P1	P2	P0	P1	P2	P0	P1	P2
Lower Poverty Line												
Metropolitan	9.8	2.12	0.67	13.1	2.61	0.8	5.06	0.91	0.26	7.88	1.75	0.61
Lower Urban	7.07	1.35	0.42	8.34	1.25	0.26	6.17	0.93	0.23	3.85	0.79	0.32
Lower Rural	27.14	7.77	3.4	21.53	3.48	0.89	11.83	1.57	0.33	5.22	0.72	0.19
Upper Urban	13.47	2.53	0.76	10.82	1.81	0.46	19.27	3.9	1.18	15.65	3.78	1.45
Upper Rural	43.46	14.24	6.63	29.32	5.39	1.5	34.15	6.57	1.82	20.41	3.68	1.04
Border Urban	2.29	0.16	0.02	5.63	1.26	0.38	3.7	0.39	0.08	3.20	0.83	0.42
Border Rural	40.11	12.52	5.45	13.82	1.75	0.36	18.31	2.97	0.66	12.03	1.82	0.37
Total	**24.32**	**7.08**	**3.1**	**19.41**	**3.39**	**0.91**	**16.74**	**2.97**	**0.8**	**10.80**	**2.06**	**0.65**
$1 a day poverty line												
Metropolitan	1.972	0.366	0.114	0.546	0.087	0.024	0.14	0.013	0.002	0.63	0.14	0.07
LowerUrban	2.768	0.733	0.3	0.395	0.047	0.008	0.16	0.027	0.008	0.47	0.17	0.14
Lower Rural	11.007	3.314	1.522	1.464	0.156	0.027	0.143	0.012	0.002	0.26	0.07	0.04
Upper Urban	1.96	0.313	0.129	1.868	0.216	0.035	0.902	0.114	0.023	2.50	0.65	0.34
Upper Rural	20.887	5.798	2.58	6.261	0.86	0.207	1.845	0.19	0.032	1.29	0.24	0.09
Border Urban	0	0	0	2.145	0.248	0.055	0	0	0	0.59	0.27	0.27
Border Rural	14.135	3.421	1.047	0	0	0	0	0	0	0.00	0.00	0.00
Total	**8.241**	**2.273**	**1.003**	**2.497**	**0.325**	**0.073**	**0.682**	**0.073**	**0.013**	**0.88**	**0.20**	**0.11**
$2 a day poverty line												
Metropolitan	22.228	5.428	2	15.515	3.127	0.971	4.923	0.846	0.236	7.99	1.79	0.62
LowerUrban	26.573	6.254	2.408	21.115	3.946	1.112	8.809	1.396	0.365	5.67	1.10	0.41
Lower Rural	46.707	15.6	7.437	44.578	9.45	2.868	21.977	3.357	0.786	11.23	1.62	0.41
Upper Urban	33.192	7.74	2.649	32.662	7.494	2.503	24.058	5.126	1.611	19.17	4.78	1.84
Upper Rural	64.471	24.663	12.542	67.187	18.637	6.886	49.46	11.356	3.638	32.29	6.80	2.11
Border Urban	11.938	2.165	0.517	22.386	5.053	1.732	4.805	0.687	0.151	4.14	1.02	0.49
Border Rural	59.974	18.975	8.605	35.402	6.331	1.582	21.45	3.529	0.83	14.14	2.36	0.53
Total	**39.447**	**12.411**	**5.687**	**41.521**	**9.932**	**3.357**	**24.836**	**4.995**	**1.488**	**16.49**	**3.33**	**1.07**

Source: *Calculated from Household Income Expenditure and Consumption Surveys of 1990/91, 1995/96 and 1999/2000, conducted by CAPMAS.*

Table B.5: Projections of Poverty Measures for 2015, Different Scenarios

	Projected Poverty rates in 2015 under different scenarios					Poverty rate at 1990/1991	Poverty rate at 1999/2000
	2% Annual increase in per capita GDP and no change in Gini index	1.5% Annual increase in per capita GDP and no change in Gini index	1% increase in Gini Index and no change in per capita GDP	Prevailed growth rate and Gini index in different regions	1.5% annual increase in Per capita GDP and annual increase in Gini by .5%		
Lower Poverty Line							
Metropolitan	0.75	1.21	25.71	6.94	3.18	9.8	5.06
Lower Urban	0.85	1.38	13.93	9.66	1.46	7.07	6.17
Lower Rural	1.75	2.87	19.98	3.07	2.39	27.14	11.83
Upper Urban	7.21	9.33	32.22	79.96	9.40	13.47	19.27
Upper Rural	14.08	17.70	39.48	28.66	15.14	43.46	34.15
Border Urban	0.51	0.79	9.94	8.28	1.07	2.29	3.7
Border Rural	6.02	7.98	26.61	1.89	7.43	40.11	18.31
Total	5.39	7.10	26.86	20.08	6.64	24.32	16.74
One Dollar a Day							
Metropolitan	0.01	0.01	1.74	0.47	0.09	1.972	0.14
Lower Urban	0.06	0.09	1.05	0.18	0.15	2.768	0.16
Lower Rural	0.03	0.05	0.91	0.00	0.07	11.007	0.143
Upper Urban	0.16	0.26	7.56	91.86	0.55	1.96	0.902
Upper Rural	0.13	0.26	6.96	0.03	0.31	20.887	1.845
Border Urban	0.08	0.10	1.10	1.94	0.20	0	0
Border Rural						14.135	0
Total	**0.07**	**0.13**	**3.44**	**10.53**	**0.20**	**8.241**	**0.682**
Two Dollars a day							
Metropolitan	0.81	1.29	25.65	7.07	3.31	22.228	4.923
Lower Urban	1.71	2.63	18.14	16.06	2.55	26.573	8.809
Lower Rural	6.00	8.46	29.45	14.68	6.95	46.707	21.977
Upper Urban	10.52	13.12	35.88	74.54	12.77	33.192	24.058
Upper Rural	26.35	30.94	51.70	50.55	26.93	64.471	49.46
Border Urban	0.81	1.24	12.77	9.54	1.52	11.938	4.805
Border Rural	7.89	10.17	29.05	3.01	9.34	59.974	21.45
Total	**10.49**	**12.98**	**34.00**	**29.70**	**11.75**	**39.447**	**24.836**

Source: *Calculated from Household Income Expenditure and Consumption Surveys of 1990/91 and 1999/2000, conducted by CAPMAS.*

Table B.6: Poverty Measures by Gender of Head of Household and Region Using Lower Poverty Line, 1999/ 2000 (percent)

	P0			P1			P2			Not of Individuals		
Region	M	F	Total	M	F	T	M	F	T	M	F	T
Metropolitan	4.93	5.97	5.06	0.90	0.99	0.91	0.26	0.25	0.26	36561	5094	41655
Lower Urban	6.10	6.76	6.17	0.90	1.09	0.93	0.22	0.29	0.23	23663	2955	26618
Lower Rural	11.96	10.58	11.83	1.58	1.51	1.57	0.32	0.36	0.33	66022	6570	72592
Upper Urban	19.49	17.29	19.27	3.90	3.92	3.90	1.17	1.23	1.18	23691	2608	26299
Upper Rural	34.99	27.38	34.15	6.78	4.85	6.56	1.90*	1.24	1.82	55165	6813	61978
Broder Urban	3.55	6.59	3.70	0.35	1.27	0.39	0.07	0.24	0.08	1778	90	1868
Border Rural	17.84	23.76	18.30	2.83	4.63	2.97	0.62	1.11	0.66	1277	110	1387
Total	**16.98**	**14.63**	**16.74**	**3.02**	**2.56**	**2.97**	**0.81**	**0.67**	**0.80**	**208157**	**24240**	**232397**

Source: *Calculated from Household income and expenditure survey, 1999/2000, CAPMAS.*

Table B.7: Average Caloric Intake and Percentage of Persons Who Cannot Obtain their Caloric Requirements by Governorate, 1999/2000

Governorate	Percentage of persons who cannot obtain their caloric requirements	Average caloric intake
Cairo	12.62	3522.22
Alexandria	8.96	3172.31
Prt Said	2.32	4027.84
Suez	7.44	3457.77
Damitta	1.96	3406.11
Dakhlia	4.72	2967.39
Sharkia	11.41	2886.70
Dakhlia	9.50	3067.08
Kafr Elsheikh	1.73	3703.24
Garbia	14.37	2838.45
Menofia	29.82	2482.18
Behera	10.81	3142.45
Ismailia	7.80	3361.97
Giza	19.51	2857.69
Beni-Suef	17.28	2600.11
Fayoum	36.37	2319.28
Menia	7.50	2981.60
Assuit	20.26	2442.01
Sohag	26.19	2436.86
Qena	11.99	2630.82
Aswan	10.58	2839.05
Luxor	29.47	3009.80
Red Sea	7.73	3457.68
New Valley	19.00	2791.90
Matrouh	17.99	2929.99
North Sinai	8.85	3027.67
South Sinai	3.13	3743.59
Total	**14.04**	**2960.25**

Source: *Calculated from Household Income Expenditure and Consumption Surveys of 1999/2000, conducted by CAPMAS.*

Appendix C
Achieve Universal Primary Education

Table C.1: Net Enrollment Rates in Primary Education by Sex and Governorate in 1995 and 2002

