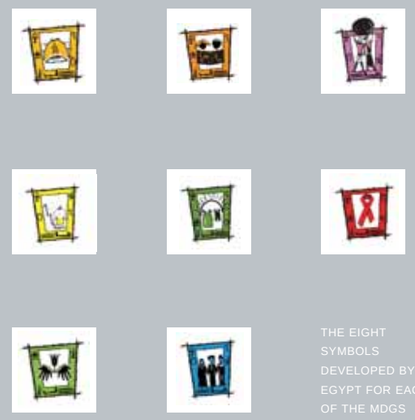
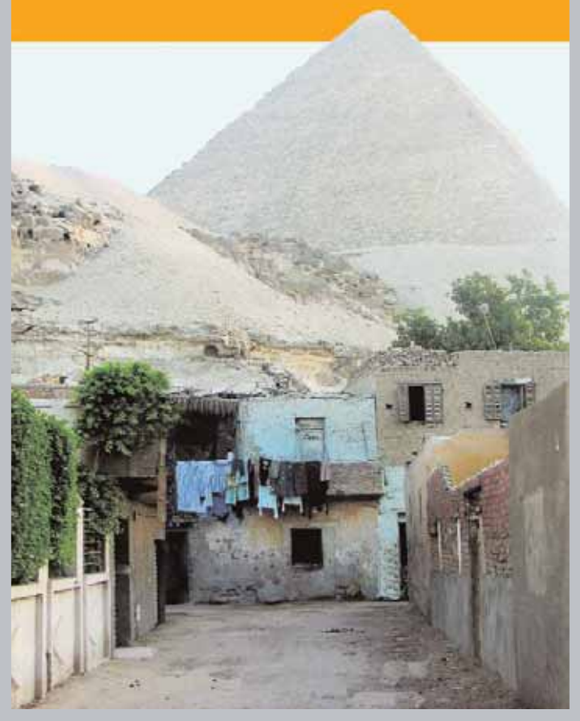


THE EIGHT SYMBOLS DEVELOPED BY EGYPT FOR EACH OF THE MDGS

EGYPT ACHIEVING THE MILLENNIUM DEVELOPMENT GOALS: A MIDPOINT ASSESSMENT

EGYPT

ACHIEVING THE MILLENNIUM DEVELOPMENT GOALS



A MIDPOINT ASSESSMENT

MINISTRY OF ECONOMIC DEVELOPMENT 2008

EGYPT

ACHIEVING THE MILLENNIUM DEVELOPMENT GOALS

A MIDPOINT ASSESSMENT

MINISTRY OF ECONOMIC DEVELOPMENT 2008

The Millennium Development Goals Report 2008 is one of the activities of the National Human Development Report Project, executed by the Institute of National Planning, Egypt, and funded by the United Nations Development Prgramme, under project number 00012375.

This report has also benefitted from the financial and technical assistance of the United Nations Development Programme (UNDP), Egypt Country Office.

Design, layout and cover: Joanne Cunningham
Photographs by UNDP (pages 13, 19, 27, 33, 41, 59), Joanne Cunningham (cover and pages 5, 49).

Printed by EgyGraph Design & Publications

ACKNOWLEDGEMENTS

The Ministry of Economic Development would like to thank their Excellencies the Ministers who have greatly contributed to this report either by making latest data available or by giving feedback on drafts of this report.

Special thanks should be extended to Dr. Hoda Rashad, the Director of the Social Research Center of the American University in Cairo who has led the team of national experts who drafted the report. The team includes: Dr. Ramadan Hamed (Chapter 1 and 2), Dr. Faten Abd El Fatah (Chapter 3), Dr. Somaya El Saadany (Chapter 4 and 5), Dr. Sherine Shawky (Chapter 6), Dr. Hala Abou Ali (Chapter 7), Dr. Ashraf El Araby (Chapter 8), with support from Amr El Sayed, Iman Mostafa, Mona Tewfik, and Amira Al-Asra (research assistants).

The Ministry would like to extend its deep appreciation to the United Nations Development Programme (UNDP) in Egypt for the support provided. Moreover, the team has greatly benefited from the valuable comments of Mr. Adib Nehmeh, UNDP Regional Advisor on the first draft of this report. The contributions of Mrs. Ghada Waly (Assistant Resident Representative and MDGs Focal Point, UNDP Egypt) throughout the process were crucial and are highly appreciated. Many thanks must go to Gillian Potter, the editor, Joanne Cunningham, the designer of the report and to Ms. Sarah Sabri, Programme Assistant at UNDP.

PREFACE

Eight years ago, in 2000, Egypt agreed on a vision for the future — a vision for a country with less poverty, hunger and disease, with greater survival prospects for mothers and their children, with a better educated population and equal opportunities for women, a healthier environment and a greater relationship with all development partners.

This follow-up report on achieving the Millennium Development Goals (MDG) for Egypt, the fourth in a series since 2000, gains a special importance as a mid-point assessment that takes into consideration the revised MDG framework approved at the 2005 World Summit, as well as national goals that go beyond the international goals set for all countries.

At the national level, and as indicated in this report, Egypt is on the right track to realizing most of the Millennium Development Goals by the set date of 2015, but regional disparities still need to be adequately addressed. The Egyptian government is strongly committed to overcome this major challenge. The last two Five-Year Development Plans covering the period 2002-2012 have given top priority to Upper Egypt, the most deprived region in the country. Indeed, more than one-third of total public investments over the last decade have been allocated to Upper Egypt governorates.

Moreover, a 'poverty map' has been recently drawn to determine the most vulnerable areas and groups. Based on this map, two innovative programs, 'Geographic Targeting' and 'Supporting Most Vulnerable Families' have been applied. These programs target the poorest villages and the poorest families in all Egypt, using an integrated and empowering approach based on reallocating resources, public expenditure and policy interventions to reach the neediest people in the poorest areas.

Geographical targeting and other integrated social policies promise to reduce regional lags and gaps now evident through governorate level analysis, and to ensure the full realization of national MDG goals in all of Egypt. This is the vision that we soundly believe will be achieved by 2015.

Dr. Osman Mohammed Osman
Minister of Economic Development

TABLE OF CONTENTS

ACRONYMS

ARI	Acute Respiratory Infections
BIO-BSS	Biological and Behavioral Surveillance Survey
BOP	Balance of Payments
CAPMAS	Central Agency for Public Mobilization and Statistics
CO_2	Carbon Dioxide
CPR	Contraceptive Prevalence Rates
CSMC	Central Safe Motherhood Committee
DAC	Development Assistance Committee
DOTS	Directly Observed Treatment Short Course
DSL	Digital Subscriber Line
ECES	The Egyptian Center for Economic Studies
EDHS	Egypt Demographic and Health Survey
EEAA	Egyptian Environmental Affairs Agency
EFS	Egyptian Fertility Survey
EIDHS	Egypt Interim Demographic and Health Survey
EHDR	Egypt Human Development Report
EIB	European Investment Bank
EOC	Essential Obstetric Care
EU	European Union
GDP	Gross Domestic Product
GHG	Green House Gas
GOE	Government of Egypt
HBV	Hepatitis B Virus
HCC	Hepatocellular Carcinoma
HCV	Hepatitis C Virus
HIECS	Household Income Expenditure and Consumption Survey
HIO	Health Insurance Organization
HIPC	Highly Indebted Poor Countries
HSR	Health Sector Reform
ICPD	International Conference on Population and Development
ICT	Information Communication Technology
IDSC	Information and Decision Support Center
IMR	Infant Mortality Rate

INP	Institute of National Planning
IT	Information Technology
IUD	Intra-uterine Device
KGs	Kindergardens
LDCs	Least Developed Countries
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MDRI	Multi Debt Release Initiatives
MIC	Ministry of International Cooperation
MMR	Maternal Mortality Rate
MOHP	Ministry of Health and Population
MSEA	Ministry of State for Environmental Affairs
NDP	National Democratic Party
NEDSS	National Electronic Diseases Surveillance System
NMMSS	National Maternal Mortality Surveillance System
NNT	Neonatal Tetanus
ODA	Official Development Assistance
ODS	Ozone-depleting substances
OECD	Organization for Economic Co-operation and Development
ORT	Oral Dehydration Therapy
PHC	Primary Health Care
PPP	Purchasing Power Parity
RAMOS	Reproductive Age Mortality Study
SFD	Social Fund for Development
SMEs	Small and Medium Enterprises
TFR	Total Fertility Rate
TT	Tetanus Toxoid
U5MR	Under 5 Mortality Rate
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USA	United States of America

THE MILLENNIUM DEVELOPMENT GOALS

A MIDPOINT ASSESSMENT

AN OVERVIEW

The MDG report is more than an instrument for tracking Egypt's international commitments. It is a tool for emphasizing priorities and guiding future actions. It is also a policy instrument for articulating national aspirations and developmental goals.

The 2007 reference date of this current report comes at a mid point between the adoption of the international goals set in 2000 and the 2015 date for achieving specific targets in Egypt. This mid point timing therefore provides an opportunity to reflect on the potential for success.

The 2007 reference date also allows an update of the indicators in the 2005 report on Egypt which has a reference point of 2004. During the three years that have passed since this last MDG report, new sets of data have been collected and are used in the current report to provide revised measures. In particular, these sets of data include the 2007 World Bank/Ministry of Education report, Egypt Poverty Assessment, 2007 Ministry of Health and Population reports, the 2007 World Bank World Development Indicators, the 2006 Census, the 2005 Egypt Demographic and Health Survey, the United Nation Development Program/Institute of National Planning Egypt Human Development 2005, and Egyptian Environmental Affair Agency reports, 2004-2007.

More importantly, this year's MDG report is an opportunity to document current public policies and actions to achieve national developmental goals and to highlight challenges that need to be addressed.

The report highlights key messages supported by facts and figures. Among them are the following:

Goal 1: Eradicate Extreme Poverty and Hunger

- Egypt's commitment to poverty alleviation has acquired clear momentum through the explicit adoption of the goal of reducing poverty to 15 percent by 2011/12 in its national Sixth Five Year Socioeconomic Plan (2007-2012). This goal is based on national poverty lines, recognizing that Egypt has already achieved its international commitment of reducing to half extreme poverty based on $1 per day.
- The Government of Egypt has also explicitly articulated a package of actions and programs to empower the poor.[1] These include short-term

1. As detailed in the papers published by the Policy Secretariat of the National Democratic Party.

deliverables, two complementary programs: 'Geographic Targeting' and 'Supporting Most Vulnerable Families,' as well as an integrated package of social policy reforms.

- The small percentage increase in the proportion of the poor during the period 2000-2005 as well as its geographic clustering – and despite a clear improvement in economic performance and growth — is receiving a great deal of attention. The government sees this as not reflecting the recent growth trend. Concern over the need to reflect shorter-term trends has resulted in a decision to monitor poverty every two years instead of the usual five years, as well as the adoption of special programs to ensure equitable benefits of growth, particularly in relation to public spending.
- Unemployment rates have witnessed some decrease but remain a serious challenge, particularly with regard to women and young people.
- Large differences in underweight children among governorates are a cause of concern. An accelerated progress is needed in some governorates to achieve the national MDG target.

Goal 2: Achieve Universal Primary Education

- Education enrolment saw substantial improvements for both males and females during the period 2000-2006. Non-enrolment and school drop-out rates remain relatively high and clustered in certain areas and in vulnerable groups, with an additional effort directed to specific social groups. It is expected that by 2015 almost all children of primary school age will be in school.
- The literacy rate for the young has improved and Egypt is approaching one hundred percent literacy among the 15-24 year old age group. Such an improvement is mainly a reflection of the progress in school enrolment. However, the universal eradication of illiteracy remains a challenge and demands the efficient implementation of new strategic directions.
- Within the framework of the Presidential Election Program of 2006, Egypt's education strategy aims not just at increasing enrolment rates but increasing number of schools and reducing class density as well as supporting early childhood development (4-5 years).

Goal 3: Promote Gender Equality and Empower Women

- Egypt is addressing women's empowerment and has demonstrated its commitment through institutional arrangements, major legislative changes and a large number of initiatives and actions.
- However, despite the expectations of a positive impact of the many national efforts on a large number of social groups, particularly those suffering from injustice and hardship, there are clearly major challenges remaining. The three fronts emphasized in the MDG's — of education and of economic and political participation — still call for concentrated actions.
- On the educational front, Egypt has already achieved the MDGs in girls' enrolment in general secondary education and is on its way to achieving this goal in primary education. Girls' technical education in Egypt remains a real challenge. This sector of education currently absorbs

around 70 percent of students, with a percentage of female to male of 85 percent, mainly concentrated in the commercial and agricultural branches that are less competitive for the labor market.

- The low quality of technical education is well recognized in Egypt and current reforms effort that are under discussion need to explicitly recognize the specificity of female enrolment in that sector.
- The other two key fronts of female economic and political participation are not showing any signs of progress. These fronts need to be further prioritized and to receive a more articulated strategy supported by a detailed action plan and implementations steps.

Goal 4: Reduce Child Mortality

- Egypt's efforts to reduce child mortality are paying off. Good progress is documented and the country is on track towards achieving the MDG targets.
- Inequities in survival between geographic and social groups remain a serious challenge. Gendered differentials are also manifested in certain vulnerable groups. Other health challenges include reduction of the relatively high neonatal mortality rate, achieving a universal full program of vaccinations, and combating childhood morbidity, particularly diarrhoeal and acute respiratory infections.

Goal 5: Improve Maternal Health

- Egypt's commitment to improve maternal health and its many national programs have already translated into a significant and impressive reduction in maternal mortality ratios and in proportion of births attended by skilled personnel.
- The impressive speed of decline in maternal mortality calls for further confirmation of the accuracy of recent measures.
- Regional variations in all available measures of maternal and reproductive health, particularly in rural Upper Egypt, demand more effective targeting.
- Additional significant gains in women's health could materialize through the comprehensive adoption of the 'reproductive health paradigm'. Such a paradigm incorporates a strong gender and social determinants component as well as a broader definition of reproductive health challenges.

Goal 6: Combat HIV/AIDS, Malaria and Other Major Diseases

- Egypt is making significant strides towards achieving this goal. The battle against HIV/AIDS was started since the appearance of the first case in the country. Egypt has succeeded in controlling malaria, while tuberculosis and schistosomiasis are regressing. Despite these achievements, Egypt should adopt steps to avoid the danger of experiencing a turning point from a low to a concentrated HIV epidemic. The HIV infection in Egypt is not only confined to the high risk groups; it is clustered in the most productive age span and the country is experiencing a relatively high share of females in the epidemic.
- Hepatitis B and hepatitis C constitute major health threats in Egypt.
- The Ministry of Health and Population has created specific preventive

and curative programs for all major illnesses and Egypt is currently reforming the health insurance system. The challenge that needs to be resolved is the overburden born by the Ministry of Health and Population in caring for those in need of medical attention, as well as for a health policy with multisectoral integration, to address health in a social context

Goal 7: Ensuring Environmental Sustainability

- Ensuring environmental sustainability in Egypt is still a challenge despite government policies, and increasing investments in protection measures. Key challenges are the need to curb population growth with its negative impact on the environment as well as better control and/or management of the increasing demand on natural resources.

Goal 8: Develop a Global Partnership for Development

- Progress on global commitments for improved aid, fairer trade and debt relief is at the core of MDG 8, and, in consequence, will determine to a large extent the successful achievement of the first seven MDGs by 2015. In the past few years Egypt has witnessed a rising trend in its ODA disbursements from a variety of rich countries and international organizations, and these have been allocated to fulfill the development needs of different sectors. Further, Egypt has also benefited from a number of bilateral and multilateral trade agreements. The share of exports of goods and services in Egypt's GDP has been increasing throughout these years.
- Egypt's external debt has witnessed stable movement in the last few years, with a decline in the ratio of debt interests to exports of goods and services.
- The Egyptian ICT sector has been growing fast in the past years especially with the increase in investments directed to it, resulting in more access to landlines and cell phones, along with the extensive use of personal computers and access to the internet.

GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

Target 1 Halve between 1990 and 2015 the proportion of people whose income is less than one dollar a day	1 . Proportion of population below $1 (PPP) per day 2 . Poverty gap ratio 3 . Share of poorest quintile in national consumption
Achieve full and productive employment and decent work for all, including women and young people	■ Growth rate of GDP per person employed ■ Employment-to-population ratio ■ Proportion of employed people living below US $1 (PPP) per day ■ Proportion of own account and contributing family workers in total employment
Target 2 Halve between 1990 and 2015 the proportion of people who suffer from hunger	4 . Prevalence of underweight children under-five years of age 5 . Proportion of population below minimum level of dietary energy consumption

Key Messages

- **Poverty reduction is one of the main objectives of the Government of Egypt which has adopted a national target of reducing poverty to 15 percent by 2011/12.[2]**
- **The recent higher rate of economic growth coupled with implementation of pro-poor policies holds great promise to achieve visible progress in reducing poverty. This is particularly based on the shallow nature of the poverty gap in Egypt.**
- **Full and productive employment for all remains a challenge, particularly for women and young people. Also, the gap between the demand for skilled labor and the supply of unskilled labor is being increasingly felt by the private sector.**
- **Geographic differences in nutritional status of children are a cause of concern.**

1.1 Status of Progress

Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day

Target 1.1.1 Proportion of population below $1 (PPP) per day

Based on international standards, Egypt has already halved the proportion of the population living in extreme poverty. According to the Household Income, Expenditure and Consumption Survey 2004/05 (HIECS), as many as 3.4 percent of Egyptians are living on less than $1 per day, (evaluated at purchasing power parity), compared to 8.2 percent in 1990. However, a small increasing trend emerges when $2 per day is used as the base, such that 42.8 percent of Egyptians are living on $2 or less a day compared to 39.4 percent in 1990.

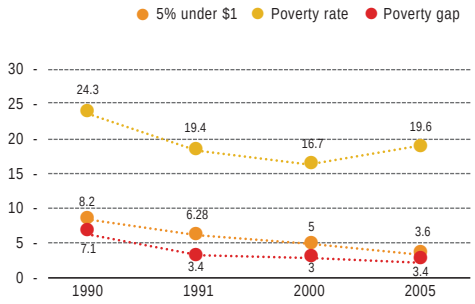
■ Share of poorest quintile in national consumption

Based on the national poverty line, one out of each five Egyptians (19.6 percent) has consumption expenditure below the poverty line and cannot obtain basic food and non-food needs compared to 24.3 percent in 1990. During the period 1990-2005, the poverty rate declined at an average annual rate of 1 percent. Clearly, Egypt needs a faster decline in the percentage of population under the national poverty level to meet the target of halving the proportion of the poor under the poverty line so as to reach 12.1 percent in 2015.

The short-term increase in the proportion of the poor between 2000 and 2005 can be mainly attributed to the slow economic growth rates during that period. Indeed, as indicated in

2. The national target refers to the percentage of the population below the national poverty line. This target has been adopted in the report, noting that Egypt has already achieved the MDG target.

Figure 1.1
Trend in measures of poverty 1990 - 2005



Source: World Bank, 2007, Egypt Poverty Assessment Update

Figure 1.2, the annual growth rate in Egypt had only started its significant improvement by 2005, while the survey used for the poverty estimates was fielded during 2004/05.

Sustaining recent economic growth coupled with pro-poor policies holds great promise for fast reduction of poverty in Egypt

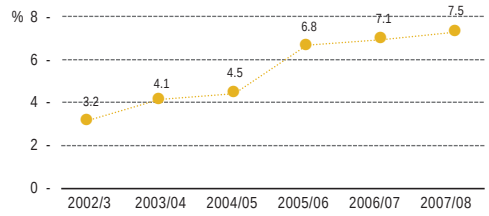
The concern with monitoring short-term trends in poverty levels and its linkage to economic growth has prompted the government to implement the HIECS survey every two years instead of the usual five years interval.

Most of the poverty analysis in Egypt relies on five successive HIECs conducted by CAPMAS, covering the period 1990–2005. This survey has the great advantage of large sample size. This allows an estimation of poverty at the governorate and district levels, not just at the national level.

■ Poverty gap ratio

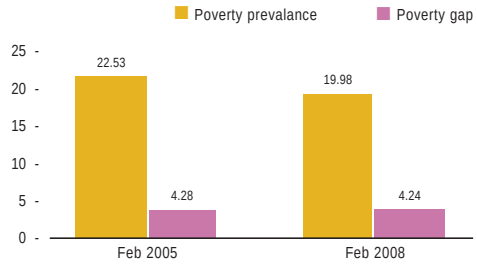
The shallowness of poverty in Egypt implies that the challenge of poverty reduction lends itself to faster returns once efficient pro-poor policies are implemented. The poverty gap between the observed expenditure levels of

Figure 1.2
Development of real GDP annual growth rate (at constant market prices). 2002/03 - 2007/08



Source: Ministry of Economic Development, 2008 Social and Economic Development Follow-Up Report for the year 2007/2008

Figure 1.3
Trend in poverty indicators, 2005 and 2008



Source: Ministry of Economic Development 2008, Trend of Standard of Living and Poverty Indicators in Egypt

poor households and the poverty line declined to half, from 7 percent in 1990 to 3.6 percent in 2005. This means that the minimum amount of consumption that needs to be transferred to pull the poor up to the poverty line has been reduced by 50 percent.

