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# Egypt and the Millennium Development Goals

## Challenges and Opportunities

Sameh El-Saharty, Gail Richardson and Susan Chase

February 2005





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## Health, Nutrition and Population (HNP) Discussion Paper

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## EGYPT AND THE MILLENNIUM DEVELOPMENT GOALS CHALLENGES AND OPPORTUNITIES

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**Abstract:** In 2000, the United Nations General Assembly adopted the Millennium Declaration, the commitment to work toward eliminating poverty and sustaining development. Goals for economic and social development measures, the Millennium Development Goals (MDGs), were established. The objective of this report is to assess Egypt's progress towards achievement of these MDGs. Egypt has made significant strides toward achieving the MDGs, including the targets for infant mortality, under-five mortality, contraceptive prevalence, primary and secondary enrollment, and access to safe drinking water. Closing the gender gap in employment, literacy, and political participation is proving more difficult. There are challenges that hinder progress toward the MDG targets in Egypt. These challenges include the pervasive differentials and gaps in the delivery, availability, and quality of publicly financed services and programs, the gender gaps; the fragmented legal system; and the lack of opportunity for civil society to participate in the development process. The report outlines a number of strategies to accelerate achievement of the MDGs in Egypt, including: 1) strengthening government stewardship and regulation, 2) encouraging community participation, 3) improving targeting of publicly financed services, 4) enhancing knowledge and awareness and promoting healthy behaviors, and 5) adopting a multisectoral framework. As 2015 approaches, there will be even greater attention given to the MDGs. The extent to which they are achieved will provide a benchmark for assessing how effective governments and the development community are at supporting human development. The momentum for achieving the MDGs in Egypt needs to be sustained to demonstrate that it has the systems, resources, and structures in place to improve the lives of its people. It is equally important that the focus on achieving the MDGs is not at the expense of programs and priority areas not directly linked to the MDGs.

**Keywords:** resource allocation and purchasing, health care financing, millennium development goals, poverty and health, governance

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## LIST OF ACRONYMS

ARI	Acute Respiratory Infections
BOP	Balance of Payments
CAPMAS	Central Agency for Public Mobilization and Statistics
CAS	Country Assistance Strategy
CBC	Communication for Behavioral Change
CPI	Consumer Price Index
EDHS	Egypt Demographic and Health Survey
EOC	Essential Obstetrics Care
ERSAP	Economic Reform and Structural Adjustment Program
GDP	Gross Domestic Product
GNI	Gross National Income
HEEP	Higher Education Enhancement Program
HIECS	Household Income, Expenditure, and Consumption Surveys
IEC	Information, Education, and Communication
IMCI	Integrated Management of Childhood Illnesses
IFPRI	International Food Policy Research Institute
IMF	International Monetary Fund
IMR	Infant Mortality Rate
KABP	Knowledge, Attitude, Behavior, and Practice
MDGs	Millennium Development Goals
MENA	Middle East and North Africa Region
MMR	Maternal Mortality Rate
MOSA	Ministry of Social Affairs
NAP	National AIDS Program
NCW	National Council for Women
NMMS	National Maternal Mortality Study
NDP	National Democratic Party
NGO	Non-Governmental Organization
OECD	Organization for Economic Cooperation and Development
PLWHA	Persons Living with HIV/AIDS
PRSP	Poverty Reduction Strategy Paper
PPP	Purchasing Power Parity
SIS	State Information System
STIs	Sexually Transmitted Infections
U5MR	Under-Five Mortality Rate
UN	United Nations
UNAIDS	Joint United Nations Program on AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization

## FOREWORD

In 2000, the United Nations General Assembly and 147 Heads of State adopted the *Millennium Declaration*, formalizing their commitment to work as a global community towards eliminating poverty, and sustaining development. Eight Millennium Development Goals (MDGs), eleven quantifiable and time-bound targets, and forty-eight indicators of economic and social development were agreed upon. Achievement of the MDGs by the 2015 target date has become a global priority.

Almost half way through the time period for achieving the MDGs, it is useful to examine where countries and regions stand vis-à-vis meeting these global targets. This publication – *Egypt and the Millennium Development Goals: Challenges and Opportunities* by Sameh El Saharty, Gail Richardson and Susan Chase – is part of a series of Discussion Papers that analyze how close countries are to achieving the MDGs and the constraints that they face in their efforts to do so.

The paper highlights that Egypt has made significant strides towards achieving the MDGs and is on track to meet some, but not all, of the targets. It will likely meet the criteria established for infant and child mortality, primary and secondary enrollment and access to safe water, but not the criteria for closing the gender gaps in employment, literacy, and political participation.

Perhaps equally important as the analysis of the degree of achievement, is an assessment of the constraints that Egypt faces in striving to meet the MDGs. The report highlights the challenges posed by the lack of reliable and timely data, the difficult choices for resource allocation, and the need to make public spending on social services more efficient and equitable. Egypt is also challenged by a fragmented legal system, social norms in parts of the country that do not favor women's participation in civil society, and cultural traditions that have led to an acceptance of achievement differences between girls and boys.

Egypt is not alone in the challenges it faces to meet the MDGs. Indeed, a common thread throughout various publications on progress towards the MDGs is that systemic problems with data, governance, and the legal framework can be found in countries that span the socio-economic spectrum.

The paper concludes by proposing a set of strategies for accelerating achievement of the MDGs in Egypt, including adopting a multisectoral framework, improving the efficiency and targeting of publicly financed services, and encouraging community participation.

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## EXECUTIVE SUMMARY

In 2000, the United Nations General Assembly and 147 Heads of State adopted the *Millennium Declaration*, the commitment to work toward eliminating poverty and sustaining development. Eight Millennium Development Goals (MDGs), eleven targets, and forty-eight indicators were agreed, as quantifiable and time-bound targets. This report assesses where Egypt stands relative to these goals.

Egypt has made significant strides toward achieving the MDGs. The targets for infant mortality, under-five mortality, contraceptive prevalence, primary and secondary enrollment, and access to safe drinking water are likely to be met. Other important goals will prove more elusive, for example, the goals of closing the gender gap in employment, literacy, and political participation. The data are not able to confirm whether the goals for HIV/AIDS and malnutrition will be achieved. Expanding access to basic social services while effectively targeting the population sub-groups that are currently not benefiting from the services and adopting multisectoral strategies are key policy steps needed for achieving the MDGs.

A number of cross-cutting and overarching challenges impede Egypt's progress toward the MDGs. These include pervasive differentials and gaps in the delivery, availability, and quality of publicly financed services and programs, gender gaps; the fragmented legal system; and the lack of opportunity for civil society participation in the development process. There is also a lack of reliable and timely data to monitor Egypt's progress toward achieving some of the MDGs.

The policies and programs needed to achieve the MDGs vary from goal to goal and are addressed under each section. There are a number of overarching strategies that warrant attention in order to accelerate the achievement of the MDGs in Egypt. These strategies include:

- Strengthening government stewardship and regulation
- Encouraging community participation
- Improving targeting of publicly financed services
- Promoting knowledge, awareness, and behavior
- Adopting a multisectoral framework.

It is important that the government and donors work together to develop appropriate and focused strategies, overcome funding gaps and fungibility issues, and ensure continuity of aid to support the government's efforts to achieve the MDGs. The United Nations Development Program (UNDP) has been designated as the focal agency for ensuring donor collaboration for the MDGs. It is important that the donor community supports this role.

As 2015 approaches, governments and the international community will focus even greater attention on the MDGs. The extent to which they are achieved will provide a benchmark for assessing how effective governments and the development community are at supporting human development in a global context. The momentum for achieving the MDGs in Egypt needs to be sustained to demonstrate to the global community that it has the systems, resources, and structures in place to improve the lives of its people. It is equally important that the focus on the MDGs does not occur at the expense of other important programs and priority areas.



# GENERAL OVERVIEW

## INTRODUCTION

The Millennium Development Goals seek to eliminate poverty and foster sustaining development, taking a time horizon to 2015. They reflect a decade of conferences and summits supported by the United Nations. The first meeting—the World Summit for Children in 1990—identified primary issues and established fundamental criteria. Primary issues include: infant, child, and maternal mortality, malnutrition, access to safe drinking water, access to education, completion of primary education, and adult illiteracy. “Goals,” “targets,” and “indicators” were discussed and outcomes, to be measured over time, were agreed. Six subsequent meetings further refined the process and areas of concern.<sup>1</sup> In 2000, the United Nations General Assembly unanimously passed and 147 Heads of State signed the *Millennium Declaration*, the commitment to work toward a world in which the highest priorities are eliminating poverty, and sustaining development.

Going beyond the *Millennium Declaration*, the United Nations Secretary General was consulted and a road map was created for fulfilling the adopted resolutions. Eight Millennium Development Goals (MDGs), eleven targets, and forty-eight indicators were agreed to by the Development Assistance Committee of the Organization for Economic Cooperation and Development (DAC/OECD), and a number of United Nations Agencies—including the International Monetary Fund (IMF) and the World Bank. The objective of this report is to assess where Egypt stands within this MDG road map.

Several intermediate or “proxy” indicators are used for Goal 1 through Goal 7 to understand the current situation, the progress achieved over the last decade, and the prospects for attaining the goals. The paper highlights the major constraints in attaining the goals. It identifies the requisite conditions and interventions—policy, sectoral, and institutional reforms—to reduce the risks of failure. And it proposes recommendations for building capacity and enhancing efficiency.

In general, Egypt is very well situated in terms of achieving the MDGs. Its regional disparities, its urban-rural disparities, and its gender disparities bespeak the enormous existing challenges and attest to the need for middle-income countries to surpass the minimal level of achievement (MDGs), and to adopt a more comprehensive approach (MDG-Plus).<sup>2</sup> This report complements the official monitoring document prepared by the United Nations Development Program and aspires to set out a framework for discussing the MDGs in Egypt, for use by international donors, the Egyptian government, and the World Bank. Table 1 summarizes the MDG goals and targets reviewed in this paper, and the degree to which these targets are likely to be achieved.

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<sup>1</sup> Conferences and summits of the 1990s sponsored by the United Nations: Children, New York, 1990; Education, Jomtien, 1990; Environment, Rio, 1992; Human Rights, Vienna, 1993; Population, Cairo, 1994; Women, Beijing, 1995; Social Development, Copenhagen, 1995.

<sup>2</sup> ‘MDG-Plus’ refers to the inclusion of additional goals/outcomes other than those agreed upon and adopted by the UN and Heads of State.

**Table 1: MDG Goals and Targets: Summary of Likelihood of Achievement in Egypt**

MDG Goal	Targets	Prospects for Achieving Target			
		Likely	Possible	Unlikely	Data Inconclusive/ Not Available
Eradicate extreme poverty and hunger	Reduce by half the percentage of the population living in poverty		X		
	Reduce by half the prevalence of underweight among children				X
Achieve universal access to education	Attain 100 percent primary school enrollment by 2015		X		
Promote gender equality and empower women	Reduce the gender gap in primary and secondary enrollment and literacy among 15-24 year olds by 2005			X	
	Increase the share of women in nonagriculture employment and in the national parliament			X	
Reduce infant and child mortality	Reduce infant and child mortality between 1990 and 2015 by 2/3	X			
Improve maternal health	Reduce the maternal mortality ratio by 3/4 between 1990 and 2015	X			
	90 percent or over of all births attended by a skilled staff by 2015	X			
Combat HIV/AIDS, malaria, and communicable diseases	Slow the rate of HIV/AIDS				X
	Increase contraceptive prevalence	X			
Ensure environmental sustainability	Reduce by half the percentage of the population without access to safe drinking water between 1990 and 2015	X			

## COUNTRY CONTEXT

### Geographic Context

Egypt is one of the oldest societies in the world and is also one of the largest (with over 1,000,000 square kilometers of land) and most densely populated of the Arab countries, with about 65 million people. Much of the land in Egypt is desert and only 6 percent of the area is inhabited. Administratively, Egypt is divided into 26 governorates, which include four exclusively urban governorates: Alexandria, Cairo, Port Said, and Suez. Each of the other 22 governorates has both urban and rural areas. These

22 include the nine governorates of Lower Egypt in the Nile Delta region; the eight governorates of Upper Egypt along the Nile River south from Cairo to Aswan; and the five frontier governorates covering Sinai and the deserts west and east of the Nile.

### **Political Context**

Egypt occupies an exceptional geopolitical position among the Arab states and on the African continent. Stability of political leadership within Egypt and extensive donor support for Egypt's economic development set the country apart from its neighbors in the 1990s. Both its size and geopolitical context have helped Egypt to become one of the largest recipients of overseas development assistance.

The government is headed by President Hosni Mubarak who was re-elected to his fourth six-year term in September 1999. The government is supported by the majority party in parliament, the National Democratic Party (NDP).<sup>3</sup> While the ruling NDP retained its parliamentary dominance, its majority was reduced from 94 percent of the parliamentary seats in 1995 to 85 percent during the last election. At the same time, the number of opposition deputies in parliament increased from 13 to 54.

Egypt differs little from the regional norm in that women are seriously under-represented in parliament. Opposition to women's rights comes from conservative sectors of society, and groups and social forces who adhere to fundamentalist versions of Islam. While the government tends to be sympathetic to demands from women's rights advocates, it is constrained by the need not to antagonize conservative social forces. At stake are not only the struggle for women's rights, but also the independence of civil society associations.

The stability of the region has an impact on Egypt's socioeconomic outlook. President Mubarak has made it a priority to end Egypt's relative isolation within the Arab world while remaining committed to the peace treaty with Israel. This approach has resulted in occasional diplomatic distancing from the United States, which remains Egypt's chief ally and source of foreign aid. Cairo had been maintaining a delicate balancing act between the need to preserve its key alliance with the United States on the one hand, and on the other satisfying domestic opinion, which is at times ill disposed toward United States policy in the Middle East. Egypt is an important player in the current Middle East peace process with Israel and Palestine and is committed to supporting peace in the region.

### **Economic Context, 1990-2003**

The stabilization efforts of the early 1990s resulted initially in low growth (from 1990 to 1995, the average growth in GDP was only 3.8 percent). However, these efforts set the stage for sustained and robust GDP growth increases during the 1996–2000 period, reaching a peak of 6.3 percent in FY99. Thereafter, economic growth began to slow because of external shocks and slow economic reforms. Since FY01, Egyptian official figures for growth hovered around 3 percent. (Growth was 3.2 percent in the most recent years for which data are available-FY02 and FY03.) Nevertheless, the long-term

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<sup>3</sup> Egypt Country Profile. 2003. *The Economist Intelligence Unit*. UK: The Economist.

development strategy for 1997 to 2017 aimed to accelerate the rate of growth to 6.8 percent by 2002 and further it to 7.6 percent for the remainder of the period.<sup>4</sup>

Growth in the 1990s did not lead to the creation of an adequate number of jobs. Unemployment was officially estimated at 9 percent in FY02, up from 8.3 percent in FY01. This is largely due to slow growth in the private sector, labor market constraints, and because the economic stimulation reforms have not yet had the anticipated effects. Addressing unemployment is a main challenge facing the government.

Despite concerns about a significant negative impact from the events of September 11, Egypt's overall balance of payments (BOP) improved over the period FY02 and the first half of FY03. In FY02, even though there was a fall in service receipts, Egypt recorded a very small current-account deficit of US\$8.5 million compared to US\$33.4 million in FY01.

- Exports of goods and services: US\$16,925 million in 2001, up from US\$10,236 million in 1991.
- Imports of goods and services: US\$21,772 million in 2001, up from US\$13,472 million in 1991.
- Government domestic debt: 221£E billion, end of period debt stock. As fiscal deficit widened, government domestic debt increased to 57.1 as a percent of GDP in FY02 and 58.2 percent of GDP in the first quarter of FY03.

The external environment has been unfavorable because of the sluggish economic growth of Egypt's main trading partners—the United States and Europe. These markets combined represent 50 percent and 7 percent of Egypt's exports and tourist arrivals, respectively. Tourism was hit hard by the events of September 11 and the Iraq war. As a result, the economy continued to decelerate in FY02 and FY03. After reaching a peak of 6.3 percent in FY99, economic growth slowed because of external shocks and slow economic reform.

*Egyptian Currency.* The Egyptian pound (£E) consists of 100 piasters. After a decade of fixed exchange rates and because of continuous pressures on the foreign exchange market over the last fiscal year, the government announced the move to a floating foreign exchange system at the end of January 2003. The system started with a rate of LE5.35/US\$1, which was close to the then prevailing parallel market rate. While the decision to float the currency is commendable, complementary measures? such as improving the investment climate, improving incentives to export, and liberalizing the banking system? need to be taken for this bold measure to enhance growth and impact economic activity.

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<sup>4</sup> World Bank. June 2001A. Egypt Social and Structural Review. Washington, DC: World Bank.

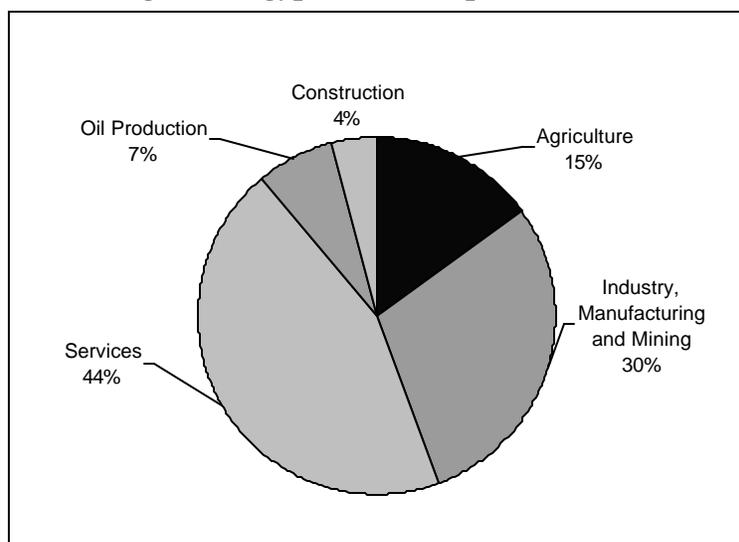
**Table 2: Economic Indicators, 2001**

Real GDP Growth (percent)	2.90
Consumer Price Inflation (average; percent)	3.80
Current-Account Balance (US\$ million)	-334.00
External Debt (US\$ billion)	29.20
Exchange Rate (average) £E:US\$	4.49

Source: World Development Indicators.

*Sources of Growth.* Agriculture remains a steady contributor to employment growth in Egypt and a large source of employment once nonwage female job creation in the sector is taken into account. During the 1990s, the focus was on increasing agricultural productivity of land and water through more efficient use of these limited resources. As a result, the annual growth rate of agricultural production increased to 3.0 percent in the 1990s from 2.8 percent in the 1980s and the food gap narrowed significantly. However, the sector's contribution to GDP has gradually fallen from 20 percent in FY86-87 to 15 percent in 2001 (see Figure 1). The number of Egyptians employed in the sector has also fallen—from 33.8 percent of the total labor force in FY90-91 to 29.5 percent in 2001.

**Figure 1: Egypt GDP Composition, 2001**



Source: World Development Indicators, 2003, Egypt Social and Structural Review, 2001  
The Economist Intelligence Unit.

Industry and mining contributed 20 percent of GDP in 1998-99. As a result of the government's privatization program, the private sector's role has steadily expanded in key sectors such as metals (aluminum, iron, and steel), petrochemicals, cement, automobiles, textiles, consumer electronics, and pharmaceuticals. The government has made high technology development, including information technology, a priority as well as attracting export-oriented manufacturing firms to Egypt. The share of manufacturing in GDP is 12 percent; manufacturing produced mainly consumer goods but also some basic industries such as iron and steel, aluminum, and cement. Manufacturing is largely dominated by the public sector and the general consensus is that this sector needs major reform. The oil and gas sector

accounted for about 7 percent of Egypt's GDP in 2001 and over 50 percent of goods exports. The most significant developments have been in the gas sector, with promising finds made in the Western Desert and in the offshore Nile Delta region, and Egyptian gas consumption is expected to rise.

To summarize, the economic reforms of the early 1990s did lead to accelerated economic growth in the 1990s and a reduction in poverty. Adverse external developments including the events of September 11 showed that more reforms are needed to sustain the momentum and preserve the commendable results achieved to date.

### **Social and Economic Context**

While Egypt does not have a Poverty Reduction Strategy Paper (PRSP), and with recent positive trends well established, the government recognizes the need to modernize the state, and increase efficiency and competition to achieve private sector led growth that creates gainful employment and reduces poverty. The country has experienced a low level of overall poverty incidence as well as a remarkable decline in poverty, particularly over the second half of the 1990s.<sup>5</sup> The incidence of absolute poverty (those living on less than US\$1 a day) is negligible (the rate for 1999 was 6 percent), and the incidence of poverty, defined as living on less than US\$2 a day, is low. At the national level, poverty is highest in agricultural activities: about 39.4 percent. Agricultural, construction, and industrial activities are over-represented within poor groups, while individuals involved in services activities and bankers have the largest share in the nonpoor groups.

Egypt has also performed well with respect to other social indicators. Net primary school enrollment rates increased to 93 by 1999; the number of Egyptians with university degrees has risen from 4.3 percent in 1986 to 7.3 percent in the late 1990s, literacy rates improved to 55.5 in 1999, and life expectancy reached 67 in 1993-99. While the overall population growth rate is relatively low at 2 percent, efforts are needed to reduce the high fertility rate of 3.6 percent.