Governorate	1995		2002	
	M	F	M	F
Cairo	100	100	100	100
Alexandria	100	100	100	100
Port-Said	95	99	97	98
Suez	100	100	100	100
Damietta	100	100	100	100
Dakahlia	92	95	90	94
Sharkia	83	81	88	92
Kalyoubia	88	85	94	92
Kafr El-Sheikh	85	84	85	87
Gharbia	87	89	87	88
Menoufia	96	92	90	86
Behera	91	80	91	90
Ismailia	99	97	100	100
Giza	97	89	100	99
Beni-Suef	78	56	94	80
Fayoum	80	59	88	78
Menia	80	55	97	84
Assyout	79	63	89	82
Suhag	71	59	77	75
Quena	83	77	88	88
Aswan	100	94	96	95
Frontier Gov's	91	79	100	89
Total Egypt	**89**	**82**	**94**	**91**

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

Table C.2: Literacy Rate (15-24) by Governorates and Sex in 1986, 1996 and 2000

Governorate	1986		1996		2001	
	Male	Female	Male	Female	Male	Female
Cairo	83.6	76.9	87.4	85.9	89.4	90.7
Alexandria	81.1	74.6	86.3	84.5	89.0	89.9
Port-Said	84.2	80.8	89.9	89.7	92.9	94.5
Suez	85.1	73.2	90.3	86.0	93.0	93.3
Damietta	65.0	65.1	77.1	83.9	84.0	95.3
Dakahlia	71.2	54.2	80.3	75.9	85.3	89.7
Sharkia	69.9	45.8	76.1	65.2	79.3	77.7
Kalyoubia	79.6	53.5	80.6	72.6	82.6	84.5
Kafr El-Sheikh	62.8	37.0	75.6	62.2	83.0	80.6
Gharbia	74.8	52.6	85.2	76.9	90.9	93.0
Menoufia	77.2	53.9	82.7	72.7	85.6	84.4
Behera	66.0	39.5	73.5	55.2	77.6	56.3
Ismailia	80.7	61.6	83.6	77.7	85.1	87.3
Giza	72.7	53.5	80.7	69.1	85.0	78.5
Beni-Suef	58.7	31.3	68.9	44.0	74.6	52.2
Fayoum	50.5	29.8	62.1	41.6	68.9	49.2
Menia	59.0	31.0	70.5	42.7	77.1	50.1
Assyout	62.9	34.5	72.2	48.8	77.4	58.0
Suhag	62.3	31.2	74.2	47.7	81.0	59.0
Quena	65.9	29.3	79.2	53.3	86.8	71.9
Aswan	81.3	55.7	89.4	79.1	93.7	94.3
Matrouh	63.3	28.9	72.3	44.9	77.3	56.0
Red Sea	81.1	67.5	88.6	83.1	92.6	92.2
New Valley	86.6	70.1	94.3	87.9	98.4	98.4
North Sinai	76.4	45.9	83.9	63.3	87.9	74.3
South Sinai	60.8	25.3	82.9	52.7	96.8	76.1
Total Egypt	**71.2**	**51.3**	**79.0**	**66.9**	**83.2**	**76.4**

Source: *Population Census & Housing in 1986, 1996 & estimates for 2001, projected using exponential method.*

Table C.3 : Projection of Literacy Rate (15-24) by Region and Sex in 2015

Region	Low Assumption			Medium Assumption			High Assumption		
	M	F	Total	M	F	Total	M	F	Total
Urban Governorates	92.4	100.0	95.0	98.8	100.0	100.0	100.0	98.8	100.0
Urban Lower Egypt	89.9	100.0	92.9	96.2	100.0	99.8	98.8	96.2	99.8
Rural Lower Egypt	92.8	89.7	90.3	100.0	100.0	100.0	100.0	100.0	100.0
Urban Upper Egypt	89.6	95.1	90.2	95.8	95.1	96.9	98.5	95.1	96.9
Rural Upper Egypt	84.1	57.0	71.7	92.5	63.8	81.9	94.4	68.9	87.0
Urban Frontier Govs.	95.9	95.2	93.8	100.0	95.2	100.0	100.0	95.2	100.0
Rural Frontier Govs.	88.3	63.8	76.3	97.1	71.3	87.2	99.1	77.1	92.5
Urban Total Egypt	91.0	100.0	93.1	0.0	100.0	100.0	100.0	100.0	100.0
Rural Total Egypt	89.1	76.0	82.4	98.0	85.0	94.2	100.0	91.9	100.0
Total Egypt	**86.9**	**97.8**	**91.9**	**95.5**	**100.0**	**92.4**	**100.0**	**100.0**	**100.0**

Source: *Projection of CAPMAS.*

Table C.4: Number of Pupils in Grade 1 in 1991/92 who Reach Grade 8 in 1998/99 and the Number and Ratio of Dropouts

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

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

Table C.5: Number of Pupils in Grade 1 in 1992/93 who Reach Grade 8 in 1999/2000 and the Number and Ratio of Dropouts

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

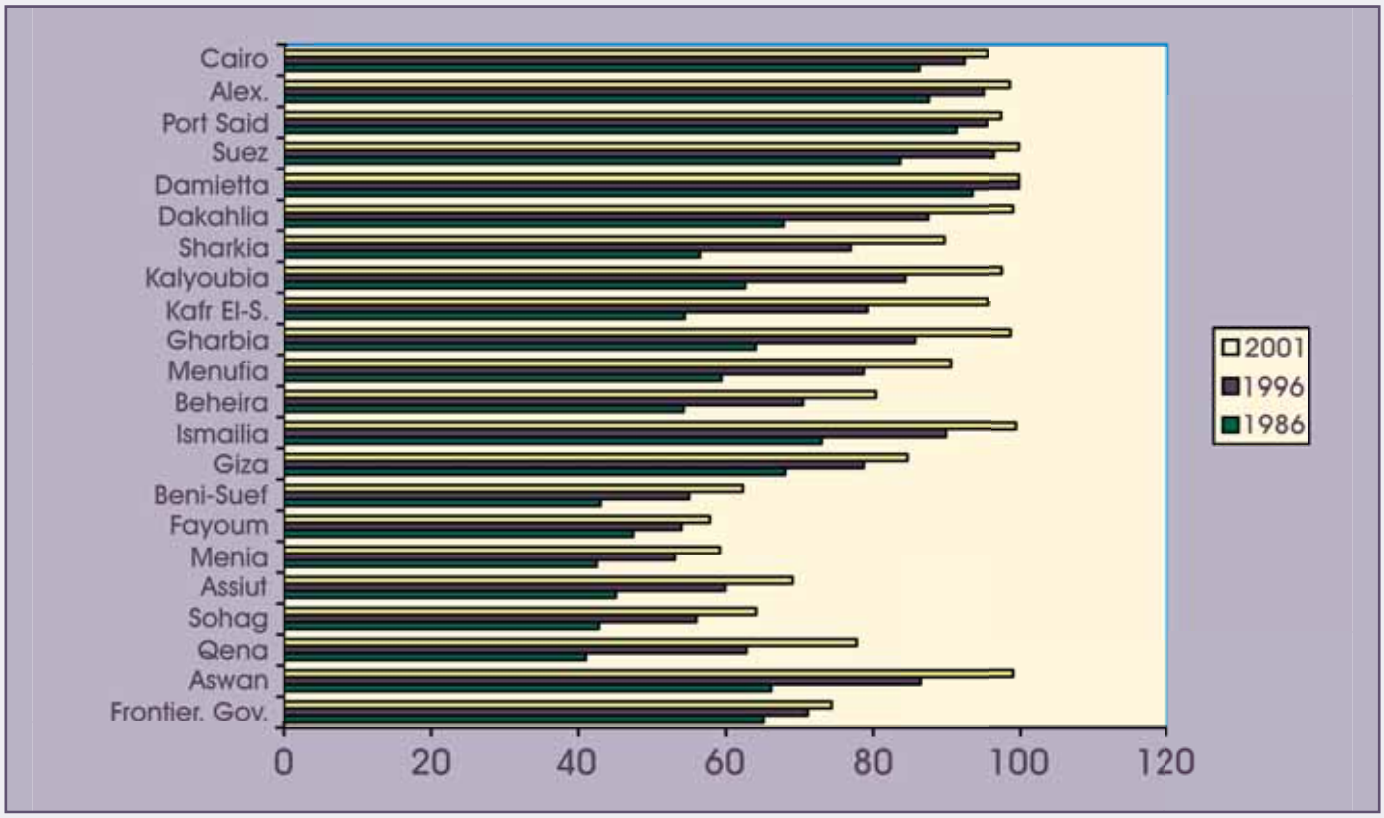
Source: *Ministry of Education, General Department foe Information and Computer, 2000*

Table C.6: Ratio of Literate Females to Males (15-24) by Governorate in 1986, 1996 and 2001 (%)