Economic growth can help to achieve visible progress in reducing poverty. The growth elasticity of poverty in Egypt as a whole is quite high at -3, meaning that 10 percent growth in real per capita consumption for everyone will reduce poverty by 30 percent. Sustaining equitable growth of 3 percent increase in per capita consumption per year over the period 2007-2012 will reduce poverty prevalence in Egypt to around 10 percent, according to the World Bank Egypt Poverty Assessment Update of 2007.

In order to better monitor poverty and to study the impact of recent economic growth on the standard of living, and on the prevalence, depth and severity of poverty, a panel HIECS was conducted in February 2008. The panel study included the same households that were interviewed in February 2005 (3691 households). The panel survey results (Figure 1.3) indicate a reduction in the prevalence of poverty from 22.53 percent in February 2005 to 19.98 percent in February 2008.

The reduction of poverty was observed in all regions including rural Upper Egypt (from 39.88 percent to 39.4 percent). The depth of poverty (poverty gap) has been slightly improved from 4.28 percent to 4.24 percent. Results also indicate that around 11.9 percent of the sample were poor in 2005 and became non-poor in 2008 compared to 9.4 percent who were not poor in 2005 and became poor in 2008.

2007/08 has seen both the highest growth rate attained throughout 2002/03-2007/08 and some decline in the unemployment rate. Unemployment remains a challenge and is particularly severe among women and young people

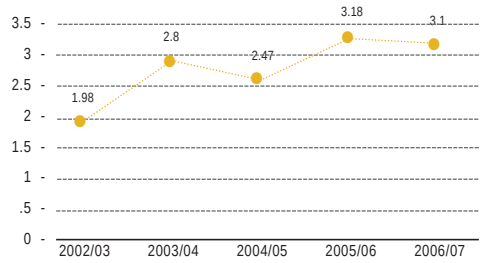
Target 1.1.2 Achieve full and productive employment and decent work for all, including women and young people

■ Growth rate of GDP per person employed

The assessment of macro economic performance in 2007/08 shows that the national economy sustained its growth at accelerated rates during the year. As a result of the economic reform programs and private sector responsiveness, the real growth in GDP more than doubled during the period 2002/03-2007/08. Figure 1.2 indicates that real GDP increased from 3.2 percent in 2002/03 to 7.5 percent in 2007/08.

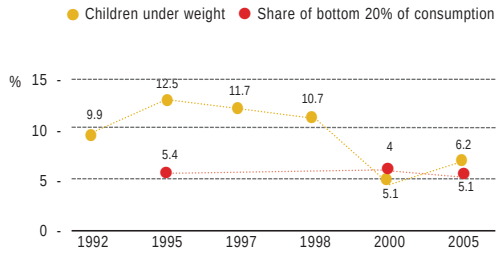
One impact of high GDP growth and accelerated investment was that employment grew by an average annual rate of 2.71 percent during

Figure 1.4
Growth rates of employment, 2002/03 - 2006/07



Source: Ministry of Economic Development, 2008

Figure 1.5
Percentages of children under weight and share of bottom 20% of consumption, 1992 - 2005



Source: El Zanaty et al., Egypt Demographic and Health Surveys, 1992-2005, World Bank, 2007, Egypt Poverty Assessment Update

the period 2002/03-2007/08. During the last two years, the employment growth rate reached a level of 3.1 percent, exceeding the corresponding growth rate of the labor force (2.3 percent). As a result, the unemployment rate declined from 9.5 percent in 2005/06 to less than 9 percent in 2007/08.

■ Employment-to-population ratio

The latest Labor Force Sample Survey (LFSS) indicates that around 22 million were employed in 2007, with the GDP growth rate per person employed at almost 4.4 percent. Around 25 percent of the employees worked for their own account or family. The annual output per worker (in constant prices) was also raised from LE 21.4 thousand in 2001/02 to LE 24.2 thousand in 2006/07.

Recent estimates of unemployment ratios by sex indicate that unemployment among females is more than threefold (CAPMAS, Labor Sample Survey, 2006), and the level among males (7 percent and 25 percent respectively). In addition, unemployment among the younger population is substantially higher. Among the age group 15 to less than 25 years, 23 percent of males and 61 percent of females are unemployed compared to 2 percent of males and 10 percent of females in the age group 25-64 years.

Conditions of work in the informal sector and small business in the private sector are a cause of concern. A recent study conducted under the auspices of Ministry of Investment indicated that the private sector denies around a quarter of its works social and health insurance benefits. In addition, there is a need for a concerted effort to address the working environment in the private manufacturing sector, where major stockholders are individuals or family.

The nutritional status of young children in Egypt shows long-term improvement but a short term fluctuating trend during the period 1992-2005

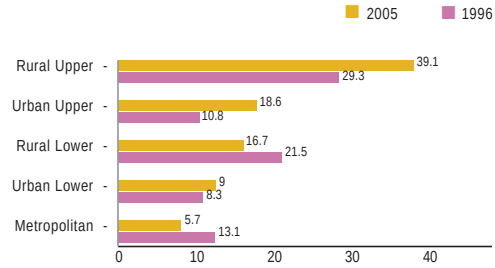
Target 2: Halve between 1990 and 2015 the proportion of people who suffer from hunger

■ Prevalence of underweight children under five years of age

The proportion of children under five years of age who are underweight declined from 9.9 percent in 1992 to 6.2 percent in 2005. The long-term decline over the period 1992-2005 of 37 percent suggests that Egypt will meet the 2015 MDG goal. However, the short-term fluctuations in prevalence of underweight children are a cause of concern. These fluctuations may be a reflection of the large sample variations known to be associated with anthropometric measures. Such fluctuations, if real, suggest that children are quite sensitive to consumption patterns.

Figure 1.6

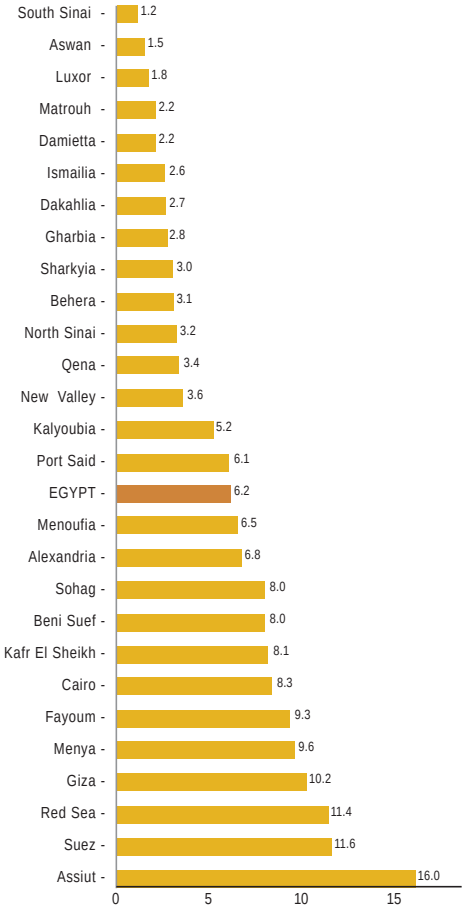
Percentage of population under poverty line by region, 1996 and 2005



Source: World Bank, 2007, Egypt Poverty Assessment Update

Figure 1.7

Percentage of children under age five who are underweight by governorate, 2005



Source: El Zanaty and Way, 2006, Egypt Demographic and Health Survey 2005

■ Proportion of population below minimum level of dietary energy consumption

Data on consumption expenditures demonstrate large differences between economic groups. According to the HIECS 2004/05, share of the bottom 20 percent is around 5 percent of consumption expenditures, that is, almost the same level of 1990.

1.2 Major Challenges

The major challenge is to ensure that the increase in poverty incidence between 2000 and 2005 was of a transitory nature resulting from slow economic growth rates and that recent economic success is translating to the aspired reduction in poverty levels.

■ Poverty tends to be more concentrated in Upper Egypt

There is a clear concentration of the poor in the rural Upper Egypt region. As Figure 1.5 indicates, the percentage of population under the poverty line is highest in rural Upper Egypt (39.1 percent) and urban Upper Egypt (18.6 percent) and is lowest in metropolitan areas (5.7 percent).

Over the period 1996-2005, poverty declined in metropolitans and rural Lower Egypt by 7 and 5 percentage points respectively. On the other hand, poverty remained unchanged in urban Lower Egypt and increased in Upper Egypt (by 8 and 10 percentage points in urban and rural areas respectively).

Poverty mapping suggest the concentration of poverty in specific pockets, even within rural Upper Egypt. Based on combined data from the population censuses and household surveys, the poverty maps for 1996 and 2006 at the sub-governorate level show that both urban and rural poverty are fairly densely concentrated in very specific areas. One third of the poorest one hundred sub-districts or Sheykhas exist in Sharkyia (12), Menoufia (10) and Qena (11). All the poorest one hundred villages are located in Upper Egypt.

■ Large differences in underweight children among governorates

Figure 1.7 indicates that the percentages of children under age 5 who are underweight

range between 16 percent in Assiut (Upper Egypt) and 1.2 percent in South Sinai (a Frontier governorate). Around half of the governorates (13) have already met the national MDG target of 5 percent or less, while meeting the target in the other half, particularly in Assiut, Suez, Red Sea, Giza, Menya and Fayoum, still require accelerated progress.

1.3 Public Policies

The Sixth Five Year Socioeconomic Plan (2007-2012) has explicitly adopted the goal of reducing the poverty rate to 15 percent by the end of the Plan. The Plan's strategy is based on achieving balanced development with due consideration to both social equity and rapid economic growth.

Indeed, social justice has acquired recent momentum through the presidential emphasis on ensuring that such a dimension is fully integrated into public policies. This dimension has been further reinforced through the adoption of a number of mechanisms and programs targeting the less disadvantaged social groups. These directions are detailed in a recent 'Conference Proceedings' document by the Policy Secretariat of the National Democratic Party in its Ninth Conference in 2007.

The GOE has already started implementing the aforementioned directions through two recent innovative programs. These target the poorest villages and the poorest families using an integrated and empowering approach. This approach consists of a program undertaking 'geographic targeting' and a program to undertake 'empowering the most vulnerable families'.

The Ministry of Housing and Utilities in collaboration with other ministries and units pioneered 'geographic targeting' in rural areas. The program is based on reallocating resources, public expenditure and policy interventions to reach the neediest people in the poorest areas, and emphasizes the complementarity of public services and household support.

The program was experimented in two local units (including 14 villages with 80,000 people) in Beni Suef and Sharkyia governorates in 2007, with the GOE investing around LE 270 million in the experimental phase. This phase covered renewal and replacement of houses for poor families, water and sanitation networks, upgrading health units and schools, literacy classes and environmetric projects. In addition, the Ministry of Social Solidarity provided financial aid and loans for the poorest families at these units. The impact of the experimental phase is now being evaluated by the Information and Decision Support Center (IDSC) affiliated with Egypt's Cabinet of Ministers.

Plans are currently underway to implement geographic targeting in six governorates (Assiut, Sohag, Menya, Fayoum, 6th October and Behera). According to the Egypt Poverty Map, Assuit, Sohag and Menya include 76 percent of the poorest one thousand villages. This phase of implementation will cover 23 local units (149 villages) with an estimated cost of LE 3250 million.

In parallel with geographic targeting, the Ministry of Social Solidarity is developing a data base for poor families and is piloting an integrated program for empowering the most vulnerable. Such a program is modeled on the experience of Conditional Cash Transfer programs implemented in a large number of developing countries.

In addition to these efforts that are specifically directed to the poor, more general policies have been adopted to address core challenges. Their general policies include:

- **Employment**

In order to reduce poverty and increase the standard of living among Egyptians, the Sixth Five Year Socioeconomic Plan (2007-2012) targets an increase in employment levels at a rate of 750 thousand individual per year, (noting that this target is set within the implementation of the 2006 Presidential Election Program). The target

will be attained through the expansion in labor intensive small and medium enterprises. It is expected that the number of employed people will reach about 23.9 million in 2011/12 compared to 20.1 million in the base year with an annual growth rate of 3.5 percent. The expected increase in employment is about 3.8 million job opportunities.

Unemployment

According to the most recent census (2006) data, the unemployed amounted to two million, corresponding to a rate of 9.3 percent of the total labor force. Given the Sixth Five Year Plan development strategy, which is based on providing about 3.8 million job opportunities during the upcoming five years, the unemployment rate is expected to decrease to 5.5 and the number of unemployed not to exceed 1.4 million by the end of the plan in 2012.

Living standards

With a real GDP growth rate of 8 percent and a population growth rate of 1.95 percent, it is expected that real per capita income will increase by about 6 percent during the Sixth Five Year Plan. Household and government consumption expenditures are estimated to amount to LE 673.9 billion (current prices) in 2007/08 compared to LE 584 billion in 2006/07, with a real growth rate of 6.9 percent. As for a household consumption breakdown, commodity consumption is estimated to reach about LE 416.5 billion and LE 711.7 billion in the first and last year of the Sixth Five Year Plan, respectively achieving a real growth rate of 6.9 percent and 7.1 percent in both years. Food and beverages share of commodity consumption amounts to about 58 percent.

Upper Egypt development

The National Project for Upper Egypt Development is one of the priority projects in the development plan. In order to implement this project, the government has adopted a group of mechanisms, which includes creating a holding company with a total capital of LE 100 million, providing a package of investment incentives to augment job opportunities, completing delivery of potable water to all villages in Egypt as well as a number of other specified activities and services.

Ministry of Social Solidarity services

The Ministry of Social Solidarity was established to meet the interests of low-income groups, as well as to extend social safety nets, including insurance, coverage against illness, disability or unemployment, and in addition to providing goods and services subsidies. The Ministry is embarking on a revision of social policies emphasizing the importance of a broad vision incorporating both a welfare and a developmental approach, calling for integrated social policies, more expansion and efficiency in current programs, as well as specific empowering interventions for the most deserving. The recent establishment of the Ministerial Group for Social Development is a cornerstone of such a revisit to social policies.

1.4 Concluding Remarks

Specific policies and strategies are needed to reduce poverty. These would reflect positively on the economy and on social cohesion and would lead to high and sustained GDP growth and more equitable distribution. Within the economic sector, a number of policy choices have to be explicitly adopted. The most important policies would be a focus on the pro-poor growth sector, the integration of equity in the monetary and fiscal policies (tax and public expenditure) as well as ensuring inclusive growth and fair access to human capital formation opportunities.

GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

Target 3

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

6. Net enrolment ratio in primary education
7. Proportion of pupils starting grade 1 who reach last grade of primary
8. Literacy rate of 15-24 year-olds, women and men

Key Messages

- **Education enrolment witnessed substantial improvements for both males and females during the period 2000-2006. Non-enrolment and school drop-out rates remain relatively high and clustered in certain areas and in vulnerable groups, with additional efforts directed to specific social groups. It is expected that by 2015 almost all children of primary school age can be in school.**
- **In addition, literacy rates for the young improved and Egypt can approach the one hundred percent literacy target among the 15-24 year-old age group. Such improvement is mainly a reflection of the progress in school enrolment. The universal eradication of illiteracy remains a challenge and demands the efficient implementation of new strategic directions.**
- **Within the framework of the Presidential Election Program, the Egyptian education strategy aims not just at increasing enrolment rates but also at increasing the number of schools, and reducing class density, as well as supporting early childhood development (4-5 years).**

2.1 Status of Progress

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

■ Enrolment ratio in primary education

The net enrolment ratio in primary education increased from 86 percent in 1990/91 to 91 percent in 2000/01 then to 94 percent in 2005/06.

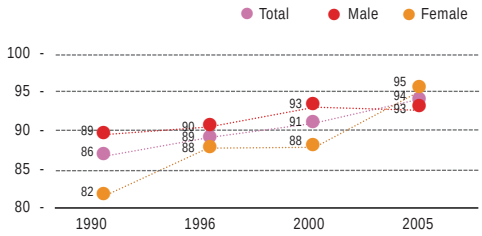
If more special attention is given to groups where non-enrolment is clustered, almost all children of primary school age can be in school by 2015

The results of Egypt Demographic and Health Survey (EDHS) 2005 indicated that 91 percent of children 6-15 years (92 percent of males and 90 percent of females) were attending school (public and private), and that around 96 percent of children 8-10 years (98 percent of males and 95 percent of females) were in school (school year 2004/05). With this progress in the enrolment ratio, it is expected — with extra efforts and specific attention to social groups where non-enrolment is clustered — that by 2015 almost all children of primary school age can be in school.

■ Proportion of pupils starting grade 1 who reach last grade of primary

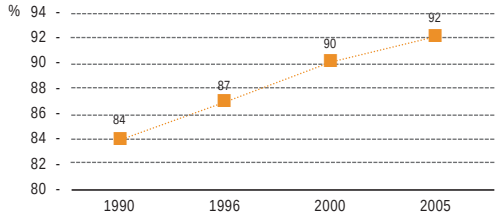
Dropping out of school during the primary stage has decreased by around 0.5 percentage point annually. The percentage of pupils who reached grade 8 increased from 84 percent in 1990 to 92 percent in 2005, indicating the need for sustaining a slightly faster rate of decline in the dropout rate to ensure achieving the millennium goal by 2015. Official statistics from the

Figure 2.1
Net enrollment ratio, 1990 - 2005



Source: Ministry of Education, 2006, Education Statistics

Figure 2.2
Percentages completed grade 8, 1990 - 2005

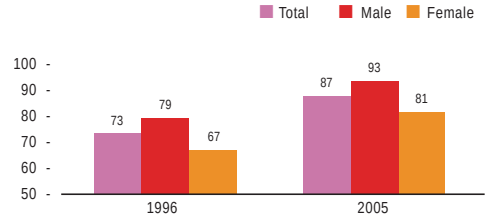


Source: Ministry of Education, 2006, Education Statistics

Dropping out of school is declining but remains a challenge requiring more attention to ensure achieving the MDG by 2015

Ministry of Education indicate that 1.6 percent of males and 1.2 percent of females dropped out of primary school during 2006/07. Dropping school is slightly higher in preparatory school (around 2 percent for both males and females in 2006/07). The findings of the recent census (2006) indicate that among the population aged 6 to less than 18 years, 10 percent (around 2.1 million) have never attended school and 4 percent (around 0.9 million) attended but then dropped schooling.

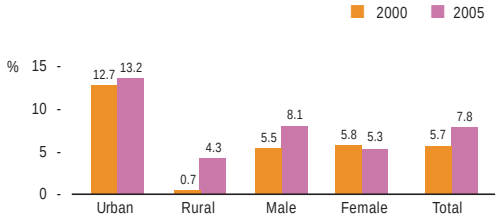
Figure 2.3
Literacy rates (15-24) years, 1996 and 2005



Source: Ministry of Education, 2006, Education Statistics

More efforts and new strategies are needed in order to achieve the millennium goal of universal literacy by 2015

Figure 2.4
Percentage of children atttending private schools, 2000 and 2005



Source: Special tabulation based on EDHS 2000, Social Contract Survey 2005

It needs more efforts and new strategies in order to achieve the millennium goal of universal literacy by 2015

■ Literacy rate of 15-24 year-olds, women and men

The literacy rate among the 15-24 year old population increased from 73 percent in 1996 to 87 percent in 2005. National surveys data indicate minor differentials in literacy by sex. The literacy rate among males 15-24 years old is at 93 percent compared to 81 percent for females in the same age group. This improvement in literacy rates and in a reduced gender gap for the young population is mainly a reflection of higher school enrolment. However, the eradication of illiteracy for those who did not join school remains a challenge and demands the efficient implementation of new strategic directions.

■ Attending private schools

Although most children (6-15 years) attend public schools, there is an increase in attending private schools. Figure 2.4 shows that in 2005, 7.8 percent of children (6-15 years) were at private schools compared to 5.7 percent in 2000. Attending private schools is more common in urban areas and among males.