Egypt has three social safety net programs which together account for about 2 percent of GDP or about 4 percent of total government expenditure in 1999. If perfect targeting were possible with these programs, it is estimated that eliminating poverty in Egypt would cost 0.8 percent of GDP or 2.9 percent of total expenditure. Because of the compression of expenditure in the first six deciles, and the predominance of poverty in disbursed rural areas, distinguishing the poor from the nonpoor is difficult and leakage can be expected.

These statistics demonstrate the government's commitment to improving the livelihood of the population, as supported through its investment in the health and education sectors, the Social Fund for Development, appropriate skills development, and encouraging the expansion of NGOs. The next phase for social development should support efforts such as wider participation, greater decentralization, and faster job creation in the private sector.

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<sup>5</sup> El-Laithy, H., M. Lokshin, and A. Banerji. May 2003. Poverty and Economic Growth in Egypt, 1995-2000. Washington, DC: World Bank.

The Social and Structural Review, completed in June 2001, provided a systematic evaluation of economic policy and structure to identify the main constraints to poverty reduction and long-term development in Egypt, and the sources of vulnerability, particularly as Egypt considers further global integration through entering into foreign trade agreements. Five priorities were identified for reform:

- To maintain Egypt's robust economic performance of the late 1990s, the government will need to strengthen economic management, which may have been pushed off-course by exogenous shocks in the latter half of the 1990s.
- Trade liberalization remains an unfinished and critical area for further reform. By reducing tariffs and trade taxes, especially on manufactures, Egypt could achieve productivity gains and wage growth.
- Government regulations need reform as they increase the cost of doing business.
- Expenditures on the bottom half of the population appear to be fairly compressed and some realignment is needed.
- Quality of life is affected by public services such as health, education, sanitation, clean water, and air quality and these could benefit from significant efficiency gains.<sup>6</sup>

The World Bank's program with the government places particular emphasis on addressing the complex nature of poverty. As noted above, the Social and Structural Review (June 2001) was conducted to identify the main constraints to poverty reduction. The Country Assistance Strategy (CAS) report for the period FY02 to FY04 emphasized Egypt's economic growth performance, based on stabilization efforts, which allowed private sector activity, reduced inflation, implemented structural reforms in the areas of capital markets, tariff reduction, and improved social safety nets. In addition, World Bank-financed programs in a number of important priority sectors are underway, including in the health, education, and social protection sectors. In 2004 the Government of Egypt and the World Bank articulated a poverty strategy, built around three pillars of growth, education and social safety nets.<sup>7</sup>

### **OUTLOOK FOR ACHIEVING THE MDGs**

Reaching the economic growth targets that Egypt has set out for itself and which will make achieving the MDGs possible will depend on the ability of the Egyptian government to achieve short and long term objectives. In the short term, concerted efforts are needed to build upon the move to float the currency by taking necessary complementary measures that will impact economic activity and provide adequate

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<sup>6</sup> World Bank. June 2001. Social and Structural Review. Washington, DC: World Bank.

<sup>7</sup> World Bank, September 2004. Arab Republic of Egypt: A Poverty Strategy for Egypt. Washington DC: World Bank. Report 27954.

incentives to export. Moreover, recent balance of payment figures show that the government has managed to limit the impact of external shocks; however, compressing imports will hinder the ability of the economy to grow quickly and is not sustainable. In the longer term, the government will need to complete the structural reform agenda. The challenge is to increase competitiveness and thus reliance on manufactured exports, which have a higher value added than natural resources and exporting labor.

### **GOVERNMENT COMMITMENT TO THE MDGS**

Egypt's national priorities are in line with the MDGs. The government is adopting an Economic Reform and Structural Adjustment Program (ERSAP), launched in 1991, that entails a strong shift from a centrally-planned economy with a relatively small private sector to a decentralized, market-based and outward-oriented economy in which the private sector plays the leading role. ERSAP aims to stabilize the economy through reform policies geared toward reducing the country's external debt, decreasing the inflation rate, increasing foreign exchange reserves, encouraging foreign direct investment, promoting the private sector, and boosting exports (recently floating its currency to support achievement of these targets).<sup>8</sup> Economic stabilization will have a direct impact on Egyptians, particularly the vulnerable sector of the population in rural and underserved areas that suffer from poverty, unemployment, illiteracy, and limited access to basic health and education services. In an effort to reduce the social cost—an outcome of the ERSAP—and to provide a social safety net for vulnerable groups, the government established the Social Fund for Development.<sup>9</sup> As the government's guaranteed public employment policy has been discontinued, the Social Fund is playing a key role in providing job opportunities through microcredit projects and in enhancing technical and vocational skills of unemployed people.

More recently, the government's commitment to the MDGs was reflected in the government's plan, as reiterated at the Consultative Group Meeting for Egypt, and the priorities stated in Egypt's National Development Plan (2002 to 2007).<sup>10</sup> The objectives of this plan are to overcome economic stagnation, decrease the unemployment rate, create jobs, improve citizens' standard of living, expand basic services to underserved areas, enhance women's role in development, integrate Egypt into the global economy, develop Egypt's industry and access to technology, and boost exports.<sup>11</sup>

The government's policies and programs, in the prospect of achieving the MDGs, have supported progress in poverty eradication, job creation, and access to basic health and education services. Two

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<sup>8</sup> United National Development Programme. 1997. First Country Cooperation Framework for Egypt, 1997-2001. Website of the Egyptian Ministry of Foreign Affairs, Foreign Policy Positions and Documents: [www.mfa.gov.eg](http://www.mfa.gov.eg), page 3.

<sup>9</sup> Ibid.

<sup>10</sup> The Consultative Group Meeting was jointly organized by the Government of Egypt and the World Bank and was held in Sharm El-Sheikh on February 5-6, 2002.

<sup>11</sup> New Development Plan Leads to Egypt's Modernization and Prosperity, *Al Ahram Newspaper*, 6 May 2003, page 3.

key areas that require particular attention are: (i) reducing by half the number of malnourished children; and (ii) making progress toward gender equality and women's empowerment.<sup>12</sup>

## POVERTY

### OVERVIEW

The definition of poverty is complex and multifaceted. It has been defined as pronounced deprivation in well-being. This deprivation includes material deprivation (such as income), as well as low achievements in education and health. More recently, this definition has been broadened to include vulnerability and exposure to risk (e.g. the risk that the head of household will fall ill and there will not be money to purchase basic food items), and a lack of "voice" and power. This broader perspective, and the policies that come with it, reinforces interactions among the elements of poverty. For example, improving people's health not only improves their well-being, but also strengthens their income potential. There is a similar relationship between education and potential for income. Providing poor people with a voice not only addresses their sense of exclusion and powerlessness, but also leads to better targeting of health and education services to match their needs. Understanding these complementarities is important for the design and implementation of policies and programs to help people escape poverty.<sup>13</sup>

The MENA region, using international purchasing power standards of US\$1 or US\$2 per capita 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. The region's low poverty headcount is particularly striking in contrast with that of Latin America - a region with roughly twice the level of per capita income - which recorded poverty levels of 12.1 percent of the population in 1998. Moreover, compared to other developing areas, during the 1990s the Middle East region has become one of the most equal in terms of income distribution.<sup>14</sup>

Unlike most developing countries, Egypt has experienced a low level of overall poverty incidence as well as a remarkable decline in poverty during the last decade.<sup>15</sup> Poverty reduction was declared as one of the main objectives of the long-term plan in Egypt, which aimed to reduce poverty to 6 percent by 2022. Poverty is a highly politically sensitive issue in Egypt. Until recently, officials denied the existence

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<sup>12</sup> World Bank. June 2001. Country Assistance Strategy for the Arab Republic of Egypt, Report No. 22163-EGT, page 5. Washington, DC: World Bank.

<sup>13</sup> World Bank 2001. World Development Report 2000/2001: Attacking Poverty; The World Bank. UK: Oxford University Press.

<sup>14</sup> Adams Jr., R. and J. Page. 2003. "Poverty, Inequality and Growth in Selected Middle East and North African Countries, 1980-2000," World Development 31: 2 (December 2003), 2027-2048.

<sup>15</sup> El-Laithy, H., M. Lokshin, and A. Banerji. May 2003. Poverty and Economic Growth in Egypt, 1995-2000. Washington, DC: World Bank.

of poverty, however, they realized that ERSAP may have an adverse impact on the standards of those living in "low income groups", and hence several policies have been designed and implemented to help those groups. Although there is no single government entity responsible for planning, monitoring, and coordinating the different programs and activities addressing the poor, the Ministry of Planning has been leading efforts in this regard. Egypt has used multidimensional strategies for raising Egyptian standards of living, including income generation, human capital and safety net strategies. The Ministry of Planning has devised short-, medium-, and long-term overall economic and social development plans, which have been translated into plans of action for the different ministries and agencies affected. The Egyptian government pursues poverty alleviation objectives through a variety of channels including: direct assistance to the poor through the Ministry of Social Affairs (MOSA); free social services such as health and education, subsidies for agriculture credit, and support to work and income generating activities through the Social Fund for Development.

Egypt has been successful in reversing a trend of declining growth that persisted since the mid 1980s. From 1997 to 2002, real GDP grew at an average of 4.7 percent, real per capita GDP grew at 3.6 percent, and inflation was brought down from a high of 21.1 percent in 1991-92 to 4.4 percent during the same period. Significant progress in social development has also been achieved. The net primary school enrollment rate increased from 63 percent in 1975 to 93 percent in 1999; infant mortality declined from 92 deaths per 1,000 live births in 1980-85 to 49 deaths per 1,000 live births in 1993-99, life expectancy at birth increased from 59 in 1980-85 to 67 in 1993-99 and the literacy rate increased from 48.2 in 1992 to 55.5 in 1999.

## **MDG ONE: ERADICATE EXTREME POVERTY AND HUNGER**

It was the bleak picture with respect to global poverty and inequality that provided the impetus for the MDGs. Each of the MDGs looks at an element of deprivation as a facet of poverty (gender inequality, access to safe drinking water, etc.). The targets for the first MDG goal look at poverty in terms of income, and one of the measurable impacts that lack of income can cause – hunger and malnutrition.

*Targets 1 to 3: Reduce by half the percentage of the population living in poverty*

*Target 4: Reduce hunger and malnutrition*

### **Current Situation**

*Poverty in 1999/2000.* Poverty data and its interpretation have been a source of controversy in Egypt. In 2002, a Government/World Bank Poverty Assessment was conducted in an effort to synthesize and come to agreement on a variety of poverty indicators. The report indicated that in 1999-2000, overall poverty in Egypt stood at 16.7 percent, using the lower national poverty line (see Table 3). This means that almost 16.7 percent of the population, or approximately 10.7 million people, could not obtain their basic food and nonfood needs. Using the upper poverty line, overall poverty in Egypt rises to 42 percent, representing almost 26.9 million individuals. Less than one percent of Egyptians spend less than US\$1 a day evaluated at Purchasing Power Parity (PPP). In contrast, 24.8 percent live on US\$2 a day.

Poverty analysis shows that most poor people were clustered just below the poverty line. This means that if there were perfect targeting of poverty-alleviating transfers, it would require only about LE 350 million per year (about 0.1 percent of GDP in 1999-2000) to lift everyone out of poverty.

**Table 3: Poverty Measures for 1990-91, 1995-96, 1999-00 and Projections for 2015**

	<i>1990-91</i>	<i>1995-96</i>	<i>1999-00</i>	<i>Projections 2015</i>
Lower National Poverty Line Headcount	24.32	19.41	16.74	10.80
Poverty Gap (National Poverty Line)	7.08	3.39	2.97	2.06
National Poverty Line Headcount	49.27	51.43	42.63	30.25
Poverty Gap (National Poverty Line)	16.98	13.92	10.83	7.16
Poverty Line at US1\$/day PPP Headcount	8.241	2.497	0.682	0.88
Poverty Gap	2.273	0.325	0.073	0.20
Poverty Line at US2\$/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

### **Current Situation: Regional Poverty in 1999-2000**

*Regional Poverty.* The Poverty Assessment found that poverty in Egypt had changed by the late 1990s from an overriding urban-rural phenomenon to a regional one. As Table 4 shows, the distribution of the poor is quite uneven across regions. Using the lower poverty line, the incidence of poverty ranges from a high of 34.2 percent (Upper Rural region), followed by 19.3 percent in the Upper Urban region, to a low of 5.1 percent in the Metropolitan region.

Poverty is heavily concentrated in the Upper Rural region: 54.4 percent of the poor in Egypt live there when using the lower poverty line and 39.7 percent when using the upper poverty line. The Upper Rural region has the greatest incidence, depth and severity of poverty, where 63.5 percent of the individuals are poor. Finally, the Upper Rural area's share in poverty far exceeds its population share (26.67 percent). This is not the same in the Metropolitan region where the share of poverty (5.06) is less than its share of the total population (less than one-third). However, the contribution of the Metropolitan region is larger when using the upper poverty line, reflecting that the poor in this area are concentrated between the lower and upper poverty levels. In general, rural areas in all regions have higher poverty measures than their urban counterparts, by more than 5 percentage points. Poverty, particularly extreme poverty, is relatively low in urban areas where 41.5 percent of the population resides.

**Table 4: Growth and Distribution of Poverty by Region, 1996-2000**

		<i>Percent Change in Incidence of Poverty between 1996 and 2000</i>		
<b>Regions</b>		<b>Growth</b>	<b>Redistribution</b>	<b>Actual Change</b>
<b>Lower Poverty Line</b>	<b>Metropolitan</b>	-9.18	1.13	-8.04
	<b>Lower Urban</b>	-0.61	-1.56	-2.17
	<b>Lower Rural</b>	-4.45	-5.25	-9.70
	<b>Upper Urban</b>	1.29	7.15	8.45
	<b>Upper Rural</b>	3.55	1.28	4.83
	<b>Border Urban</b>	6.84	-8.77	-1.93
	<b>Border Rural</b>	29.06	-24.57	4.48
	<b>Total</b>	-1.72	-0.95	-2.68
<b>Upper Poverty Line</b>	<b>Metropolitan</b>	-17.48	1.55	-15.93
	<b>Lower Urban</b>	-1.52	-4.36	-5.87
	<b>Lower Rural</b>	-5.22	-9.91	-15.13
	<b>Upper Urban</b>	2.34	2.47	4.81
	<b>Upper Rural</b>	3.55	-5.41	-1.86
	<b>Border Urban</b>	11.53	-34.57	-23.05
	<b>Border Rural</b>	22.00	-26.77	-4.77
	<b>Total</b>	-3.43	-5.37	-8.80

The percentage of the ultra poor was also estimated. The ultra poor are defined as those individuals whose total expenditure is less than the food poverty line. Overall, the ultra poor represent 2.9 percent of the Egyptian population. These percentages vary tremendously among regions, ranging from as little as 0.58 percent in Lower Urban region to 7.38 percent in Upper Rural region. Thus 7.38 percent of Upper Rural population cannot obtain their basic food requirements even if they spend all their expenditure only on food items.

*Poverty Trends.* Table 3 illustrates trends in poverty measurements at the national and regional levels, for the period 1990-91 to 1999-2000. Highlights of the analysis are as follows:

- Trends in poverty measures are not consistent when comparing different poverty lines.<sup>16</sup>
- The poverty gap and severity indices declined, indicating improvements in the expenditure inequality of the poor, even though their relative percentage increased.
- Patterns of poverty changes between 1995-96 and 1999-2000 differ. The poverty incidence increased substantially in Upper Egypt, from 29.3 percent to 34.2 percent in rural areas and from 10.8 percent to 19.3 percent in urban areas. The Metropolitan and Lower Egypt regions are the only regions that experienced declines in their poverty measurements. The decline in poverty was

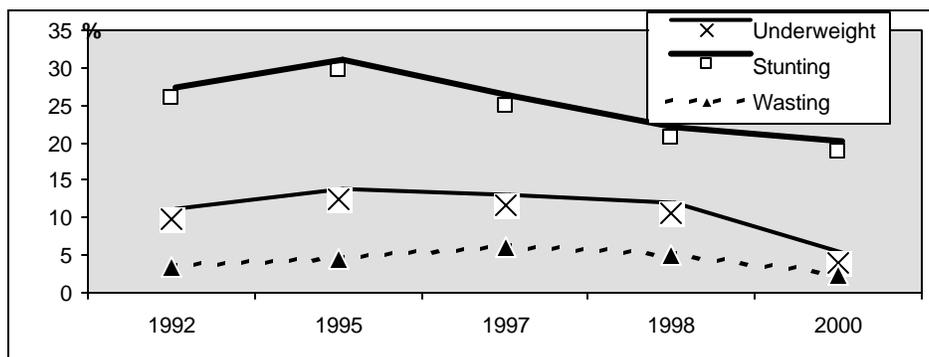
<sup>16</sup> Using a lower poverty line, the percentage of the population in poverty declined steadily from 24.3 percent in 1990-91 to 16.7 percent in 1999-2000. Applying the international poverty line of US\$1 a day, the trend was similar. However, applying a national poverty line, poverty increased between 1990-91 and 1995-96 by about 2 percentage points and then declined sharply by 9 percentage points during 1995-96 to 1999-2000.

substantial in the Metropolitan region (from 13.1 percent to 5.06 percent) and in the Lower Rural region (from 21.53 percent to 11.83 percent).

- The change in poverty could be attributed to changes in the distribution of living standards as distinct from growth in average living standards. Growth in the Lower regions was pro-poor while growth in the Metropolitan region was large enough to cause improvements in poverty levels but it was not pro-poor growth.

*Hunger and Malnutrition.* Egypt is one of the countries in the region where malnutrition is a challenge. Malnutrition is mainly represented using underweight (weight for age), a composite indicator that combines chronic malnutrition or stunting (height for age), and acute malnutrition or wasting (weight for height). Figure 2 shows trends in the three indicators. In 2000, malnutrition was estimated at 4.0 percent, stunting at 18.7 percent, and wasting at 2.5 percent.<sup>17</sup> This report focuses primarily on underweight and stunting.

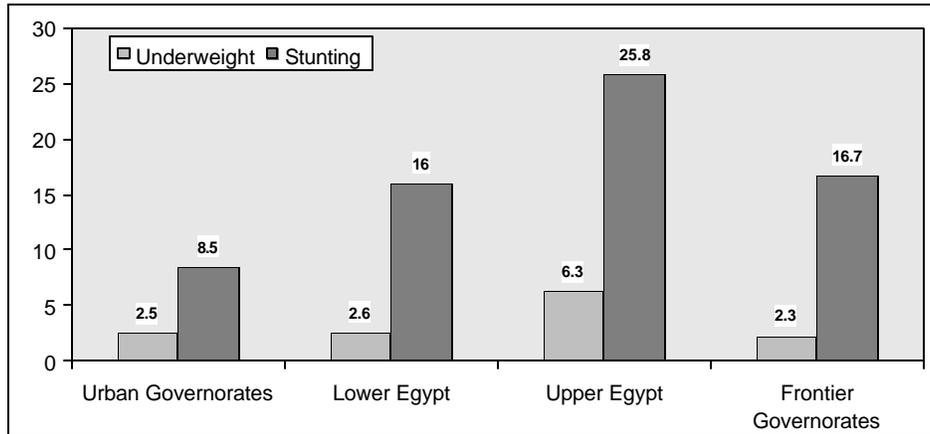
**Figure 2: Trends in Malnutrition of Children in Egypt, 1999-2000**



In terms of regional variation, Upper Egypt had the highest prevalence, where malnutrition was 6.3 percent and stunting 25.8 percent in 2000 (Figure 3).

<sup>17</sup> El-Zanaty, F. and A. Way. January 2001. Egypt Demographic and Health Survey (EDHS) 2000.

**Figure 3: Regional Variation for Underweight and Stunting in Egypt, 2000**



In terms of rural-urban differentials, the incidence of underweight was 4.7 percent in rural areas compared to 3.0 percent in urban areas, and the incidence of stunting was 21.8 percent in rural areas compared to 13.8 in urban areas. The most affected areas are Rural Upper Egypt, where underweight was 6.8 percent and stunting was 27.2 percent.

The main contributing causes to malnutrition are inadequate dietary intake and disease. These causes are affected at the household level by: (i) insufficient access to food; (ii) inadequate maternal education and childcare; and (iii) poor water/sanitation; and (iv) inadequate health services. A selected number of factors that affect malnutrition in Egypt are examined below:

- *Breastfeeding.* Almost all Egyptian children are breastfed (95 percent) for some period of time. However, only one third are exclusively breastfed (34 percent). Breastfeeding continues for the majority of Egyptian children (80 percent) beyond the first year of life.<sup>18</sup>
- *Complementary foods and bottle feeding.* Grain-based foods (e.g., porridge) are the most common weaning foods, followed by sweet potatoes and other tubers, fruit, and fish, eggs or poultry. At 8 to 9 months, about one in six children was not being given solid or mushy food or other milk in addition to breast milk.<sup>19</sup>
- *Birth order.* Malnutrition is higher among children of birth order four or higher compared to other children.
- *Birth interval.* A child born less than 24 months after an older sibling is around 50 percent more likely to be malnourished than a child born 48 months or longer after an older sibling.

<sup>18</sup> The United Nations Children's Fund (UNICEF) recommends that during the first six months of life, children should be exclusively breastfed.

<sup>19</sup> It is important to introduce complementary foods at around six months of age since, at that stage, the mother's breast milk no longer provides adequate nutrition for the child.