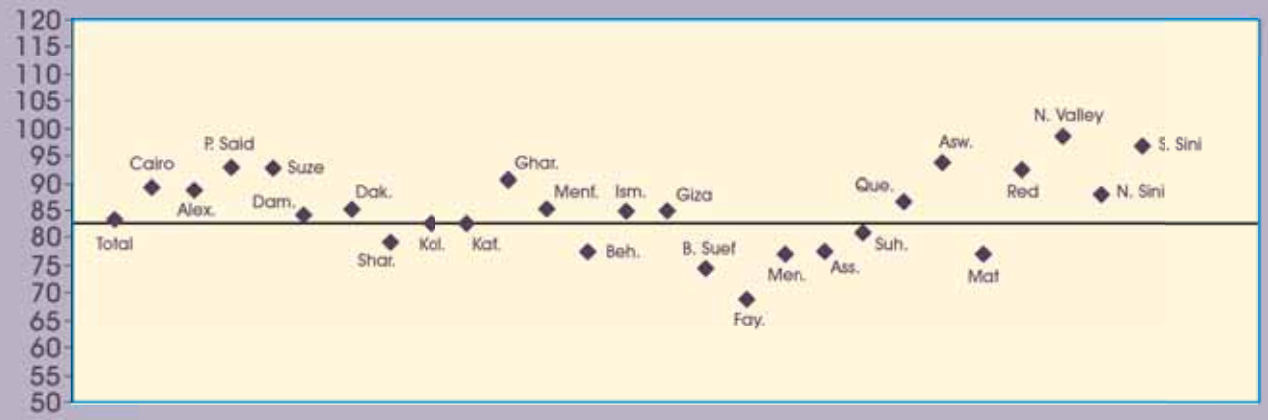
Governorate	1986	1996	2001
Cairo	86.2	92.3	95.5
Alexandria	87.5	94.9	98.8
Port-Said	91.2	95.4	97.6
Suez	83.6	96.6	100.0
Damietta	93.4	100.0	100.0
Dakahlia	67.9	87.4	99.2
Sharkia	56.6	76.9	89.6
Kalyoubia	62.7	84.3	97.7
Kafr El-Sheikh	54.5	79.2	95.5
Gharbia	64.1	85.6	98.9
Menoufia	59.5	78.7	90.5
Behera	54.4	70.5	80.3
Ismailia	73.0	89.8	99.6
Giza	68.1	78.7	84.6
Beni-Suef	42.9	55.1	62.4
Fayoum	47.3	54.1	57.9
Menia	42.4	53.0	59.3
Assyout	45.0	59.8	68.9
Suhag	42.7	55.9	64.0
Quena	40.9	62.7	77.6
Aswan	66.0	86.6	99.2
Frontier Gov's	65.0	71.0	74.2
Total Egypt	**64.4**	**77.8**	**85.5**

Source: *Population Census & Housing in 1986, 1996 & 2001, projected using exponential method.*

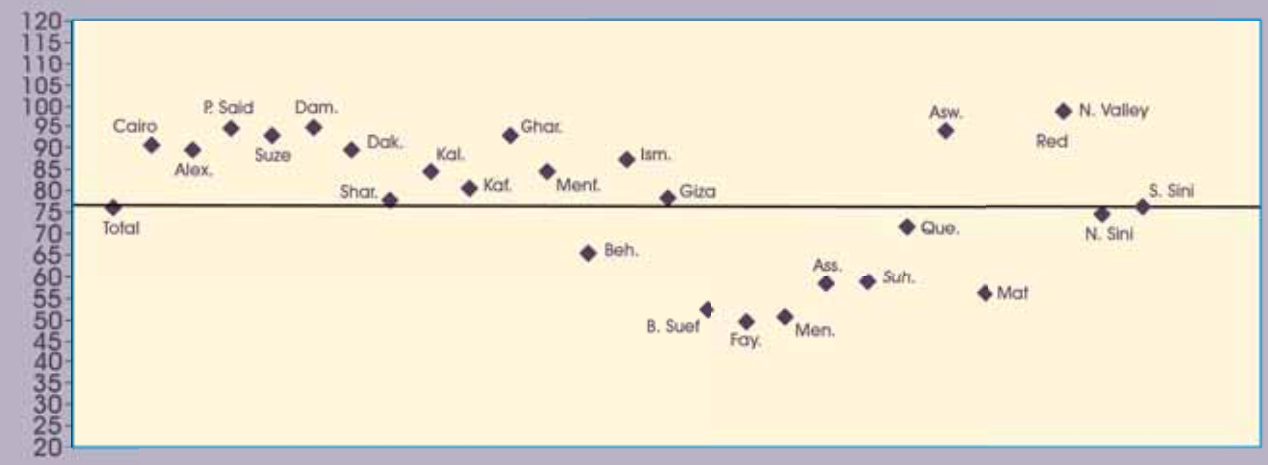
Ratio of Literate Females to Males (15-24) by Governorate in 1986,1996 and 2001 (%)



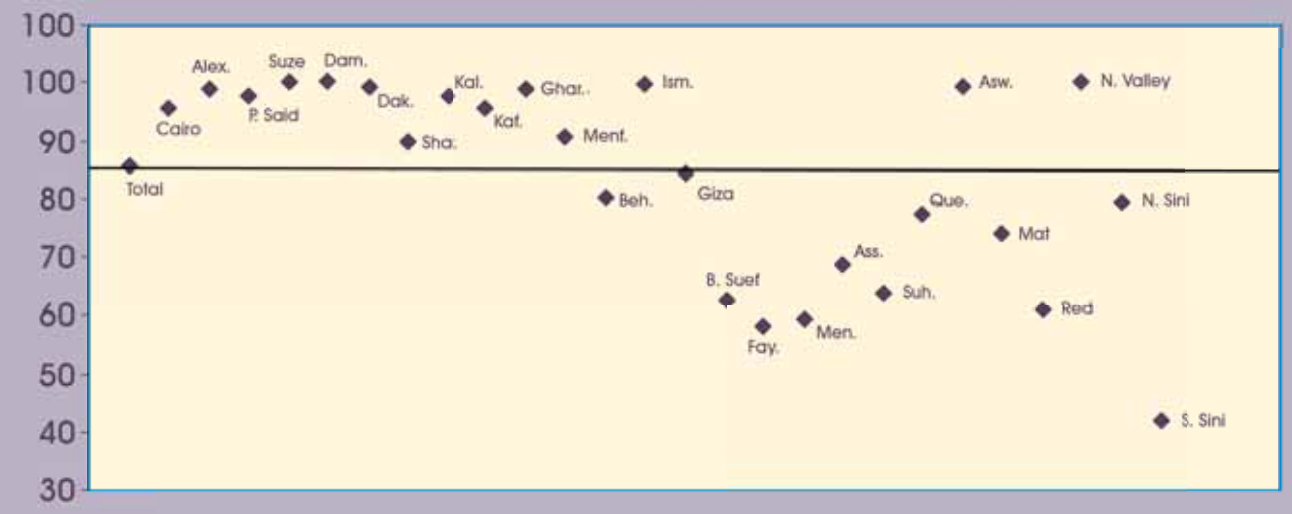
Literacy Rate (15-24) By Governorates in 2001 (Male)



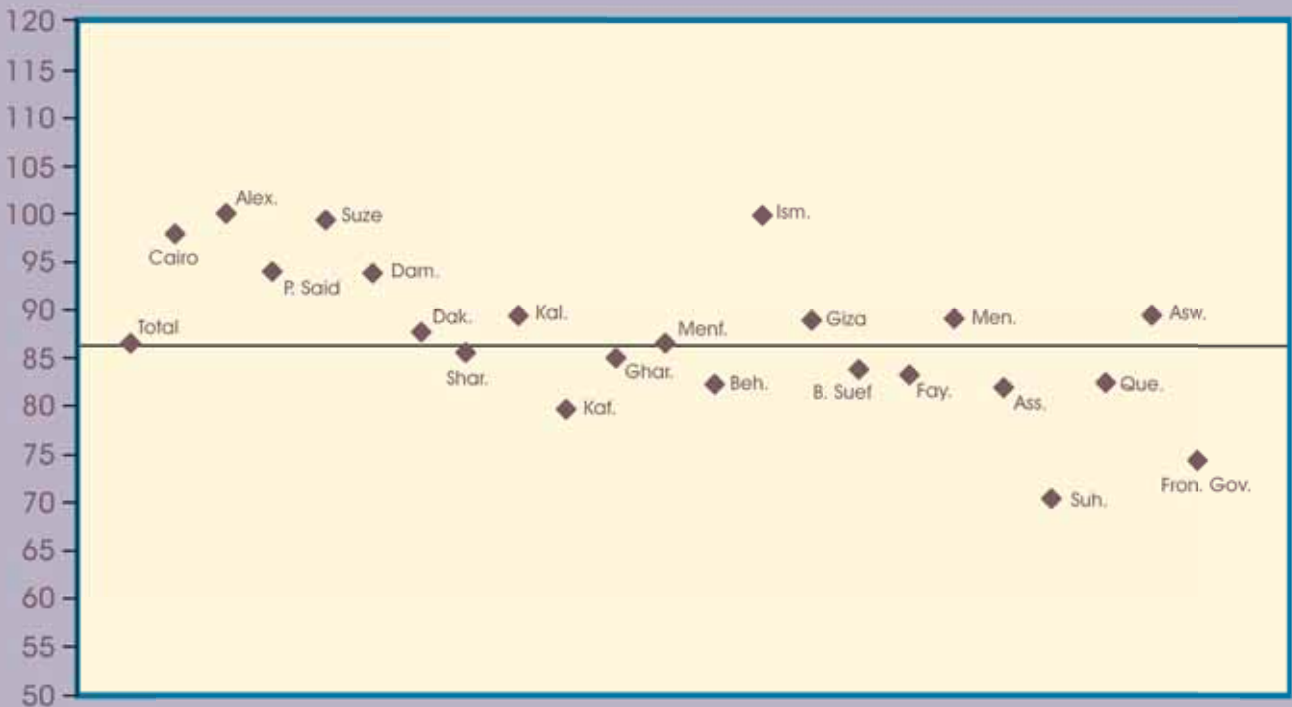
Literacy Rate (15-24) By Governorates in 2001 (Female)