2.2 Major Challenges

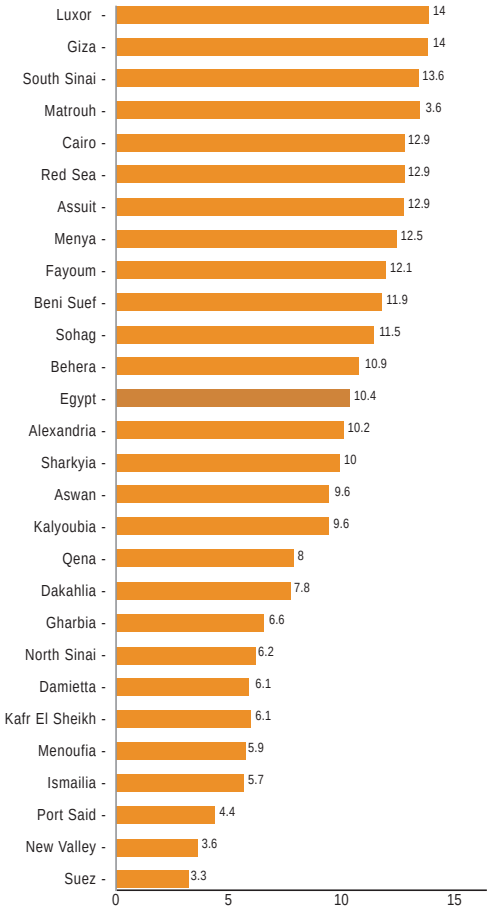
■ Differentials in attending and dropping out of school

The results of the 2006 census have highlighted significant issues in the disparities in attending and dropping out from school at the governorate level. Never attending school and dropping out are the main sources of illiteracy. One tenth of the children aged 6 to less than 18 years (2.1 million) have never attended school, according to the census. Part of this number may be due to late enrolment (those who enroll after age 6), but a major part of this figure reflects the cumulative impact of non-enrolment during the 10 years preceding the census. However, the disparities in these rates are expected to reflect current patterns. The percentage of children of 6 to 17 years not attending school ranges between 3.3 percent in the Suez governorate to 14 percent in Giza and Luxor governorates. As much as twelve governorates experienced a high level of not attending school (more than 10 percent).

Around 4 percent of children 6 to 17 years old dropped school before completing Grade 8. The probability of dropping out of school is 4 percent or more in 13 governorates out of 27. This probability is higher in Giza, Damietta, Matrouh and South Sinai (more than 6 percent).

Figure 2.5

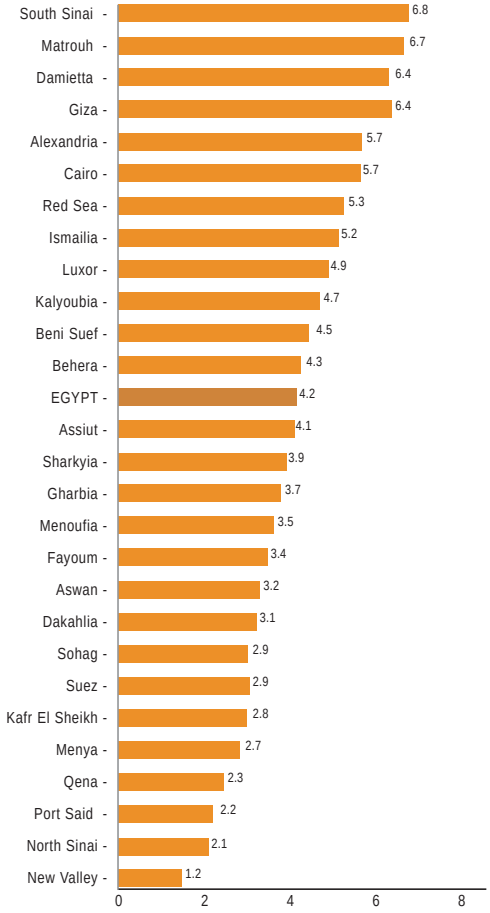
Percentage of population aged 6-17 years who have never attended school by Governorate, 2006



Source: CAMPAS, 2007, Preliminary Findings of Population Census 2006

Figure 2.6

Percentage of population aged 6-17 years who have dropped primary school by Governorate, 2006



Source: CAMPAS, 2007, Preliminary Findingss of Population Census 2006

2.3 Public Policies

The education strategy in the Sixth Five Year Socioeconomic Plan (2007-2012) aims at:

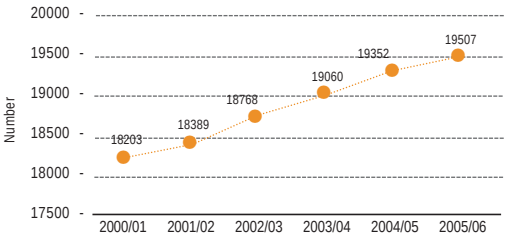
- Increasing enrolment rates at all the different educational stages whilst taking into account the increase in population categories of schooling age.
- Increasing the number of schools and reducing class density within the framework of the Presidential Election Program (relating to the building of 3500 schools).
- Supporting early childhood development (4-5 years) and expanding KG classes to reach an admission rate of 60 percent, and upgrading the quality of pre-school education.
- Reducing the illiteracy rate from 29 percent in the base year (2006) to 27.5 percent in the first year of the Plan, and to about 20 percent by the final year.

The plan included specific programs to achieve these objectives. Among them are:

- **Program to eradicate illiteracy**

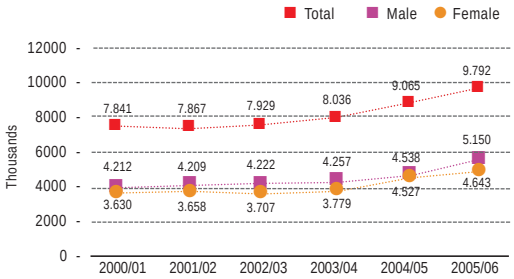
  It is planned to reduce the illiteracy rate from 29 percent in the base year to about 20 percent by the end of the Plan, giving a target number of nearly 8 million beneficiaries. Special attention will be given to areas of high illiteracy rates — especially in Upper Egypt — and to illiterate females.

Figure 2.7
Trend in number of primary schools (including Al Azhar), 2000/01 - 2005/06



Source: CAPMAS, 2007, Statistical Year Book, 2007

Figure 2.8
Trend in number of students in primary schools (including Al Azhar), 2000/01 - 2005/06



Source: CAPMAS, 2007, Statistical Year Book, 2007

The literacy program will adopt a new non-centralized strategy. According to this local authorities (governorates, districts and villages councils) will be responsible for detailed planning and implementation of the literacy program. Planning at the central level, curriculum development and monitoring of the implementation will remain the responsibility of Egypt's Adult Education Authority.

■ Schooling establishments program

The number of primary schools — including those run by the Al Azhar religious authorities, has increased by around 7 percent since 2000/2001. In the same period, the number of students in the primary stage increased by 25 percent to reach about 10 million in 2005/06. The rate of increase was greater among females (28 percent) compared to males (22 percent). The investment in education grew by 24 percent during 2006/07, reaching about LE 4.6 billion, in contrast to LE 3.7 billion in 2005/06.

The schooling establishment program includes creating and furnishing operating schools and technical education workshops. An additional 2915 schools will be established during the Sixth Five Year Plan period including about 40 thousand classrooms. Maintenance will be carried out for 1250 schools during the Sixth Five Year Plan years.

■ Operating schools and Technical Education workshops

This program prepares and equips schools by the beginning of each school year, and provides technical workshops with the equipment and machinery necessary for training.

The Ministry of Education targets investments of about LE 8.3 billion over the Sixth Five Year Plan years.

2.4 Concluding Remarks

Given the importance of not only ensuring enrolment and eradicating illiteracy but also of improving the quality of education, there is a pressing need to work on two fronts: *first*, to sustain and expand on the improvements in enrolment and the reduction in gender gaps; and *second*, for serious reforms directed at the quality of education. The current strategic vision for improved education demands higher resource allocation and consolidation of efforts.

GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

Target 4

Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

9. Ratios of girls to boys in primary, secondary and tertiary education
10. (Dropped)
11. Share of women in wage employment in the non-agricultural sector
12. Proportion of seats held by women in national parliament

Key Messages

- **Gender disparities in education are improving rapidly due to considerable efforts by the GOE, especially over the last ten years. Egypt has not already eliminated gender disparities in general secondary education but also achieved a higher ratio of girls to boys in this particular sector of education. Egypt is also on its way to achieving that goal in primary education.**
- **However, in spite of efforts made to address imbalances, the target might not be met at the technical education level, where the majority of students are clustered, and in all governorates, by 2015.**
- **The female participation rate in Egypt's economy is still lagging behind that of males and is far less than the relative share of women in the total population.**
- **Achieving gender equality and empowerment of women is even more difficult on the political front. Women's representation in the People's Assembly remains low and has even slightly decreased, while the representation of women in the Al Shura (Upper) Council is low and has been made possible only through presidential appointment with just one exception.**

3.1 Status of Progress

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

■ Ratio of girls to boys in primary education

The ratio of females to males in primary education at the national level increased from 88 in 2000/01 to 93 in 2006/07 (Figure 3.1). These improvements reflect the growing access of girls to education at the national and at the governorate levels. Cairo, Dakahlia, Menoufia, Fayoum, Luxor, Red Sea, and South Sinai governorates have succeeded in eliminating gender disparity in this primary stage. Another five governorates have already achieved more than a 98 ratio of girls to boys' enrolment at the same stage. These are Kalyoubia, Kafr El Sheikh, Giza, Beni Suef, and Aswan.

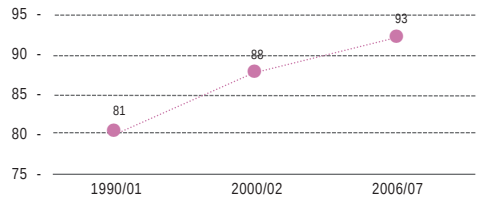
■ Ratio of girls to boys in secondary education

Secondary education in Egypt consists of three main streams: general secondary, technical secondary, and El-Azhar secondary. The total number of secondary school students enrolled in 2005/06 in all three streams was 4,983,10. Out of this number 24.9 percent were enrolled in general secondary education, 5.6 percent in El-Azhar secondary education, and 69.5 percent in technical secondary education.

The overall enrolment of girls to boys in secondary education is at 93 percent, which indicates that there is still a gender gap at the secondary level. In terms of the different secondary streams, general secondary education shows an elimination of gender disparities while a gap is still detected at the level of the other two streams.

Figure 3.1

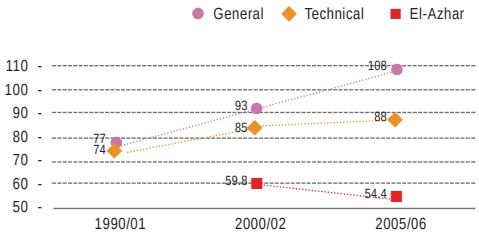
Percentage of enrolled girls to boys in primary education, 1990 - 2006



Source: CAPMAS, 2007, Calculated from Statistical Year Book, 2007

Figure 3.2

Percent of enrolled girls to boys in secondary education at a national level, 1990 - 2006



Source: CAPMAS, 2007, Calculated from Statistical Year Book, 2007

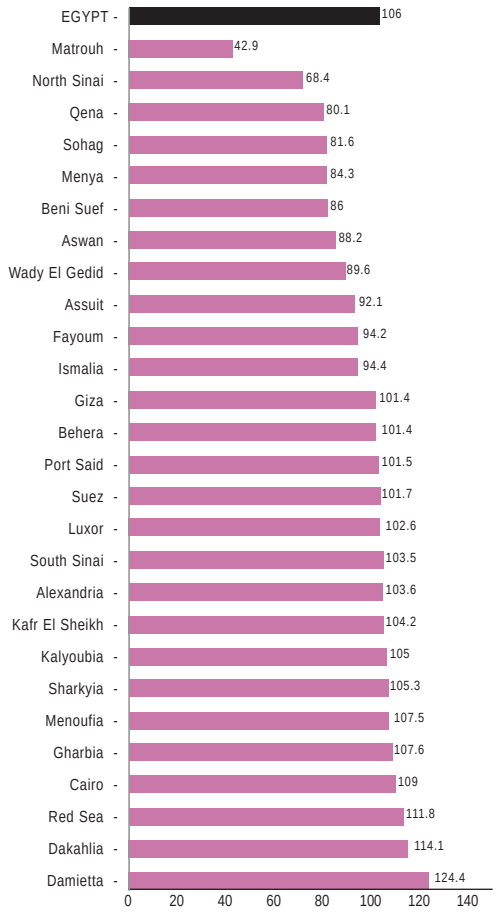
Figure 3.2 shows that Egypt has not just eliminated gender disparities in general secondary education but also achieved a higher ratio of girls to boys. It should be noted that the ratio of enrolment of girls to boys in general secondary education increased from 77 in 1990/91 to 93 in 2000/01 then to 108 in 2006/07, while the gender gap can still be detected at the level of the other two streams.

Reduction in gender gaps at the national level and their elimination in some governorates are needed

At the governorate level, around 11 governorates have not yet succeeded in eliminating gender disparity at the general secondary stage. Also, the ratio of girls to boys is noticeably low for two governorates, Matrouh and North Sinai (Figure 3.3).

Figure 3.3

Percentage of enrolled girls to boys in general secondary education by Governorate, 2005



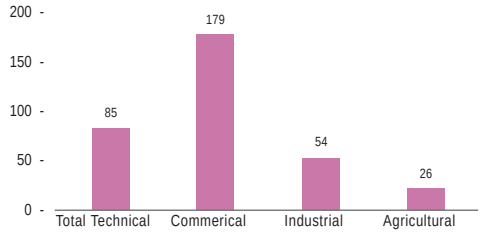
Source: CAPMAS, 2006, Calculated from Statisical Year Book, 2005

There are still significant challenges facing women's participation in wage employment

In technical education, the ratio of gender disparities have been declining over time from 74 in 1990 to 85 in 2005. Technical secondary education has three sub sectors: commercial (346006 boys and 620331 girls), industrial (646838 boys and 348551 girls), and agricultural (199580 boys and 52846 girls). The share of girls to boys (Figure 3.4) is 179, 54, and 26 in commercial, industrial and agricultural disciplines respectively. Clearly there is a large gender gap in technical education and significant imbalances in the concentration of girls in certain disciplines that are less competitive for thelabour market.

Figure 3.4

Enrolment ratio of girls to boys at the technical secondary education level, 2005



Source: Ministry of Education, 2006, Education Statistics

Table 3.1

Share of women in wage employment in the non agricultural sector according to place of residence, 1990-2005

Years	Urban	Rural	Total
1990	22.2	13.6	19.2
2000	23.4	12.7	19.0
2005	21.7	12.8	17.7

Source: CAPMAS, Labor Force Sample Surveys, Years 1990-2005

Share of women in wage employment in the non-agricultural sector

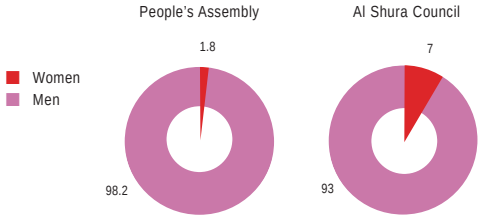
As indicated in Table 3.1, share of women in wage employment in the non agricultural sector is quite low and is even showing some deterioration across time.

Proportion of seats held by women in Parliament

Achieving gender equality and empowerment of women is even more difficult on the political front. The percentage of Egyptian women representation in the last six years in Parliament has fluctuated at a low level. The percentage of elected and appointed women in the People's Assembly has decreased over time from 3.9 percent in 1987/1990 to 2.2 percent in 1990/1995, to 2.6 in 1995/2000 and 1.8 in 2000/2005.

As for the Shura Council or Upper House of Parliament, women members increased from 5.7 percent in 2000 to 6.8 percent in 2005 then increased again to 7 percent in 2008, but participation is still far below expectations (Figure 3.5).

Figure 3.5
Women's Participation in People's Assembly and Al Shura Council, 2008



Source: Unpublished Data from National Council for Women, 2008

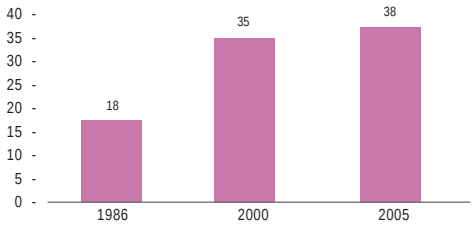
Women are facing significant challenges in their political participation, reflected in the low and fluctuating level of representation in parliament

Major factors behind the low participation of women in politics and decision making positions and the reluctance of women to enter politics are due to several factors such as the gendered norm of male leadership; time constraints as women already combine employment, domestic tasks, and childcare; lack of adequate financial resources; and the prevailing climate of political violence during elections only or widespread? Further, Egypt's political parties have made little effort to groom women members for election to assemblies.

Encouraging signs, however, are emerging in the increase in the percent participation of women in voting, as presented in Figure 3.6. Women who are registered for voting has increased from 18 percent in 1986 to 38 percent in 2005. This increase has not translated into in the election of more women.

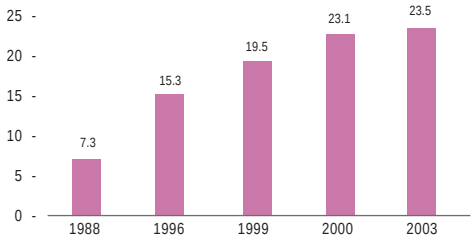
However, the number of women who hold public office has significantly increased, from 7 percent in 1988 to 23.5 percent in 2003 (Figure 3.7).

Figure 3.6
Percentage of women who are registered for voting at elections, 1986 - 2005



Source: CAPMAS, 2006, Statistical Year Book, 2007

Figure 3.7
Percent of women who hold public office, 1988 - 2003



Source: CAPMAS, 2006, Statistical Year Book, 2005

3.2 Major Challenges

The indicators provided clearly document that the progress attained in equity in education is yet to translate into equality in the work place and on the political front. There is clearly a need to ensure women's right to participate in the workforce and to achieve higher level positions, as well as to have a voice in policy and decision-making — both at the national and at the local level.

Key challenges contribute to this clear inconsistency between improved capacity building through education enrolment, and weak utilization of such capacities through participation in public life, particularly on the economic and policy fronts.

Some of the challenges include:

- Traditional and conservative social constructs that discourage women's participation on the policy front, and that impede the provision of the needed family and

institutional support to allow women to combine the dual burden of productive and reproductive roles.
- The difficulties encountered by women in exercising their rights of control over resources and in enjoying equitable and co-operative gender relations.
- The well documented gender imbalances in skills development and training opportunities.
- The clustering of both shortages of skills and the absence of an enabling environment in poor and disadvantaged families.

3.3 Public Policies

The establishment of the National Council for Women in 2000 is seen as a very strong signal of Egypt's full commitment to women's empowerment. Further, the efforts of the National Council for Childhood and Motherhood to address gender biases and harmful traditional practices as well as to increase girls' enrolment in schools are seen as a cornerstone for effective public policies.

In addition, the recent emphasis on social policy reforms and on poverty alleviation initiatives relies on the principle of social justice and the concept of citizenry as cornerstones. Both imply a commitment to women and their non-discriminatory treatment (citizenry) and a fair share in public resources (social justice).

There have been some key achievements over the last few years. These include:
- A constitutional change specifying the objective of fair representation for women. Such a change is expected to guide the development of a new election law that is currently being prepared, to allow more women to become members of parliament.
- Mainstreaming gender, and for the first time in Egypt, also mainstreaming in the Five Year Socioeconomic Development Plan (2007-2012). This was achieved through identifying development needs and projects from the perspective of women, starting from the village level, followed by the district, and finally, the governorate levels. During the last phase of the mainstreaming gender project, discussions were conducted with central ministries to assure the social and economic feasibility of proposed projects. The governorates' plans for women's empowerment were mainstreamed and included several major programs, namely: education and training, health, preservation of the environment, poverty reduction, culture and awareness building, tourism, information technology, and social care.
- The appointment of 30 new female judges followed by further actions to expand that number.
- Major and significant improvements in legislation, including a series of recent reforms in Personal Status laws that have sought to strengthen women's rights, facilitate their access to the legal system, and enhance the performance of the courts. Additionally, efforts are underway to draft a comprehensive and substantive Personal Status law that would address problems that continue to face women in divorce, maintenance, and paternity dispute cases, due to gaps in existing laws and shortcomings in the implementation process. Examples of legislative reforms include:
  - Provision of matrilineal transfer of nationality. The new and recent Egyptian Nationality Law allows women to pass their nationality on to their children.
  - Article 20 of Law No. 1 of 2000 now gives women the right to file for no-fault divorce.
  - Article 17 of Law No. 1 of 2000 gives women in unregistered marriages the right to file for divorce.
  - A new procedural decree in Law No. 1 of 2000 regulates all family law

cases with the aim of simplifying and enhancing the effectiveness of the litigation process.