- *Educational level of the mother.* Among children whose mothers never attended school, 5 percent were underweight and 23 percent stunted compared to 3 percent underweight and 15 percent stunted of children whose mothers completed the secondary level or higher.
- *Prevalence of diarrhea.* Children 6 to 23 months (25 percent) are more likely to have diarrhea than older or younger children. In the majority of cases (70 percent), the child had been given less than the normal amount of food during the most recent diarrheal episode. In about quarter of the cases, the mother either stopped feeding the child at all (10 percent) or gave the child much less than normal to eat (13 percent).

### Prospects of Attaining Poverty, Hunger, and Malnutrition Targets

*Poverty.* Simulation results show that Egypt could achieve its MDG on poverty if per capita expenditure grows by 1.5 percent per annum and income inequality continues to change at the same rate prevailing during the period 1990-91 to 1999-2000. These rates are applied for all regions. With this scenario, poverty declines to 10 percent (using the lower poverty line), which is a decrease of more than half the rate in 1990-91. When US\$2 a day poverty line is applied, the poverty rate declines by 58 percent of the 1990-91 rate (see Tables 3 and 5).

**Table 5: Elasticity of Poverty Measures to Mean Consumption and Inequality, 1999-2000**

		<i>Consumption Elasticity</i>	<i>Gini Index Elasticity</i>
<b>Metropolitan</b>	P0	-5.67153	12.16966
	P1	-6.80346	17.74424
	P2	-7.25491	21.85869
<b>Lower Urban</b>	P0	-5.82759	6.45804
	P1	-5.76357	8.49529
	P2	-5.06005	9.82384
<b>Lower Rural</b>	P0	-5.91886	3.69503
	P1	-7.04383	6.02161
	P2	-7.30733	7.81038
<b>Upper Urban</b>	P0	-3.23797	3.33996
	P1	-4.24356	6.40871
	P2	-4.77250	8.98581
<b>Upper Rural</b>	P0	-2.89425	0.91316
	P1	-4.27326	2.66375
	P2	-5.24449	4.28569

*Malnutrition.* Since 1988, at least seven national surveys have measured the prevalence of underweight children and their results are shown in Table 6.<sup>20</sup>

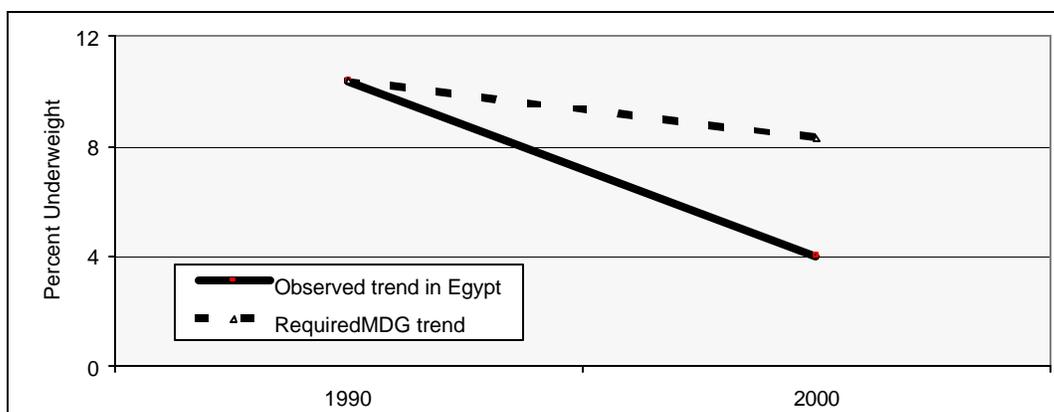
<sup>20</sup> In order to calculate the trend in malnutrition (underweight) for assessing whether Egypt is making enough progress at current rates to reach the MDG by 2015, some have used endpoints (a base-year and the most recent estimate). However, as all surveys have standard errors and are subject to other errors, the results of a single survey should not unduly influence an analysis of trends. This is especially the case when there are doubts about the

**Table 6: Percentage of Children under Five Who Are Underweight**

<i>Underweight</i>	<i>Lower Egypt Rural</i>	<i>Lower Egypt Urban</i>	<i>Upper Egypt Rural</i>	<i>Upper Egypt Urban</i>	<i>Egypt</i>
<b>1988</b>	14.5	5.5	19.7	13.7	13.4
<b>1990</b>	7.6	7.4	17.8	8.5	10.4
<b>1992-93</b>	9.3	4.5	13.8	8.8	9.9
<b>1995-96</b>	9.9	8.8	17.8	11.0	12.4
<b>1997-98</b>	9.7	7.4	16.8	8.9	11.7
<b>1998</b>	9.5	4.7	14.2	12.1	10.7
<b>2000</b>	2.8	1.9	6.8	5.0	4.0

The nutrition goal is to reduce the prevalence of underweight children by half between 1990 and 2015, meaning that by 2000, 40 percent of this goal should have been achieved. If endpoints (1990 and 2000) are used to estimate the trend in underweight, Egypt would clearly be "on track" to reach the nutrition goal (see Figure 4), already having achieved the goal.

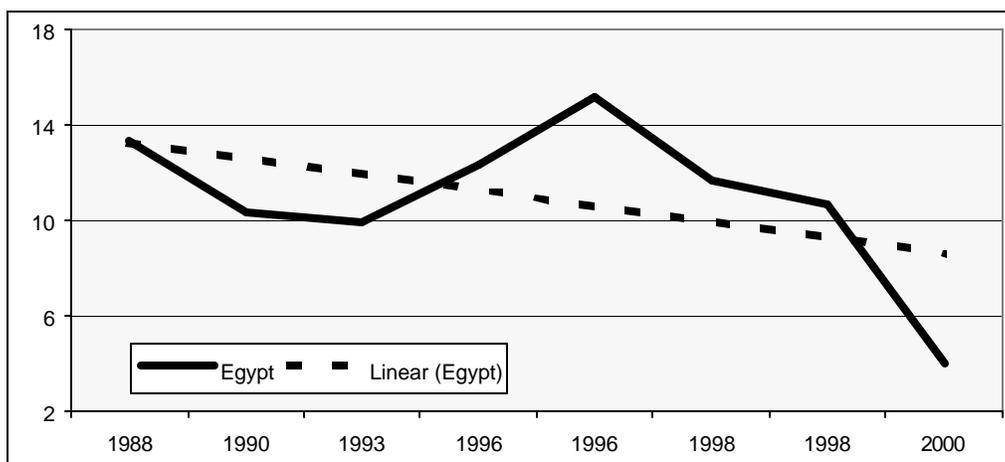
**Figure 4: Trend in Underweight, 1999 and 2000**



If, however, all available national survey estimates from 1988 to 2000 are used, and the trend line is estimated with a regression, the rate of decline is slower, estimated at 8.3 percent in 2000, but still sufficient to reach the MDG by 2015 (see Figure 5).

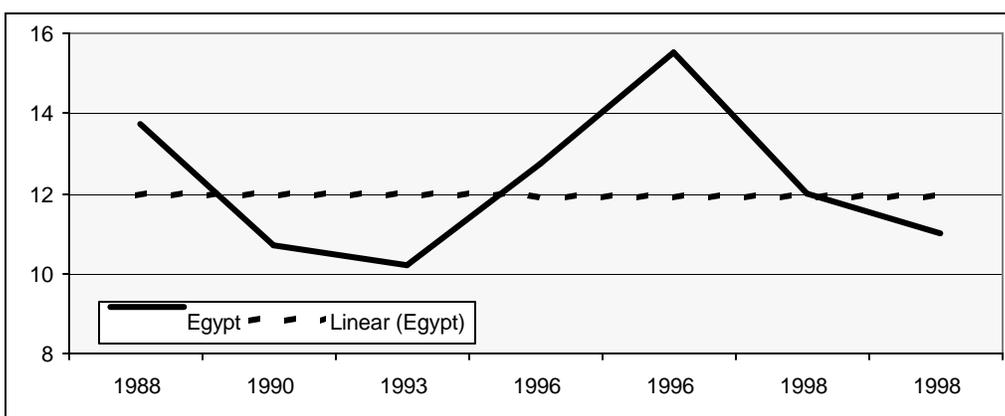
validity of the last point, as is the case for the 2000 survey results. It is therefore better to take all survey findings during the 1990s into account to estimate the trend.

**Figure 5: Trend in Underweight Using All Observations**



If the 2000 observation is not included in the estimate of the trend line because of the doubts about its validity, then the trend is virtually flat, and the MDG would not be achieved (see Figure 6).<sup>21</sup>

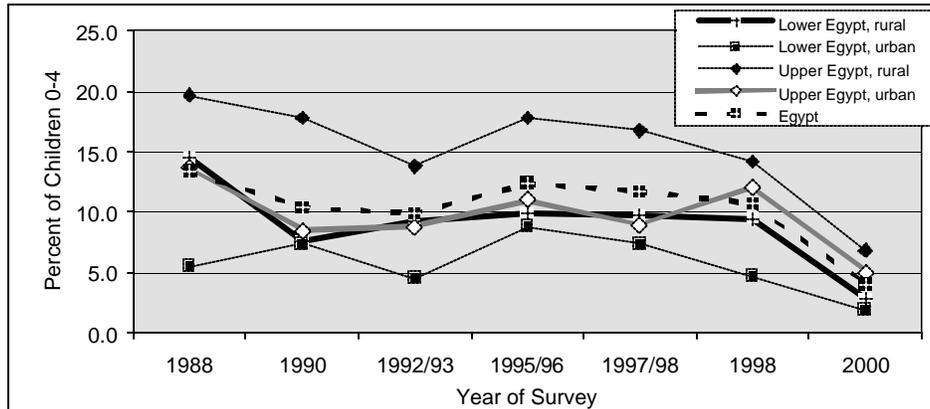
**Figure 6: Trend in Underweight Excluding 2000 Observations**



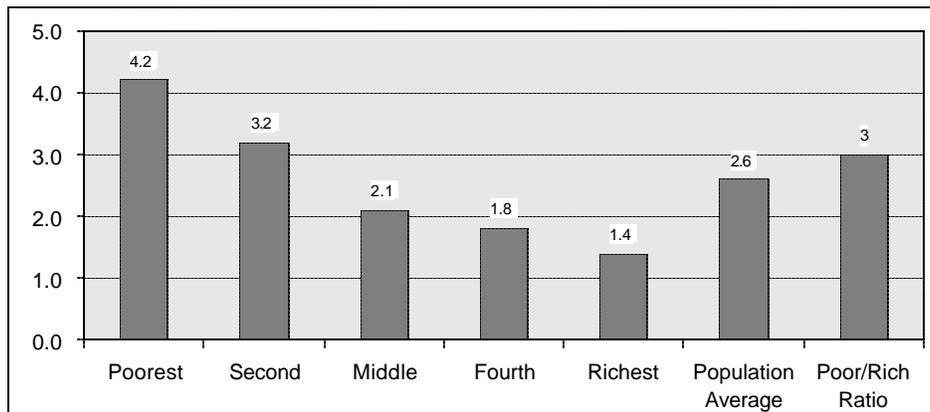
Analyzing the trend of underweight by region reveals that there are no clear patterns in differences in progress in urban and rural areas of Upper and Lower Egypt. If the 2000 data are included, all areas appear to be making progress (see Figure 7). It is important however to note that the estimated prevalence in rural Upper Egypt is 6.8 percent in 2000. Moreover, there is a large socioeconomic differential, where the poorest quintile of the population has three times higher rates of underweight children than the richest quintile (see Figure 8).

<sup>21</sup> The findings of surveys that measure child malnutrition are routinely evaluated by WHO (Global Database on Child Growth and Malnutrition). For the 2000 results, the weight data were said to be "possibly flawed". The report of the EDHS 2000 also appears to be concerned about the findings, stating that the survey was conducted during a cold period of the year, when children wear heavier clothing.

**Figure 7: Trends in Malnutrition: Percent Underweight Egypt, 1988-2000**



**Figure 8: Socioeconomic Differences in Children Underweight (Percent Severe)**



On the other hand, the stunting data are believed not to suffer from the data problems affecting the weight data. The data show that stunting is still a serious problem, even though progress is being made. Rural Upper Egypt shows slower declines in stunting prevalence. Given the questions about the 2000 survey findings, it is therefore unclear whether Egypt is "on track", and the trend so far may be best characterized as "possibly on track", with rural Upper Egypt being the key challenge.

### Requisite Conditions for Achieving Poverty, Hunger, and Malnutrition Targets

The conditions needed to achieve the MDG of reducing poverty, hunger and malnutrition, are part and parcel of the conditions needed to achieve the other MDGs. Poverty cannot be alleviated through economic development alone.

The specific conditions needed to achieve these MDG targets include:

- *Expand economic opportunity for the poor:*

- maintain macroeconomic stability and pursue economic reforms to enhance growth and job creation in the private sector;
  - better target government programs aimed at assisting the poor such as food subsidies and Social Fund for Development activities.
- *Provide the poor with access to quality basic health and education services so that the poor are better prepared to capitalize upon emerging opportunities. More specifically:*
    - improve education of girls (future mothers)
    - promote birth spacing
    - improve effectiveness of health services in combating diarrhea
      - expand the Integrated Management of Childhood Illnesses (IMCI) program
    - introduce targeted improvements in basic health services in rural areas in availability of qualified staff and drugs
    - adopt a rigorous Communication for Behavior Change (CBC) strategy focused on nutrition, coupled with strengthening the institutional capacity of the State Information System (SIS), the Ministry of Health and Population, and other pertinent institutions to:
      - (i) *promote* exclusive breastfeeding in the first six months after birth and desirable weaning practices related to
        - (a) the timing of the introduction of complementary feeding
        - (b) the type of foods during supplementary feeding
      - (ii) *promote* better household and family care in order to improve child care during health and illness
- *Target* interventions to Rural Upper Egypt, particularly interpersonal communication to overcome negative cultural and social beliefs.

## THE EDUCATION SECTOR

### OVERVIEW

Since the 1990s, the key focus of the government in the education sector has been to increase access to basic education in order to achieve universal coverage as affirmed in the Jomtien declaration (1990). This resulted in a large construction program to increase access to basic education. Between 1992 and 1996 the number of classrooms increased by 53 percent and by 1997 primary education was accessible to 99 percent of all villages. With this achievement, the government was able to shift its focus from expansion to improving equity and quality of education. The Basic Education Enhancement Program, launched in 1996, was designed to extend full coverage to disadvantaged groups, particularly girls, and to raise the quality of instruction through an ambitious teacher training program. Financial support for this program was provided by the European Union and the World Bank. This program targeting basic education has been complemented by other important government-sponsored reform

programs focusing on secondary and higher education with the support of the World Bank. In the late 1990s, a 20-year secondary education improvement strategy was developed to address the problems of quality, relevance, and efficiency. At the same time, the government prepared a long-term (2002 to 2017) reform program for higher education to improve governance and efficiency and to raise quality. The World Bank is supporting the government in implementing this reform program through the Higher Education Enhancement Project (HEEP), which provides US\$50 million for the first phase of the reform program.<sup>22</sup>

At the level of basic education, real progress has been made on a number of important areas: narrowing regional disparities, reducing gender disparities, reducing class size, and eliminating second and third shifts to a great extent. Egypt's progress in basic education reflects, in part, a dramatic change in sectoral priorities and a consequent reallocation of resources within the sector. Since 1990 resources have been shifting from higher education to basic and secondary education. This has led to a 33 percent increase in public expenditure per student at the pre-university level and a corresponding 45 percent decrease in per student expenditure in higher education.

While Egypt is to be lauded for its significant achievements, problems persist. Of particular concern is the burden placed on the poor. The poor face numerous disadvantages in educating their children – more children per household, low parental education, limited access to kindergarten, and a high private cost of public schooling. As a result, of all children age 7 to 11 who are not attending school, 50 percent are from the poorest population quintile. Although government policy ensures that all children have access to primary school, the high cost of attending school and taking compulsory examinations, which screen students at the end of each grade level, constrain poor children's opportunities. Thus, while the poorest population quintile represents 25 percent of all primary school students, they represent 14 percent of secondary students, and only 4 percent of higher education students. The poor are further challenged by the tradition of households paying for private lessons to complement public education. This presents a real financial burden, as the share of a poor household's budget taken up by tutoring is greater.

Another issue facing the education sector is the differentials between the education of girls and boys and between urban and rural areas in school attendance, repetition, and dropout rates. The Egypt Demographic and Health Survey (EDHS) 2000 reports that while most children included in the survey who were between the ages of 6 and 15 were attending school, 16 percent had either never attended school or had attended but dropped out.<sup>23</sup> Overall, girls were twice as likely never to have attended school. In urban areas, of the children who had never attended school, there was no significant difference between girls and boys. However, in rural areas there was a marked difference in the proportion of children who never had attended school: 9 percent of these children were boys while 19

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<sup>22</sup> Information from this section is drawn largely from: World Bank. October 2002. The Arab Republic of Egypt Education Sector Review: Progress and Priorities for the Future. Report No. 24905-EGT. Washington, DC: World Bank.

<sup>23</sup> El-Zanaty, F. and A. Way. January 2001. Egypt Demographic and Health Survey (EDHS) 2000.

percent were girls. Place of residence is also a significant variable: almost 20 percent of the girls in the Frontier Governorates and more than 25 percent of the girls in rural Upper Egypt have never attended school. The reasons for not sending children to school included reasons related to the child (52 percent, including that the child is too young or not interested) and to cost (39 percent).<sup>24</sup>

Looking more closely at the children who drop out, most (63 percent) were between the ages of 9 and 12, while 18 percent were between the ages of 6 and 8. Boys are slightly more likely to drop out than girls.

Of the children who attend school, the EDHS 2000 reports that 14 percent had repeated at least one grade. Boys were more likely than girls to have repeated at least one grade.

One MDG goal focuses in particular on the performance of the education sector: achieving universal access to education. In addition, a comparison of the education of girls and boys is part of the review of gender issues.

## **MDG TWO: ACHIEVE UNIVERSAL ACCESS TO EDUCATION**

*Target 1: Attain 100 percent primary school enrollment by 2015*

### **Current Situation**

One result of Egypt's commitment to education has been increased coverage. Today, almost all children have access to basic education. Net enrollment ratios for primary education (grades 1 to 5), the preparatory level (grades 6 to 8), and the secondary level (grades 9 to 12) are 97 percent, 74 percent, and 65 percent, respectively. The 97 percent net enrollment ratio at the primary level in 2000 is a marked improvement over the 92 percent ratio just four years earlier (1996).<sup>25</sup>

### **Prospects of Attaining Education Targets**

As noted above, the net enrollment ratio at the primary level in 2000 was 97 percent. While this is indeed commendable, the challenge will be to reach the remaining 3 percent and ensure that they enroll and complete primary school. Therefore, a key challenge to attaining the MDG of 100 percent primary school enrollment will be to identify and target those who are not currently enrolled in school. While no information is available on who these children are, it is likely that they include children of Bedouin populations, the poor, the disabled, and vulnerable children (e.g., street children).

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<sup>24</sup> Although the child being too young was provided as a reason for not sending their children to school, the official age for entry into the primary level is six.

<sup>25</sup> This ratio includes students who attend Al-Azhar Schools, which are publicly funded but privately managed schools offering religious instruction as part of the curriculum.

As expected with imperfect data, figures for the current net primary enrollment ratio vary. The World Bank SIMA database records a 92 percent net primary enrollment ratio for 1999. Applying statistics from this database, one notes a 0.5 percent annual increase in the net primary enrollment ratio for the period 1990 to 2000. If this current trend continues, the net primary enrollment ratio will be 100 percent by 2015. This rather mechanistic approach to the analysis of the prospects for attaining this MDG target does not take into consideration the challenges the government will face in enrolling the cohort of children who are not currently attending school, as noted above. It does, however, support the notion that attainment of this goal is feasible, and likely if the conditions for achieving 100 percent primary school enrollment are met.

### **Requisite Conditions for Achieving Education Targets**

Given that achieving high rates of enrollment is not the primary issue in Egypt, the major challenges are: (i) to ensure that those children who currently are not attending school are enrolled, and that the special needs of these children are addressed (e.g., the needs of the handicapped); and (ii) to sustain the achievements to date while continuing to improve the quality of education. The means to address these challenges include community participation efforts, awareness campaigns, and school-based programs; enhancing the efficiency of resource utilization; supporting early childhood education; ensuring the availability of teachers in remote areas; and strengthening the skills of teachers.

Making primary education universal received a considerable boost through the government's school construction program, which is now largely complete. The more recent strategy, the continuation of which will be critical for achievement of the MDG, includes support for community participation and targeted subsidies to increase the probability of enrollment and retention.

Community mobilization efforts and awareness campaigns will help identify the children who are not currently attending school, and those at risk for dropping out. Such outreach will help the government identify specific measures (such as targeted subsidies) needed to bring the children into school and to ensure that those who are there continue.

Identifying the disadvantaged population for direct subsidy is very important. The Ministry of Education is conducting an "Awareness Campaign with Subsidy Program" that is successfully raising girls' enrollment in basic education. Under this pilot project, the government provides LE50 to 12,000 children (approximately 0.15 percent of the targeted population). The subsidy is used to cover the private cost of education (e.g., the cost of school uniforms or school bags). This pilot effort should be assessed to ensure its effectiveness. If effective, it should be expanded to reach other children in need of support to ensure that they join and continue with their schooling.

It is also recommended that both the community mobilization (awareness campaigns) and targeted subsidy programs be expanded to early childhood education. International experience has demonstrated that early childhood education has the highest returns on improving retention, reducing dropout, and improving quality of learning in primary education. The effect is particularly pronounced for the poor versus the well-to-do.