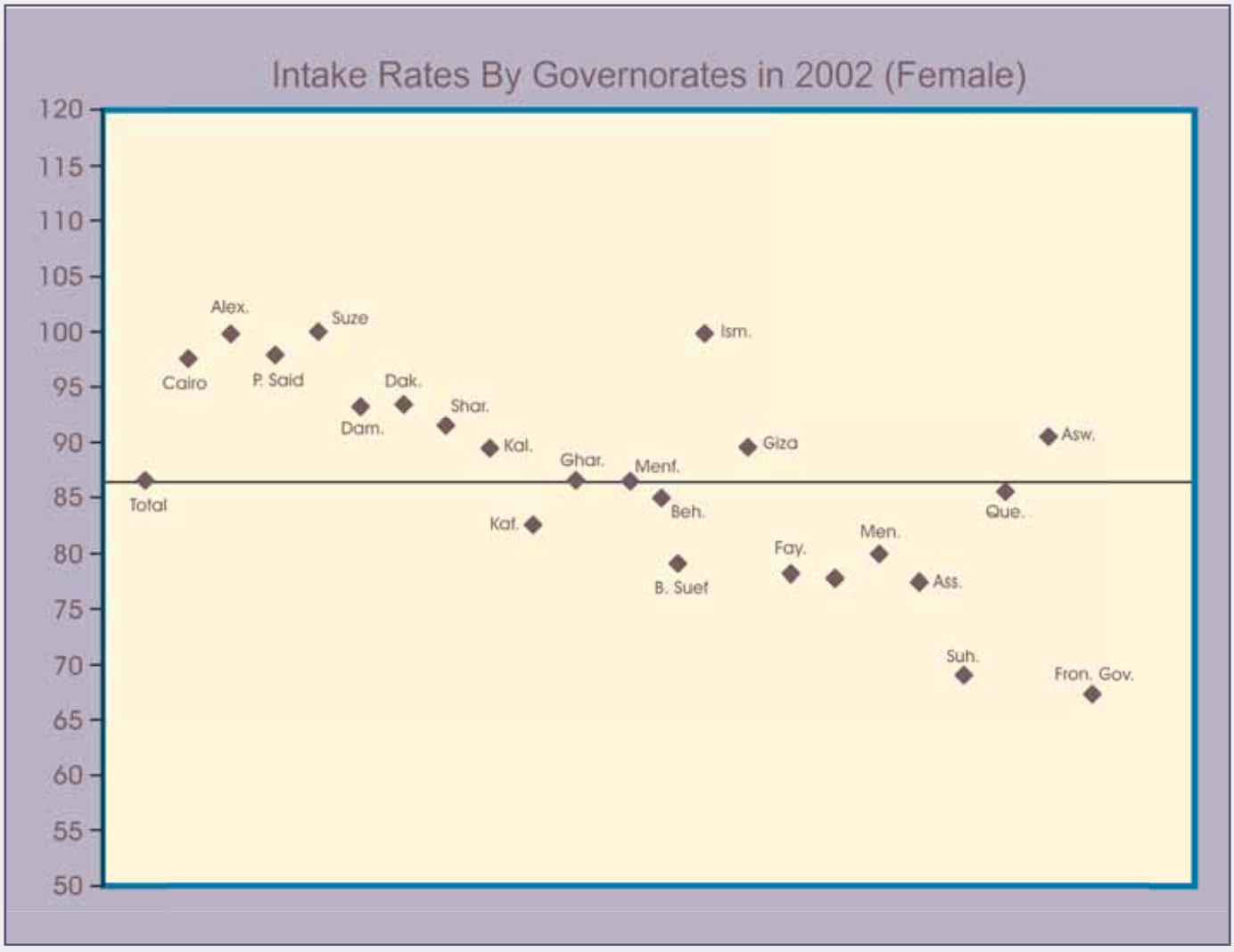


Literacy Rate (15-24) By Governorates in 2001 (Total)



Intake Rates By Governorates in 2002 (Male)




Intake Rates By Governorates in 2002 (Female)
120
115
110
105
100
95
90
85
80
75
70
65
60
55
50
Alex.
Suze
Cairo
P. Said
Dak.
Dam.
Shar.
Kal.
Ism.
Giza
Asw.
Ghar.
Menf.
Total
Beh.
Que.
Kaf.
Men.
Fay.
B. Suef
Ass.
Suh.
Fron. Gov.

Appendix D
Promote Gender Equality and Empower Women

Table D.1 : Unemployment Rate by Sex & Region (1990 – 1995 – 2001)

Region		1990(*)			1995(*)			2001(**)		
		M	F	T	M	F	T	M	F	T
Urban Govs.		7.1	23.7	**10.7**	6.3	21.5	**9.1**	4.5	17.7	**7.1**
Lower Govs.	Urban	7.3	27.4	**12.5**	8.2	32.4	**14.1**	6.6	26.2	**11.9**
	Rural	5.2	10.3	**6.9**	8.5	25.1	**12.6**	5.9	23.5	**10.0**
Upper Govs.	Urban	5.9	23.0	**10.0**	8.8	29.1	**13.5**	6.6	26.4	**11.0**
	Rural	3.7	5.6	**4.2**	5.6	13.6	**7.3**	5.0	18.9	**6.9**
Frontier Govs.	Urban	6.2	15.4	**8.3**	12.3	30.4	**16.7**	6.9	23.2	**11.0**
	Rural	3.9	37.3	**10.3**	15.2	31.8	**18.9**	9.6	31.5	**13.7**
Total	Urban	6.9	24.6	**11.0**	7.6	27.6	**11.9**	5.7	23.1	**9.7**
	Rural	4.6	8.8	**5.9**	7.3	21.0	**10.5**	5.5	22.1	**8.9**
	Total	**5.6**	**14.4**	**8.1**	**7.4**	**23.8**	**11.1**	**5.6**	**22.6**	**9.2**

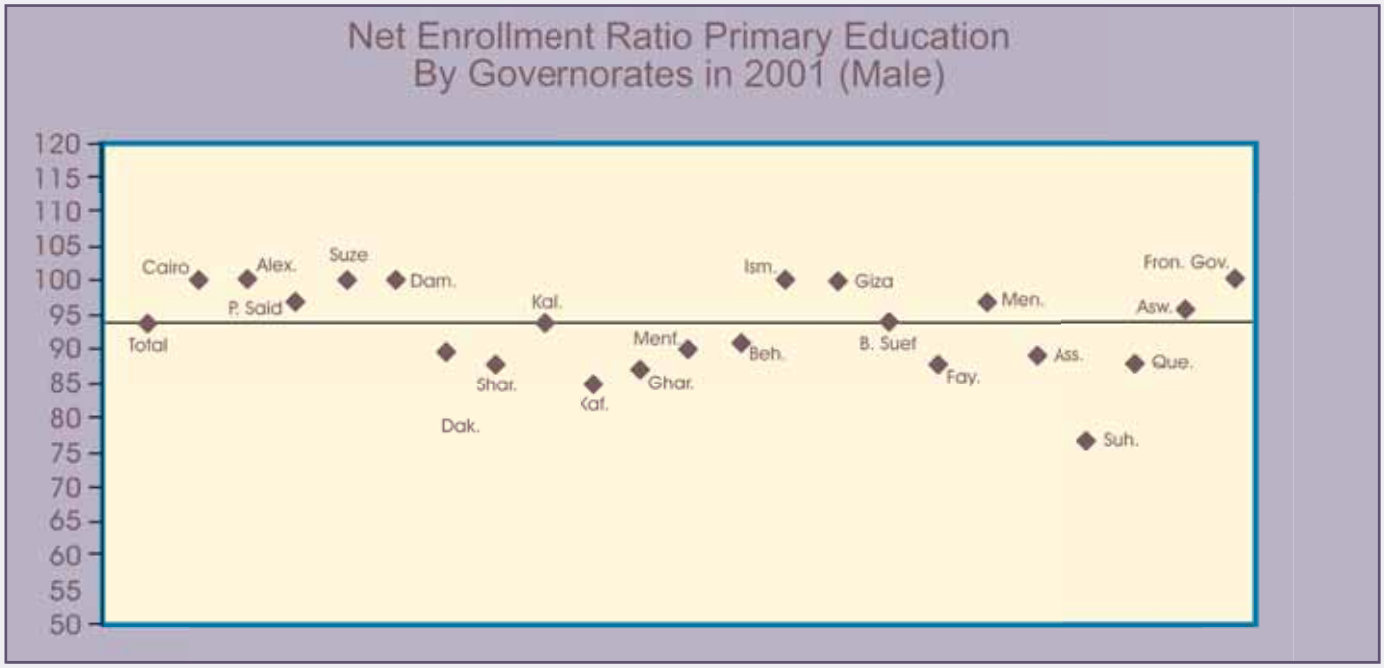
(*) Unemployment Rate for Ages (12 – 64).
(**) Unemployment Rate for Ages (15 – 64).