- New family courts have been established with the aim of setting up a specialized legal system that provides alternative mechanisms for resolving disputes, and seeks to make the legal process efficient, affordable and just.
- New legislation (Law. No. 11 of 2004) sets up a government-run fund to facilitate the implementation of court orders for spousal and child maintenance and alimony.

- On the educational front, the adoption of the 'Girls' Initiative' to increase girls' enrolment in schools, and the establishment of 1000 schools between 2002 and 2007.

3.4 Concluding Remarks

Egypt has clearly embarked on addressing women's empowerment and has demonstrated its commitment through institutional arrangements, changes in legislation as well as in a large number of initiatives and actions.

The impact of these efforts is expected to be felt by a large number of social and age groups. Young girls and women facing family disruption and in poor families have clearly been targeted.

However, the impact of these efforts on women in economic and political participation is yet to be felt.

GOAL 4: REDUCE CHILD MORTALITY

Target 5

Reduce by two-thirds between 1990 and 2015 the under-five mortality rate

13. Under-five mortality rate
14. Infant mortality rate
15. Proportion of 1 year-old children immunized against measles

Key Messages

- **Infant and child mortality rates in Egypt are undergoing sustained decline. Additionally, there is noticeable progress in measles immunization coverage. Egypt is on track towards achieving the target.**
- **However, disparities in mortality by region as well as by social class (the illiterates, the poor) and gender are key challenges.**

4.1 Status of progress

4.1.1 Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

■ Infant and child mortality rates

Figures 4.1 and 4.2 provide measures of infant and under five mortality rates based on vital registration figures and surveys. Both measures, while from different sources, portray remarkably similar declining trends.[3] Between 1990 and 2006 the registered infant and under-five mortality rates declined by 49.5 percent and 56.1 percent, respectively (with an average annual rate of decline of 3.1 and 3.5 percent respectively).

Infant and child mortality rates in Egypt are undergoing sustained decline. Egypt is on track towards achieving the target

As indicated in Figures 4.1 and 4.2 and in Table 4.1, infant and under-five mortality were estimated to be 27.9 and 33.0 respectively per 1000 live births in 2007. This is if mortality rates follow the recent annual rates of decline at 4.3 percent and 5.2 percent in registered rates between 2003 and 2006. The achievement of targeted decline of 66 percent by 2015 appears within reach.

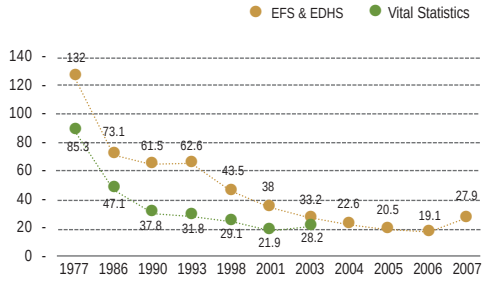
In terms of the composition of infant mortality, neonatal deaths accounted for only around one-third (31 percent) of total infant deaths during 1974-1979, but by 2000-2005 the relative share had grown to reach 48 percent. Clearly, child survival programs have tended to focus on preventable diseases (pneumonia, diarrhea, malaria, and vaccine-preventive conditions) that have resulted in reducing deaths after the first month of age, and also in an increasing share of reduced neonatal mortality. More attention is currently needed to pregnancy, childbirth and the neonatal process and health care.

National averages mask differences among regions and disparities among socioeconomic groups. Regional and social variations in mortality indicators constantly reveal that rural Upper Egypt residents, the less educated, and the poor are experiencing higher infant and under-five mortality. Moreover, there are gender differentials in post-neonatal mortality in rural areas, and in rural Upper Egypt in particular, and among the less educated population (less than primary educated), see Table (4.2).

3. Estimates of infant and under-five mortality based on vital registration are believed to suffer from under-registration, mainly in rural areas.

Figure 4.1

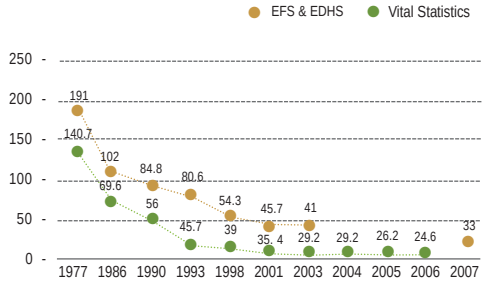
Registered and estimated infant mortality rates, 1997 - 2007



Source: Table 4.1

Figure 4.2

Registered and estimated under five mortality rates, 1977 - 2007



Source: Table 4.1

Table 4.1

Infant mortality rates (IMR) and under-five mortality rates (U5MR), 1977-2007

	IMR		U5MR	
Year	EFS & EDHS	Vital Statistics (8)	EFS & EDHS	Vital Statistics (8)
1977	132 (1)	85.3	19.1(a)	140.7
1986	73.1 (2)	47.1	102 (2)	69.6
1990	61.5 (3)	37.8	84.8 (3)	56.0
1993	62.6 (4)	31.8	80.6 (4)	45.7
1998	43.5 (5)	29.1	54.3 (5)	45.7
2001	38.0 (6)	28.2	45.7 (6)	35.4
2003	33.2 (7)	21.9	41.0 (7)	29.2
2004		22.6		29.2
2005		20.5		26.2
2006				24.6 (a)
2007	27.9 (b)		33.0 (b)	
2015 target	20.5	191 (1)	28.3	

(a) Provided by Ministry of Health and Population
(b) Estimated assuming the same percentage decline between 2003 and 2006 as registered rates

Sources
(1) Hallouda et al., 1983
(2) Sayed et al., 1989
(3) El Zanaty et al., 1993
(4) El Zanaty et al., 1996
(5) El Zanaty and Way 2001
(6) El Zanaty and Way 2004
(7) El Zanaty and Way 2006
(8) Calculated from Births and Deaths Statistics 1977, 1986, 1990, 1993, 1998, 2001, 2003, 2004 and 2005

■ Proportion of children 12-23 months immunized against measles

A successful national program of vaccination has greatly reduced the threat that vaccine-preventable diseases pose to Egyptian children. MOHP data indicate that immunization coverage against vaccine-preventable diseases exceeded 97 percent, with little variations by region. As a result, these diseases now affect relatively few children.

There has been noticeable progress in measles immunization coverage, increasing from 82 percent in 1992 to 97 percent in 2005. The proportion of children 12-23 months receiving measles vaccine is higher than that of children who are fully immunized against all other diseases, see Table 4.3.

Additionally there is little variation in the recent levels of measles' vaccination coverage by region and almost no variation by gender.[4] It is expected that Egypt will achieve the goal of full measles immunization by 2015 if the rate of progress remains the same as between 2000 and 2005.

4. See El Zanaty and Way, (2006), p.142.

Table 4.2

Neonatal, post-neonatal mortality rates for ten-year period preceding the 2005 survey by sex, place of residence and, mother's education

	Neonatal Mortality		Post-neonatal Mortality	
Background Characteristics	Male	Female	Male	Female
Region				
Urban	26.4	16.4	10.7	10.3
Rural	26.6	20.3	21.1	23.6
Rural Upper	29.2	20.1	29.5	35.5
Level of Education				
Less than primary	29.3	21.8	25.9	30.4
Secondary+	23.6	15.2	7.7	7.3

Source: Special tabulations based on EDHS 2005
Note: Reference point is around midpoint of calendar period 2000

Table 4.3

Percentage of children 12-23 months fully immunized and those receiving measles vaccines by region, 2003 and 2005

		Fully		Fully
Region	Measles	Immunized	Measles	Immunized
Urban Governorates	94.7	87.2	97.0	90.3
Urban Lower Egypt	97.6	86.5	97.1	89.5
Rural Lower Egypt	96.5	87.2	97.7	91.2
Urban Upper Egypt	96.2	93.7	96.6	87.5
Rural Upper Egypt	94.1	86.3	95.3	85.9
Total Egypt	95.6	87.5	96.6	88.7

Source: El Zanaty and Way, Egypt Demographic and Health Surveys 2003 and 2005

Considerable progress has been achieved in combating vaccine-preventable diseases, especially measles

■ Other vaccine-preventable diseases

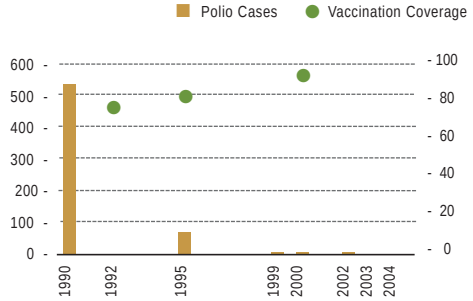
Figures 4.3 and 4.4 illustrate the progress in tackling the other two vaccine-preventable diseases that have been prioritized globally — polio and neonatal tetanus. It shows that polio eradication has been particularly successful. Indeed, with the last reported case occurring in 2004, there are hopes that polio is on its way to full eradication.

Considerable progress has been achieved in combating vacine-preventable diseases, especially measles

■ Other communicable diseases

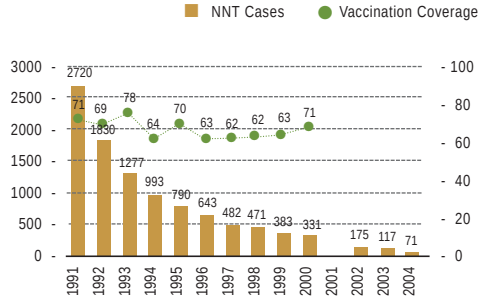
Diarrhoeal disease and acute respiratory infections (ARI) represent two particularly important threats to the survival and good health of young

Figure 4.3
Progress in combating Polio, 1990 - 2004



Source: Ministry of Health and Population. 2005. Health Statistics

Figure 4.4
Progress in combating Tetanus, 1991 - 2004



Source: Ministry of Health and Population. 2005. Health Statistics

Table 4.4
Prevalence of ARI and Diarrhea in under-fives in two weeks preceding survey according-to mother reports, 1995-2005

Surveys		ARI 6 months	ARI 6-11 months	ARI Under 5 years	Diarrhea 6 months	Diarrhea 6-11 months	Diarrhea Under 5 years
EDHS 2005	April - June	7.2	13.4	9.0	22.0	33.6	18.4
EIDHS 2003	May – June	7.3	15.5	10.2	20.1	37.7	18.9
EDHS 2000	Feb. – April	8.3	12.5	9.5	8.6	14.5	7.1
EDHS 1995	Nov. – Jan.	19.8	30.3	23.2	19.0	31.8	15.9

Sources: El Zanaty et al., Egypt Demographic and Health Surveys 1995-2005

Table 4.5
Percent of infant and under–five deaths from Diarrhea and ARI, 2003-2006

Year	% of Deaths from Diarrhea IMR	% of Deaths from Diarrhea U5MR	% of Deaths from ARIA IMR	% of Deaths from ARIA U5MR
2003	12.88	12.29	28.42	27.53
2004	11.74	11.46	29.71	28.64
2005	10.93	10.77	28.94	27.98
2006	9.86	9.98	24.09	24.18

Source: MOHP, 2007, General Management Information Center for Programs of Childhood Diseases

Egyptian children. The prevalence of these infections is difficult to estimate and they vary widely by season. Table 4.4 demonstrates that a relatively high proportion of children suffer from respiratory and diarrhoeal diseases especially during the critical age 6 - 11 months.

ARI is the leading cause of infant and childhood mortality in Egypt, responsible for almost one quarter of infant and under-five total deaths in 2006. Mortality from diarrhoeal diseases dropped markedly due to the efforts of the national program, although it remains the second cause of infant death responsible for around 10 percent of total infant and under five mortality in 2006 (Table 4.5).

4.2 Major Challenges

Disparities in performance indicators between geographic areas are a challenge to the health system. Upper Egypt, especially in its rural areas, needs to continue the recent pattern of progress to be able to achieve the 2015 MDG targets. Rural Upper Egypt has the poorest developmental indicators compared to the rest of the country.

Another challenge for Egypt is to focus on reducing deaths during the neonatal period. Neonatal mortality and stillbirths are closely related to maternal health and maternal health care. Efforts to reduce neonatal mortality and stillbirth rates will need to focus on these issues which will, in turn, also bring further reduction on the maternal mortality front.

A third challenge is the availability of reliable data on infant and child mortality and on childhood diseases. Due to the high level of underregistration of neonatal deaths, Egypt Demographic and Health Surveys are the only available sources for mortality indicators. However, they do not provide mortality indicators at governorate levels.

Although Egypt has achieved good progress in terms of measles vaccination coverage, the Expanded Program of Immunization still faces major challenges in which several socioeconomic and cultural factors have strong leverage. Sustaining Egypt's commitment to the eradication of poliomyelitis is one of them. Although the government is committed to reach 100 percent coverage of all children below 24 months with the polio vaccine, a case of acute flaccid paralysis resulting from poliomyelitis was recorded in 2004.

Acute respiratory infections have now shifted from being the second to become the first cause of IMR and U5MR and need to be particularly targeted. Enhancing access to information about home management, sources of treatment and ensuring the continuous availability of low-cost effective drugs are essential measures to reduce their complications.

Diarrhoeal diseases are still a major problem for child morbidity and sustaining the achievements in reducing their contribution to IMR and U5MR requires a continuation of past efforts in increasing knowledge and use of Oral Rehydration Therapy (ORT). This is particularly important as some studies have shown a decline in the use of ORT.

4.3 Public Policies

The Government of Egypt is committed to achieving the goals of reducing infant and child mortality. Many programs, such as the National Diarrhoeal Control Program, the Child Survival Program, the Expanded Program of Immunization, the Integrated Management of Childhood Illness, and Healthy Mother - Healthy Child, target the major causes of childhood mortality and morbidity, either through prevention or through management of illness. Moreover, institutionalization of such programs within the Ministry of Health and Population (MOHP) have accelerated the efforts to reduce infant and child mortality.

Currently, MOHP and the Health Insurance Organization have succeeded in covering all children in the basic education stage as well as pre-school children. Furthermore, childhood illness is included in the basic benefits package of the health sector reform in order to provide a more comprehensive approach for health care provision and access to care for children in the different stages of development.

The introduction of the family physician system is also expected to play a role in improving access to quality care. Other programs such as family planning, antenatal care, and immunization of pregnant mothers against neonatal tetanus play both a major role in lowering neonatal mortality as well as an indirect role in reducing infant and child mortality.

4.4 Concluding Remarks

Egypt recognizes the road-map for achieving the target by 2015 through, first and foremost, an increased focus on health equity. The disparities in infant and under-five mortality by regions and social groups are clear areas where current and future efforts should concentrate. Strengthening health equity means going beyond contemporary concentration on the immediate causes of disease.

Child survival programs have tended to focus on preventable diseases resulting in both reduced deaths after the first month of age and an increasing share of reduced neonatal mortality. A more comprehensive approach that views child survival as a package strongly inter-related to the various elements of reproductive health is yet to be implemented. Increased attention to improving health systems performance around the time of childbirth is expected to reduce not only neonatal deaths but also stillbirths and maternal deaths.

Integrating the social determinants of health with the biomedical focus of the Primary Health Care package is essential if we are targeting greater and sustainable returns.

GOAL 5: IMPROVE MATERNAL HEALTH

Target 6 Reduce by three-quarters between 1990 and 2015 the maternal mortality ratio	16. Maternal mortality ratio 17. Proportion of births attended by skilled health personnel 19c. Contraceptive prevalence rate
Achieve by 2015 universal access to reproductive health	■ Adolescent birth rate ■ Antenatal care coverage (at least one visit and at least four visits) ■ Unmet need for family planning

Key Messages

- **Egypt has succeeded in achieving significant reduction in the maternal mortality ratio and has already achieved the MDG target. The proportion of births attended by skilled personnel has also shown substantial increases. This increase in medically assisted deliveries was associated with increases in the proportions of women who delivered in health facilities. There is a systematic increase in antenatal care utilization.**
- **The contraceptive prevalence rate (CPR) in Egypt has increased over time but the last five years have experienced a slow rate of decline. The level of unmet need for family planning has significantly declined.**
- **With the health system continuing to provide quality maternal and child services, it is expected that the maternal mortality ratio and women's reproductive health will sustain and expand the current positive changes. Additional significant gains could materialize through the comprehensive adoption of the reproductive health paradigm. Such a paradigm incorporates a strong gender and social determinants component as well as a broader definition of reproductive health challenges. Given the speed of decline, there is a need to conduct external evaluation and confirmation of recent measures.**

5.1 . Status of Progress

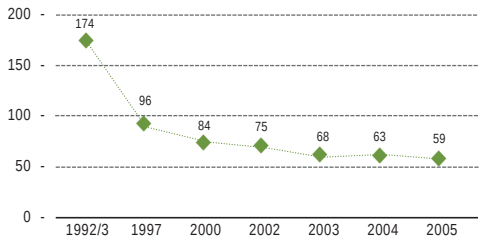
5.1.1 Target 6: Reduce by three-quarters between 1990 and 2015 the maternal mortality ratio

Maternal mortality ratio

Two national maternal mortality surveys have been conducted in Egypt in the recent past. According to the first survey in 1992, there were 174 maternal deaths per 100,000 live births. The second national maternal survey in 2000, based on the Reproductive Age Mortality Study (RAMOS), provided an estimate of 84 maternal deaths per 100,000 live births, marking a significant reduction in maternal mortality through the period 1992-2000, (MMR decreasing by 51.7 percent). A study however, provided a point estimate for the same year of 130 maternal deaths per 100,000 live births with 25 percent reduction through the same period, and a lifetime risk of maternal death of 1 per 230.[5]

Egypt has succeeded in achieving significant reduction in the maternal mortality ratio. The decline during 1992/93 and 2006 may have reached as high as 66 percent. But there is a need to conduct external evaluation and confirmation of recent measures

Figure 5.1
Maternal mortality ratio,1992/93 - 2006



Source: Ministry of Health and Population, National Maternal Mortality Surveys 1992, 2000, and Health Statistics 2006

The proportion of births attended by skilled personnel has shown substantial increases over the last ten years

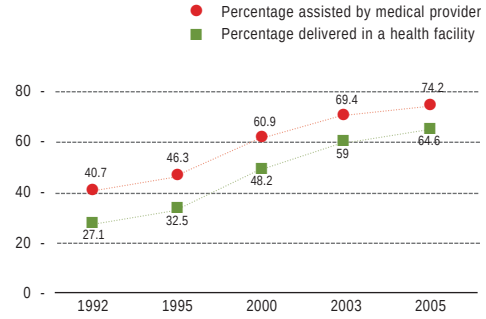
The difference between the two measures of MMR is related to the choice of reference point within the sampling variation of RAMOS.[6]

Starting in 2001, the Ministry of Health and Population, in collaboration with USAID, began implementing the National Maternal Mortality Surveillance System (NMMSS). This system is generally believed to be more accurate than the routine civil registration system.5 Based on NMMSS, the Egypt maternal mortality ratio continued to decline to reach 43.5 deaths per 100,000 live births in 2015 (Figure 5.1). In line with other country experiences (the United States and the United Kingdom), this surveillance system should identify maternal deaths more accurately than those identified by the routine civil registration system.[7] However, given the speed of decline reflected in NMMSS, there may be a need for independent confirmation of this measure and a critical evaluation of the accuracy of MMR provided by NMMSS.

5. WHO, UNICEF, UNFPA, and the World Bank (2005), Maternal Mortality in 2005, p 24.
6. The reported MMR was based on the lower limit of uncertainty. The upper limit of uncertainty was the RAMOS estimate multiplied by 2. The midpoint of the uncertainty limits was taken as the point estimate of MMR, (WHO et al., 2005, p.11).
7. According to the most recent report of the confidential *Enquiry into Maternal Deaths in United Kingdom* (for 2000-2002, 44 percent more maternal deaths were identified than was reported in the routine civil registration system,(Lewis G., 2004; Cited in WHO et al., 2005). Other studies on the accuracy of the number of maternal deaths reported that civil registration systems have shown that the true number of maternal deaths could be up to almost 200 percent higher than routine reports, (Deneux-Tharaux C, et al., 2005; Cited in WHO et al., 2005).