Another area that is very important for achieving universal enrollment is providing teachers with training, both in-service and pre-service, and improving the status of teachers. Improving the curriculum and performance of the faculties of education is crucial for improving teaching and reducing waste in the education sector. Bridging the gap between the quality of service provided in the close urban areas and the remote rural areas is a must in order to achieve universal enrollment. In general Egypt has a large surplus of teachers, yet rural areas, particularly those in remote governorates, have difficulty in securing and retaining teachers. Accordingly, the teacher per classroom ratio varies significantly. In urban areas, the number of teachers per classroom can be up to four times greater than in remote rural areas. A different incentive system than that which is currently in place needs to be introduced and thoroughly applied.

## **GENDER**

### **OVERVIEW**

In Egypt, gender issues are largely women's issues, given their disproportionate disadvantages. The issues that women face are numerous and multi-faceted. In broad terms, these issues include more limited opportunities to become educated and hence higher illiteracy rates, poorer health status, fewer opportunities in the job market, limited political voice, and social constraints on participating in socioeconomic development. Many of the key development issues facing Egypt have important gender dimensions. From political voice to family laws, from reproductive health to education levels and employment opportunities, gender roles and relations not only influence socioeconomic issues but also affect the impact of interventions.

The government has exerted considerable effort to reduce gender-related disparities. For example, it has increased the total number of schools, making education more accessible. It has supported awareness campaigns to better understand and address reasons for keeping girls out of school. And, over the last fifteen years it has created three significant branches within the government. To address and to coordinate motherhood concerns, the National Council for Childhood and Motherhood was established in 1989. In 1993 a National Women's Committee was established to prepare for the 1995 United Nations Conference for Women (Beijing). In 2000, the National Council for Women (NCW) was founded. Its mandate is to plan, monitor, and evaluate the implementation of programs and policies aimed at enhancing the status of women and to submit relevant proposals to the concerned authorities. The NCW is active in all phases of the legal process: it recommends laws necessary for the advancement of women, it advises on pertinent draft laws prior to issuance; and it comments on all agreements related to women. The NCW has been successful in creating Gender Units in 20 ministries. More recently the government made a commitment to integrate gender into its National Development Plan, 2002-2007.

The third MDG goal focuses on promoting gender equality and empowering women. Its three specific targets provide a glimpse into the challenges facing governments as they strive to ensure equity and equality among girls and boys, women and men. Opportunity underlies all three targets: the opportunity to have an education; the opportunity to be active in the labor market; and the opportunity to participate in the political process.

### **MDG THREE: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN**

*Targets 1 and 2: Reduce the gender gap in primary and secondary enrollment and in literacy among 15-24 year olds*

*Target 3: Increase the share of women in nonagricultural employment and in the national parliament*

#### **Current Situation**

*Schooling.* Gender disparity has been a persistent problem in Egyptian education, however it is improving. The education of girls, particularly in poor areas, is inhibited by household opportunity costs and cultural factors. For families in rural areas, comparative international experience shows that educating girls is more costly than educating boys because of the need to have daughters perform household chores. Furthermore, the education of girls is not considered to be as important as the education of boys by some segments of the population. The implications of the gender gap in schooling are pronounced, as evidenced by analysis which indicated that the MENA per capita income would have grown by an additional 0.5 to 0.9 percent per year if countries in its region had closed the gender gap in schooling as East Asia did between 1960 and 1992.<sup>26</sup>

As noted above, gender disparity in education is closing quickly although there are still significant regional and urban/rural differentials. The net enrollment ratio in primary education for both boys and girls increased from 90 percent in 1996-97 to 98 percent in 2001-02. Girls' enrollment increased from 87.5 percent in 1996-97 to 96.2 percent in 2001-02, while boys' enrollment increased from 93.9 percent to 99.6 percent over the same time period. Translated, between 1996-97 and 2001-02, the gender gap shrank from 7 percent to 3.5 percent. If this trend were to be sustained, there should be no gender gap at the primary level by 2005. There are significant issues remaining to be addressed, however. As noted in the previous section on education, girls from rural areas and from certain governorates are less likely to have ever attended school.

In general secondary education the number of girls enrolled in 2000-01 exceeded the number of boys.<sup>27</sup> Girls' enrollment increased from 44.2 percent in 1991-92 to 50.5 percent of the total enrollment in

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<sup>26</sup> Klasen, S. 1999. "Does Gender Inequality Reduce Growth and Development? Evidence from Cross-Country Regressions." Background paper for Engendering Development—Through Gender Equality in Rights, Resources, and Voice. Washington, DC: World Bank. 2001.

<sup>27</sup> Based on figures from Mubarak and Education for the period from 1991-92 to 2000-01.

2000-01. The same phenomenon appears in commercial secondary education where the number of girls (594,257) exceeds the number of boys (358,803), despite the fact that the percentage of girls to the total enrollment dropped from 70 percent in 1991-92 to 62.4 percent in 2000-01. In industrial secondary education, the percentage of girls increased from 25.1 in 1991-92 to 34.5 in 2000-01 of the total enrollment. However, in agricultural secondary education, the percentage of girls fell slightly from 22.5 percent in 1991-92 to 21.4 percent in 2000-01 (although the total number of female students increased). The percentage of girls in all secondary education types represents 47.6 percent of the total enrollment.

When statistics about primary and secondary schooling are combined, the ratio of girls to boys in primary and secondary education was 88 percent in 1999, which is up from 78 percent in 1990.<sup>28</sup> *Literacy.* With respect to literacy, the gender gap is quite pronounced. According to the 2002 Government Statistical Yearbook, 50 percent of women are illiterate, compared to 29 percent of men and 39 percent of the total adult population.<sup>29</sup> The urban-rural population differences are also pronounced: 63 percent of women in rural areas, compared to 36 percent of men, are illiterate; and 34 percent of women in urban areas, compared to 20 percent of men, are illiterate.<sup>30</sup> These illiteracy rates, it is important to note, represent a considerable improvement. In 1960 the percentage of illiterate women was 81.5: the current percentage of young literate females to males (ages 15-24) is 82.<sup>31</sup>

The government is working to improve literacy in the country. Formal programs have been created to increase enrollment in schools as well as informal education programs to encourage literacy. For example, a recently launched program was allocated 1£E billion to be spent over the next three years to train people to read and write.

*Employment.* Female participation in the labor market has increased considerably. Some important dynamics occurred between 1986 and 1996: (i) the rural labor force—female and male—grew faster than the urban labor force (3.5 percent versus 2.4 percent per year); (ii) the female labor force grew much faster than the male labor force (6.5 percent versus 2.4 percent per year); and (iii) female employment also increased at a faster pace (7.2 percent versus 2.7 percent per year). Toward the end of the 1990s, however, this phenomenon appears to have changed. Labor force survey data indicate that between 1995 and 1999 female employment growth slowed markedly to 1.6 percent per year and was bypassed by male employment growth of 2.3 percent per year.

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<sup>28</sup> World Bank. SIMA Database.

<sup>29</sup> Note: This 50 percent figure is higher than the one cited in the 2003 Human Development Report, which states that in 2001, 54 percent of women were literate (46 percent were illiterate). The Human Development Report does not have male/female comparators.

<sup>30</sup> Central Agency for Public Mobilization and Statistics (CAPMAS). 2002. Statistical Yearbook, Labor Force Sample Survey. Cairo: The Agency.

<sup>31</sup> World Bank (2003). pp. 46.

Women still lag far behind men in participation in economic activity. In spite of rapid growth in the female labor force, women in 1999 comprised only 21.4 percent of the Egyptian labor force (20.26 percent in rural areas and 22.2 percent in urban areas) and 18.7 percent of all employees. As in many other developing countries, problems of measurement and underreporting, particularly in agriculture and in the informal sector where females are highly engaged, make it difficult to gauge participation accurately. If these activities were included, it is likely that the participation level of Egyptian women in the labor force would be substantially higher, particularly in rural areas.

Unemployment is much higher for women than for men. The overall rate of unemployment reached 8.1 percent in 1999. There is an overwhelming gender gap in unemployment: a moderate 5.1 percent unemployment rate of males against a very high 19.4 percent female unemployment rate (almost four times higher than men). The pattern is similar for both urban and rural areas—female unemployment rates were 19.3 percent and 19.4 percent respectively. Women are underrepresented in the labor force and employment, and overrepresented among the unemployed. By 1999 more than half of the 1.5 million unemployed were women.

In Lower Egypt unemployment among women is particularly significant. Fifty eight percent of all unemployed women live in Lower Egypt, whereas forty three percent of the population resides there. The main reason for this appears to be that educated females in Lower Egypt no longer opt to work in agriculture, rather they prefer to queue for a job in the government administration.

In fact, the government administration remains the key employer of women, particularly in urban areas. In spite of structural reforms during the 1990s, employment in the government administration sector grew rapidly for both males and females. However, (i) female employment within government administration grew more rapidly (2.6 versus 2.4 percent), and (ii) government administration represented the fastest growing sector for the employment of women. For men, private sector employment grew faster.

The discrepancy between women and men in Egypt is striking compared to other lower middle-income countries. Female participation is lower than in some other comparable countries of the MENA region and much below that of countries of comparable income levels outside the region, such as Bulgaria and the Philippines. Moreover, women who do enter the labor market have a much higher probability of ending up unemployed than they do in other countries. It is possible that the unfavorable conditions are a major reason for the low participation rates in the first place, as discouraged workers drop out of the labor force.

Agricultural activity remains the main employer of women. In 1999 it absorbed nearly 32 percent of all employed females and more than 55 percent of all females in rural areas. The education sector ranks second and employs 22 percent of total females. Its relative importance as a source of employment is more pronounced in urban areas, as it employs almost 30 percent of urban females, which is nearly double the corresponding percentage in rural areas. Health and social work together with public administration (excluding education and health) make up 20 percent of women's employment in total. Manufacturing and trade are the only significant private sector activities that absorb female labor to any

degree. The overwhelming majority of Egyptian females are employed in these six branches, with a very marginal role of other branches of economic activity in employment. Many women are still employed in low-productivity activities outside the formal sector, i.e., agriculture and services, where income is low and uncertain and safety nets are nonexistent.

In growth sectors, women's participation has increased. Female employment in agriculture declined from 1995 to 1999, and more so than male. In manufacturing, employment for women grew faster than their male counterparts' and trade and tourism almost at par. In this respect, female private sector employment growth was—with the exception of agriculture—actually concentrated in sectors where value added growth was increasing fast. It appears that the growth pattern has not been unfavorable to women per se, though government administration continued to contribute most to new jobs for women.

Women with education may prefer to be engaged in government and public sector jobs and, failing that, prefer unemployment to the private sector. The broadly defined public sector comprises most of the occupations that traditionally have a high representation of women: education, health, management, and clerical work. In addition, the work hours in the public sector are shorter than in the private sector, a matter that allows women to meet their family obligations. The stability of public employment work is another encouraging factor. Again, low participation in private sector activities and high unemployment rates among educated females may to some extent be voluntary, for females may prefer to wait for public employment opportunities rather than accept private sector jobs. Thus, the government remains the major employer of skilled women, particularly in urban areas, while the private sector appears to be inhospitable to females whose education and skills, in any case, are not geared toward the needs of a changing labor market.

*Political Participation.* According to the 1971 Constitution, Egyptian men and women have without distinction equal political rights. Women have the right to vote and to run for Parliament, the Consultative Council, and local councils. Law 41 of 1979 made it incumbent on all citizens entitled to exercise political rights, whether male or female, and to enroll in the electoral register. Yet the lack of identity cards, which prevents enrollment in the electoral register and exercise of political-legal rights, is prevalent among women in Egypt, particularly among the uneducated and those in rural areas. Combined with an environment that does not promote political participation, and compounded by the gender gap in literacy, education, and employment, this translates into a significant gender gap in political participation. Indeed figures show that the participation of women in legislative councils, whether as voters or candidates, is not commensurate with their numerical weight in society.

In the 1970s, a thirty-seat-female quota was established in the People's Assembly. In 1986 there were 30 female members of Parliament. Subsequent to its cancellation, the elections of 1987 resulted in 18 female Parliamentarians, of which 4 were appointed. By 1995 the number of women were 5 elected and 4 appointed; in the 2000 elections, 7 elected and 4 appointed. Similar downward trends are evident in local councils. Elections in 2000 and 2002 demonstrated a lack of commitment to support women candidates for legislative and local councils by almost all the political parties. These negative developments raise concerns.

Nevertheless, some qualitative progress has been achieved in the number of candidates running for elections. While 90 female candidates ran for election in 1995, 112 female candidates ran in 2000. Interestingly, out of the 7 elected female members of Parliament in 2000, 3 were elected in Upper Egypt, which is recognized to be more conservative. Moreover, female enrollment in electoral registers increased from 3.6 million in 1986 to 8.8 million in 2000, representing 35 percent of the total electorate.

In the Consultative Council, which is the Upper House, female membership in 1996 was 5.7 percent, as compared to 3.3 percent in 1980. This is fundamentally due to the increase in the number of female members appointed by the President of Egypt, who used legal prerogatives.

Despite the fact that equality has been mandated by law and that all governments from 1952 until the present have been supportive of women's rights, women's participation in political decision-making bodies remains limited. Analysis of trends in women's representation in parliamentary assemblies and councils at the national and local levels indicate that, overall, little or no progress has been made and that substantial gender gaps exist. Moreover, Egyptians still regard politics as a male's domain and women still lack equal access to the power structure that shapes Egyptian society. All this points to the importance of some kind of positive discrimination, at least for some period of time, to encourage and increase women's political participation.

### **Prospects for Attaining Gender Gap Targets**

*Schooling.* It is unlikely that the gender gap in schooling at both the primary and secondary levels will be closed by 2005 (the target date for achievement of this MDG). As noted above, the ratio of girls to boys in both primary and secondary school combined was 88 percent in 1999. If the 1.3 percent annual increase from the 1990 figure were sustained, the corresponding ratio in 2005 would be 94 percent, which falls short of the 100 percent target.<sup>32</sup>

*Literacy.* It is unlikely that gender equality in literacy rates among youth will be achieved by 2005. As noted above, the ratio of young literate females to males is currently 82 percent. It is important to note that this is a substantial increase over the 72 percent ratio in 1990, and represents a 1.3 percent annual increase. However, if this trend continues (the 1.3 percent annual increase), the corresponding figure for 2005 would be 87 percent, which certainly falls short of the 100 percent target.

The literacy gap among youth is expected to continue to decrease. In fact, if the target date had been 2015 instead of 2005, the gap would have closed, assuming that the 1.3 percent annual increase continued. As with the achievement of other targets it is unlikely that past trends will continue into the future. And, the closer the government comes to achieving the target, the more difficult it will be to draw in the last remaining members of the cohort.

*Employment.* It is unlikely that women's participation in the nonagricultural sectors of the labor market will increase in the short term. As noted previously, economic prospects for the near future are not strong and prospects for growth are further compromised by regional instability and the lingering impact

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<sup>32</sup> World Bank. SIMA Database.

of the war in Iraq, which will likely continue to impact tourism and foreign investment. It is therefore unlikely that there will be many new jobs created overall, and even fewer that would be open and available to women. In the longer term, however, the picture is less bleak. The government's current economic reform program, including its efforts to encourage growth in the private sector, will stimulate women's participation in the labor force. Women's participation in the longer term will also be encouraged by efforts in the education sector to increase the participation of girls and improve literacy.

*Political Participation.* With respect to increasing women's participation in the national parliament, substantial improvements are not likely in the short term. Although the appointment and election of women into political positions has been declining, more women are registering to vote and more women are running as candidates for elected positions. In general, Egypt tends to be a conservative culture: without concerted efforts by the government to encourage women's participation in the political process, significant improvement in the number of national female parliamentarians is not expected.

### **Requisite Conditions for Achieving Gender Gaps Targets**

*General.* Traditions and attitudinal barriers are important impediments to enhancing the status of women in Egypt and to their ability to participate in their country's economic and political life as full and equal citizens. To overcome these cultural constraints and develop an environment supportive of women, a major governmental and non-governmental effort is required to change behavioral patterns and values. Interventions should target both men and women. They should focus on changing the perception of women's role in society from marginal to essential and reinforce the image of the cooperative and supportive husband, father, and brother. This is a difficult task that would involve a comprehensive campaign targeting the education system, the media, community and religious leaders, and the family. It has to be initiated by the government, with leadership provided by an agency such as the NCW and active participation by relevant NGOs and representatives from the various sectors concerned (e.g. education, media, religious institutions).

*Schooling and Literacy.* As noted above, it is unlikely that the MDG targets for reducing gender gaps in primary and secondary education and literacy will be achieved by 2005. At this point, it is perhaps not as important to meet the 2005 target date as it is to continue to implement programs that support further reduction of the gender gaps over time. The reduction of the gender gap in primary and secondary enrollment can be attributed, in part, to government efforts. It increased the total number of schools and therefore made education more accessible, and launched "awareness campaigns" targeted at the poorer communities, which involved assessing the causes for repeating grades and dropping out of school as well as identifying solutions.

The conditions needed to achieve these MDG targets in the longer term are similar to those for achieving universal primary education. Targeted interventions are needed. To attain universal enrollment of girls in the weakest seven governorates, the Ministry of Education in collaboration with United Nations agencies established the Girl's Education Initiative, which supports the achievement of this target.

Specifically, the government and its partners need to continue community participation efforts and targeted subsidies to ensure that girls who are not currently attending school be identified and given the opportunity to do so.

*Stimulating Women's Employment.* There are four measures proposed to improve the position of women in the labor market:

*Growth in private sector employment should be encouraged.* New and sustainable jobs, which reflect enhanced productivity and can sustain real wage increases, need to be created to increase the welfare of both males and females. Economic liberalization and the transition to a more outward-looking market economy could potentially raise the demand for female labor in export manufacturing industries, which traditionally tend to employ females. But women are more vulnerable to structural changes, since they have traditionally depended on government employment as well as informal employment in agriculture. The modernization of Egypt's economic structure will most likely preclude important job creation in either of these areas, leaving the private sector to take the lead. The challenge is thus twofold: first, ensure sufficiently rapid growth in private sector employment; and second, ensure that women benefit from the employment growth.

*Labor laws and regulations need to be revised to remove disincentives to hiring women.* Some labor regulations pertaining to women may impose high costs on employers and may need to be reviewed. Although the regulations might be commendable, the current situation—where they are either not applied, where they may discourage female employment, or where their cost may be passed on to women through lower wages—is not optimal. International experience shows that there are advantages to bringing the cost of social protection from “within firms” to “outside firms.” If the central government, instead of individual enterprises, bears the brunt of the cost, safety nets can be preserved without discouraging employment of women at the firm level.

*Public sector wage and employment policies may provide difficult competition for the private sector.* Although the official public sector job guarantee has disappeared, the government administration continues to provide an attractive alternative for educated youth, especially females. In the context of rigid labor market regulations, the private sector may find it difficult to compete for female labor.

*Women need greater access to credit and to information.* Poor access to collateral and smaller operations limit women's access to credit and constitute a constraint in farming and nonfarming activities, in the formal and informal sectors. Special credit programs, such as those of the Social Fund for Development, using nontraditional forms of collateral could thus be helpful. Here, it could be useful to look at the experience of other countries where microcredit schemes for women have proved successful. Enhancing access to credit and training, in particular to rural females, is highly desirable to establish income-generating nonagricultural projects.

*Encouraging Women's Political Participation.* Affirmative action by the government through legal reform and positive engagement is essential to encourage women's participation in political structures. Moreover, empowerment of women and promotion of their active participation in the political process

require major changes in society's cultural and behavioral patterns. A national movement—spearheaded by the NCW, other women's organizations, and political parties—is therefore necessary to organize training programs for women, to help women develop basic political leadership skills, and to assist women in becoming politically active at the grassroots level. If Egyptian women succeed in making full use of their voting rights, their electoral weight will be recognized by all political parties.

## THE HEALTH SECTOR

### OVERVIEW

Over the last two decades, Egypt has achieved significant improvements in the health status of the population. Between 1980 and 1998, the infant mortality rate declined from 120 per 1,000 live births to 49; and the total fertility rate declined from 5.1 to 3.3. The country has invested extensively in the health service infrastructure, and has provided good access to safe water, sanitation, and basic public health programs.<sup>33</sup>

Notwithstanding these achievements, there are a number of challenges facing the health sector. There exist large differentials in health outcomes by geography (urban/rural), gender (male/female), and income (rich/poor). As Egypt enters into the middle-income transition, it faces a dual disease burden. Communicable and other infectious diseases remain to be dealt with, at the same time as emerging problems associated with the socioeconomic transition, namely an increase in risk factors such as obesity, smoking and hypertension lead to a rise in the burden resulting from noncommunicable diseases. Other key challenges facing the health sector include: (i) wide inequities in accessibility and quality of health care services; (ii) significant inefficiencies (such as low hospital occupancy rates, oversupply of physicians, and excessive prescribing and use of drugs); (iii) lack of equity in health financing (regressive financial burden) and in health insurance coverage (as the most needy are not covered, e.g. unemployed, informal sector workers, and children not attending schools); and (iv) the lack of financial sustainability of the Health Insurance Organization responsible for the social health insurance program.