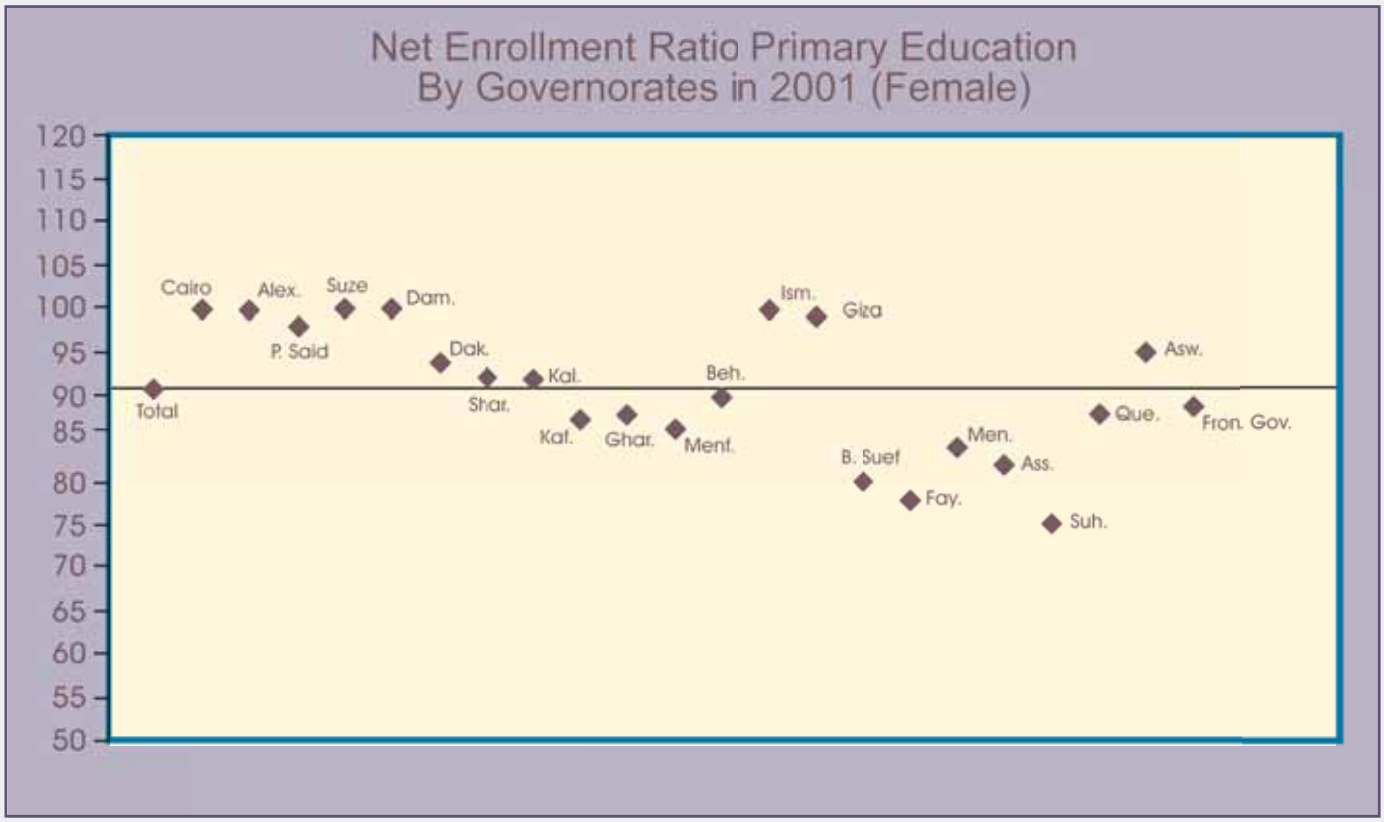
Source: *Labor Force Sample Survey.*

Table D.2: Percent Distribution of Labor Force (15-64) by Educational Status, Sex and Region in 1990, 1995 and 2001

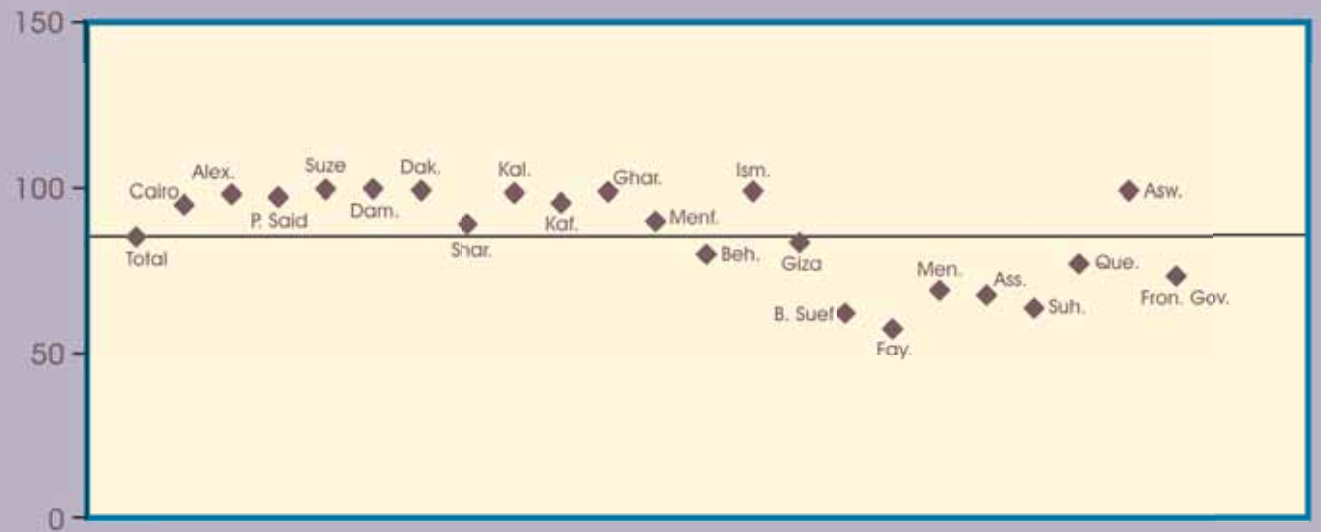
		1990			1995			2001		
		Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Illiterate	M	23.5	52.5	39.5	17.3	44.1	32.1	8.6	31.1	21.4
	F	17.1	78.8	56.8	6.3	58.8	36.3	3.3	39.2	22.2
	T	22	60.6	44.3	14.9	47.5	33	7.3	32.8	21.6
Read & Write	M	25.4	22.3	23.7	24.8	22.7	23.6	20.6	25.4	23.3
	F	4.5	3.9	4.1	3.7	3.1	3.3	2.9	5.6	4.3
	T	20.5	16.6	18.3	20.2	18.2	19.1	16.5	21.4	19.3
Less than Intermediate	M	9.4	5.5	7.2	8.8	5.3	6.9	9	5.8	7.1
	F	3.8	1.5	2.3	2.4	1.4	1.8	1.9	1.7	1.8
	T	8.1	4.3	5.9	7.4	4.4	5.8	7.3	4.9	6
Intermediate	M	20.9	13.7	16.9	25.5	19.6	22.2	30.8	27.2	28.8
	F	43	11.6	22.8	48.7	29.2	37.5	48.2	40.2	44
	T	26.1	13.1	18.6	30.5	21.8	25.7	34.8	29.8	32
Less than University	M	3.8	1.7	2.7	4.9	3.1	3.9	6.5	3.1	4.5
	F	8.7	1.8	4.3	11.5	4	7.2	10	4.4	7
	T	5	1.7	3.1	6.3	3.3	4.7	7.3	3.3	5.1
University+	M	17	4.3	10	18.7	5.2	11.3	24.6	7.4	14.8
	F	22.8	2.4	9.7	27.5	3.5	13.8	33.9	8.8	20.7
	T	18.4	3.7	9.9	20.6	4.8	11.8	26.7	7.7	16.1
Total	M	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
	F	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
	T	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: *Labor Force Sample Survey, 1990, 1995 and 2001.*

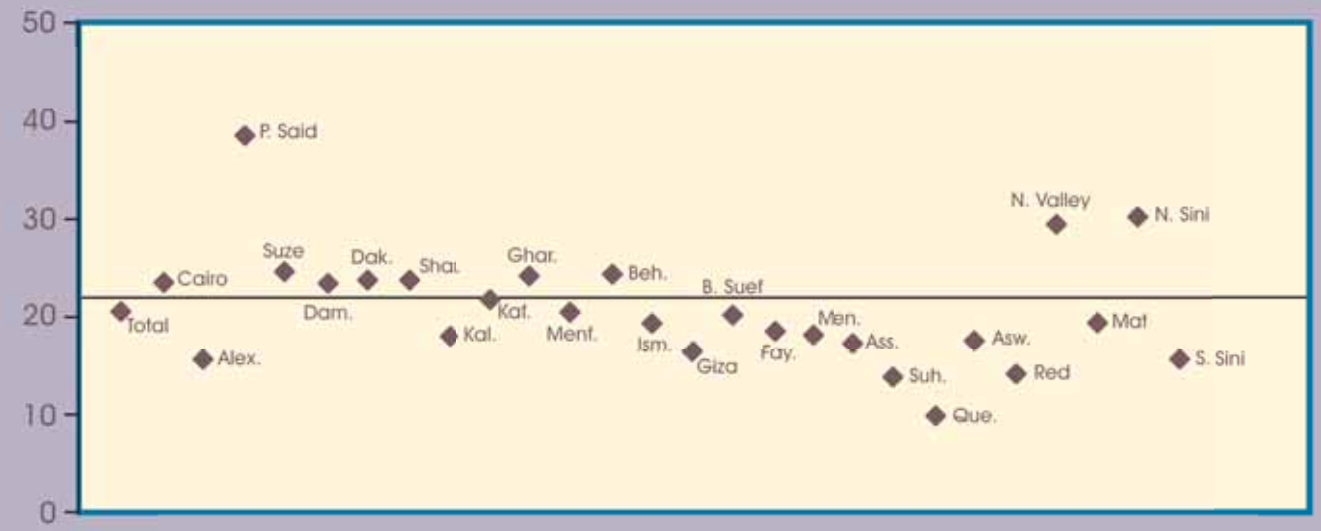

Net Enrollment Ratio Primary Education
By Governorates in 2001 (Male)
120
115
110
105
100
95
90
85
80
75
70
65
60
55
50
Cairo
Alex.
Suze
Dam.
P. Said
Total
Kal.
Ism.
Giza
Fron. Gov.
Men.
Asw.
Ment.
Beh.
B. Suef
Ass.
Que.
Fay.
Shar.
Kaf.
Ghar.
Dak.
Suh.