Figure 5.2

Percentage of births whose mothers were medically assisted at delivery and delivered in a health facility



Source: El Zanaty et al., Egypt Demographic and Health Surveys 1992-2005

Table 5.1

Trend in CPR and TFR, 1991 - 2005 and target for 2017

Year	CPR	TFR
1991	47.6	4.1
1992	47.1	3.9
1995	47.9	3.6
2000	56.1	3.5
2003	60.0	3.2
2005	59.2	3.1
2017	72.0*	2.1

* An estimate of the needed level of CPR to achieve 2.1 TFR.
Source: El Zanaty and Way, 2006, Egypt Demographic and Health Survey 2005

Figure 5.3

Percentage of births whose mothers were medically assisted at delivery by region, 2005

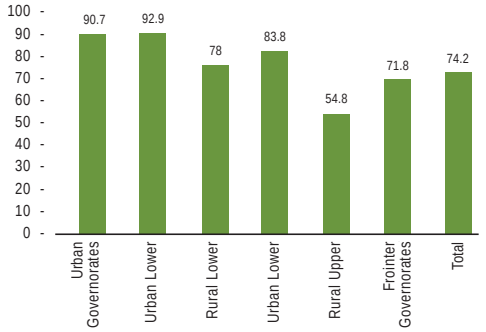
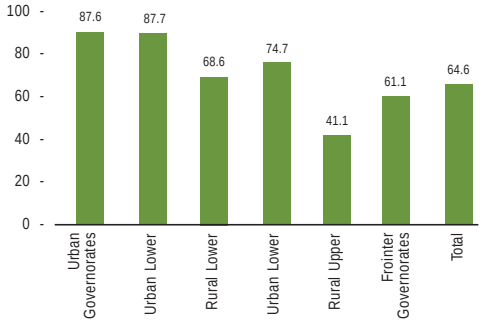


Figure 5.4

Percentage of births whose mothers delivered in a health facility by region, 2005



Improvements in maternal mortality are expected to be associated with substantial efforts directed towards decreasing risks of maternal deaths through promoting safe motherhood care. This includes increasing antenatal and postnatal care utilization, securing safe deliveries and decreasing risks of unwanted pregnancies.

Recent published data by the Ministry of Health and Population do not allow measuring the contribution of the avoidable factors to the measure of maternal deaths or examining the current disparities and trends in regional differentials.

■ Proportion of births attended by skilled health personnel

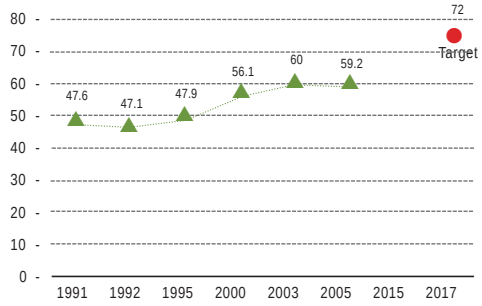
The proportion of births attended by skilled personnel has shown substantial increases over the last ten years. The Egyptian Demographic and Health surveys revealed a significant increase in the proportions of mothers assisted at delivery by medical provider from 40.7 percent in 1992 to 74.2 percent in 2005 (Figure 5.2).

Regional differentials in this indicator persist, with urban regions showing the highest proportions of medically assisted deliveries and rural Upper Egypt reflecting the lowest proportion with only 54.8 percent of deliveries assisted by medical personnel (Figure 5.3).

Increases in medically assisted deliveries were also associated with increases in the proportions of women who delivered in health facilities, from 27 percent in 1992 to 64.6 percent in 2005 (Figure 5.2). The 2005 Egypt Demographic and Health Survey (EDHS) revealed that rural Upper Egypt still maintains the lowest proportions of facility-based deliveries where 41.1 percent of all deliveries are being carried out in health facilities (Figure 5.4).

Figure 5.5

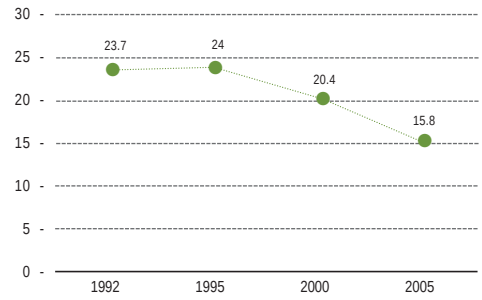
Trend in contraceptive prevalence rate, 1991 - 2005



Source: El Zanaty and Way, 2006, Egypt Demographic and Health Survey 2005

Figure 5.6

Percentage of women who gave first birth at age less than 18 years old, 2005.



Source: El Zanaty and Way, 2006, Egypt Demographic and Health Surveys 1992-2005

Contraceptive prevalence rate

Use of contraceptives, to reduce total fertility, to space births, and to reduce unwanted births and pregnancies, has a positive effect on maternal health and contributes to the reduction in maternal mortality. It also reflects the quality of one aspect of reproductive health services in the primary care setting. Since 1990, the total fertility rate (TFR) has been slowly declining from 4.1 in 1991 to 3.5 in 2000. An additional decline in TFR to 3.1 was shown by EDHS 2005. Egypt's target is to reach TFR of 2.1 by 2017. This requires accelerated efforts to raise contraceptive prevalence to reach 72 percent (Table 5.1 and Figure 5.5).

The contraceptive prevalence rate (CPR) in Egypt has shown an increasing trend over time from 47.6 percent in 1991 to 59.2 percent in 2005. However, the rate of increase has slowed since the mid 1990s (Figure 5.5).

There exist large regional differentials in CPR. In particular, rural Upper Egypt lags behind all other regions with a rate of 45.2 percent in 2005. Also, most governorates in Upper Egypt have lower CPR than the national average while all Lower Egypt governorates exceed the national average. A focus on Upper Egypt is essential.

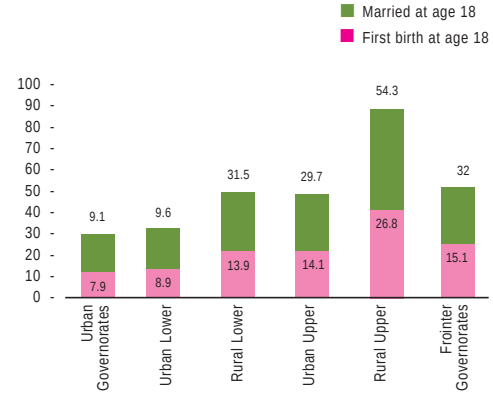
If Egypt maintains the annual rate of increase reflected in the long-term trend in contraceptive use, it could reach a CPR of 66.5 percent by 2015 at the national level, (which is still behind the target). Furthermore, rural areas of the Upper Egypt governorates would still be far below the national average in 2015. However, Lower Egypt, both rural and urban, would exceed the national average reaching a CPR of 68 percent and 71.8 percent by 2015, respectively. It should be noted that use of contraceptives in Egypt is mainly for limiting rather than for spacing pregnancy, and there is almost no use of contraceptives before having the first child.

The contraceptive prevalence rate (CPR) in Egypt has shown an increasing trend overtime. However, the rate of increase has slowed since the mid 1990s

Also, discontinuation rates are high. Indeed as indicated in the Egypt Demographic and Health Surveys, almost 29 percent of women discontinue the use of modern contraceptive methods within 12 months of use, mostly due to reasons that could be avoided by proper counseling.

Figure 5.7

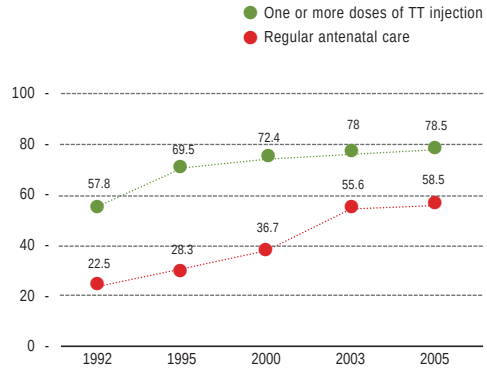
Percentage of mothers who married and had their first birth at age less than 18 years, by region, 2005



Source: El Zanaty et al., Egypt Demographic and Health Survey 2005

Figure 5.8

Percentage of births whose mothers recieved regular antenatal care and one of more doses of the Tetanus Toxoid vaccination, 1992 - 2005



Source: El Zanaty et al., Egypt Demographic and Health Surveys 1992 - 2005

5.1.2 Target 6: Achieve by 2015 universal access to reproductive health

■ Adolescent birth rate

Adolescent females face numerous health risks along the path to adulthood. Their early marriage and early childbearing have long-term effects on the length and quality of their life. Young women suffer complications from childbirth, including preterm and obstructed labor, infections, anemia, and other complications. They also often have little or no control over whom they marry and where they live. Early marriage hinders adolescents' capacity to negotiate sex and reproduction as well as other aspects of domestic and public life.

The proportion who gave their first birth at ages less than 20 and 18 has been slowly declining

The four national Egypt Demographic and Health Surveys' data indicate that the percent of women currently aging 15-19 who ever married shows little decline over the time period 1992-2005 — from 14.2 percent to 12.3 percent (a decline of 13 percent). This means that around one out of every ten women is still married in her teens.

The proportion who gave their first birth at age less than 18 has declined from one-quarter to almost one-eighth (Figure 5.6). Furthermore, 22.6 percent gave two or more births prior reaching age twenty. Early marriage exposes young women to experience parenthood in their teens.

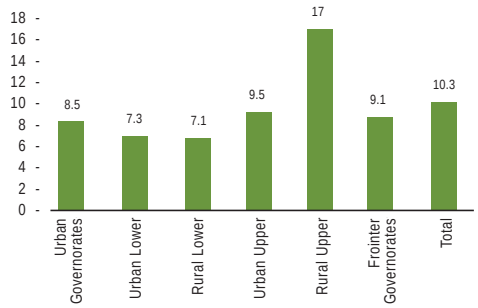
The level of unmet need for family planning has significantly declined

Early marriage is typically driven by poverty, parental concerns about premarital sex, and other economic and cultural reasons. Regional differences are strongly apparent with regard to all measures. The percentage that married and gave first birth in their teens is the highest in rural Upper Egypt (Figure 5.7). Egypt has just passed a new child law raising the minimum age at marriage to 18. The successful implementation of this law is expected to translate into improved health measures.

■ Antenatal care coverage

Among the main avoidable factors identified in the Maternal Mortality Surveys is non- or poor utilization of antenatal care. In the 1992/93 Maternal Mortality Survey, 33 percent of the maternal deaths were attributed to this factor. In

Figure 5.9
Percentage of currently married women with unmet for family planning by region, 2005



Source: El Zanaty et al., Egypt Demographic and Health Surveys 2005

There is a systematic increase in the antenatal care utilization by women and in tetanus toxoid vaccination

2000, only 20 percent of the maternal deaths were associated with non-utilization of antenatal care.

However, over the period 1995-2005, the EDHS surveys have monitored a systematic increase in antenatal care utilization by women, from 28.3 percent in 1995 to 58.6 percent in 2005. Furthermore, tetanus toxoid vaccination increased during the same period, from 69 percent to 78.5 percent (Figure 5.8)

■ Reducing unmeet need for family planning

Unmet need for contraception can lead to unintended pregnancies, which pose risks for women, their families, and society. One particularly harmful consequence of unintended pregnancies is unsafe abortion. In addition, unwanted births pose risks for children's health and well-being.

In 1999, the United Nations General Assembly convened a special session, ICPD+5, to review progress towards meeting the ICPD goals, and governments set a new benchmark: reducing unmet need by half by 2005 and entirely by 2015.

According to the EDHS 2005, the level of unmet need for family planning has significantly declined to a 48 percent reduction — from 19.8 percent in 1992 to 10.3 percent in 2005

As indicated in Figure 5.9, regional differentials persist with rural Upper Egypt exhibiting the highest levels of unmet need.

5.2. Major Challenges

Egypt still faces challenges in improving maternal health. Some of these relate to use of maternity care services. There are marked differences among Egyptian women with regard to use of maternity care services, with women of low socioeconomic status and those living in rural and rural Upper Egypt, in particular, less likely to use them.

Requirements for further reduction of maternal mortality include expansion of nation-wide coverage of the Essential Obstetric Care (EOC) program with an efficient referral system as well as improving the quality of the training of medical professionals and their ability to follow guidelines in service delivery. In every region, the presence of skilled birth attendants is lower in rural than in urban areas.

Evaluation studies independent of NMMSS are needed to establish accuracy of the maternal surveillance system in Egypt. The provision of high quality family planning services including clinical and counseling services as well as responding to women's other health concerns is a major challenge. Quality services are vital in increasing CPR, reducing rates of discontinuation and further decreasing unmet needs and unwanted pregnancies.

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

Other major challenges are attributed to non-health related elements, particularly cultural attitudes encouraging early marriage, early pregnancy, and short spacing between pregnancies. A multisectoral approach, especially combining health and education efforts is needed to deliver information and services to young people, both married and unmarried.

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

It should be noted that population policies and strategies are a multi-disciplinary task and require the mobilization of several ministries and community-based organizations in order to provide a more integrated and sustainable approach to improving maternal health. The integration of civil society, religious figures and community leaders plays an important role in shaping people's perceptions regarding reproductive health issues and promoting the adoption of better attitudes and behaviors regarding maternal health.

5.3 Public Policies

In response to Egypt's commitment to improve maternal health, the maternal health program, Safe Motherhood, was one of the main vertical programs implemented by MOHP. This program introduced the development of an MCH service package that included basic, comprehensive and nation-wide coverage of the Essential Obstetric Care (EOC) program with an efficient referral system, and improving the quality of the training of medical professionals. MOHP, in collaboration with the Social Fund for Development, has implemented the Women's Health Project. About 300 maternity centers were upgraded with more than 170 of these centers in the underserved urban and rural areas. MOHP has also implemented the National Maternal Mortality Surveillance System and established the Central Safe Motherhood Committee (CSMC) headed by the Minister of Health and Population, as well as similar committees at the governorate level.

Egypt also launched its Health Sector Reform (HSR) program in response to GOE recognition of the major challenges facing health care provision. HSR aims to improve general health and reproductive health outcomes of the population through more equitable access to basic health care service.

5.4 Concluding Remarks

There are significant improvements in the average levels of the various reproductive health dimensions. However, in many dimensions, differentials among women by region of residence and by socioeconomic class persist. This is particularly evident in rural Upper Egypt, with the uneducated and the poor being more susceptible to higher reproductive health risks.

The full implementation of reproductive health services in the Primary Health Care package and the acknowledgement that all its elements are strongly inter-related are central components in reducing maternal mortality and improving women's health.

In order to achieve continuous and sustainable improvements in maternal and reproductive health a multi-disciplinary approach mobilizing several ministries, civil society, community-based organizations and religious figures is needed.

GOAL 6: COMBAT HIV/AIDS, MALARIA AND OTHER MAJOR DISEASES

Target 7 Have halted by 2015 and begun to reverse the spread of HIV/AIDS	18. HIV prevalence among population aged 15-24 years 19a. Condom use at last high-risk sex 19b. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS 20. Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	Proportion of population with advanced HIV infection with access to antiretroviral drugs
Target 8 Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	21. Incidence and death rates associated with malaria 22. Proportion of children under 5 sleeping under insecticide-treated bednets and proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs 23. Incidence, prevalence and death rates associated with tuberculosis 24. Proportion of tuberculosis cases detected and cured under directly observed treatment short course

Key Messages

- **Egypt is making significant strides towards achieving this Millennium Development Goal. It has started its struggle against HIV/AIDS since the appearance of the first case in the country. Despite achievements, Egypt should adopt steps to avoid experiencing a turning point from a low to a concentrated HIV epidemic. The HIV infection in Egypt is not only confined to the high risk groups, it is clustered in the most productive age span and the country is experiencing a relatively high share of females in the epidemic.**
- **Egypt has succeeded in controlling malaria, while tuberculosis and schistosomiasis are regressing. However, hepatitis B and hepatitis C constitute major health threats in the country.**
- **The Ministry of Health and Population (MOHP) has established specific preventive and curative programs for the major illnesses and the health insurance system is being reformed. The challenge to be faced to catalyze Egypt's progress towards achieving this MDG is the overburden borne by the MOHP in caring for the exposed and affected population, as well as the need for a health policy with multisectoral integration to address health in a social context**

6.1 Status of Progress

6.1.1 Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

HIV prevalence in Egypt appears to be low and has never been a health threat in the country. Since the detection of the first case, the Ministry of Health and Population has been fully committed to slowing down the spread of the infection and to care for the infected. Egypt's first HIV/AIDS case was discovered in 1986. Since then the number of detected cases is estimated to double nearly every five years (Figure 6.1). The reported number of HIV cases from 1986 till end of 2007 is 2969, of whom 283 (75.5 percent were Egyptian, and 788 (26.5 percent) developed AIDS.

HIV/AIDS is not a health threat in Egypt, yet there is a persistent increase in the number of detected HIV/AIDS cases

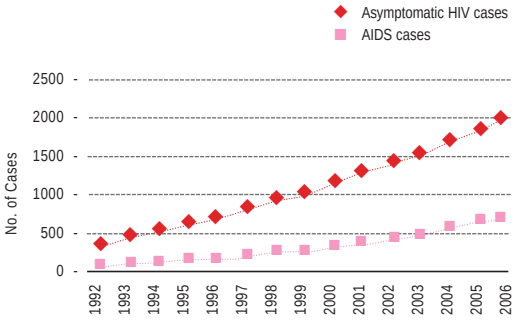
The increase in the number of people living with HIV in Egypt may be mainly a reflection of the persistent efforts of the MOHP to improve the case reporting, as well as to introduce voluntary testing in 2004 and to conduct the first round Biological and Behavioral Surveillance Survey (BIO-BSS) in 2006.

HIV prevalence is estimated to be less than 1 percent in the general population. The Egypt BIO-BSS in 2006 estimated HIV prevalence in men who have sex with men at 6.2 percent (Table 6.1). This in itself should be considered an alarm signal. Egypt could face the risk of moving towards a concentrated HIV epidemic.

The HIV infection in Egypt is not just confined to the high risk groups and there is a risk that the

Figure 6.1

Number of HIV/AIDS reported cases in Egypt, 1992 - 2006



Source: Ministry of Health and Population, 2007, HIV/AIDS Surveillance Report 30/1/2007

Table 6.1

HIV Prevalence among high risk groups in Egypt, 2006

	Sample size	HIV prevalence
Street boys	408	0.0
Street girls	192	0.0
Female sex workers	118	0.8
Men who have sex with men	267	6.2
Male injecting drug users	413	0.6
Female injecting drug users	16	0.0

Source: Ministry of Health and Population, 2006, Egypt Biological and Behavioral Surveillance Survey, Summary Report 2006

The HIV infection is clustered in the productive age span and the share of infected women is relatively high

infection may spread to the general population There exists the myth that the HIV infection is confined to a minority with high risk behaviors who do not have any contact with the general population. Heterosexual transmission, homosexual transmission, spread of infection through injecting, drug use and transmission through the practice of a combination of risk behaviors constitute the main routes of infection in Egypt. But the spread of HIV is not only limited to risk behaviors. Table 6.2 shows that 13.2 percent of HIV/AIDS cases were infected through transfusion of blood and blood products and mother-to-

Table 6.2
Distribution of HIV accumulated cases in Egypt according to mode of transmission till 2007

	Asymptomatic HIV cases	AIDS cases	Total HIV/AIDS cases
Heterosexual	670	380	1,050
Homosexual	285	213	498
Injecting drug use	28	33	61
Multiple risk behaviors	16	15	31
Blood/blood products	320	72	392
Mother-to-child	31	6	37
Unknown	2,181	69	900

Source: Ministry of Health and Population, 2007, HIV/AIDS Surveillance Report 31/12/2007

HIV prevention and knowledge need more support to halt the spread of HIV/AIDS

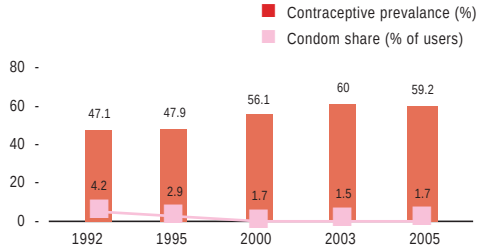
child transmission. Moreover, the BIO-BSS results have revealed that the high risk groups have close contacts with the general population, as a considerable proportion of them, even the men who have sex with men, are either married or have multiple opposite sex partners.

The HIV infection is affecting adults in the productive age who, in turn, lose their health and productivity. It is estimated that 89.1 percent of HIV cases in Egypt are between 15-49 years of age. In 2006, HIV prevalence was estimated to be around 2 per 100,000 in the population aged 15-24 years. The share of females in Egypt could be considered relatively high, representing 18.5 percent of people living with the HIV infection.

While Egypt maintains an upward trend in contraceptive use and condoms are readily available, condom use is very low and the share of condom use among contraceptive methods is regressing (Figure 6.2).