In 1998, the government embarked upon an ambitious Health Sector Reform Program (HSRP), designed to be a blueprint for a comprehensive reform of Egypt's health sector over the next two decades. The HSRP represents a major shift away from more traditional vertical health programs and is to consolidate the fragmented health financing system to ensure a more equitable distribution of resources and therefore services. While the program moves the sector in the right direction, its implementation has proved to be challenging. Despite the acceptance of the overall objectives and strategic framework for reform, the administration in its day to day decision-making process continues to exhibit tendencies toward centralized control. Moreover, there has been a lack of progress on the

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<sup>33</sup> World Bank. June 2001. Country Assistance Strategy for the Arab Republic of Egypt, Report No. 22163-EGT. Washington, DC: World Bank.

reform of health care financing. This could undermine the intention of the reform strategy, as well as the achievement of the MDGs.

On the other hand, the government continues to demonstrate its commitment to maternal and child health. It has actively participated in a number of international summits, and hosted the 1994 International Conference on Population and Development.

While all the MDG goals are relevant to the health sector, three goals focus largely on the performance of the health sector: (i) reducing infant and child mortality; (ii) improving reproductive health; and (iii) slowing the spread of communicable diseases including HIV/AIDS and malaria.

## **MDG FOUR: REDUCE INFANT AND CHILD MORTALITY**

*Targets 1 and 2: Reduce infant and child mortality by two-thirds from 1990 level*

### **Current Situation**

Although the disease profile in the MENA region is changing, infectious diseases remain the leading cause of ill-health and disease among children under five years of age.<sup>34</sup>

In Egypt, addressing infant and child health is a priority for the government as demonstrated by improvements in many of the child survival determinants and the interventions dealing with infant and child mortality. Despite these improvements, diarrhea and acute respiratory infections (ARI) continue to be the most common causes of childhood death in Egypt, as in other countries of comparable socioeconomic development.

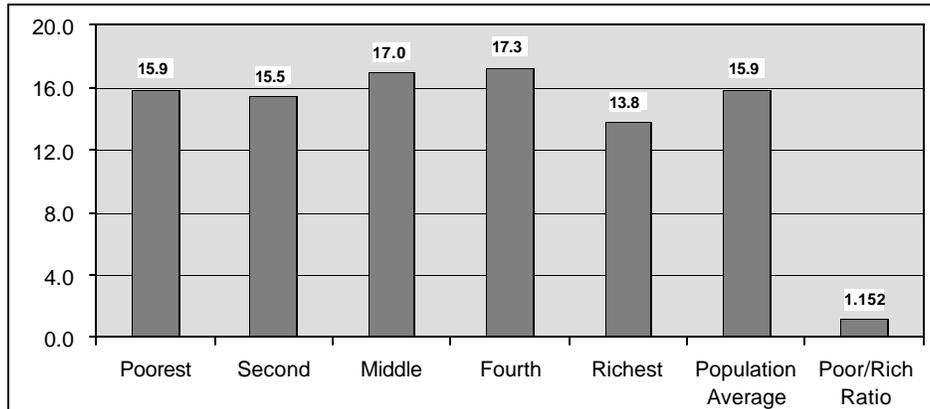
Child survival determinants include the incidence of diarrheal diseases, which is partly affected by immunization coverage and access to safe water, and control of acute respiratory infections. Nutrition, a major determinant of child survival, was discussed under the “poverty” section.

*Diarrheal Diseases.* The EDHS 2000 noted that the prevalence of diarrhea among children under five years old was 7.1 percent, down from 15 percent in 1997. Children in rural Upper Egypt had twice the prevalence of children in urban governorates. On the other hand, there was no significant difference between the richest (13.8 percent) and the poorest (15.9 percent) quintiles in the prevalence of diarrhea.

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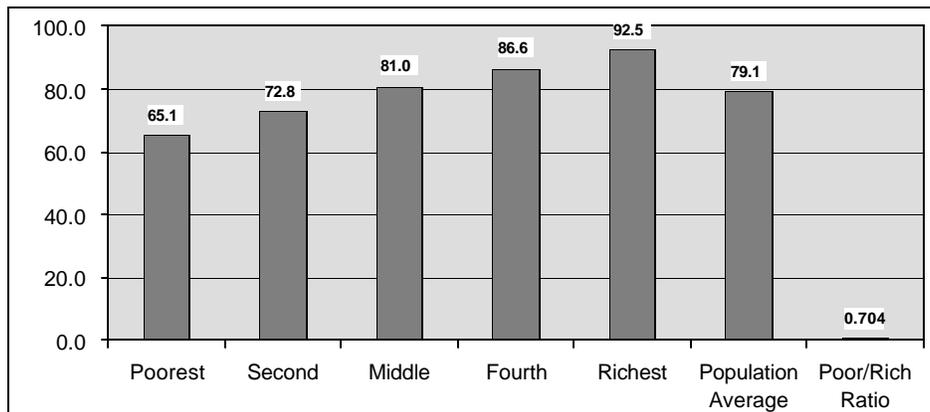
<sup>34</sup> World Bank. June 2002. Public Health in the Middle East North Africa: A Situation Analysis. Washington, DC: World Bank.

**Figure 9: Socioeconomic Differences in the Prevalence of Diarrhea, 1997**



*Immunization Coverage.* The EDHS 2000 noted that 92 percent of children were fully immunized, up from 54 percent in 1988, and 84 percent just two years earlier (in 1998). Increased immunization coverage was correlated with socioeconomic status. For example, the immunization coverage of the richest quintile of the population is almost 1.5 times higher than the poorest quintile in 1997.

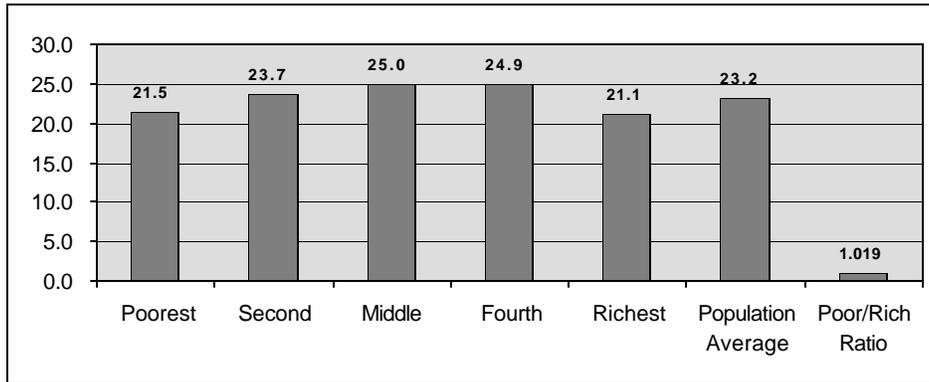
**Figure 10: Socioeconomic Differences in Immunization Coverage, 1997**



*Safe Water.* Having access to safe water for drinking and hand washing is important for preventing diarrheal disease. Of the families included in the EDHS 2000, more than 80 percent had water available, with a significant difference between urban (95.7 percent) and rural (66.8 percent) areas.

*Acute Respiratory Infections (ARI).* The EDHS 2000 found an ARI prevalence of 10 percent among children under five. Children from urban areas were more likely to receive antibiotics (81.6 percent versus 72.5 percent). There were significant variations in whether a mother would seek medical advice for an ill child according to her level of education. Almost 86 percent of the children whose mothers were more educated received antibiotics compared to 70 percent of children whose mothers had no formal education. There was no significant rich/poor differential in the treatment of ARI.

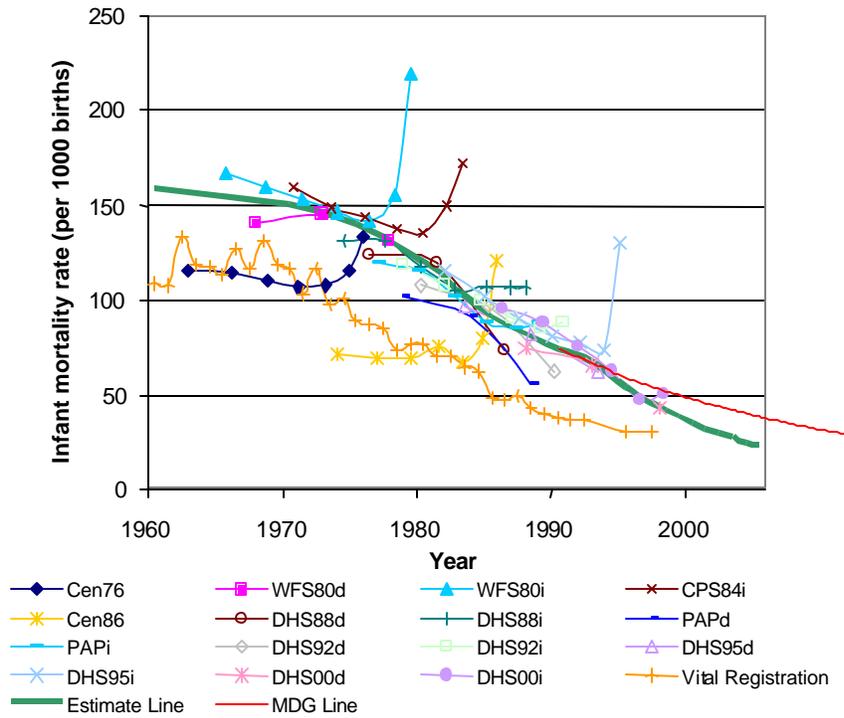
**Figure 11: Socioeconomic Differences in Acute Respiratory Infection, 1997**



*Infant Mortality.* In 2001, the infant mortality ratio was estimated at 33 deaths per 1,000 live births, which is a significant reduction from 73 in 1997 and 76 in 1990 (Figure 12). This represents an annual 6.9 percent decrease.<sup>35</sup> According to the EDHS, IMR was 44 in 2000, down from 62 in 1990, which represents an annual decrease of 3.4 percent. It was also noted that IMR in rural areas was 1.5 times higher than in urban areas. Rural Upper Egypt had the highest IMR of 77.3, which is more than double that of the urban governorates. Neonatal mortality (under one month of age) constituted almost 60 percent of all IMR in urban governorates and in Lower Egypt. However, there was no difference noted in Upper Egypt.

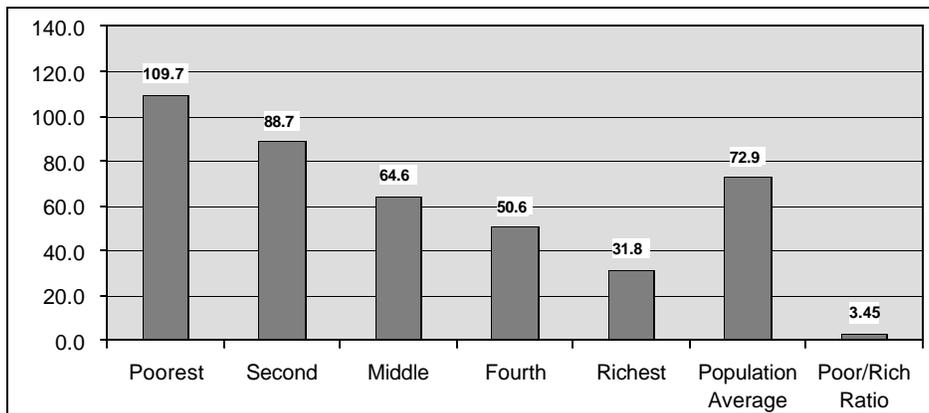
<sup>35</sup> World Bank. SIMA Database.

**Figure 12: Infant Mortality Rate Trends<sup>1</sup>**



In terms of socioeconomic differences, infants of the poorest quintile of the population had 3.5 times higher mortality rate than the richest quintile in 1997 (Figure 13).

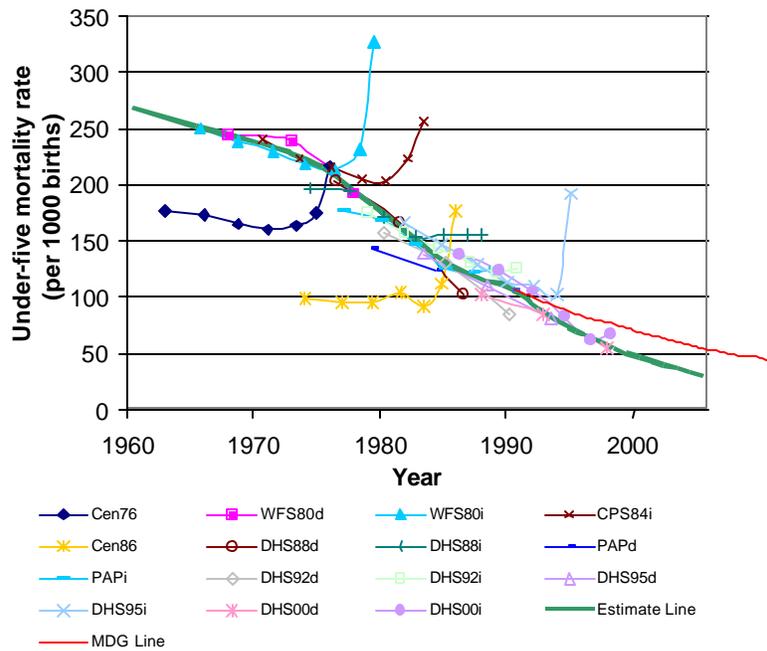
**Figure 13: Socioeconomic Differences in Infant Mortality Rate, 1997**



*Child Mortality.* Figure 14 depicts the under-five mortality trend indicated by a regression line based on a number of data sources. In 2001, the under-five mortality rate (U5MR) was 41 deaths per 1,000

live births, which is down from 104 in 1990, and represents an annual 8.0 percent decrease.<sup>36</sup> The EDHS 2000 noted that U5MR was 54 deaths per 1,000 live births in 2000 and down from 85 in 1990, which represents an annual decrease of 4.4 percent. It was also noted that U5MR was 1.5 times higher in rural than urban areas with rural Upper Egypt having almost double the rate of urban governorates.

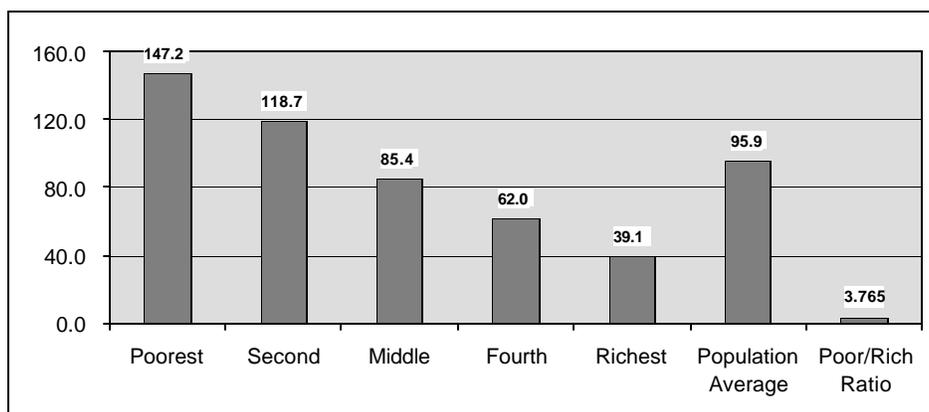
**Figure 14: Under-Five Mortality Rate Trends<sup>1</sup>**



In terms of socioeconomic differences, infants of the poorest quintile of the population had a mortality rate 3.8 times higher than the richest quintile in 1997 (Figure 15).

<sup>36</sup> World Bank. SIMA Database. Analysis for figure completed by Eduard Bos and Emi Suzuki (HDNHE).

**Figure 15: Socioeconomic Differences in Under-Five Mortality Rate, 1997**



### Prospects of Achieving Infant and Child Mortality Targets

The above data suggest that while the government has been successful at reducing deaths due to vaccine-preventable diseases, additional work is needed to target other common causes of infant and childhood morbidity and mortality. In addition, attention is needed on other determinants of child survival in addition to vaccination efforts and the provision of clean water and sanitation services such as indoor air pollution, the availability of quality health services, and the education of women.

*Infant Mortality.* It is likely that this MDG target will be achieved, as indicated in Figure 12. For this to happen, the infant mortality ratio would have to be 25.3 by 2015 (which represents a reduction by two-thirds from the 1990 figure of 76) according to World Bank estimates. As noted above, the ratio in 2001 was 33, down from 37 in 2000. If the current rate of decrease were to continue, the infant mortality ratio in 2015 would be 12.6, which is clearly below the target of 25.3. On the other hand, the EDHS data suggest an annual decline of only 3.4 percent, and if this were to be the future trend, IMR would reach only 26.3, which would fall short of the target of 21 (which represents a reduction of two thirds from the 1990 figure of 62). IMR will remain a challenge and for its MDG target to be achieved, the government will have to adopt targeted strategies as detailed below.

*Child Mortality.* It is likely that the target for reducing by two-thirds the U5MR from the 1990 level will be achieved by 2015, as is indicated in Figure 14.<sup>37</sup> As noted above, the child mortality rate in 1990 was 104. To achieve the target of a reduction by two-thirds, the rate would have to be 35 by 2015. If the current trend continues (an annual 8.0 percent reduction), the child mortality rate in 2015 will be 12.8, which clearly exceeds the 35 target rate. On the other hand, according to the EDHS 2000, only a decrease of 4.4 percent was noted annually between 1990 and 2000. Assuming the EDHS base of U5MR of 85 in 1990, the target would be 28 and the expected achievement would be 27.3, still exceeding the target.

<sup>37</sup> World Bank. SIMA Database. Analysis for figure completed by Eduard Bos and Emi Suzuki (HDNHE).

## Requisite Conditions for Achieving Infant and Child Mortality Targets

Although the MDG targets for reducing infant and child mortality are likely to be achieved, there is no room for complacency. Programs targeting infant and child health need to continue to be strengthened, particularly among the poor and in rural areas. Public health and water supply and sanitation programs are key to this effort. Ensuring that quality care is provided when a child is ill is also extremely important. More specifically, a number of key strategies need to be adopted and/or scaled up to complement those already implemented or piloted.

*Targeting Neonatal Mortality in Urban Areas.* As noted above, neonatal mortality constitutes almost 60 percent of all IMR in urban areas. Improving perinatal care through the supply side (health services) and demand side (household awareness) may have a dramatic impact both on neonatal mortality and consequently on both IMR and U5MR.

*Developing Geographically Focused Interventions in Rural Upper Egypt.* This would be effective in rural Upper Egypt, where the highest IMR and U5MR were noted. Also from a socioeconomic perspective, the poverty level is very high in rural Upper Egypt, therefore this will also contribute to bridging the rich/poor gap noted above. It is important to mobilize local communities in this regard to overcome social and cultural constraints.

*Adopting a Communication for Behavior Change (CBC) Strategy.* This is key in influencing the behavior of the individual, which is a key determinant in seeking health care and providing care at the household level.

## MDG FIVE: IMPROVE MATERNAL HEALTH

*Targets 1 and 2: Reduce maternal mortality and increase the proportion of births attended by skilled staff*

### Current Situation

Reducing maternal mortality is a priority for the government. Its current goal is to reduce MMR to at least 50 per 100,000 live births by 2010.

The 2000 National Maternal Mortality Study (NMMS) recorded a significant decline in maternal mortality: from 174 in 1992-1993 to 84 deaths per 100,000 live births in 2000.<sup>38</sup> This dramatic decline is attributed in part to the government's efforts to improve the quality of obstetric care, increase access to family planning services, and train traditional birth attendants (dayas) to recognize and refer obstetrical complications. Most maternal deaths occurred during delivery or the 24 hour period following delivery (49 percent) or during the six-week period following delivery (27 percent). Most

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<sup>38</sup> National Maternal Mortality Study 2000: Findings and Conclusions. June 2001. Cairo: Egypt Ministry of Health and Population.

deaths (62 percent) occurred in health facilities. Hemorrhage was the leading direct cause of maternal death (43 percent), followed by hypertensive diseases (22 percent), and sepsis and ruptured uterus (both 8 percent). Substandard care on the part of the health providers (general practitioners and obstetricians in particular) was the most significant avoidable factor, contributing to 54 percent of all maternal deaths (see Table 7).

**Table 7: Maternal Mortality Ratio**

	1992-93	2000
<b>Level of Maternal Mortality Ratio</b>		
National	174	84
Metropolitan	233	48
Upper Egypt	217	89
Lower Egypt	132	93
<b>Main Direct and Indirect Causes of Death</b>		
Hemorrhage	56	32
Hypertensive diseases	28	18
Sepsis	14	7
Ruptured uterus	12	7
Cardiovascular diseases	23	11
<b>Recognition of Problem/Delay in Seeking Medical Care</b>		
Deaths due to delay in recognition of problem and seeking care	73	25
<b>Logistics to Reach Quality Care</b>		
Deaths due to lack of transport	7	4
<b>Quality of Care</b>		
Substandard care by:		
Obstetrician	82	36
General Practitioner	21	9
Daya	21	7

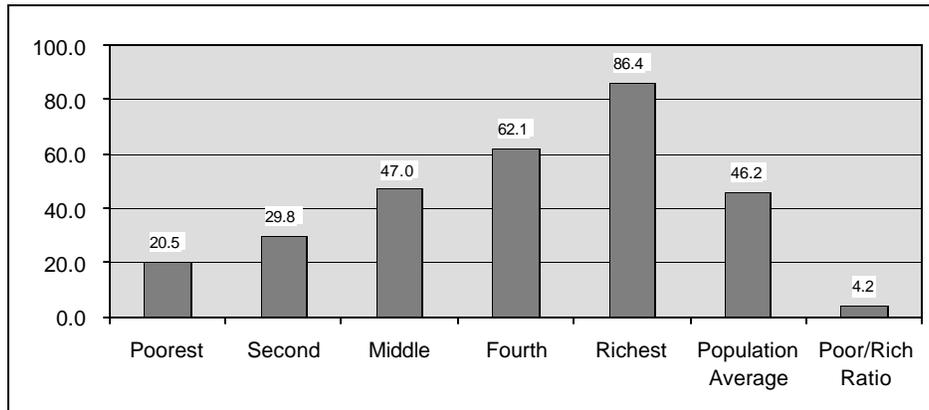
*Source:* National Maternal Mortality Study 2000: Findings and Conclusions. June 2001

The NMMS also noted significant variations in the MMR by region. The ratios varied from 48 in the Metropolitan Region to 120 deaths per 100,000 live births in the Frontier Region.