Net Enrollment Ratio Primary Education
By Governorates in 2001 (Female)
120
115
110
105
100
95
90
85
80
75
70
65
60
55
50
Cairo
Alex.
Suze
Dam.
P. Said
Dak.
Kal.
Ism.
Giza
Asw.
Total
Shar.
Beh.
Que.
Fron. Gov.
Kaf.
Ghar.
Ment.
Men.
B. Suef
Ass.
Fay.
Suh.

Ratio of Literate Females to Males (15-24) By Governorates in 2001



Share of Female In Wage Employment In Non Agriclture Sector By Governorates in 2001

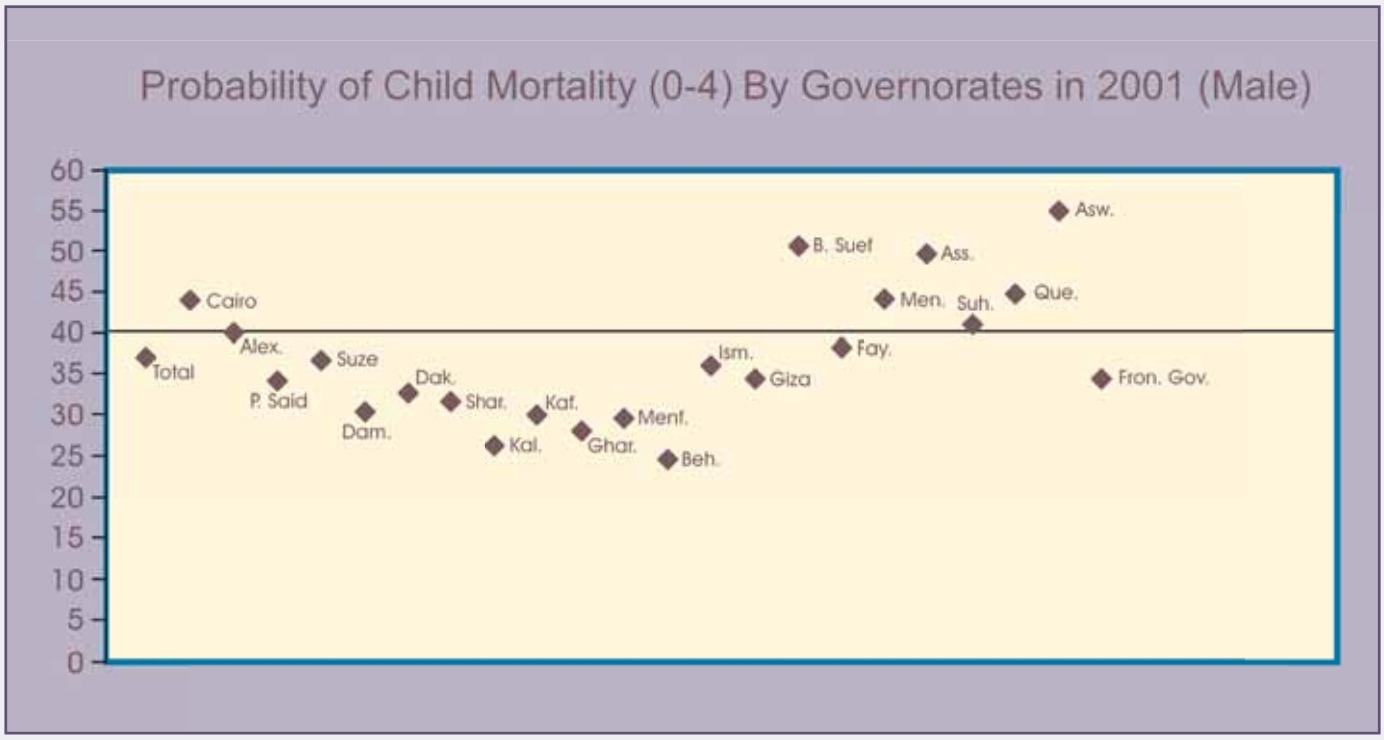


Appendix E
Reduce Child Mortality

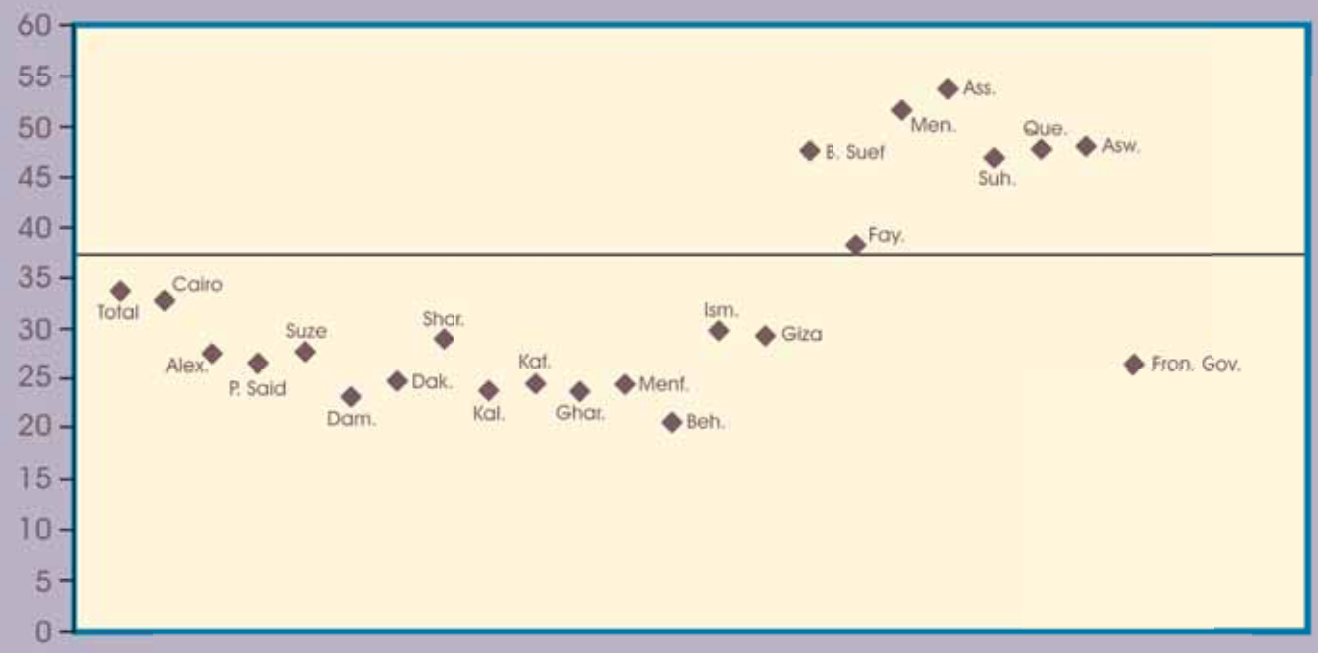
Table E.1: Trends in Nutritional Status of Children Under Five by Place of Residence according to 1992, 1995, 2000 and (EIDHS) 2003

Region	1992			1995			2000			2003		
	Ht. for Age	Wt. for Ht.	Wt. for Age	Ht. for Age	Weight for Height	Weight for Age	Height for Age	Weight for Height	Weight for Age	Height for Age	Weight for Height	Weight for Age
Urban	16.8	4.5	7.4	18.4	5.4	9.1	8.5	1.8	2.5	15.6	3.1	5.7
Lower Gover.	27.0	2.6	7.7	28.0	3.0	9.6	16.0	3.1	2.6	10.9	3.1	6.2
Lower Urban	20.5	2.3	4.4	25.6	2.4	8.8	13.7	3.3	1.9	10.0	2.2	4.8
Lower Rural	29.1	2.7	8.8	28.8	3.2	9.9	16.8	3.1	2.8	11.3	3.4	6.8
Upper Gover.	28.7	3.7	11.4	36.4	5.2	16.0	25.8	2.2	6.3	20.4	5.3	11.9
Upper Urban	24.6	2.8	8.3	27.2	4.7	11.0	21.9	2.3	5.0	16.7	6.3	10.5
Upper Rural	30	4.0	12.4	39.7	5.3	17.8	27.2	2.2	6.8	21.8	4.9	12.4
Frontier	Na	Na	Na	32.5	26.1	35.2	16.7	0.8	2.3	Na	Na	Na
Total	**26.0**	**3.4**	**9.2**	**29.8**	**4.6**	**12.4**	**18.7**	**2.5**	**4.0**	**15.6**	**4.0**	**8.6**