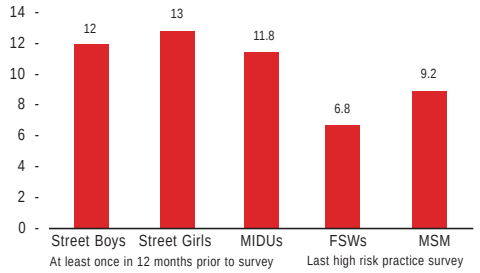
Results of the BIO-BSS have also indicated that condom use at high-risk practice among the high risk groups is insufficient (Figure 6.3). Moreover, results reveal that facts and information on HIV/AIDS are low among members of the high risk groups, with numerous misconceptions that prevail.

Figure 6.2
Contraceptive prevalance rate among currently married women and share of condom use, 1992 - 2005



Source: Ministry of Health and Population, 2007, HIV/AIDS Surveillance Report 30/1/2007

Figure 6.3
Percentage of condom users reported by street children, male injecting drugs users (MIDUs), female sex workers (FSWs), and men who have sex with men (MSM) in high risk practice, 2006



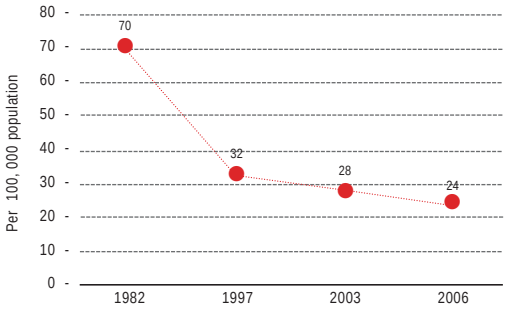
Source: Ministry of Health and Population, 2006. Egypt Biological and Behavoiral Surveillance Survey Summary Report 2006

There are no indigenous malaria cases reported since 1998; however cases are still reported in travelers between Egypt and other African Countries

6.1.2 Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

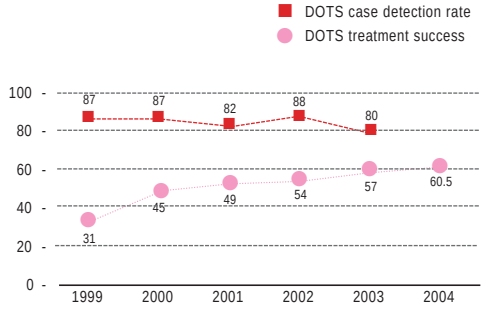
Malaria control in Egypt has achieved considerable progress over the last few decades. In 1989 and in 1994-95, two outbreaks of malaria (198 and 808 cases respectively) occurred in the Fayoum Governorate. After the application of intensive control measures, only 4 indigenous cases were reported in 1997. Since 1998, no indigenous malaria cases were registered by the Malaria Control Program throughout the whole country. However, there are still cases occurring among ship passengers travelling between Egypt and Sudan or other African countries.

Figure 6.4
Incidence rates of Tuberculosis in Egypt, 1982 - 2006



Source: Ministry of Health and Population, 2007, Health Statistics 20/6/2007

Figure 6.5
DOTS case detection rate and treatment success in Egypt, 1999 - 2004



Source: World Health Organisation <www.who.int/whosis/index.htm>

Incidence and prevalence of tuberculosis in Egypt are regressing and DOTS is showing success

There are about 30-50 malaria cases imported annually, either through the southern border with Sudan or Egyptians returning from malaria-endemic countries.

The reporting of the tuberculosis incidence rate started in Egypt in 1951. Then, the rate was estimated at 350 per 100,000. Since then, it has showed a steady decline, and by 2007 was at 23 per 100,000 (Figure 6.4).

WHO statistics show that the prevalence of tuberculosis was nearly constant in the 1990s. However, a steady decline was reported starting in the new millennium and was estimated to be 32 per 100,000 by 2007. WHO statistics in 2005 also revealed that 2.9 people per 100,000 died from tuberculosis among the HIV-negative population in Egypt and there were no deaths due to tuberculosis among people living with HIV.

In 1996, the national program for tuberculosis control started an internationally recommended protocol known as the Directly Observed Treatment Short Course (DOTS). An increasing number of tuberculosis patients are being treated under DOTS (Figure 6.5). In 2007, DOTS case detection reached 67 percent. Further, DOTS treatment success ranged from 80 to 88 percent.

The prevalence of schistosomiasis in Egypt is showing a steady decline

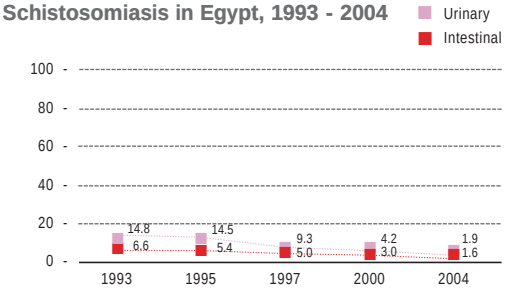
Schistosomiasis is endemic in Egypt and has been present for centuries, sometimes even called the pharaoh's disease. As a result of the continuous effort by the MOHP spread over many years, the prevalence of schistosomiasis is showing a steady decline (Figure 6.6). In 2004, its prevalence was estimated as 1.6 percent for the urinary variant and 1.9 percent for the intestinal variant.

Hepatitis B and C viral infections are major health threats in Egypt. Chronic hepatitis B and chronic hepatitis C are the main causes of liver cirrhosis and liver cancer in the country. Both viral diseases are on the top of the list as leading causes of death.

Hepatitis B viral (HBV) infection in Egypt is of intermediate endemicity ranging from 2 to 8 percent. Screening of blood in 2006 revealed that 1.1 prcent of collected blood bags across the country were HBV positive. Most HBV infections are acquired through unsafe sex or infected blood or blood products. Egypt also has a high prevalence of hepatitis C viral (HCV) infection. Nationally, an estimated 8.8 percent of the total population has chronic HCV and 1 percent has both HBV and HCV. Around 20 percent of Egyptian blood donors are carriers of HCV.[8] Blood screening in 2006 showed that 8.7 percent of blood bags were

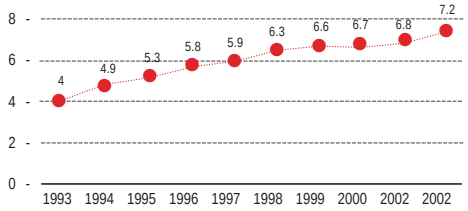
8. Mohammed, (2004).

Figure 6.6
Prevalence of Urinary and Intestinal Schistosomiasis in Egypt, 1993 - 2004



Source: Ministry of Health and Population, 2005, Health Statistics

Figure 6.7
Trend of Hepatocellular Carcinoma among chronic liver diseased patients in Egypt (%), 1993 - 2002



Source: El Zayadi, et al., Hepatcellular Carcinoma in Egypt

HCV positive. Egypt has higher rates of HCV than either neighboring or other countries with comparable socioeconomic conditions and hygienic standards for invasive medical, dental or paramedical procedures. The major route of exposure appears to be the use of glass syringes in the treatment of schistosomiasis, reuse of used syringes, and unsafe medical interventions. Transmission of HCV through non-medical procedures such as tattooing, ear piercing, circumcision, shaving at barber shops, nail trimming (manicure or pedicure) at beauty salons are frequent routes of transmission.

Hepatitis B and hepatitis C viral infections are the leading causes of severe liver damage, hepatocellular carcinoma and death in Egypt

Hepatocellular carcinoma (HCC) is one of the most common fatal malignancies intimately related to HBV and HCV. HCC was diagnosed in 5.9 percent of 22,450 Egyptian chronic liver diseased patients attending a specialized care center.[9] The incidence of HCC in these patients showed a sharp annual increase, almost doubling between 1993 and 2002 (Figure 6.7).

6.2 Major Challenges

Major challenges hinder Egypt's efforts to meet MDG 6;

First, the MOHP carries a heavy burden in providing free health services to the sick. The soaring costs of the required services in a highly populated country such as Egypt reflect a huge economic burden on government, individuals, families, and community.

A major challenge is the overburden borne by the MOHP in the care of exposed and affected people

Second, despite intensive efforts to collect comprehensive information on cases of illness and disease, MOHP resources have been unable to sustain the information base and the surveillance system necessary in an accurate or timely way so as to produce and update the indicators used for monitoring MDG progress. This also deprives policy makers from the essential evidence needed for decision making.

Third, Egypt's geographic location and leading regional role expose it to multiple exogenous risks and health hazards. Egypt yearly receives thousands of tourists from all over the globe. It shelters an ongoing flow of refugees and attracts scores of students for education, as well as numerous persons seeking medical care. These come from all the surrounding African and Asian countries. Further, over two million Egyptians work or travel abroad yearly for short periods.

9. El-Zayadi et al., (2005).

Social and demographic dynamics can also pose endogenous health threats. Certain groups are more vulnerable than others. Egypt's young population is large. Around 14 million out of the total population is between 15-24 years of age. Street children and residents of slum areas are documented as susceptible to numerous health hazards. The lifestyle of prison populations, the police and members of the military exposes them to frequent health risks. All of these and many other endogenous concerns demonstrate the vast number of tasks the MOHP must undertake to confront health threats on multiple fronts.

Fourth, it is beyond doubt that Egypt's conservative culture has contributed to slowing down the progress of the HIV epidemic. However, traditional norms do not fully protect Egypt from the spread of the HIV infection. Many groups do, regardless, engage in high risk behaviors. It is true that they represent a minor fraction of the population but their existence cannot be denied.

MOHP efforts have helped Egypt to create a rich preventive and curative package

Even if the currently reported low prevalence estimate in Egypt is widely accepted, experience from other countries has shown that the spread of the HIV infection from high risk groups to the general population can occur fairly rapidly as they pass the infection on to their spouses and other sex partners.

Moreover, cultural norms in Egypt often contribute to the strong stigmatization and social exclusion of people living with HIV/AIDS. The perceived shame and disgrace that people living with risk behavior inflict on their families force them to conceal their lifestyles and avoid seeking counseling, testing or health care if they are HIV positive. There is the general belief that caring for socially deviant groups is in opposition to cultural and religious norms and a fear that tolerance could be interpreted as approval, and therefore legitimize the practice of risk behavior. This is a serious misconception. It creates a rift between the right of these minorities to seek health care, and the social disapproval that prevents it.

Fifth, the MDGs place health within a social context and set ambitious targets to tackle the root causes of ill health. However, health policy in Egypt still applies a biomedical model that is mainly founded on hospital and curative care. This model overburdens the MOHP, and reflects on its performance levels as it cannot resolve the social causes of disease that normally are in the domain of other ministries. MOHP endeavors cannot substitute for or replace the missing social factors in addressing the root causes of ill health.

6.3 Public Policies

The responsibility for controlling the major diseases in Egypt relies exclusively on the MOHP, which has programs that provide preventive and curative care free of charge. In addition, the MOHP has developed case reporting, screening and surveillance systems. The MOHP National Electronic Diseases Surveillance System (NEDSS) is currently active and is designed to include data on 26 priority infectious diseases that are electronically entered by public hospitals, laboratories, teaching hospitals, the Health Insurance Organization and the private sector.

There is a need for a health policy with multisectoral responsibilities to address health in a social context

The MOHP also has numerous mass media and health education campaigns. It works in partnership with its peers in neighboring countries and provides technical assistance to avoid the importing of diseases. It is currently a pioneer in the region with its voluntary counseling and testing (VCT) centers for high risk groups and in the application of the first round BIO-BSS.

In addition, the Health Insurance Organization (HIO) works under the auspices of the MOHP. The HIO has succeeded in covering around half of

the population in Egypt. The health insurance schemes have effectively reduced the out-of-pocket expenditure borne by beneficiaries on health care.[10]

Currently Egypt is working on reforming the health insurance system as part of a nationwide health care reform strategy. In the GOE's Sixth Five-Year Socioeconomic Plan, Egypt is targeting a gradual expansion of health insurance, allowing it to cover new segments of the population until universal coverage for all Egyptians is achieved by 2012, within a framework of a unified health insurance law.

6.4 Concluding Remarks

It is time that Egypt moves from its disease focus and the biomedically oriented health policy paradigm to a health policy encompassing a broad social and economic development context. There is a need for strategies and policies targeting the major diseases in Egypt to go beyond a narrow health sector focus and for health to be viewed as a multisectoral responsibility. Experience indicates that national programs are most effective when they combine socially sensitive interventions tailored to the specific social context within a comprehensive multisectoral partnership.

10. Nandakumar et al., (2000); Shawky, (2007).

GOAL 7: ENSURING ENVIROMENTAL SUSTAINABILITY

Target 9 Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources	25. Proportion of land area covered by forest 27. (Dropped) 28. CO2 emissions, total, per capita and per $1 GDP (PPP), and consumption of ozone-depleting substances 29. (Dropped) ■ Proportion of fish stocks within safe biological limits ■ Proportion of total water resources used
Reduce biodiversity loss, achieving by 2010 a significant reduction in the rate of loss	26. Proportion of terrestrial and marine areas protected ■ Proportion of species threatened with extinction
Target 10 Halve by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation	30. Proportion of population using an improved drinking water source 31. Proportion of population using an improved sanitation facility
Target 11 By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	32. Proportion of urban population living in slums

Key Messages

Ensuring environmental sustainability in Egypt remains a challenge despite government policies and increasing investments. Egypt faces the need to curb population growth and its negative impact on the environment, as well as better control the increasing demands made on natural resources.

7.1 Status of Progress

Egypt is facing a number of environmental challenges mainly due to rapid population growth and the necessity for extensive development to meet the needs of the growing population. This has placed pressure on natural resources following expansion in industrial, agricultural and tourism activities. Consequently, Egypt has directed significant concern to resolve the pressing environmental problems by taking several measures — including ratifying various international environmental conventions and treaties — to be harmonized into the national legislative framework.

Progress measurement and follow-up towards the achievement of the set targets of the MDGs has been carried out through national reports. Such reporting exercises worldwide has led to the identification of a need to review the set of indicators in the MDG framework and to further refine them in order that they more closely meet national environmental priorities. This has come to be referred to as the 'nationalization' of the MDG targets and indicators.

This national report incorporates the 'nationalization' perspective when reporting on MDG 7 achievements. This is considered the basis not only for improved reporting, but also for promoting the national commitment to sustainable development principles and to more inclusion of environmental sustainability within national developmental schemes.

The Ministry of State for Environmental Affairs (MSEA), through its membership of the National Committee for Sustainable Development, seeks to integrate the environmental dimension in all national policies, plans, and programs relevant to the protection of human health and management of national resources. For example, the MSEA seeks to reduce current pollution levels to minimize health hazards and improve the quality of life. The MSEA also aims to preserve the national resources base, the national heritage, and biodiversity, within the context of development. Recognizing the gravity of Egypt's multifaceted environmental problems, the National Environmental Action Plan (2002-2017) emphasizes the changes needed in the areas of water, sanitation, energy and biodiversity. It states that the ultimate goal is "attaining development that is economically, politically, and environmentally sustainable".

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

- **Proportion of land area covered by forests**

At the turn of this decade, Egypt focused on afforestation with the aim of carbon sequestration, optimizing the use of scarce water resources and reducing sources of pollution through wastewater. In consequence, the Egyptian Environmental Affairs Agency (EEAA) has focused on the implementation of the national program in water reuse for forest plantation.

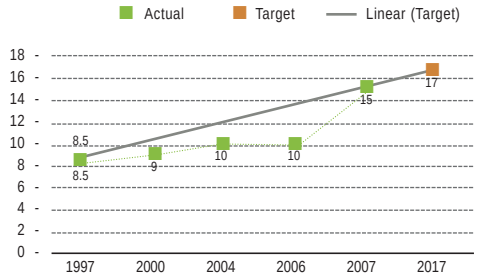
The proportion of land area covered by forest will increase by about 27 percent

This program has been implemented in 24 different regions in 16 governorates. Around 5.5 and 5.7 thousand feddans were planted during 2004 and 2005 respectively. A further 890 and 1000 feddans were added successively in 2006 and 2007.[11] This means that the current share of land area covered by forests is around 5.41 percent of the total area of the country.

11. EEAA Reports; CAPMAS (2007) Egypt in Figures

Efforts to maintain the protected area network and to enhance nature conservation in Egypt are needed. These include the development of extensive infrastructure, the integration of local communities in protected area management; and the implementation of international and regional agreements concerning biodiversity

Figure 7.1
Percent of area covered by Natural Protectorates, 1997-2007 and target for 2017



Source: EEAA Annual Reports (2004, 2007), CAPMAS 2007, Egypt in Figures

Most of these man-made forests are located in Upper Egypt (Qena, Luxor and Edfu) and in the New Valley. However, the share of afforested land area is still very limited compared to the inhabitable area of Egypt. This should not be regarded as a major problem since the government is currently in the process of allocating the appropriate funds to increase the planted forests to 80 thousands feddans; the proportion of land area covered by forest will therefore increase by around 27 percent. It should be noted that the quantitative target for that indicator for year 2015 is not identified. Besides, this is a typically unsuitable indicator in the Egyptian context according to the 'Blue Plan.' and to the environmental and natural resources indicators of the Arab League. The Blue Plan is a Regional Activity Centre of Mediterranean Action Plan, which is established under the aegis of United Nations Environment Program.

Natural protectorates and biodiversity

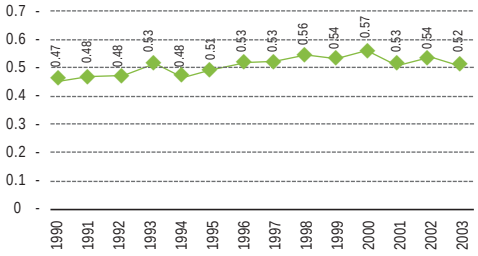
Egypt is endowed with a rich natural heritage which the GOE seeks to conserve for the benefit of present and future generations. At present, there are 27 protectorates covering about 15 percent of the country's total territory (Figure 7.1). There are, however, plans to add further protectorates in the coming years to reach 40 by 2017, covering about 17 percent of Egypt's total area. Efforts to maintain the protected area network and to enhance nature conservation in Egypt include the development of extensive infrastructure, such as the integration of local communities in protected area management; the implementation of international and regional agreements concerning biodiversity; and visitor centers and educational facilities.

In 2007, biodiversity was monitored and evaluated in four different protectorates. A biodiversity map including more than 600 thousand species was prepared within the framework of a BioMap project. This will enable future identification of the proportion of species threatened with extinction.

Egypt's CO_2 emissions are still considered low

The MSEA pays special attention to deepening local involvement in environmental issues to ensure sustainable environments. Based on effective participation, local communities would enjoy better educational and health services, as well as a wider scope for employment, and a higher standard of living. About 337 new paying jobs were created within the protectorates area in 2007 for the purpose of environmental management. Furthermore, an MSEA study (2007) to value the goods and services offered by the present protectorates estimated their value at about LE 12 billion per year.

Figure 7.2
CO_2 Emmissions (kg per 2000 PPP $ of GDP), 1990 - 2003



Source: World Bank, 2007. World Development Indicators 2007

Climate Change

According to the World Development Indicators (WDI) of 2007, total CO_2 emissions per capita and per US $1 GDP reached 0.52 kg in 2003. Figure 7.2 depicts the trend in CO_2 emission during the decade up to 2003.

The previous figure shows that Egypt's CO_2 emissions were fairly stable during the period 1990-2003. As compared to industrialized countries, Egypt's CO_2 emissions are still considered low, and are marginal on a global level. Further development of projects to reduce greenhouse gases (GHG) emissions would offer Egypt an opportunity to upgrade its energy, transportation, and industrial sectors. One such project has been CO_2'Sink' action. This is the action of planting trees that will capture carbon thereby leading to an increase in Egypt's CO_2 absorptive capacity.

The sources of GHG emissions is fuel combustion in the energy sector (22 percent), in industry (21 percent), in the transport sector (18 percent), in the agricultural sector (15 percent), and in 'other' sectors (24 percent).[12] The government has made efforts to institutionalize clean development mechanisms and to undertake several measures to reduce the emission of GHG. These efforts include:

- The ratification of the Kyoto Protocol in 2005.

If the current birth rate continues, population growth will put greater pressure on average annual per capita share of water, and desert land reclamation projects, to provide water and food for an increasing population

- Promoting energy efficiency policies, the use of natural gas, hydropower electricity, and other renewable sources. In order to achieve these tasks the MSEA is cooperating with the industrial sector.
- Promoting the compliance of the industrial sector to environmental laws.
- Promoting collection, transformation and re-use of agricultural waste in cooperation with the Army National Service.