The study also found that the proportion of all births attended by skilled staff has increased considerably from 35 percent of all births attended by a doctor, nurse or midwife in 1986 to 63 percent in 1998. The number of births attended by a daya declined during this period (from 57 percent in 1986 to 34 percent in 1998).

On the other hand, the EDHS 2000 noted that medically assisted deliveries in urban areas was 1.7 times higher than in rural areas; with rural Upper Egypt having less than half the rate of urban governorates. In 1997, a socioeconomic differential was also noted, where medically assisted deliveries of the richest quintile was four times higher than the poorest quintile of the population as shown in Figure 16.

**Figure 16: Socioeconomic Differences in Percent Delivery Attended by a Medically Trained Person, 1997**



### Prospects of Achieving Maternal Health Targets

The decline in MMR between 1992-93 and 2000 was more than 50 percent and represents an annual decrease of 8.7 percent. For this MDG target to be achieved, the MMR would have to be 42.5 in 2015. If the current rate of progress is maintained the target will be achieved.

However, MMR is affected by a myriad of complex determinants and simple exponential or mechanistic decline is unlike. Moreover, it is always easier to get the first 50 percent improvement of any indicator. In the case of MMR in Egypt, getting from 174 to 84 over 8 years required adopting more general strategies and targeting easily accessible population groups. Any further decline in MMR would therefore require additional resources and different penetration strategies.

Between 1990 and 2000, the proportion of all births attended by skilled staff was estimated at 37 and 61, respectively. Even though this estimation provides a lower figure for 2000 than the NMMS mentioned above; the rate of decline is estimated at 5 percent annually, which would clearly lead to exceeding the MDG target of 90 percent in 2015. It is important however to note that the regional, geographic, and socioeconomic gaps have to be bridged.

### Requisite Conditions for Achieving Maternal Health Targets

Reducing maternal mortality in Egypt is also challenged by the cultural environment in which pregnancy and childbirth are generally regarded as natural processes, and therefore do not require medical intervention. The results from the NMMS suggest that concerted efforts are needed along a number of fronts to reduce maternal mortality mostly through medical and health care interventions. It is important to note that the significant regional variations in maternal mortality rates also suggest that additional analysis needs to be done to identify the reasons for these large differences, and services and programs strengthened accordingly in areas with the higher rates of maternal death. These variations have socioeconomic dimensions that have to be addressed in addition to health interventions.

*Expanding the Successful Programs of Essential Obstetrics Care (EOC).* EOC has been piloted in Egypt and includes the following interventions: (i) improving the clinical skills of service providers in managing EOC; (ii) conducting communications campaigns to increase the awareness of pregnant women and their relatives to alarming signs which require medical care; (iii) strengthening blood banks and ensuring the availability and safety of the blood supply and its derivatives; (iv) strengthening the national Emergency Medical Care Program in order to ensure availability of ambulances to transport pregnant women who are in critical need of care; and (v) establishing a surveillance system to monitor the pattern of maternal mortality.

*Increasing Contraceptive Use.* This is important to promote child spacing and satisfy the unmet need for contraception. This will require building on the success of the Information, Education and Communication (IEC) campaigns of the national Family Planning Program by targeting mass media and interpersonal communication programs to rural areas and Upper Egypt using a CBC approach to increase demand for family planning service particularly among those who do not want to use contraception for social, cultural, or religious reasons. The program needs to embrace the social and cultural values of the targeted communities in order to change their behavior in favor of smaller and healthier families. Special attention needs to be given to early childbearing and child spacing. This would be coupled with increasing access to quality family planning services in public facilities by including family planning services in health facilities owned by the Health Insurance Organization and in private facilities, by training private providers including pharmacists. Other measures could include expanding the range of the contraceptive method mix to respond to different family planning needs and strengthening the logistics system of contraceptive storage and distribution to ensure availability of contraceptives in health facilities particularly in rural and remote areas. Equally important is to improve the counseling skills of family planning service providers, particularly females, to reduce discontinuation rates and contraceptive failure.

*Reducing Early Marriage.* Early marriage continues to be a challenge. Five percent of currently married women aged 20 to 24 years were married by age 15. While laws prohibiting underage marriage exist, they are not enforced; enforcing them is especially difficult for girls without birth certificates. Mass media and interpersonal communication campaigns are needed particularly in Upper Egypt and in rural areas using a Communication for Behavior Change (CBC) approach to increase awareness about the negative aspects of early marriage and ultimately change the behavior of parents. At the same time, increased opportunities for girls to enroll in schools and participate in income-generating activities will help discourage early marriages.

## **MDG Six: COMBAT HIV/AIDS, MALARIA, AND OTHER MAJOR DISEASES**

*Targets 1 and 2: Slow the rate of HIV/AIDS, malaria, and other major diseases, and increase contraceptive prevalence*

## Current Situation

Egypt has made impressive progress in public health programs over the last two decades. Of the communicable diseases reported in government statistics for 2000, the highest number of cases was due to bronchopneumonia (15,648), followed by viral hepatitis (14,671) and tuberculosis (2,231). Of these, the total number of cases of tuberculosis showed the greatest reduction (down from 8,931 in 1998), due in large part to the implementation of a successful directly observed treatment, short-course (DOTS) strategy against tuberculosis. Malaria has been steadily declining over the past decade and firm control over the disease is maintained. Egypt's goal is the elimination of residual malaria transmission. The incidence rate of malaria has declined from 4 per 1,000 population in 1990 to almost zero in 2000. This section will examine HIV/AIDS, which is important in the global context and is an indication of a government's capacity to manage emerging public health issues. In this context, contraceptive prevalence rate will be also examined.

*HIV/AIDS.*<sup>39</sup> There are 1,711 persons living with HIV/AIDS (PLWHA) in Egypt (1,153 Egyptians and 558 foreigners) out of a total of 5 million tested within the period 1990 to 2003, according to the National AIDS Program (NAP) HIV/AIDS Surveillance Report of January 2003. From the total number of HIV-positive individuals, 368 are known to have developed AIDS. Most of the known infections are HIV-1 with only a few documented HIV-2 cases (Hassan, et al., 1996). Regular NAP Surveillance Reports depict HIV cases, but only offer detailed information (such as transmission modes) for cases that have already developed into AIDS. As such, the most recent detailed information about HIV infections in Egypt is for the end of 2001 when the cumulative number of HIV infections was 1,238. From this data, 81 percent of the known HIV cases were male and 42 percent (518 of the 1,238) were in people aged 30 to 39 years. The predominant mode of infection is sexual with 65 percent of HIV infections (669 cases of heterosexual transmission, 134 homosexual) followed by blood/blood products infection (24.4 percent). Only 12 cases of HIV infection through injecting drug use were reported and almost 9 percent of HIV infections up to 2002 were of unknown transmission mode. Mother-to-child transmission of HIV appears negligible in Egypt, as only 10 cases have ever been reported.

The UNAIDS/WHO estimates put the number of PLWHA in Egypt by the end of 2001 at 8,000.<sup>40</sup> For a population of 69 million, these estimates confirm that prevalence remains low (0.01 percent), however a nationally representative seroprevalence survey has not been conducted in the general population or among specific vulnerable groups. Moreover, the prevalence rate among adults is estimated to be 0.02 percent.

Discrimination against HIV/AIDS patients occurs on a global level. In Egypt, the low prevalence of the disease coupled with the conservative nature of Egypt's culture increase the stigmatization of PLWHA.

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<sup>39</sup> United Nations. 2003. Assessment of the HIV/AIDS Situation and Response in Egypt 2003. Draft report prepared by the Expanded UNAIDS Theme Group on HIV/AIDS, Egypt. New York: UN.

<sup>40</sup> United Nations AIDS/World Health Organization. 2002. Epidemiological Fact Sheet 2002 Update. New York: UN.

Stigmatization of and discrimination against PLWHA is mainly due to lack of awareness regarding the nature of HIV/AIDS including methods of transmission and prevention. Given that 20 percent of a sample of physicians believe HIV/AIDS can be acquired by an insect bite (Sallam, et al., 1995), 29 percent of a sample of health care workers think they could contract HIV/AIDS from sharing toilets (Faris and Shouman, 1994) and 50 percent of a sample of secondary school students think they could get infected by sharing a glass with an infected person (Shokr, et al., 2002), it is no surprise that strict measures are applied against PLWHA.

In the regional context, Egypt has the second highest total number of adult PLWHA among the lower/middle income countries of the MENA region (behind Algeria which recorded 11,000 PLWHA). If all countries of the region are considered, Egypt ranks third in total number of PLWHA (in addition to Algeria, Djibouti recorded 35,000 PLWHA in 1999).

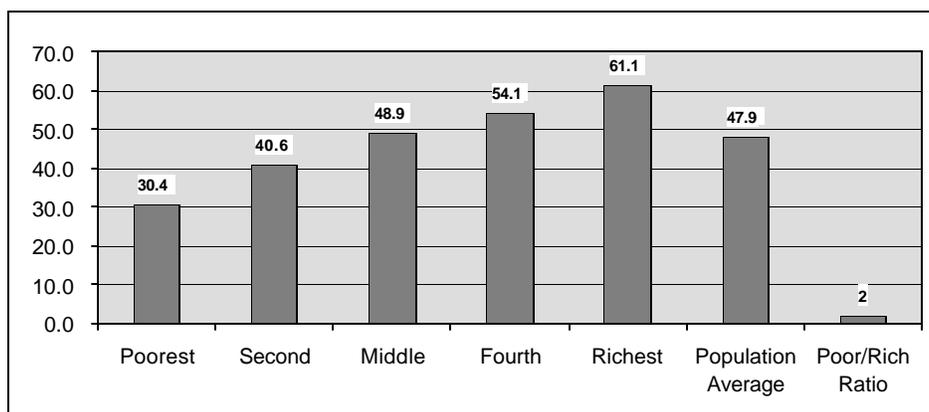
*Contraceptive Prevalence.* The current use of contraceptives among married women has more than doubled over the last two decades, increasing from 24 percent in 1980 to 56 percent in 2000. The pace of increase has varied: in the 1980s the use of contraceptives was increasing 3 percentage points a year, while in the 1990s the rate slowed to 1 percent per year. Of the 56 percent of married women using contraceptives, 54 percent were using a modern method, and only 2 percent were relying on a traditional method of contraception. Of the 54 percent currently using a modern method, the most common contraceptive was the IUD (36 percent), followed by the pill (10 percent). Use of the IUD has increased significantly over time: from 4 percent in 1980 to 36 percent in 2000, while the proportion of women using the pill has decreased, from 17 percent in 1980 to 10 percent in 2000.

Consistent with international experience, women from urban areas, those with at least a primary level of education, and women who are employed are more likely than their counterparts to have used family planning.<sup>41</sup> Sixty-one percent of married women in urban areas and 52 percent of married women in rural areas are using some method of contraception. A socioeconomic difference existed where the richest quintile of the population was twice as likely to use contraception as the poorest quintile in 1997 (Figure 17).

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<sup>41</sup> El-Zanaty, F. and A. Way. January 2001. Egypt Demographic and Health Survey 2000. Calverton, Maryland, USA: Ministry of Health and Population (Egypt), National Population Council and ORCO Marco.

**Figure 17: Socioeconomic Differences in Use of Modern Contraception by Females, 1997**



The 2000 EDHS also notes regional variations in contraceptive use among married women in the survey. Women from Upper Egypt or the Frontier governorates recorded lower rates of contraceptive use (45 percent and 43 percent respectively).

### Prospects of Achieving Targets

*HIV/AIDS.* Although the current rate of HIV infection appears to be relatively low in Egypt, early intervention to curb the spread of HIV/AIDS is vital because once the prevalence of the infection exceeds a certain threshold, HIV spreads exponentially--it can increase tenfold in five years, as it has in several sub-Saharan African countries. The more widely HIV/AIDS spreads, the more difficult and costly prevention and treatment become. The longer the introduction of programs is delayed, the greater the likelihood that the epidemic will grow exponentially.

In order to determine whether Egypt will halt the spread of HIV/AIDS, it is necessary to identify the current rate at which HIV/AIDS spreads. Unfortunately, current data is based on case reporting by governmental health institutions and screening of donated blood. In the absence of regular screening of vulnerable groups and anonymous voluntary counseling and testing, it is not possible to ascertain the true incidence and prevalence rates of HIV/AIDS in Egypt.

Nevertheless, the current (reported and estimated) prevalence rate of HIV/AIDS remains low at less than 0.1 percent. The relevance of the HIV/AIDS MDG itself is in question for such a low-prevalence country where the goal should be to maintain the low prevalence rate and to establish a strong surveillance system to monitor this rate. In order to do so, a number of issues need to be addressed and key strategies developed.

*Contraceptive Prevalence.* It is expected that the contraceptive prevalence rate will continue to increase and the goal will be achieved. The prospects and conditions were discussed previously under the maternal mortality section.

## Requisite Conditions for Achieving HIV/AIDS Targets

*HIV/AIDS.* With respect to curbing the spread of HIV, Egypt has two policy options: (i) delay action while HIV prevalence is low and face far higher expenses to control it once it spreads; or (ii) take comprehensive action now to prevent the spread of HIV infection before it becomes a serious issue. A recent report commissioned by the UNAIDS Thematic Group in Egypt provided solid analysis of the HIV/AIDS situation and made recommendations.

### *Programmatic recommendations:*

*Expand Voluntary Counseling and Testing (VCT).* VCT services have to be convenient to clients, but most important is to ensure anonymity. This will also support surveillance, prevention and treatment of cases.

*Adopt a Communication for Behavior Change (CBC) Strategy.* CBC is critical and is probably the most effective strategy to inhibit the spread of HIV, facilitating better understanding of the underlying causes of risky behavior and promoting change in this behavior, particularly among high-risk groups. In this context, peer education has proven to be one of the most successful interventions to change risky behavior.

*Strengthen the Prevention and Treatment of Sexually-Transmitted Infections (STIs) and Condom Use Promotion.* There is a correlation between the incidence of HIV/AIDS and STIs, which suggest that the latter may be predisposing factors. It is therefore important to strengthen and scale up health services that provide treatment and prevention of STIs as well to promote condom use.

*Involve the Private Sector in the HIV/AIDS Combat Strategy.* The private business sector should be encouraged and assisted in providing HIV/AIDS awareness and support to their employees particularly in the business sectors that may deal with high-risk groups, such as tourism and transport. The private sector can also play a role in sponsoring HIV/AIDS activities.

### *Institutional strengthening:*

*Strengthen the HIV/AIDS Surveillance System.* HIV/AIDS surveillance needs to be strengthened to obtain accurate and timely data on the extent of the problem, trends, and socioeconomic and cultural factors which may contribute to its spread. A “second generation surveillance” system is needed. This can be accomplished in several ways. Biological surveillance may be greatly improved if regular HIV screening of vulnerable groups is conducted through repeat cross-sectional serosurveys and should include regular knowledge, attitude, behavior and practice (KABP) studies of the general population and vulnerable groups. Case reporting should be strengthened in private health care settings as well as among patients with STIs and tuberculosis.

*Create an Enabling Environment to Minimize the Harms of Risky Behavior.* There should be political and legal support to remove obstacles to the provision of health and social services to high-risk

groups (such as injecting drug users, commercial sex workers and men who have sex with men) within prisons and rehabilitation centers as well as in the community. Furthermore, outreach to vulnerable groups must be encouraged to provide care and rehabilitation, referral, education and health services. Given that HIV/AIDS usually spreads first within those communities, efforts to curb its spread must be initiated within those communities.

*Strengthen the NAP.* It is important to strengthen the systems and institutional capacity of the NAP to improve its management capacity and ability to address HIV/AIDS.

*Develop an Integrated National Strategic Plan.* The process should be initiated to provide a strategic framework for the national response including developing fundamental principles, broad strategies and an institutional framework for HIV/AIDS action in Egypt. The plan should highlight the multisectoral response to the epidemic and not only that of the health sector.

*Support Research on HIV/AIDS-Related Topics.* This is pertinent to provide an in-depth understanding of the context of risk within vulnerable populations, the status of STIs, the pattern of drug use, and barriers to condom use among the general population and among vulnerable groups.

## THE ENVIRONMENT

### OVERVIEW

The Nile River is Egypt's major source of water. This factor has intensified Egypt's geo-political relations with the other eight riparian countries of the Nile. Increasing demand for limited water resources is placing greater pressure on the government to devise policies and programs to improve water allocation among competing water users. Agriculture currently uses more than 80 percent of available water—a reallocation away from water-intensive crops is sorely needed as is addressing rural sanitation and water pollution problems which have been neglected.

Over the last two decades, the government has made extensive efforts to increase access to safe drinking water. Major themes that can be drawn from a recently approved policy include: (i) optimal use of available water resources; and (ii) water quality protection and pollution abatement.

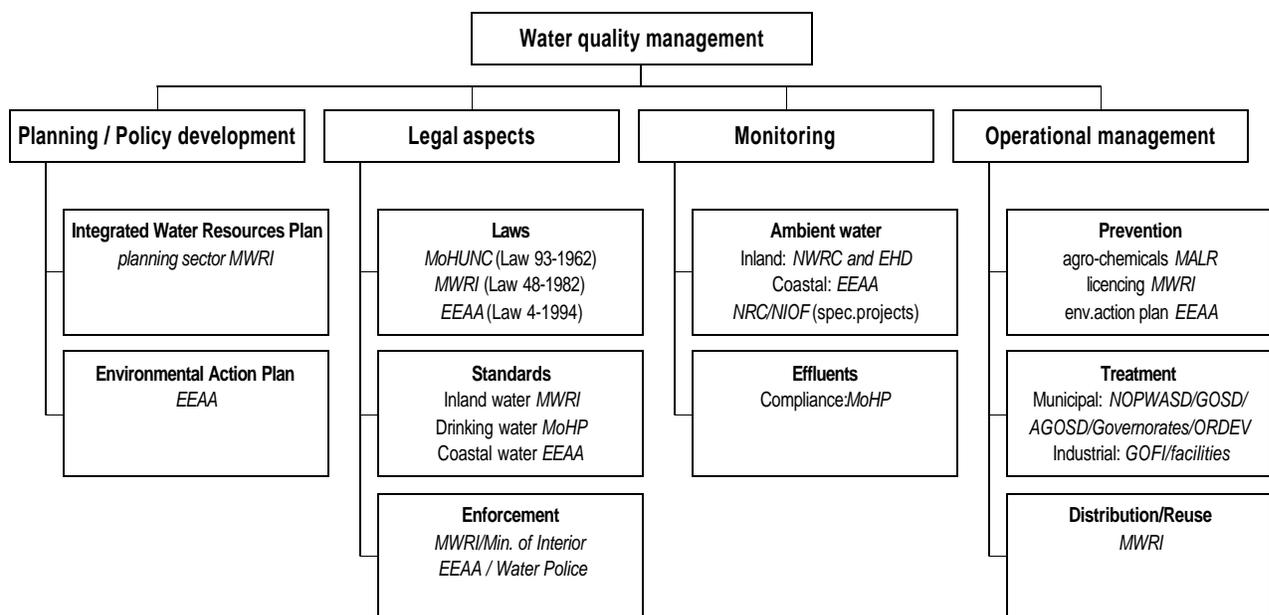
This policy aims to fulfill the population needs regarding water resources based on the principles of food security and equity through national projects such as the Salam Canal, which transports Nile waters to the Sinai Peninsula, and the development of large desert areas in the south (Toshka Project). To secure adequate water supply while honoring international agreements on Nile water use, a reuse policy has been adopted and aims to use agricultural drainage water optimally.

Complementing this plan, the Ministry of Agriculture and Land Reclamation has adopted a plan to reduce agro-chemical use in agriculture. Subsidies on fertilizers and pesticides were removed and some

agriculture chemicals with long-lasting effects were banned. Biological and genetic engineering techniques were introduced to replace pesticides. Among the achievements of this plan is the noticeable decline in the use of nitrogen and phosphorus fertilizers.

Several ministries are directly or indirectly involved in ensuring secure accessibility to safe drinking water. Figure 18 provides an illustration of the institutional framework in support of water quality management.

**Figure 18: Institutional Framework in Support of Water Quality Management**



## MDG FIVE: ENSURE ENVIRONMENTAL SUSTAINABILITY

*Target: Better and sustainable access to safe drinking water*

### Current Situation

In 2000, 95 percent of the population had access to an improved water source, up from 94 percent in 1990.<sup>42</sup> The Egypt Human Development Report of 2003 states that 97.5 percent of the urban population have access to piped water, while only 82.1 percent of the population in rural areas have such access. Similarly, 99.6 percent of the urban population, and only 78.2 percent of the rural, have adequate sanitation in their homes.<sup>43</sup>

<sup>42</sup> World Bank. SIMA Database.