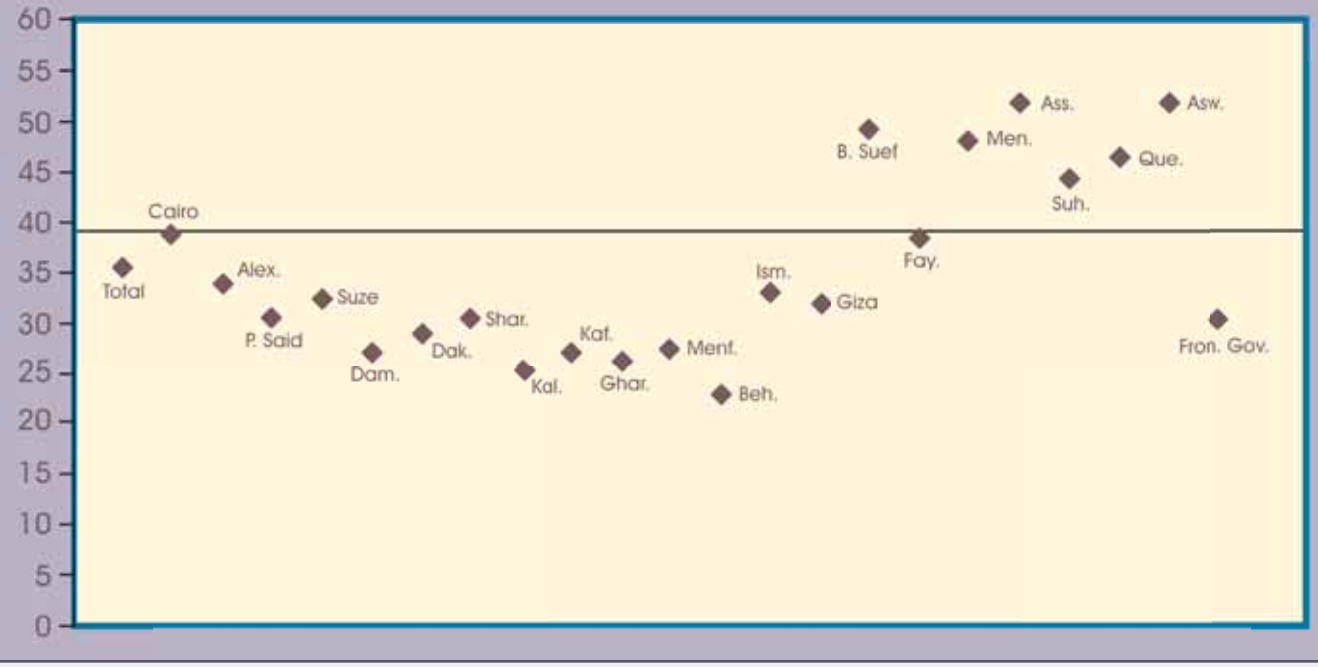
(Ht. = Height and Wt. = Weight)

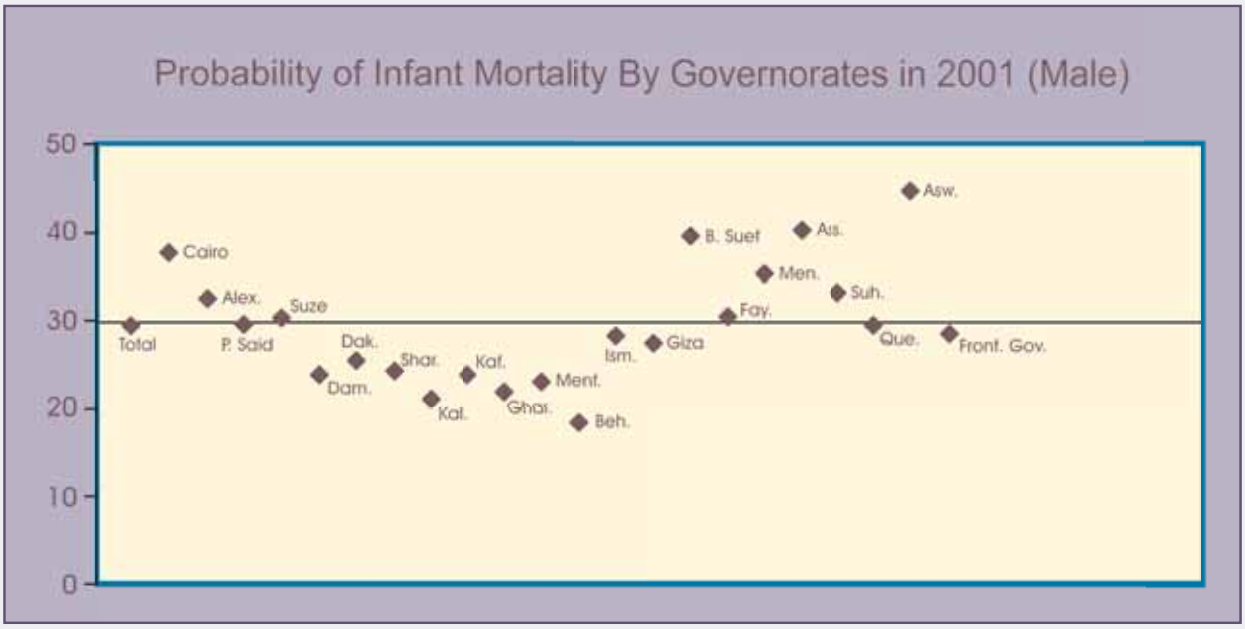


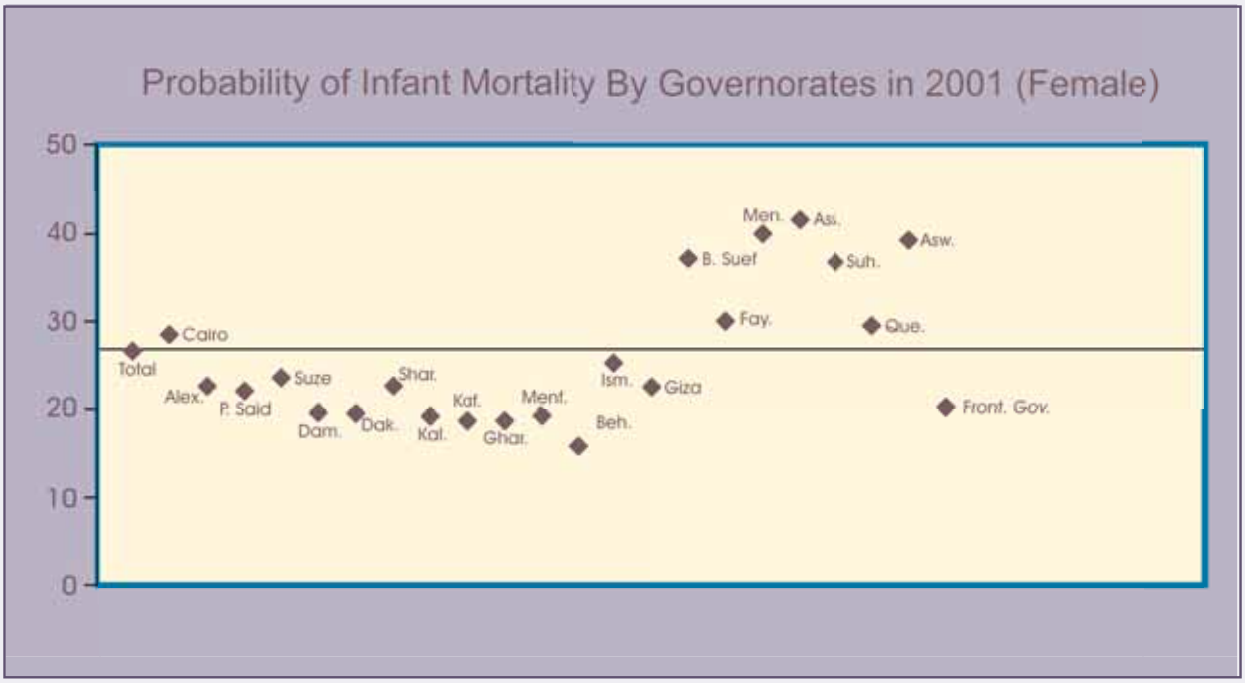
Probability of Child Mortality (0-4) By Governorates in 2001 (Female)

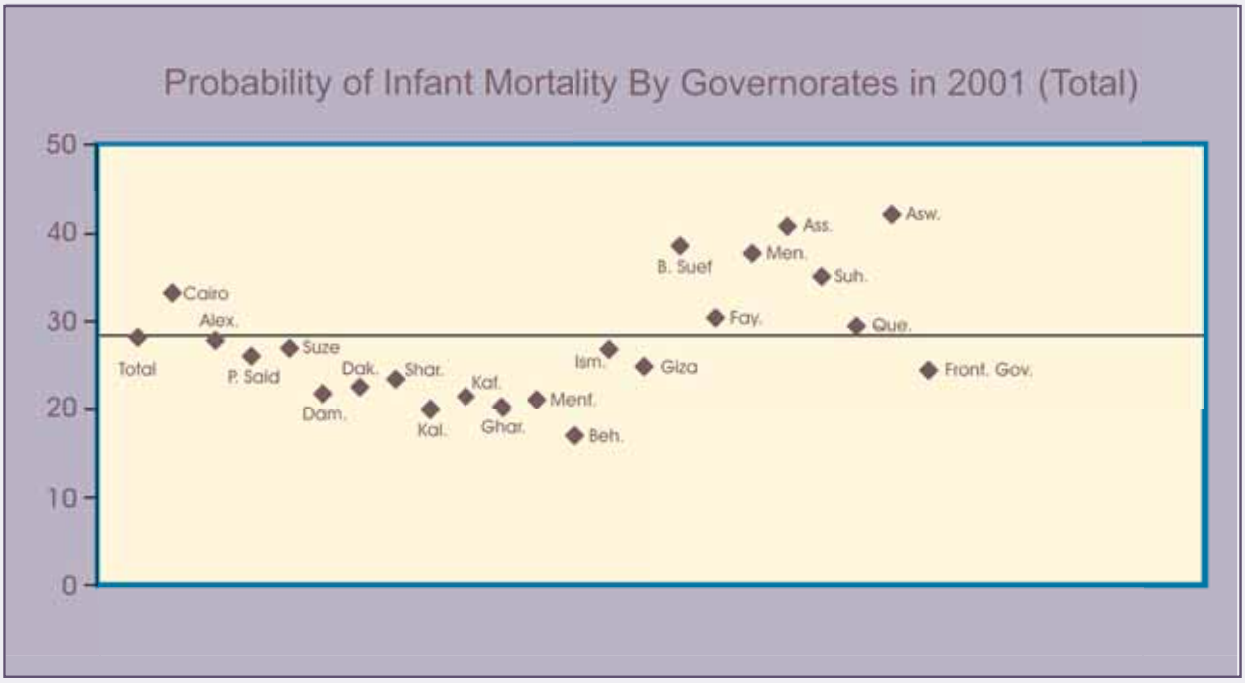


Probability of Child Mortality (0-4) By Governorates in 2001 (Total)




Probability of Infant Mortality By Governorates in 2001 (Male)
50
40
30
20
10
0
Total
Cairo
Alex.
P. Said
Suze
Dam.
Dak.
Shar.
Kal.
Kaf.
Ghar.
Ment.
Beh.
Ism.
Giza
B. Suef
Fay.
Men.
As.
Suh.
Que.
Asw.
Front. Gov.