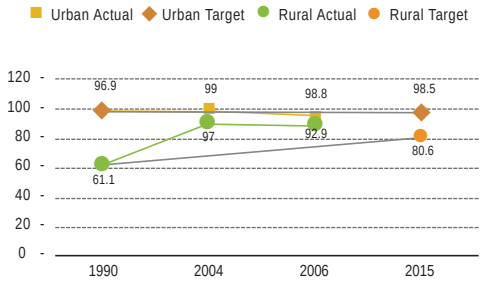
The MSEA is working to raise awareness on the negative health impact of ozone-depletion and on undertaken and planned measures to decrease the use of ozone-depleting substances (ODS). This has been implemented through the ban of ODS in foam and refrigerators production as well as in other sectors using ODS. As a result, Egypt's consumption of ODS is expected to further decrease during the coming years.

Population growth

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

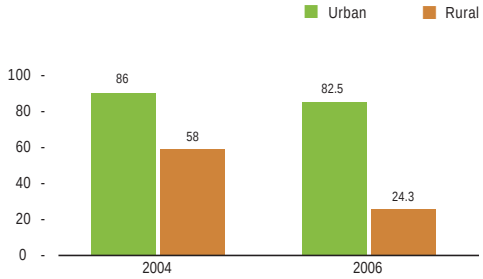
12. Egyptian Environmental Affairs Agency Report, 2000.

Figure 7.3
Actual and targeted proportions of population using an improved drinking water source, 1990 - 2006 and target for 2015



Source: Data complied from UN and Ministry of Planning, 2005. MDGs Second Country Report and INP, 2005; CAPMAS, 2007

Figure 7.4
Actual proportions of population using improved sanatation faciliity, 2004 and 2006



Source: UNDP and INP, 2005, EHDR 2005, capmas, 2007

Though the access level to water services still meets the 2015 target, the challenge facing the government is to sustain it

7.1.2 Target 10: Halve by 2015 the proportion of people without sustainable access to safe drinking water and basic sanitation

■ Access to improved drinking water

Government policy has aimed at increasing the efficiency of water utilities and to implement its National Water Quality Management Program. Approximately all the urban population and 93 percent of the rural population of Egypt rely on an improved drinking water source (Figure 7.3). However, recent figures from the 2006 Population Census reveal a decrease in coverage. Therefore, in spite of continuous government efforts to extend water services to all urban and rural population, the water service does not catch up with rapid population growth, and hence service coverage is worsening. Though the access level still meets the 2015 target, the challenge facing the government is to sustain it. Moreover, these figures do not reveal the disparities that exist between governorates.

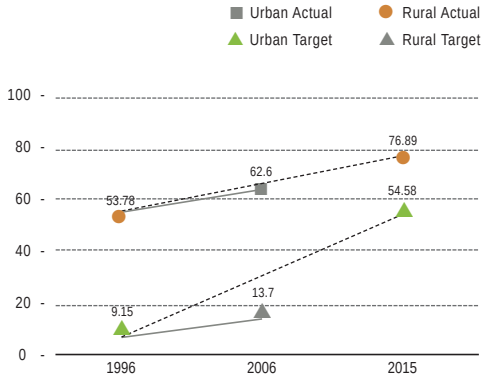
At the governorate level, the proportion of households with sustainable access to an improved water source has increased over the years for most governorates. In 2006, the governorates with the largest access were Alexandria and Suez at almost 100 percent. The worst observed access is found in Matrouh (73.6 percent) and North Sinai (80.7 percent). Nevertheless, it is one of the GOE's targets that by 2015 almost all Egyptian governorates will have full access to improved water sources.

The proportion of urban and rural people with access to improved sanitation has decreased over the period from 2004 to 2006

■ Access to improved sanitation facility

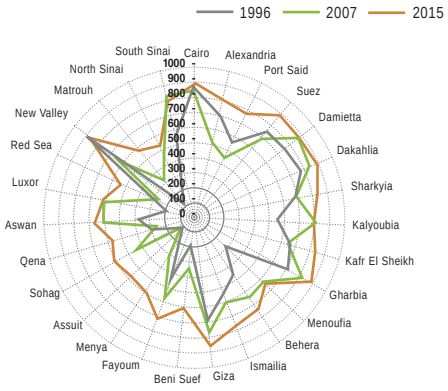
Government policy has not only been aimed at increasing the efficiency of water utilities, but has also given attention to sanitation programs. Nevertheless, the proportion of urban and rural population with access to improved sanitation (Figure 7.4) has decreased over the period from 2004 to 2006. The disparities are apparent between and within governorates where the latter disparities are due to discrepancy between urban and rural regions. The governorates of Cairo, Port Said, Suez, Damietta, Dakahlia, Kalyoubia, Kafr El Sheik, Ismailia, Giza, Red Sea, and South Sinai are around or above average in regard to sanitation services. All other governorates are below average, with worst access to sanitation in Assiut.

Figure 7.5
Actual and targeted proportion of buildings with access to improved sanitation, 1996, 2006 and target for 2015



Source: CAPMAS, 2007, Preliminary Findings of Population Census 2006; CAPMAS,1998, Population Census 2006

Figure 7.6
Actual and targeted proportion of buildings with access to improved sanitation by governorate and urban/rural disparities



Source: The Population Census, 1996 and 2006, CAPMAS

Given these figures it is unlikely that all governorates will meet their targets by 2015. On the other hand, comparing the situation in 2004 to 2006, it appears that the GOE has had no vision to consistently upgrade and rehabilitate sanitation provision, as reflected by varying ranking of services between governorates over the two year period. For example, in 2004, Sohag had the worst sanitation services among governorates in terms of deprivation of sanitation services. It moved to 5th place in 2006, while Assiut, which had initially been ranked 4th in 2004, moved to head the list on deprivation by 2006.

However, it should be noted that the indicator of access to sanitation for 2004 and 2006 comes from two different sources and may be measured differently, which would lead to uncertainty. In the former year, access is measured by the type of toilet facility without taking into consideration its connectivity to sewerage systems. In the latter year, access is based on the census and measured by the connectivity to sewerage systems. Therefore, the 2006 source appears more accurate than the 2004 figure, also giving a more realistic measure to indicate access to improved sanitation facilities. The 2004 methodology of measuring access, on the other hand, is often criticized for not providing a realistic picture of the degree of access to basic services such as sewerage.

In order to avoid this data problem the indicator may be slightly modified from proportion of population using an improved sanitation facility to the proportion of buildings using an improved sanitation facility between 1996 and 2006. This may be an underestimate of the population with access but any bias will be consistent over time. Figure 7.5 suggests it is most likely that the urban area will reach the target by year 2015. Unfortunately, the story is not so positive for rural areas which need more intensive programs and policies in order to reach the MDG target.

The status of sanitation at the governorate level is depicted in Figure 7.6, where the concentric circles portray the percentage of buildings with access to improved sanitation by governorate. Each governorate and the city of Luxor are represented by the respective radius of the figure. The sanitation coverage in 1996 by governorate is illustrated by the grey circular line. The green line shows the level achieved in 2007. Finally, the mustard line gives a picture of the targeted proportion of buildings with access to improved sanitation in 2015. Examination of the figure highlights that the proportion of buildings with access to an improved sanitation facility has increased over the years for most governorates with a large urban/rural disparity.

Figure 7.7
Proportion of urban population living in slums, 2004 and 2006

Source: UNDP and IN, 2005, EHDR 2005; CAPMAS, 2007, Preliminary Findings of Population Census 2006

It is not just slum areas that have increased but also the share of urban population living in slums, which has increased by 3.5 percent from 2004 to 2006

In 2007, urban areas may be categorized into three groups. The first is the group of governorates where the service has improved with a high possibility of reaching the target by 2015. This group includes Cairo, Damietta, Dakahlia, Kalyubia, Menoufia, Behera, Giza, Aswan, Luxor and South Sinai. The second group of governorates is that where services have improved but will most probably lag behind the target. The third category encompasses governorates currently offering lower services than in 1996. If this trend persists, it will be impossible for these governorates to reach the target. The governorates with receding services are Alexandria, Port Said, Suez, Assiut, and New Valley.

As for rural areas, only the governorate of Dakahlia may be able to reach its target. The worst observed access in rural areas is to be found in Upper Egypt and the frontier governorates. Nevertheless, it is one of the government targets that by 2015 almost all Egyptian governorates will reach 97 percent access to improved sanitation facility. However, this is a very optimistic goal given current achievements.

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

■ Urban population living in slums

The well-being of Egypt's slum dwellers is negatively affected by their limited access to education, health services, and water. Slum areas have increased in number between 2004 and 2006. The Inter-agency and Expert Group on MDG Indicators recommends that the actual share of people living in slums should be measured as a proxy, represented by households in the urban population living in dwellings characterized by at least one of the following four characteristics:

(i) lack of access to improved water supply;
(ii) lack of access to improved sanitation;
(iii) overcrowding; and
(iv) dwellings made of non-durable material.

Applying these guidelines, slum areas have not only increased (from 1174 to 1210 between 2004 and 2006) but also the share of urban population living in slums, which has increased by 3.5 percent from 2004 to 2006 (Figure 7.7).

If this trend persists it will limit Egypt's ability to contribute to the MDG target of achieving a significant improvement in the lives of at least 100 million slum dwellers by year 2020. Egypt's poor, and those living in slum areas in general, still need access to multiple services including better education and health provision (including for reproductive health), better access to water and sanitation services, and, generally, upgraded infrastructure and housing to improve their well-being.

7.2 Major Challenges

The current efforts of MSEA, with the assistance of aid donors, aim at effectuating environmental awareness programs to create public concern over the conservation of natural resources. The absence of a systematic monitoring system of environmental indicators is an additional and major challenge facing Egypt's ability to meet the goal of ensuring environmental sustainability.

Despite government policies and increasing investments, protecting the environment within sustainable economic development in Egypt is still a challenge. One example of this is the environmental degradation arising from speedy tourism development in some recreational destinations well-endowed with natural resources.

Challenges may take the following forms:

- Population growth and the increasing demand for and pressure on natural resources.
- Enhanced environmental education and awareness activities, which to date appear to have had little impact on increasing environment-friendly behavior among citizens.
- The expansion in economic activities, especially industrial, without compliance to 'clean development' mechanisms.
- Low standard of living in the rural areas placing barriers to the expansion of water and sanitation services.
- Weakness in the implementation and enforcement of environmental laws and policies.

7.3 Public Policies

It is clear that the GOE is concerned about pollution and environmental degradation, and, as indicated earlier, has taking serious steps towards achieving the MDG by invested heavily in the water sector, through major irrigation projects, drinking water supply, and sanitation infrastructure. It has also played a central role in cooperating with other Nile riparian countries on water resources.

Several steps have also been taken towards improving the quality of air. The MSEA has formulated a plan to relocate heavily polluting activities outside populated areas, including those emitting noxious fumes. In addition, it has established environmental inspection units at the central level, which have helped it to draft the first policies and procedures manual in the field. In 2005, the MSEA started the implementation of the Green Belt project around Greater Cairo in order to improve the quality of air. The project aims at planting around 500 thousand trees in a circle periphery of 100 km around Greater Cairo. To date about 14 kilometers have been planted and 10 kilometers are in the process of plantation.

There is strong donor-government cooperation in the area of protectorates development. Examples are the collaboration with the European Union in South Sinai, with USAID in the Red Sea, and the Italian Government in Fayoum, as well as with UNDP in North Sinai. In addition, the MSEA is in the process of preparing a strategic plan for sustainable use and conservation of medical plants in arid and semi-arid lands.

It is important to mention that the Ministry of the Environment, in cooperation with line ministries, has already set the 'General Framework for Sustainable Development' for Egypt. Further steps are currently being undertaken to finalize a national strategy for sustainable development and to guarantee its incorporation in all national development plans.

7.4. Concluding Remarks

In order to ensure environmental sustainability, there is a need to support the following:

- Capacity building for environmental planning and management as a tool to achieve sustainable development;
- Implementation of initiatives to bridge geographical disparities and guarantee equal access to resources and services;
- Raising consumer awareness and promoting community-based interventions;
- Developing and expanding the use of alternative sources of energy, especially renewable and solar energy;
- Planning and developing environmentally sustainable urban communities with affordable low-cost housing and the improved operation and maintenance of water and sanitation services.
- Augmenting and improving efforts targeting water demand management.

- Curbing Egypt's population growth.
- Setting up monitoring units to report on slum conditions and management related to infrastructure as well as housing and land tenure.
- Developing and implementing urban development strategies to guide local action.
- Monitoring national participatory policy implementation within the context of urban and environmental development efforts.
- Strengthening environmental institutions and enforcing sound environmental behavior.

It is also recommended to adopt the country specific indicators of MDG 7 proposed by the Ministry of the Environment, which would primarily rest on the consensus of the appropriate and directly concerned government ministries and authorities on targets and performance indicators. Such indicators need to be adapted to data regularly collected and nationally accessible. Further, it is recognized that a well-established institutional mechanism for self-monitoring and reporting involving the ministries and authorities involved is essential. Stocktaking of and building on existing experiences and on previous national initiatives is also indispensable with respect to monitoring and reporting, using indicators on environmental and sustainable development.

GOAL 8: DEVELOP A GLOBAL PARTNERSHIP FOR DEVELOPMENT

Target 12
Develop further an open, rule-based, predictable, non-discriminatory trading and financial system

Includes a commitment to good governance, development and poverty reduction — both nationally and internationally

Target 13
Address the special needs of the least developed countries

Includes tariff and quota free access for the least developed countries' exports; enhanced program of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; more generous ODA for countries committed to poverty reduction

Target 14
Address the needs of landlocked developing countries and small island developing States (through the Program of Action for the Sustainable Development of Small Island Developing States and outcome of the 22nd Special Session of the General Assembly)

Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries and small island developing States.

Official development assistance (ODA)

33. Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income
34. Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation)
35. Proportion of bilateral official development assistance of OECD/DAC donors that is untied
36. ODA received in landlocked developing countries as a proportion of their gross national incomes
37. ODA received in small island developing States as a proportion of their gross national incomes

Market access

38. Proportion of total developed country imports (by value and excluding arms) from developing and least developed countries, admitted free of duty
39. Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries
40. Agricultural support estimate for OECD countries as a percentage of their gross domestic product
41. Proportion of ODA to help build trade capacity

Target 15 Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	**Debt sustainability** 42. Total number of countries that reached HIPC decision point and number that reached HIPC completion points (cumulative). 43 Debt relief committed under HIPC and MDRI Initiatives. 44 Debt service s percentage of goods and exports.
Target 16 Achieve full and productive employment and decent work for all, including women and young people	45. (Replaced by new indicators in Goal 1)
Target 17 In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	46. Proportion of population with access to affordable essential drugs on a sustainable basis
Target 18 In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	47a. Telephone lines per 100 population 47b. Cellular subscribers per 100 population 48. Internet users per 100 population

Key Messages

Egypt's ODA disbursement has seen a rise of 5 percent in the period between 2001 and 2007. The government's Sixth Five Year Plan (2007-2012) has set a number of policies in order to enhance export performance and competitiveness. The good performance of exports has been reflected in the decline of the ratio of debt interests to exports of goods and services. The ICT sector in Egypt has been growing fast in the past years, especially with the increased access to cell phones and the internet.

8.1 Status of Progress

8.1.1 Target 12: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system

Target 13: Address the special needs of the least developed countries

Target 14: Address the special needs of landlocked developing countries and Small Island Developing States (through the Program of Action for the Sustainable Development of Small Island Developing States and the outcome of the Twenty-Second Special Session of the General Assembly)

Target 15: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term

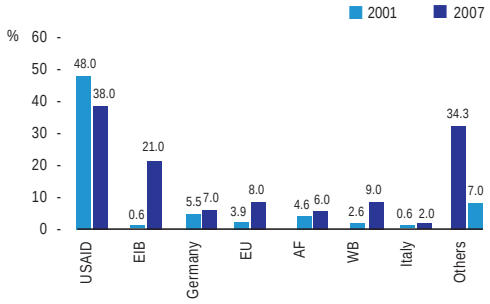
■ Official Development Assistance (ODA)

Egypt's ODA disbursements during the fiscal year 2007 amounted to $1.7 billion, with a 5 percent increase compared to 2001 (then at $1.6 billion). With the increase in population between the two years by almost 16 percent, ODA per capita witnessed a decline from 25 percent in 2001 to 23 percent in 2007.

As the number of ODA donors reached 55 donors in 2007, USAID continued to be a major partner in development, accounting for 38 percent of the total disbursement, despite the fact that USAID assistance has decreased by 16.4 percnt, compared its value in 2001. It is expected to reach a fixed low level of $407.5 million in financial year 2009 as per the Camp David Agreement.[13] The European Investment Bank share of total disbursement reached 21 percent in 2007 and has witnessed a huge rise between the two years (Figure 8.1)

Figure 8.1

ODA disbursement distribution by donors, 2001 and 2007



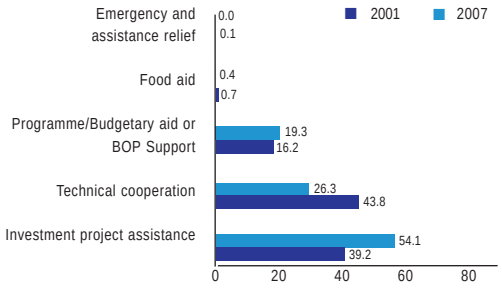
Source: DECODE Ministry of International Cooperation, 2007

Most of the ODA disbursements in 2007 are in the form of investment project assistance, accounting for about 54 percent of the total disbursement, compared to about 39 percent in 2001. The shares of program budgetary aid have increased in the same period to about 19 percent, while that of technicl cooperation has fallen to almost 26 percent compared to its share in 2001 (Figure 8.2).

The distribution of ODA disbursement across sectors has changed within the two years 2001 and 2007 (Figure 8.3), where the share of most of the important sectors declined except that of energy generation and supply, and the trade sectors, where it reached almost 25 percent for the former, and 14 percent for the latter, compared to about 5 and 8.5 percent respectively in 2001.

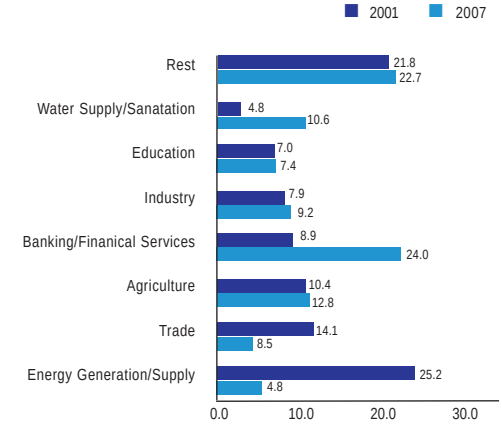
13. Development Cooperation Report (2007), Ministry of International Cooperation, Egypt.

Figure 8.2
Percent classification of ODA disbursements by type of assistance, 2001 and 2007



Source: DECODE Ministry of International Cooperation, 2007

Figure 8.3
ODA disbursements by sector, 2001 and 2007



Source: Ministry of International Cooperation, 2007

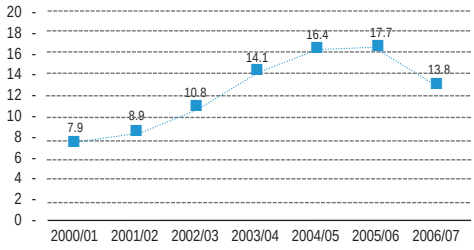
■ Market access

The share of exports of goods and services in Egypt's GDP increased through the years, reaching 17.7 percent in 2005/06, then decreasing to 13.8 percent in 2006/07 (Figure 8.4). The EU and the United States are the main export markets, where the EU's share of Egyptian exports reached almost 34 percent in 2006/07, while USA's share reached 31 percent (Table 8.1). Arab countries received 12.4 percent of Egypt exports. However, Egypt's trade is diversified among a large number of countries, which makes it less vulnerable to external shocks.

■ Debt sustainability

Egypt's external debt has witnessed stable movement in the last few years where it has increased from $26.6 billion in 2000/01 to $29.9 billion in 2006/07, making an average of around $29 billion throughout the last seven years. At the same time, one of the main debt performance indicators shows that the ratio of debt services to exports of goods and services has decreased during the period to reach 5.5 percent in 2006/07, reflecting the good performance of exports. (Figure 8.5)

Figure 8.4
Export of goods and services as a percent of GPP, 2000/01 - 2006/07



Source: Ministry of Economic Development, 2008, *25 Years of Development*; Central Bank of Egypt, Statistical Bulletin, various monthly issues.