<sup>43</sup> UNDP. 2002. "Service coverage varies regionally and from one governorate to another. While 97 percent of the population in urban areas have access to piped water, the figure is only 65 percent in rural areas. Though some governorates managed to reach 100 percent service coverage (Port Said and Damietta), other governorates in Upper Egypt still lag behind (Menia and Suhag; EDHS 2000). Also, the proportion of population with access to improved

Egypt's high population density and concentration of industry along the Nile Valley and the Delta have led to an increased burden on the country's natural resource base and have adversely affected public health. One of the main environmental issues is acute water scarcity and declining water quality.

Water scarcity will be a critical challenge for the future of Egypt. Per capita water availability in Egypt is about 950 cubic meters per year, even lower than the regional average of 1,200 cubic meters per year. Compounding the problem of water quantity are issues related to the quality of water because of waterlogging, salinity, and degradation by pollution. Some water savings can be expected from the reuse of drainage water, rainwater harvesting, and watershed management (mainly along the Mediterranean coast), limited desalination, reduction of Nile water flows to the sea, and the continuation of irrigation and drainage infrastructure improvements.

Per capita water availability is expected to fall from the current level of about 950 cubic meters per year to about 670 cubic meters by 2017. Water quality in the Nile River and the canals deteriorates in a northward direction due to the disposal of municipal and industrial effluents, agricultural drainage as well as decreasing flow. Drainage canals are heavily polluted. While access to safe drinking water is increasing in urban areas, rural areas lag behind. Public health is, therefore, seriously affected, with water-borne diseases and contamination of many of the shallow wells in the Nile aquifer.

The level of pollution in water systems is increasing, largely due to inadequate treatment of urban and hazardous wastes. The major sources of outdoor pollution are due to large water discharges from the heavy metallurgical industries, refineries, cement plants, and power plants, as well as from an aging transport sector. In addition, some 15 million tons of municipal solid waste are generated annually, of which about 2.5 million tons remain uncollected and no appropriate sanitary landfills exist for their disposal. Hazardous, agricultural, and hospital waste are also mixed with municipal waste in open dumps where burning is the most common method of disposal. Water pollution is not surprisingly a source of respiratory and allergic ailments, especially among children.

### **Prospects of Achieving Environmental Targets**

The MDG requires halving the population that does not have access to safe drinking water by 2015. For Egypt, the target would require an increase in coverage by 2.5 percent to reach 97.5 of the population, which is likely given the trend in the last decade.<sup>44</sup> The question is not so much whether the target will be achieved in terms of quantity and access, but whether the quality of the water resources will be adequate. Focus therefore needs to be on improving the quality of large waterways and water sources for households.

sanitation also increased from 85 percent in 1990 to 95 percent in 2000. However, these figures do not reveal the large disparities that exist between Upper Egypt, Lower Egypt and frontier governorates.”

<sup>44</sup> UNDP. 2002. “It is important to note that in order to achieve 100 percent coverage on water and wastewater services, an investment of US\$19.2 billion is required, of which US\$4 billion is needed just to maintain current levels of service.”

## Requisite Conditions for Achieving Environmental Progress

For this MDG target to be achieved, the following three areas should be underscored: (i) improving water-use efficiency, (ii) enhancing cost recovery for water delivery, and (ii) improving water quality management. The government has to maintain its current reform strategies in water, rural development, and agriculture to address the key challenges facing the water sector, namely, water management, promotion of agricultural exports, and a concerted effort to eradicate rural poverty. To achieve or even accelerate increased access to an improved water source, the following integrated strategies are recommended:

*Decreasing water loss* by using modern irrigation methods to improve efficiency particularly in new lands, conjunctive use of surface and ground water, redesign of canal cross, changing the intake for drinking water plans to decrease daily abstraction and improving the methods of removal of waterweeds.

*Developing and implementing a comprehensive strategy* to improve water quality management.

*Improving water resource allocation within the agriculture sector*—which uses more than 80 percent of available water—by gradually moving out of water-intensive crops such as rice and sugarcane.

*Developing and implementing different models of cost-sharing mechanisms* to rationalize water use, which may be carried out Water Users' Associations.

*Changing crop patterns* by developing crop packages that best suit each region.

*Encouraging private sector participation* in water-supply projects.

*Formulating policies to improve water allocation* among various water users.

*Improving efficiency* of ground water use.

*Reusing secondary treated wastewater* in the cultivation of non-freshly consumed crops.

*Developing and implementing different models for securing rainfall and flashfloods*, especially in the Sinai and the Eastern Desert in Upper Egypt.

# STRATEGIES FOR ACCELERATING THE ACHIEVEMENT OF THE MDGS

## CONCLUSIONS AND MAJOR CHALLENGES AHEAD

Egypt has made significant strides toward achieving the MDGs. The criteria established for infant mortality, under-five mortality, contraceptive prevalence, primary and secondary enrollment, and access to safe drinking water, are likely to be met. Attaining other important goals will prove more elusive, such as closing the gender gap in employment, literacy, and political participation. The data are not able to confirm whether the goals for HIV/AIDS and malnutrition will be achieved. Expanding access to basic social services while effectively targeting those population sub-groups who are currently not benefiting from such services, and adopting multi-sectoral strategies are key policy shifts and policy steps needed in achieving the MDGs.

There are a number of cross-cutting and overarching challenges which may impede achieving the MDGs (or MDG Plus) in Egypt. These key challenges include the pervasive differentials and gaps in delivery, availability, and quality of publicly financed services and programs, as well as the gender gaps; the fragmented legal system which makes developing and implementing even well-founded policies and programs difficult; and the lack of opportunity for civil society to actively participate in the development process. In addition, the lack of reliable and timely data makes it more difficult for the government and its development partners to measure and monitor the path toward achievement of the MDGs. These challenges are considered in more detail in the points that follow.

***Differentials and Gaps.*** There are significant regional (North versus South) variations, suggesting an inequity in the allocation of resources within the country. Such variations are quite pronounced with respect to poverty levels, employment of women, girls' participation in school, infant mortality rate, under-five mortality rate, and maternal mortality rate. The data also indicate that there are major differences among urban and rural populations in a number of important indicators, including access to health services and safe water. Finally, the gender gaps suggest that women are not able to play an equal role in society, as demonstrated by the low proportion of women involved in the political process. As the country and the donor community enter into this next phase toward achievement of the MDGs, concerted attention needs to be given to addressing these inequities to ensure that it is the population as a whole that benefits from socioeconomic development programs.

***Fragmented Legal and Institutional Framework.*** A plethora of laws and decrees addressing multitudinous issues, ranging from the environment to licensing requirements for health facilities, are extremely complicated and poorly enforced. Mandates and programs are duplicated and overlap because there are too many public institutions, councils, committees, institutes, public organizations, and semi-autonomous bodies. In the health sector alone, there are more than 20 public sector organizations involved in health care policy formulation, planning, financing, and service delivery. The end result is weak overall performance by the public systems, e.g., civil service, information technology,

maintenance, management, public financing, and supply of commodities (school books, pharmaceuticals).

***Weak Participation of Civil Society.*** The mechanisms for participation by civil society (such as NGOs, community-based organizations, local councils) are weak. This is a result of the restrictive NGOs laws and weak NGO infrastructure, as well as the general feeling among the populace that their involvement will have little impact. International experience clearly demonstrates that promoting citizen consultation in public service delivery and decentralizing decision-making to the local level increases transparency, accountability, and effectiveness. The government has recognized the benefits of involving civil society, as evidenced by the participatory process used during development of the Five Year Plan. Much more needs to be done in this area, including decentralizing decision-making, and facilitating the roles of the more than 14,000 NGOs that provide social services and are an integral part of the social safety net.<sup>45</sup>

***Reliability and Validity of Data.*** The availability of data and proper measurement of indicators continue to be a widespread problem in Egypt. This is perhaps best demonstrated by the unavailability of good data on the prevalence of HIV/AIDS. A major challenge to the government will be to strengthen the collection and use of data and information as a foundation for sound policy analysis and decision-making.

As 2015 approaches, governments and the international development community will give even greater attention to the MDGs. Whether or not the MDGs are achieved will provide a benchmark for assessing how effective governments and the development community are at supporting human development in a global context. It is therefore important that the momentum for achievement of the MDGs in Egypt is sustained to demonstrate to the global community that it has the systems, resources, and structures in place to improve the lives of its people. It is equally important that the focus on achieving the MDGs does not occur at the expense of programs and priority areas not directly linked to the MDGs.

## **STRATEGIES FOR ACCELERATING THE ACHIEVEMENT OF THE MDGS**

The policies and programs needed to achieve the MDGs vary from goal to goal and were addressed under each section. There are, however, a number of overarching strategies which warrant attention by both the government and the donor community in order to accelerate the achievement of the MDGs (and MDGs plus) in Egypt.

***Strengthening Government Stewardship and Regulation.*** Government oversight is needed to achieve better system performance. To accelerate the achievement of the MDGs in Egypt, the legislative framework to support growth needs to be reviewed and greater transparency in the application of laws ensured. The capacity of the public sector to deliver basic services more effectively and efficiently needs

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<sup>45</sup> World Bank. June 2001. Country Assistance Strategy for the Arab Republic of Egypt, Report No. 22163-EGT. Washington, DC: World Bank.

to be strengthened, and public/private partnerships need to be fostered to bring about faster growth. All these are integral components of the ongoing reform programs in Egypt such as the economic, education, health, and water sector reform programs. Reform in any country comes with terrific opportunities as well as costs. Reform challenges the environment in which people work and their incentives for doing so. There are also political challenges that can only be met with strong, directed, and consistent leadership. Vested interest groups may try to thwart reform. To overcome this challenge will require the government to be able to bring such groups along in the reform process by addressing their concerns. The general populace as well needs to be well informed of the changes to come and their rationale.

Against this background, in health, there is a need for merging and consolidating the fragmented health insurance programs under the Health Insurance Organization, which will entail legal and institutional reforms. Also, there is a need to improve the quality of health services both in the public and private sector by adopting appropriate licensing and accreditation programs. To reduce the gender gap and empower women, there is a need to increase the age of marriage and revise the nationality law, family law, and the labor code. In particular, there is a need for a new family law that would govern all substantive aspects of family relations in a more progressive and comprehensive manner. At the same time, labor laws need to be revised to remove disincentives to hiring women. Affirmative action by the government through legal reform and positive discrimination is also important to promote women's active participation in the political process.

***Encouraging Community Participation.*** Involving the community is a cornerstone for effective development. Soliciting a community's input into the identification of needs and the development and implementation of programs and policies to address these needs is key for program sustainability and effectiveness. In addition, civil society, represented by the NGOs, is a critical partner in development.

In Egypt, the Social Fund for Development is probably one of the most effective strategies for encouraging local participation in development. Microcredit particularly for women, population projects to promote increased demand, and girls' education and schooling in rural areas are examples of the programs it supports. For example, the recent success in the education sector has demonstrated the effectiveness of community involvement efforts as communities have helped to identify families in need of targeted incentives to encourage enrollment of their children. Further, households play an important role in determining health outcomes through their demand for services and household-level interventions. The community, with appropriate guidance, is best able to identify the constraints they face in their efforts to keep their children free from disease. Moreover, Egypt has a long history of working in partnership with local and international NGOs to support the financing and delivery of services. A major challenge for the Egyptian government is therefore to continue and build upon its community participation efforts to ensure the achievement of the MDGs. Government interventions that have been successful in improving various indicators may soon reach limits. The "last 5 percent" of most MDGs targets and closing the rural/urban and rich/poor gaps will not be achieved without community participation and civil society involvement.

***Improving Targeting of Publicly Financed Services.*** The influence of government reflects a set of strategic choices about how publicly financed services are to be delivered. Egypt has largely adopted a more traditional approach in this regard by delivering publicly financed services through a network of government-run providers. It is therefore the government that will have to take responsibility for and the lead in addressing the major challenge of bringing in the last segment of the population, whose needs with respect to a particular target are not currently being met. Identifying these last members of the cohort and providing appropriately targeted resources and programs will be key for achieving a number of MDG targets. For example, to get all children enrolled in primary school (100 percent primary school enrollment) will require targeting subsidies to families that would not otherwise be able to send their children to school. Further reductions in maternal mortality will require that resources be targeted to communities in which maternal mortality is higher than in other areas. It is therefore critical that the government and the donor community work together to ensure appropriate targeting of efforts, resources, and services towards the poor in order to achieve (and even overshoot) the MDG goals within the agreed timeframe.

Targeting of efforts suggests narrowing the focus to sub-groups of the population. In the context of Egypt, it will also be important to “scale-up” certain programs to expand access to the target population. For example, there needs to be an expansion of social services among the poor. Effective expansion requires the development of sustainable financing measures and policy changes, both of which must occur to support achievement of the MDGs.

In Egypt it is important to consider targeting publicly financed service delivery, particularly in health and education, where there are “market failures.” A gradual reduction of publicly financed tertiary-level services and redirection of public resources to expand and improve basic services would be required. The pilot program of health insurance coverage for a primary health care package for all the population under the health sector reform program is the right step in that direction, which should be consolidated and expanded. Moreover, geographic resource-allocation formulas, which were useful in narrowing regional gaps in industrialized countries, may be useful for making a difference in poor governorates such as Sohag and Qena in Upper Egypt.

***Promoting Knowledge, Awareness, and Behavior.*** Knowledge and behavior play an important part in shaping most MDGs. Health outcomes, for example, are influenced by knowledge and behavior through their impact on preventive activities, health-seeking behaviors, and compliance during treatment. Health education and information need to be improved to promote healthy behavior at the household level and to limit the adverse effects of informational asymmetries. The use of almost all child-health interventions is higher in households with better-educated mothers. Hence, increasing education, especially among girls, is likely to lead to better health. But health knowledge is also provided through health workers training.

Egypt was successful in conducting mass media campaigns in the health sector particularly with regard to immunization and family planning programs. Building on this experience may accelerate achievement of several MDGs such as infant and child mortality (child injury and accidents at home), maternal

morality (recognizing early dangerous signs during pregnancy that require medical attention), girls' education, gender gaps, and the environment.

***Adopting a Multisectoral Framework.*** Achievement of the MDGs requires a multisectoral approach. Considering the link between health and other sectors, research has demonstrated the link between mother's education and child survival. Education increases the demand for health care and the ability to use suitable approaches for preventing and treating illness within the household. Improving nutrition requires working with the agriculture sector to ensure that healthy foods are available and affordable. Health can be improved and mortality reduced if safe drinking water is made available at the local level. For example, research demonstrated that access to clean water reduces the probability of child mortality by an average of 55 percent. Electricity can help maintain food quality and facilitate safe water use. Road improvements may make the difference between people using a health facility and not using it. Moreover, reducing maternal mortality requires working with the infrastructure sector to ensure that roads and communication systems are in place so that a woman in need can be transferred to an appropriate facility. By closing the gender and income gaps in health, nutrition, educational and water and hygiene services, the human development MDGs can be achieved. In sum, achievement of a number of indicators goes beyond one particular sector. It is therefore critical that the government develop the means for cross-sectoral collaboration and cooperation among the ministries and relevant non-governmental organizations.

In Egypt, there is a strong need to adopt such a framework, not only by the government but also by development partners, who tend to focus their programs on specific sectors. Multisectoral programs that have geographic focus should be encouraged. Moreover, it is important that the government and donors work together to overcome funding gaps, fungibility issues, and continuity of aid to ensure that the government has the support needed to achieve the MDGs. The UNDP has been designated as the focal agency for ensuring donor collaboration for the MDGs. It is important that the donor community supports this role.



# ANNEX: POVERTY ANALYSIS

## INTRODUCTION

This annex includes the complete text of the poverty analysis to support the analysis of Egypt's achievement of the MGD goals and targets. Highlights of this analysis are included in the main text of the report.

## OVERVIEW

Although Egypt has enjoyed progress in social and human development, there has been limited formal and consistent empirical evidence on the levels and changes in poverty and inequality in Egypt during the 1990s. This paper attempts to fill this gap by estimating the evolution of poverty back to the baseline of 1990 and then moving forward to the 2015 projection. As noted above, Egypt does not have a Poverty Reduction Strategy Paper (PRSP). A PRSP is useful because it provides a critical examination of what policies would best promote economic growth and reduce poverty and how to use external support. The PRSP process provides a forum for adapting the MDGs to country circumstances. National PRSPs improve the poverty impact of expenditures financed by external partners and the effectiveness of technical advice by increasing country ownership and shifting policy to a more results-oriented approach. This MDG poverty analysis will offer suggested areas of focus relevant to attaining the MDG goals.

Unlike most developing countries, Egypt has experienced a low level of overall poverty incidence as well as a remarkable decline in poverty during the last decade. The MENA region, using international purchasing power standards of US\$1 or US\$2 per capita 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. The region's low poverty headcount is particularly striking in contrast to that of Latin America - a region at roughly twice the level of per capita income - which recorded poverty levels of 12.1 percent of the population in 1998. Moreover, compared to other developing areas, during the 1990s the Middle East region has become one of the most equal in terms of income distribution.

Poverty reduction was declared as one of the main objectives of the long-term plan in Egypt, which aims at reducing poverty to 6 percent by the year 2022. Poverty is a highly politically sensitive issue in Egypt. Until recently, officials denied the existence of poverty, however, they realized that the Economic Reform and Structural Adjustment Program (ERSAP) may adversely impact living standards of "low income groups", and hence several policies have been designed and implemented to help those groups. Although there is no government entity responsible for planning, monitoring, and coordinating the different programs and activities addressing the poor, Egypt has used multi-dimensional strategies for raising the Egyptian standards of living, including income generation, human capital and safety net strategies. The Ministry of Planning has devised short-, medium-, and long-term overall economic and social development plans, which have been translated into plans of action for the different ministries and agencies affected. The Egyptian government pursues poverty alleviation objectives through a variety of

channels including: direct assistance to the poor through the Ministry of Social Affairs (MOSA); free education and literacy programs through the Ministry of Education; free health care through local health units and large public hospitals of the Ministry of Health; subsidies for bread, flour, sugar and oil through the Ministry of Trade and Supply; and rural development projects through the Ministry of Agriculture.

During the 1970s and early 1980s, Egypt achieved progress in social, economic and political development. However, poverty still persists. Egypt enjoyed high rates of economic growth within this period (GDP grew by about 9 percent), with increasing reliance on external resources. Government expenditure on social services expanded substantially with growth, leading to improvements in household welfare. The development progress was financed largely by external resources, foreign aid and the quasi-rental income earned by the state, as a result of exogenous rises in oil prices and remittances. (The oil sector is an important contributor to GDP, both directly and indirectly.) During the 1980s the position of wage laborers and small landholders, two groups traditionally described as poor, improved as a result of the increase in rural wages and remittances. However, remittances and increased wages are vulnerable to fluctuations in the price of oil. Limited exports (other than oil) and high imports of western goods led to increased debts. Since 1981, the strong external position weakened sharply when the oil related sources of foreign exchange started to decline, which was compounded by the Gulf Crisis in 1991. The decline in oil prices and the consequent decline in revenue indirectly affected the poverty situation through a decrease in public expenditure and development programs related to the poor.

In 1987, the government responded to the deteriorating situation with a series of economic reforms to reduce the budget and external accounts deficit, including ERSAP. The largest single element of policy effort to reduce fiscal deficit, on the revenue side, was the exchange rate reform in early 1991. This raised revenues from oil receipts, the Suez Canal and taxes on international trade. In addition, the introduction in 1991 of sales taxes and their subsequent expansion contributed about 1.4 percent point to the revenue effort. On the expenditure side, the total cut was distributed between current and investment expenditure in the ratio of 16 and 64 percent. With investment expenditure, the share of spending accruing to the social services sector remained unchanged. Within current expenditure, which was reduced by 1.2 percent, subsidies and transfers declined about 2.4 percent, while wages and salaries (including pension payments) showed a modest reduction of about 0.6 percent of GDP.

Egypt has been successful in reversing a declining growth trend that had persisted since the mid 1980s. From 1997 to 2002, real GDP grew at an average of 4.7 percent, real per capita GDP grew at 3.6 percent, and inflation was brought down from a high of 21.1 percent in 1991-92 to 4.4 percent during the same period. Significant progress in social development has also been achieved. The net primary school enrollment rate increased from 63 percent in 1975 to 93 in 1999; infant mortality declined from 92 in 1980-85 to 49 in 1993-99, life expectancy at birth increased from 59 in 1980-85 to 67 in 1993-99 and the literacy rate increased from 48.2 in 1992 to 55.5 in 1999.

### **Current Situation: Poverty in 1999-2000**

In 1999-2000, overall poverty in Egypt stood at 16.7 percent, using the lower national poverty line (Table 9). This meant that almost 16.7 percent of the population, or approximately 10.7 million people, could not obtain their basic food and non-food needs. The poverty gap index was 2.97 percent, implying a per capita poverty deficit of LE 248 and an average deficit of LE 1,482. Using the upper poverty line, overall poverty in Egypt rises to 42 percent, representing almost 26.9 million individuals. Less than one percent of Egyptians spent less than US\$1 a day evaluated at Purchasing Power Parity (PPP). In contrast, 24.8 percent live on US\$2 a day.

Poverty in Egypt is shallow, with relatively low values of the distribution-sensitive measures P1 and P2. The poverty gap index (P1) was 2.97 percent, implying an annual poverty deficit per capita of just about LE 30 –that is, most poor people were clustered just below the poverty line. This means that if there were perfect targeting of poverty-alleviating transfers, 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 poverty severity index, P2, was 0.8, which is also relatively low by the standard of middle-income countries.