Probability of Infant Mortality By Governorates in 2001 (Female)
50
40
30
20
10
0
Total
Cairo
Alex.
P. Said
Suze
Dam.
Dak.
Shar.
Kal.
Kaf.
Ghar.
Ment.
Beh.
Ism.
Giza
B. Suef
Fay.
Men.
As.
Suh.
Que.
Asw.
Front. Gov.


Probability of Infant Mortality By Governorates in 2001 (Total)
50
40
30
20
10
0
Total
Cairo
Alex.
P. Said
Suze
Dam.
Dak.
Shar.
Kal.
Kaf.
Ghar.
Ment.
Beh.
Ism.
Giza
B. Suef
Fay.
Men.
Ass.
Suh.
Que.
Asw.
Front. Gov.

Appendix F
Improve Maternal Health

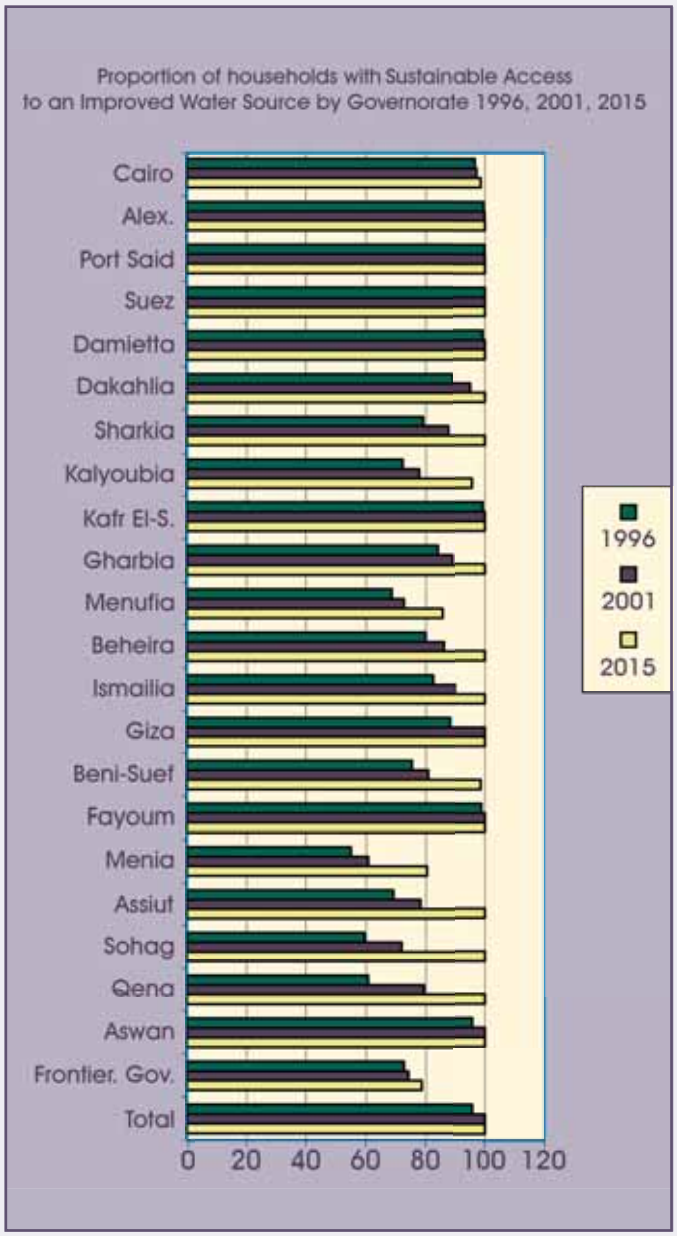
Table F: Maternal Health Rate by Governorates (2001)

Governorate	Maternal Mortality Rate (2001)
Cairo	42.2
Alexandria	58.7
Port Said	88.8
Suez	65.5
Damietta	24.8
Dakahlia	58.8
Al Sharkia	52.8
Al kalyoubia	30.3
Kafr El-Sheikh	35.7
Al-Gharbia	54.7
Al Menoufia	43.6
Al Behera	25.6
Ismailia	52.7
Giza	54.4
Beni-Suef	48.6
Al Fayoum	42.5
Al Menia	45.9
Assyout	36.2
Suhag	51.3
Quena	58.6
Luxor	95.2
Aswan	96.9
Red Sea	78
New valley	28.3
Matrouh	67.1
North Sinai	36
South Sinai	46.1
Egypt	56.4

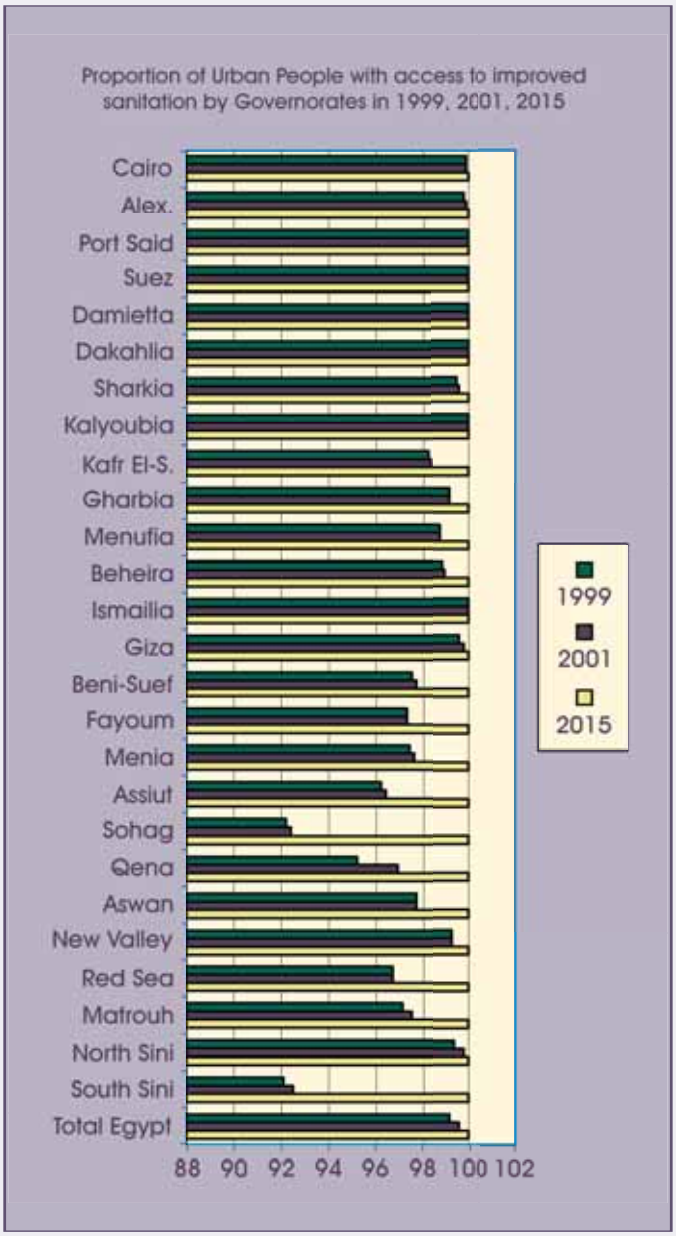
Source: EDHS 2002.

Appendix G
Ensure Environmental Sustainability

Graph G.1



Graph G.2



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Development Goals:

Complete page of the Goals and Targets, Including data by the WB, Country Tables, goal Tables by Region, Definitions and Sources, Maps, etc. Data is presented for 4 of the last 10 years, starting with 1990, as available. Each of seven Goal tables represents the relevant indicators for every country—in alphabetical order within regions. http://www.developmentgoals.org/ OECD/DAC RESOURCES

OECD/DAC Indicators home page. The site provides regional and country progress charts (updated in August 2001), links to maps on the development goals web site and to data sources for all indicators in the core set. Includes Regional Charts, links to data sources, Goals, country progress charts, and other relevant sites. http://www1.oecd.org/dac/Indicators/index.htm OECD's statement in support to the MDGs (September 2001) http://www1.oecd.org/media/release/un_millenium1909.htm

Description of the Millennium Declaration, the full 8 goals, 18 targets and 40+ indicators http://webnet1.oecd.org/pdf/M00017000/M00017310.pdf Complete page of the Goals and Targets, Including data by the WB, Country Tables, goal Tables by Region, Definitions and Sources, Maps, etc. Data is presented for 4 of the last 10 years, starting with 1990, as available. Each of seven Goal tables represents the relevant indicators for every country—in alphabetical order within regions. http://www.developmentgoals.org/

OECD/DAC Resources:

OECD/DAC Indicators home page. The site provides regional and country progress charts (updated in August 2001), links to maps on the development goals web site and to data sources for all indicators in the core set. Includes Regional Charts, links to data sources, Goals, country progress charts, and other relevant sites. http://www1.oecd.org/dac/Indicators/index.htm OECD's statement in support to the MDGs (September 2001) http://www1.oecd.org/media/release/un_millenium1909.htm

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