### **Current Situation: Regional Poverty in Egypt in 1999-2000**

Overall poverty masks differences in welfare among regions and among governorates in regions. In Egypt, poverty is strongly correlated with geographic area. The incidence of poverty is highest in Upper Egypt. Using the lower poverty line, poverty incidence is highest in the Upper Rural region (34.15 percent), followed by Upper Urban Egypt (19.27 percent) and is least in the Metropolitan region (5.06 percent). Differences in poverty measures across regions are statistically significant. The ranking of regions remains unchanged for other measures of poverty, indicating that not only do poor households in the Upper Egypt region represent large proportions of their population, but that their expenditure level is far below the poverty line. In general, rural areas in all regions have higher poverty measures than urban areas, with more than 5 percentage point differences. The picture is similar when using the upper poverty line. The Upper Rural region has the greatest incidence, depth and severity of poverty, where 63.49 percent of the individuals are poor. This region also exhibits the highest inequality among the poor as it has the highest poverty gap and severity indices.

Poverty is still concentrated in rural areas. 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 Rural areas. The Upper Rural region makes the highest contribution to national poverty. Almost 54.42 percent of the poor in Egypt live in the Upper Rural region when using the lower poverty line and 39.7 percent when using the upper poverty line, and its share in poverty far exceeds its population share (26.67 percent). Moreover, its share in overall poverty increases with the distribution sensitive measures, reflecting the low standards of living of the poor in this region. The Metropolitan region contributes a smaller share compared to its share in population, (less than one third). However, the contribution of the Metropolitan region is larger when using the upper poverty line, reflecting that the poor in this area are concentrated between the lower and upper poverty levels.

In addition to differences in educational levels, job availability, and the availability of public services, roads and markets, variation in the quality, cropping patterns and land ownership of agricultural land may contribute to wealth gaps among regions.

The percentage of the ultra poor was also estimated. The ultra poor are defined as those individuals whose total expenditure is less than the food poverty line. Thus they are people who cannot obtain their basic food requirements even if they allocate all their expenditures to food. Overall, the ultra poor represent 2.9 percent of the Egyptian population. These percentages vary tremendously among regions, ranging from as little as 0.58 percent in the Lower Urban region to 7.38 percent in the Upper Rural region. Thus 7.38 percent of Upper Rural population cannot obtain their basic food requirements even if they spend all their expenditure only on food items.

*Poverty trends.* Poverty in Egypt changed by the late 1990s from an urban-rural phenomenon to a regional one. There were significant differences in poverty and inequality across regions in Egypt, with poverty being worst in Upper Egypt, both in rural and urban areas, and lowest in metropolitan areas. This holds regardless of the methodology chosen.

Using the results of the Household Income, Expenditure, and Consumption Surveys (HIECS) of 1990-91, 1995-95, and 1999-2000, a consistent assessment of the evolution of poverty in Egypt is attempted. The availability of values and quantities consumed by each household in the sample, for both years, allowed an evaluation of the cost of the food basket (used to draw a food poverty line) and the food poverty lines—both of which were kept constant in real terms. The non-food components of the poverty lines were deflated with the corresponding regionally disaggregated non-food CPI. The real value of the poverty line is therefore maintained constant across regions and over time. Thus, by controlling for inter-regional differences in the cost of living and for intra-regional temporal changes in the cost of living, consistent poverty measures are achieved.

Table 9 illustrates poverty measurements at the national and regional levels, for the period 1990-91 to 1999-2000. Trends of poverty measures are not robust for changes in poverty lines. Using a lower poverty line, and at the national level, all three measurements showed a steady decline since 1990-91— from 24.3 percent in 1990-91 to 19.4 percent in 1995-96, and a further decline to 16.7 percent in 1999-2000. Poverty measures show similar trends when using the international poverty line of US\$1 a day. The picture is different when the notion of a poverty line is adopted. Poverty measures increased during the period 1990-91 to 1995-96 by about 2 percentage points and then declined sharply by 9 percentage points during 1995-96 to 1999-2000. Regardless of the poverty line chosen, the poverty gap and severity indices declined over the period 1990-91 to 1995-96 and 1995-06 to 1999-2000, indicating improvements in the expenditure inequality of the poor, even though their percentage increased.

Two consistent patterns of poverty evolution over 1990-1995 emerge when a lower poverty line is considered. First, the incidence of poverty has increased in Metropolitan and Lower Urban regions—by 3 and 1 percentage points, respectively. Second, the other three main regions experienced declines in poverty rates. Patterns of poverty changes between 1995-96 and 1999-2000 showed different stories.

First, the incidence of poverty has increased substantially in Upper Egypt over the period under consideration, from 29.32 percent to 34.15 percent in rural areas and from 10.82 percent to 19.27 percent in urban areas. The poverty gap and severity indices follow a similar pattern. Second, the Metropolitan and Lower Egypt regions are the only regions that experienced declines in their poverty measurements over the period 1995-96 to 1999-2000, and the decrease in poverty measures was substantial in the Metropolitan region (from 13.1 percent to 5.06 percent, for p0) and in the Lower Rural region (from 21.53 percent to 11.83 percent).

Similar trends in the evolution of poverty can be observed for all regions and at the national level, when using the upper poverty line notion, except for the Upper Rural Egypt where a slight decrease in poverty measures is observed. In this region, it seems that the 63 to 65 percentile of the expenditure distribution experienced a greater change in their expenditure than the change in the poverty line.

Poverty is always the highest in the Upper Rural areas, regardless of the year under investigation, the poverty measures or poverty line. However, poverty changed from a rural phenomenon in 1990-91 and 1995-96 to an Upper Egypt one, with both urban and rural areas in Upper Egypt exhibited the highest poverty measures.

The change in poverty could be attributed to changes in the distribution of living standards as distinct from 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, where reduction in poverty resulting from increased real per capita mean expenditure (-9.18 percentage points) was hampered by deterioration in inequality (1.134 percentage points). The picture differed in Upper and Lower Egypt, where both growth and redistribution effects worked in the same direction. In the Lower Egypt regions, improvements in inequality were coupled with improvements (reduction) in the Gini index, resulting in a reduction in poverty levels (growth components are -0.61 and -4.45 for urban and rural areas respectively while redistribution components were -1.55 and -5.25). The opposite was witnessed in Upper Egypt, where both per capita expenditure and inequality deteriorated. These trends resulted in a rise in all poverty measures, confirming that growth in the Lower regions was pro-poor, whereas growth in the Metropolitan region was large enough to improve poverty levels but was not pro-poor.

Elasticity of poverty measures to changes in mean expenditure and inequality were estimated. The elasticity of poverty measures to the mean expenditure and to the inequality index were least (in absolute terms) for the Upper Rural followed by the Upper Urban regions, where poverty was highest, while elasticity was highest for the Lower Rural region where poverty and inequality were low. 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 point 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 the Lower Urban region. This may explain, to some extent, change in poverty between 1995-96 and 1999-2000.

Expenditure and distribution elasticities were used to predict poverty measures in various regions in 2015, using different scenarios and different poverty line. Simulation results show that Egypt could achieve its MDG on poverty if per capita expenditure grows by 1.5 percent per annum and income inequality continues to change at the same rate prevailing during the period 1990-91 to 1999-2000. These rates are applied to all regions. With this scenario, poverty declines to 10 percent, using the lower poverty line (by more than half the rate in 1990-91). When the US\$2 a day poverty line is applied, the poverty rate declines by 58 percent of the 1990-91 rate (see Table 10).

## METHODOLOGY FOR ESTIMATING HOUSEHOLD SPECIFIC POVERTY LINES

### Data and Sampling Design

This 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 of collecting statistics, dating back to the beginning of the twentieth century. Household budget surveys have been conducted since 1957-58 and it was planned to conduct these surveys every five years. However, shortages of funds interrupted the survey schedule some times. Surveys were done in 1957-58, 1964-65, 1974-75, 1981-82, 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 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 Program (ERSAP).

### Household Specific Poverty Lines

The report uses 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 food and nonfood prices across the seven regions. They also incorporate differences in household size and age composition, and their food and nonfood 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. This begins with estimating 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 that 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 (BMR) and rural individuals are assumed to need 2.0 times average BMR. Thus, each household has its own caloric requirements depending on its location, age of its members and their gender.

**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 households in the second quintile, rather than by pricing the cheapest way of obtaining the calories or following a recommended diet. For the second quintile of households ranked by nominal per capita consumption, average quantities of all food items are constructed. Total calories generated by this bundle are calculated using calorie contents for 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 lines.

This stage can be explained mathematically as follows: let  $Z_r$  denote the actual food consumption vector of the reference group of households initially considered poor. The corresponding caloric values are represented by the vector  $k$ , and the food energy intake of the reference group is then  $kz = k \cdot Z_r'$ . The recommended food energy intake for household  $h$  is  $kh$ . The reference food consumption bundle used in constructing the food poverty line for household  $h$  is then given by  $z_h$ , where  $z_h$  is obtained by multiplying every element of  $Z_r$  by the constant  $kh/kz$ . 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 8: Quantities and Calories Generated by the Reference Food Bundle**

<i>Category of Food</i>	<i>Daily Intake of Calories</i>	<i>Quantity in KG</i>	<i>Percent of Total Calories</i>
Cereals and Starches	1,327.12	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 and Milk Products	62.38	0.07	2.71
Oil and Butter	271.87	0.03	11.79
Sugar	203.45	0.05	8.83
Others	30.95	0.02	1.34
Tea and Coffee Drinks	1.59	0.01	0.07
Soft Drinks	2.83	0.00	0.12
Alcoholic Drinks	0.00	0.00	0.00
Total Food	2,305.38		100.00

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 nonfood bundle. Following Engel's law, food shares are regressed against the 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 nonfood allowance for each household can be estimated in two ways; (i) regressing the food share against total expenditures and identifying the nonfood 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 nonfood 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 nonfood expenditures, considered to be a minimum indispensable level of nonfood 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 nonfood 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. 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 the poverty line for a single male household is LE 1264. If this man were to marry, the poverty line would be LE 2242. Obviously, the latter poverty line is less than twice the former line, reflecting economies of scale and gender differences.

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 Household Income, Expenditure and Consumption Surveys (HIECS) were used. Ravallion argued that the use of the CPI for updating the base year poverty line might generate errors in poverty trends since the construction of the CPI (based on a particular basket of 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-values 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 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 for the poverty line. As unit values for nonfood items could not be obtained, official CPIs were used to deflate the nonfood poverty line.

## ADDITIONAL TABLES

**Table 9: Poverty Measures for 1990-91, 1995-96, and 1999-2000 and Projections for 2015**

	1990-91			1995-96			1999-2000			2015		
	P0	PP1	P2	PP0	PP1	PP2	PP0	PP1	PP2	PP0	PP1	P2
<b>Lower Poverty Line</b>												
Metropolitan	.80	.12	.67	3.1	.61	.80	.06	.91	.26	.88	.75	.61
Lower Urban	.07	.35	.42	.34	.25	.26	.17	.93	.23	.85	.79	.32
Lower Rural	7.14	.77	.40	1.53	.48	.89	1.83	.57	.33	.22	.72	.19
Upper Urban	3.47	.53	.76	0.82	.81	.46	9.27	.90	.18	5.65	.78	1.45
Upper Rural	3.46	4.24	.63	9.32	.39	.50	4.15	.57	.82	20.41	.68	1.04
Border Urban	.29	.16	0.02	.63	.26	.38	.70	.39	.08	.20	.83	.42
Border Rural	0.11	2.52	.45	3.82	.75	.36	8.31	.97	.66	2.03	.82	.37
Total	4.32	.08	.10	9.41	.39	.91	6.74	.97	.80	0.80	.06	.65
<b>Upper Poverty Line</b>												
Metropolitan	2.67	.64	.01	35.58	.98	.98	9.64	.75	.70	7.41	.73	1.85
Lower Urban	1.92	.59	.68	3.55	.01	.73	7.72	.79	.81	6.66	.34	1.11
Lower Rural	2.44	8.04	.57	7.13	4.68	.12	2.00	.62	.53	4.23	.22	1.14
Upper Urban	5.94	13.13	.20	4.04	2.34	.73	8.87	4.90	.12	8.26	1.49	4.86
Upper Rural	6.60	26.82	13.98	5.34	8.83	.23	3.49	8.19	.88	9.02	2.35	4.36
Border Urban	4.81	2.76	.68	6.19	.57	.47	3.15	.69	.75	.33	.13	.85
Border Rural	1.98	7.08	3.50	6.97	2.02	.99	2.20	1.32	.01	9.45	.29	2.29
Total	9.27	6.98	.06	1.43	3.92	.15	2.63	0.83	.86	0.25	.16	2.55
<b>\$1 a Day Poverty Line</b>												
Metropolitan	.972	.366	.114	.546	.087	.024	.140	.013	.002	.63	.14	.07
Lower Urban	.768	.733	.300	.395	.047	.008	.160	.027	.008	.47	.17	.14
Lower Rural	1.007	.314	.522	.464	.156	.027	.143	.012	.002	.26	.07	.04
Upper Urban	.960	.313	.129	.868	.216	.035	.902	.114	.023	.50	.65	.34
Upper Rural	.887	.798	.580	.261	.860	.207	.845	.190	.032	.29	.24	.09
Border Urban	.000	.000	.000	.145	.248	.055	.000	.000	.000	.59	.27	.27
Border Rural	4.135	.421	.047	.000	.000	.000	.000	.000	.000	.00	.00	.00
Total	.241	.273	.003	.497	.325	.073	.682	.073	.013	.88	.20	.11
<b>\$2 a Day Poverty Line</b>												
Metropolitan	2.228	.428	2.000	5.515	.127	.971	.923	.846	.236	.99	.79	.62
Lower Urban	6.573	.254	.408	1.115	.946	.112	.809	.396	.365	.67	.10	.41
Lower Rural	6.707	5.600	.437	4.578	.450	.868	1.977	.357	.786	1.23	.62	.41
Upper Urban	3.192	.740	.649	2.662	.494	.503	4.058	.126	.611	9.17	4.78	1.84
Upper Rural	4.471	4.663	2.542	7.187	8.637	.886	9.460	1.356	.638	2.29	.80	2.11
Border Urban	1.938	.165	.517	2.386	.053	.732	.805	.687	.151	.14	.02	.49
Border Rural	9.974	8.975	.605	5.402	.331	.582	1.450	.529	.830	4.14	.36	.53
Total	9.447	2.411	.687	1.521	.932	.357	4.836	.995	.488	6.49	.33	1.07

**Table 10: Projections of Poverty Measures for 2015, Different Scenarios**

	<i>Projected Poverty Rates in 2015 under Different Scenarios</i>					Poverty rate at 1990-1991	Poverty rate at 1999-2000
	2 percent annual increase in per capita GDP and no change in Gini index	1.5 percent Annual increase in per capita GDP and no change in Gini index	1 percent increase in Gini Index and no change in per capita GDP	Prevailing growth rate and Gini index in different regions	1.5 percent annual increase in Per capita GDP and annual increase in Gini index by 0.5 %		
<b><i>Lower Poverty Line</i></b>							
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
<b><i>Upper Poverty Line</i></b>							
Metropolitan	8.91	10.95	31.19	16.88	13.83	32.67	19.64
Lower Urban	10.31	13.22	33.94	43.61	11.60	31.92	27.72
Lower Rural	18.09	22.38	44.89	45.39	18.84	52.44	42
Upper Urban	31.39	35.28	53.95	71.73	32.70	45.94	48.87
Upper Rural	44.72	49.55	66.39	74.97	44.48	66.6	63.49
Border Urban	3.75	5.17	22.64	14.30	5.09	14.81	13.15
Border Rural	23.31	27.20	46.25	16.15	24.26	71.98	42.2
Total	24.08	27.88	47.77	50.52	25.44	49.27	42.63
<b><i>One Dollar a Day</i></b>							
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
<b><i>Two Dollars a Day</i></b>							
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

## ENDNOTES

<sup>1</sup> Data source and type	Acronym
Vital registration	Vital Registration
1976 census (indirect)	Cen76
1980 Egyptian Fertility Survey (direct)	WFS80d
1980 Egyptian Fertility Survey (indirect)	WFS80i
1984 Egypt Contraceptive Prevalence Survey (indirect)	CPS84i
1986 census (indirect)	Cen86
1988-1989 Egypt Demographic and Health Survey (direct)	DHS88d
1988-1989 Egypt Demographic and Health Survey (indirect)	DHS88i
1991-1992 PAPCHILD (direct)	PAPd
1991-1992 PAPCHILD (indirect)	PAPi
1992 Demographic and Health Survey (direct)	DHS92d
1992 Demographic and Health Survey (indirect)	DHS92i
1995 Demographic and Health Survey (direct)	DHS95d
1995 Demographic and Health Survey (indirect)	DHS95i
2000 Demographic and Health Survey (direct)	DHS00d
2000 Demographic and Health Survey (indirect)	DHS00i

**Direct estimates:** Infant and under-five mortality rates are calculated from the data from a sample survey that collects birth histories, with a mother being asked for information on the date of birth and, if relevant, the age at death of every live-born child she has had. However, the collection of such information by surveys is complex and requires high levels of interviewer quality and training. The surveys are therefore quite expensive and can only cover small samples.

**Indirect estimates:** Indirectly, under-five mortality and infant mortality can be calculated by asking each woman surveyed for very simple information: her age, the total number of children she has borne, and the number of those children that have died. Indirect estimates adjust the proportions dead by age group of mother for an estimated exposure distribution in order to arrive at pure measures of under-five mortality and of reference dates for these measures. The information from the younger women gives under-five mortality of more recent years whereas the information from the older women gives under-five mortality of more distant years. The adjustment process assumes certain patterns of fertility and under-five mortality by age (East, North, South, West model life tables), and results can be quite sensitive to the choices made.

**Estimates line:** The line was estimated by fitting a regression line to the relationship between infant or under-five mortality rates and their reference dates using weighted least squares. The method of estimation is adopted from the papers: 1) K. Hill, R. Pande and G. Jones, Trends in child mortality in the developing world: 1990 to 1995, UNICEF staff working papers, Evaluation, Policy and Planning Series, UNICEF, New York, 1997. 2) K. Hill et al, Trends in child mortality in the developing world: 1990 to 1996, unpublished report, UNICEF, New York, January 1998.

## REFERENCES

- Adams Jr., R. and J. Page. 2003. "Poverty, Inequality and Growth in Selected Middle East and North African Countries, 1980-2000," *World Development* 31:2 (December 2003), 2027-2048.
- Central Agency for Public Mobilization and Statistics (CAPMAS). 2002. Statistical Yearbook, Labor Force Sample Survey. Cairo: The Agency.
- Ebeid Overviews the Ministry of Information and Technology's New Projects, *Al Ahram Newspaper*, 4 May 2003, page 12.
- Egypt Country Profile. 2003. *The Economist Intelligence Unit*. UK: The Economist.
- El-Laithy, H., M. Lokshin, and A. Banerji. May 2003. Poverty and Economic Growth in Egypt, 1995-2000. Washington, DC: World Bank.
- El-Zanaty, F. and A. Way. January 2001. Egypt Demographic and Health Survey 2000. Calverton, Maryland, USA: Ministry of Health and Population (Egypt), National Population Council and ORCO Marco.
- Klasen, S. 1999. "Does Gender Inequality Reduce Growth and Development? Evidence from Cross-Country Regressions." Background paper for Engendering Development—Through Gender Equality in Rights, Resources, and Voice. Washington, DC: World Bank. 2001.
- National Maternal Mortality Study 2000: Findings and Conclusions. June 2001. Cairo: Egypt Ministry of Health and Population.
- New Development Plan Leads to Egypt's Modernization and Prosperity, *Al Ahram Newspaper*, 6 May 2003, page 3.
- United Nations. 2003. Assessment of the HIV/AIDS Situation and Response in Egypt 2003. Draft report prepared by the Expanded UNAIDS Theme Group on HIV/AIDS, Egypt. New York: UN.
- United Nations AIDS/World Health Organization. 2002. Epidemiological Fact Sheet 2002 Update. New York: UN.
- United Nations Development Programme. 2002. Arab Human Development Report 2002. New York: UNDP.
- . 1997. First Country Cooperation Framework for Egypt, 1997-2001. Website of the Egyptian Ministry of Foreign Affairs, Foreign Policy Positions and Documents: [www.mfa.gov.eg](http://www.mfa.gov.eg), page 3.
- World Bank. December 2003. Egypt: Country Gender Assessment, Cairo, Egypt. Washington, DC: World Bank.
- . June 2002. Public Health in the Middle East North Africa: A Situation Analysis. Washington, DC: World Bank.
- . October 2002. The Arab Republic of Egypt Education Sector Review: Progress and Priorities for the Future. Report No. 24905-EGT. Washington, DC: World Bank.
- . June 2001. Country Assistance Strategy for the Arab Republic of Egypt, Report No. 22163-EGT. Washington, DC: World Bank.
- . June 2001A. Egypt Social and Structural Review. Washington, DC: World Bank.
- . 2001. World Development Report 2000/2001: Attacking Poverty, The World Bank. UK: Oxford University Press.
- . SIMA Database. Washington, DC: World Bank.
- World Factbook, The. 2002. [www.odci.gov/cia/publications/factbook](http://www.odci.gov/cia/publications/factbook).







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