Table 8.1:
Egypt main export markets, 2001/02-2006/07 (%)

	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07
EU	29.5	34.1	33.8	37.2	37.6	33.8
USA	36.8	37.2	35.4	33.4	30.6	31
Arab Countries	13.2	11.4	12.2	11.3	11.5	12.4

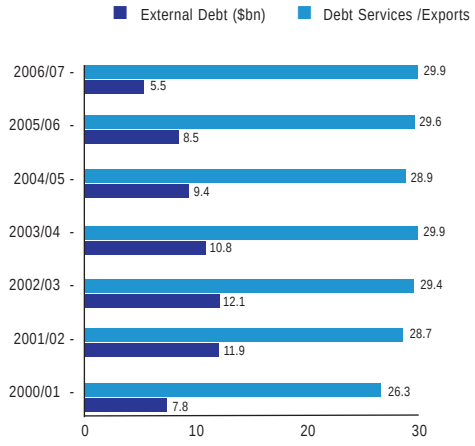
Source: Central Bank of Egypt, Different Series of Monthly Statistical Bulletin

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

■ Telephone lines, cellular subscribers / Internet users per 100 population

Egypt has witnessed significant progress in the last six years in the field of information and communication technology, with the rise in the number of fixed line subscribers by almost 45.5 percent during the reference period. As new technologies have appeared in the field of wireless communications, the number of cell phone subscribers has risen from 6 per hundred people in 2001/02 to 32.5 per hundred people in 2006/07. The number of internet users has increased to reach 9.6 percent in 2006/07 compared to 1.8 per hundred people in 2001/02, especially with the intensive DSL service provided by a larger number of IT companies (Table 8.2).

Figure 8.5
External debt indicators, 2000/01- 2006/07



Source: Central Bank of Egypt. Different series of monthy statistical bulletin

8.2 Major Challenges

The Egyptian government faces a number of challenges in the area of international partnerships and such challenges need to be met in order to assist in improving the business climate, generate more job opportunities and enhance Egyptian exports.

Official development assistance

There are a number of factors affects the efficient usage of ODA, some of which are related to the donor countries or the Egyptian government side, and others related to both sides.

The donor side

- Placing conditions on the donor side to continue providing aid after certain conditions have been met.
- Delaying the provision of finance, action plans, offering bids, and completion of deals.
- Not providing the GOE with any role in the monitoring of projects financed by ODAs.

14. An account opened by the Ministry of Finance at the Central Bank in which the recipients of aid deposit money in Egyptian pounds.

Table 8.2:
Main ICT Indicators, 2001/02-2006/07 (per 100 people)

Indicator	01/02	02/03	03/04	04/05	05/06	06/07
No. fixed lines subscribers	11	-	-	-	-	16
No. cell phone subscribers	6	7.5	9.3	14.1	20.2	32.5
No. internet subscribers	1.8	3.1	4.8	6.4	7.6	9.6

Source: Ministry of Information and Communication Technology, 2006, Year Book 2006; <www.idsc.gov.eg/nds/nds.aspx>

The GOE side

- Inaccurate feasibility studies conducted to allocate aid to various projects.
- The length of time taken to apply some agreements.
- A lack of commitment by contractors to their contractual agreements.
- The existence of a number of financial, organizational and administration problems.
- Insufficient attention given to education, training and capacity building so as to sustain adequate levels of maintenance and upgrading.

Factors related to both sides

- Not using the funds given in some aid agreements.
- The length of time consumed to apply some agreements.
- The existence of a number of financial, organizational, and administration problems.
- The implementation contracts of some projects. are not signed by one or more of the partners to the agreement.

Other factors relate to the efficient use of the available funds placed in the 'Special Account'.[14] These are:

- Allocating funds for some projects in excess of their actual needs.
- The delay in making use of equipment shipped to some projects.
- The delays from various institutions in using the funds appropriated to them.

Employment targeted projects should be increasingly negotiated and encouraged to be implemented, particularly in Lower Egypt which hosts the highest unemployment density rates. More protocols are encouraged to target this type of project in support of the national agenda of the GOE.

Focusing on labor-intensive sectors guarantees a sustained reduction of unemployment rates. This invites allocation of more ODA to the agriculture, manufacturing and industry sectors, but not at the expense of greater assistance to the ICT and information sectors the top priorities of the GOE.

There is a need to encourage more partnership with the private sector to improve the competitiveness of business establishments, which can effectively take place via the creation of more 'Business Development Services Centers in Upper and Lower Egypt to be responsible for providing all forms of services to SMEs, including access to finance, vocational training, technical manufacturing assistance and exportation.

Maintaining increased support to the current top priority sectors of energy generation, transport and storage as well as other infrastructural sectors, will indirectly affect the competitiveness position of the Egyptian economy and its attractiveness to more international and domestic investments. This further also increases its readiness to exports. These infrastructural sectors should be further implemented in regions that relatively lack infrastructural services such as Upper Egypt and Frontier governorates, which enjoy the least share of these services.

Negotiating additional debt–to-swap agreements with development partners will achieve the double impact of decreasing debt burden and increasing development resources after realizing a stabilized trend.

8.3 Public Policies

Official development assistance

The Egyptian government has set different policies to enhance the efficiency of ODA and the way in which they are distributed on the sectoral level or by type. These such policies are mainly to:

- Attract more forms of effective ODA from current development partners, and that have more positive spillovers on the development process. Resume continuous negotiations required for involving new partners in the development process, with agendas in line with GOE priorities.
- Coordinate the distribution of ODA according to national program priorities to the favor of marginalized regions and to less centralization; favor Upper Egypt and Frontier governorates and encourage development partners to take GOE priority areas there into their agenda.
- Deploy further efforts for the implementation of tangible projects, particularly in Frontier governorates and Upper Egypt, to help in improving the development infrastructure and to expand the potentialities of these regions.
- Maintain and nourish the trend in decreasing the technical assistance component in favor of an increased component of investment-based assistance and transfer of know-how and technology.
- Allocate additional and diversified resources to agencies and institutions supporting and strengthening SMEs, especially to Egypt's Social Fund for Development (SFD). This is vital given the SME role in generating employment and its potential in enhancing exports.
- Draw more attention to the development of the insurance sector.
- Give more attention to the design of accurate feasibility studies, and ensure

their flexibility to incorporate changes during project implementation.
- Create and develop cooperation between different agencies involved in the use of aid.
- Incorporate the GOE in the implementation and monitoring of all projects.
- Overcome the administrative and organizational obstacles facing the implementation of projects by providing the necessary infrastructure and guarantees, whether from government or the Ministry of Finance.
- Increase the dependence on Arab sources of finance which enjoy more flexibility than other sources.

Trade policy

At the level of Egypt's trade policy, the GOE's Sixth Five Year Plan (2007-2012) has initiated a number of policies to enhance export performance and competitiveness. These are:

- Commitment to applying quality control and assurance in line with international specifications and standards, so as to ensure the competitiveness of Egyptian products.
- Providing data on foreign markets and investigating export opportunities.
- Facilitating export and import procedures.
- Intensifying efforts aiming at marketing Egyptian products in foreign markets.
- Increasing the financial resources of the Export Development Fund.
- Developing transactions with regional and global economic blocs, and speeding up the completion of infrastructure works that deepen Egypt's integration in the world economy.
- More coordination concerning existing and new trade-based projects is required between the Ministry of International Cooperation (MIC) and the Ministry of Industry and Foreign Trade. For this purpose, a joint committee is being set up to underline jointly the required areas of development. These efforts will enhance the competitiveness of Egyptian exports and the restructuring of the international trade system, in cooperation with development partners. The committee is expected to identify and propose those areas that represent drawbacks and that are in need of more support to enhance engagement in international trade. These issues would be highlighted by the Ministry of International Cooperation in its negotiations with development partners, ending with the implementation of coordinated development projects.

Information and communication policy

GOE policy for the ICT sector included in the Sixth Five Year Plan (2007-2012) aims at achieving an annual increase of 20 percent in internet users and information technology clubs, and of 25 percent in mobile phone users, and 15 percent in number of companies working in the field of communication and information technology.

8.4 Concluding Remarks

Despite the improvements in ODA disbursements and in Egypt's relationship with donors, especially with regard the high share of ODA to the industrial sector — indicating coherence between GOE policies and ODA allocation among different economic sectors, with good export performance and use of technology — there is still much needed, with more concentration on efficient budget resource allocation such that it will reduce the public debt, and in order for Egypt to achieve and sustain a global partnership.

ANNEX

Revised MDG monitoring framework including new targets and indicators, as recommended by the Inter-agency and Expert Group on MDG Indicators

At the 2005 World Summit, world leaders committed themselves to achieving four additional targets to the ones included in the Millennium Declaration (2005 World Summit Outcome A/RES/60/1). The General Assembly at its 61st Session took note of the Report by the Secretary-General on the Work of the Organization (A/61/1) in which he recommended (paragraph 24) the inclusion of four new targets.

The technical work for the selection of the appropriate indicators for the new targets was undertaken by the Inter-Agency and Expert Group on MDG Indicators, coordinated by the United Nations Department of Economic and Social Affairs and mandated with the preparation of statistics and analysis on trends towards the Millennium Development Goals and the review of methodologies and technical issues in relation to the indicators.

The new formulation of the monitoring framework, including the new targets and corresponding indicators as recommended by the Inter-agency and Expert Group on MDG Indicators, is presented below.

Where relevant, indicators will be calculated by sex and by urban and rural areas.

Millennium Development Goals (MDGs)

Goals and Targets (from the Millennium Declaration)	Indicators for Monitoring Progress
Goal 1: Eradicate extreme poverty and hunger	
Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	1. Proportion of population below $1 (PPP) per day[1] 2. Poverty gap ratio 3. Share of poorest quintile in national consumption
Achieve full and productive employment and decent work for all, including women and young people	Growth rate of GDP per person employed Employment-to-population ratio Proportion of employed people living below $1 (PPP) per day Proportion of own account and contributing family workers in total employment
Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	4. Prevalence of underweight children under-five years of age 5. Proportion of population below minimum level of dietary energy consumption
Goal 2: Achieve universal primary education	6. Net enrolment ratio in primary education
Target 3: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	7. Proportion of pupils starting grade 1 who reach last grade of primary** 8. Literacy rate of 15-24 year olds, women and men.**
Goal 3: Promote gender equality and empower women	**7.** Ratios of girls to boys in primary, secondary and tertiary education
Target 4: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	10. (dropped) [2] 11. Share of women in wage employment in the non-agricultural sector 12. Proportion of seats held by women in national parliament
Goal 4: Reduce child mortality	13. Under-five mortality rate
Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	14. Infant mortality rate 15. Proportion of 1 year-old children immunized against measles
Goal 5: Improve maternal health	16. Maternal mortality ratio
Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	17. Proportion of births attended by skilled health personnel 19c. Contraceptive prevalence rate [3]
Achieve, by 2015, universal access to reproductive health	
Goal 6: Combat HIV/AIDS, malaria and other diseases	18. HIV prevalence among population aged 15-24 years 19a. Condom use at last high-risk sex
Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	19b. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS 20. Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years
Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	Proportion of population with advanced HIV infection with access to antiretroviral drugs
Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	21. Incidence** and death rates associated with malaria 22. Proportion of children under 5 sleeping under insecticide-treated bednets and Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs**

	23. Incidence**, prevalence and death rates associated with tuberculosis 24. Proportion of tuberculosis cases detected and cured under directly observed treatment short course
Goal 7: Ensure environmental sustainability **Target 9: Integrate the principles of sustainable development into country policies and programs and reverse the loss of environmental resources**	25. Proportion of land area covered by forest 27. (dropped)[4] 28. CO2 emissions, total, per capita and per $1 GDP (PPP), and consumption of ozone-depleting substances** 29. (dropped)[5] Proportion of fish stocks within safe biological limits Proportion of total water resources used
Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	26. Proportion of terrestrial and marine areas protected** Proportion of species threatened with extinction
Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	30. Proportion of population using an improved drinking water source** 31. Proportion of population using an improved sanitation facility**
Target 11: By 2020, to have achieved a significant improvement in the lives of at least 100 Million slum dwellers	32. Proportion of urban population living in slums [6]**
Goal 8: Develop a global partnership for development	Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked developing countries and small island developing States.
Target 12: Develop further an open, rule-based, predictable, non-discriminatory trading and financial system **Includes a commitment to good governance, development and poverty reduction – both nationally and internationally**	**Official development assistance (ODA)** 33. Net ODA, total and to the least developed countries, as percentage of OECD/DAC donors' gross national income 34. Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation)
Target 13: Address the special needs of the least developed countries **Includes: tariff and quota free access for the least developed countries' exports; enhanced programme of debt relief for heavily indebted poor countries (HIPC) and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction**	35. Proportion of bilateral official development assistance of OECD/DAC donors that is untied 36. ODA received in landlocked developing countries as a proportion of their gross national incomes 37. ODA received in small island developing States as a proportion of their gross national incomes
Target 14: Address the special needs of landlocked developing countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)	**Market access** 38. Proportion of total developed country imports (by value and excluding arms) from developing countries and least developed countries, admitted free of duty 39. Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries 40. Agricultural support estimate for OECD countries as a percentage of their gross domestic product 41. Proportion of ODA provided to help build trade capacity

Target 15: Deal comprehensively with debt problems of developing countries through national and intrnational measures, in order to make debt sutainable in the long term.	**Debt sustainability** 42. Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative) 43. Debt relief committed under HIPC and MDRI** Initiatives 44. Debt service as a percentage of exports of goods and services
Target 16: replaced by new target in Goal 1	45. (Replaced by new indicators in Goal 1)[7]
Target 17: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	46. Proportion of population with access to affordable essential drugs on a sustainable basis
Target 18: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	47a. Telephone lines per 100 population ** 47b. Cellular subscribers per 100 population** 48. Internet users per 100 population**

* The numbering of the targets and indicators will be undertaken through the inter-agency process of the Inter-agency and Expert Group on MDG Indicators.

** The language has been modified for technical reasons, so that the data can be more clearly reflected.

Notes:

1. For monitoring country poverty trends, indicators based on national poverty lines should be used, where availble.
2. Previously: “Ratio of literate women to men, 15-24 years old”.
3. Moved from Goal 6.
4 .Previously: “Energy use (kg oil equivalent) per $1 GDP (PPP)”.
5. Previously: “Proportion of population using solid fuels”.
6. The actual proportion of people living in slums is measured by a proxy, represented by the urban population living in households with at least one of the four characteristics: (a) lack of access to improved water supply; (b) lack of access to improved sanitation; (c) overcrowding (3 or more persons per room); and (d) dwellings made of non-durable material.
7. Previously: “Unemployment rate of young people aged 15-24 years, each sex and total”.

REFERENCES

Central Agency for Public Mobilization and Statistics (CAPMAS), 2007, *Egypt in Figures* , Cairo, Egypt.

Central Agency for Public Mobilization and Statistics (CAPMAS), 2007, *Preliminary Findings of Population Census 2006*, Cairo, Egypt.

Central Agency for Public Mobilization and Statistics (CAPMAS), *Statistical Year Book*, 2005, 2006, 2007, Cairo, Egypt.

Central Agency for Public Mobilization and Statistics (CAPMAS), *Labor Force Sample Survey* 1990, 2000, 2005, 2006, Cairo, Egypt.

Central Agency for Public Mobilization and Statistics (CAPMAS), 1977, 1986, 1990, 1993, 1998, 2001, 2003, 2004, 2005, *Births and Deaths Statistics*, Cairo, Egypt.

Central Agency for Public Mobilization and Statistics (CAPMAS), 1998, *Population Census 1996*. Cairo, Egypt.

Central Bank of Egypt, Different Series of Monthly Statistical Bulletin.

Deneux-Tharaux C, Berg C, Bouvier-Colle MH, Gissler M, Harper M, Nannini A, 2005, "Underreporting of Pregnancy-related Mortality in the United States and Europe". *Obstet Gynecol* 2005; 106:684-692.

Egyptian Environmental Affairs Agency, *Annual Reports* 2000-2007.

El- Zanaty, F. and A. Way, 2006, "Egypt Demographic and Health Survey 2005", Cairo, Egypt: Ministry of Health and Population, National Population Council, El- Zanaty and Associates, and ORC Macro.

El- Zanaty, F. and A. Way, 2004, "Egypt Interim Demographic and Health Survey 2003", Cairo Egypt: Ministry of Health and Population, National Population Council, El- Zanaty and Associates, and ORC Macro.

El- Zanaty, F. and A. Way, 2001, "Egypt Demographic and Health Survey 2000", Calverton, Maryland, USA, Ministry of Health and Population Egypt, National Population Council and ORC Macro.

El- Zanaty, F., E. Hussein, G. Shawky, A. Way, and S. Kishor, 1996, "Egypt Demographic and Health Survey 1995", Calverton, Maryland, USA, National Population Council [Egypt] and Macro International Inc.

El- Zanaty, F., H. Sayed., H. Zaky, and A. Way, 1993, "Egypt Demographic and Health Survey 1992", Calverton, Maryland, USA, National Population Council [Egypt] and Macro International Inc.

El-Zayadi et al., 2005, "Hepatocellular carcinoma in Egypt: A Single Center Study over a Decade". *World Journal of Gastroenterology*, 2005; vol 11 (Number 33): 5193-5198.

Hallouda, a., S. Amin, and S. Farid 1983, The Egyptian Fertility Survey 1980, vol. 2, "Fertility and Family Planning", International Statistical Institute, Central Agency for Public Mobilization and Statistics, Cairo, Egypt.

http://www.idsc.gov.eg/nds/nds.aspx

Kheir El Din, H. and H. El Laithy, 2006, "An Assessment of Growth, Distribution and Poverty in Egypt: 1990/91-2004/05", ECES, Working Paper No., 115.

Lewis G. ed., 2004, *Why Mothers Die 2000-2002: the Confidential Enquiry into Maternal Deaths in the United Kingdom*. London: RCOG Press.

Ministry of Economic Development, 2008, *Book of 25 Years of Development*. Egypt.

Ministry of Economic Development, 2008, "Social and Economic Development Follow-Up Report for the Year 2006/07". Egypt.

Ministry of Economic Development, 2008, "Trend of Standard of Living and Poverty Indicators in Egypt".

Ministry of Economic Development, 2007, "The Sixth Five Year Socioeconomic Plan (2007-2012)". Egypt.

Ministry of Education, 2006, General Department of Information and Computers, "Education Statistics Connected to MDG", Unpublished, Egypt.

Ministry of Health and Population, 2007, General Management Information Center for Programs of Childhood Diseases. Egypt.

Ministry of Health and Population, 2007, "Health Statistics", Unpublished, 20/6/2007. Egypt.

Ministry of Health and Population, 2007, "HIV/AIDS Surveillance Report 30/1/2007". Egypt.

Ministry of Health and Population in collaboration with USAID and Family Health International, 2006. "Egypt Biological and Behavioral Surveillance Survey, Summary Report 2006". Cairo, Egypt.

Ministry of Health and Population, 2005, 2006, "Health Statistics Connected to MDG", unpublished, Egypt.

Ministry of Health and Population, 2001, Directorate of Maternal and Child Health Care, "National Maternal Mortality Study 2000", Egypt.

Ministry of Health and Population, 1993, "National Maternal Mortality Survey 1992/93". Egypt.

Ministry of Information and Communication Technology, 2006, *Year Book 2006*. Cairo, Egypt.

Ministry of International Cooperation, 2007, "Development Cooperation Report 2005", various issues, Egypt.

Mohamed. M. K., 2004, "Epidemiology of HCV in Egypt 2004". *The Afro-Arab Liver Journal*, 2004; vol 3 (No 2): 41-52.

Nandakumar A, Reich M, Chawla M et al., 2000, "Health Reform for Children: the Egyptian Experience with School Health Insurance", *Health Policy* 2000; 50: 155-170.

National Council for Women, 2008, Unpublished data. Cairo, Egypt.

Sayed, H. M. Osman, F. El Zanaty., and A. Way, 1989, "Egypt Demographic and Health Survey 1988", Columbia, Maryland, USA, National Population Council [Egypt], and Institute for Resource Development/ Macro Systems, Inc.

Shawky S., 2008, "The Inequities in the Health Insurance System in Egypt". IUSSP International Seminar on Health Inequity: Current Knowledge and New Measurement Approaches, Cairo, Egypt. February 16-18.

The National Council for Childhood and Motherhood, 2007, "Girls' Initiative to Establish", Cairo, Egypt.

The Policy Secretariat of the National Democratic Party, 2007, *Proceedings of the 9th National Democratic Party Conference*. Cairo, Egypt.

Under-secretary for Endemic Disease, General Department of Malaria, Ministry of Health & Population. http://www.emro.who.int/rbm/pdf/Malaria_Egypt.pdf

United Nations and Ministry of Planning, 2004, MDG Second Country Report. Cairo, Egypt.

United Nations Development Programme and Institute of National Planning, 2005, *Egypt Human Development Report 2005*. Cairo, Egypt.

World Health Organization http://www.who.int/whosis/en/index.html

WHO EMRO. Roll Back Malaria. http://www.emro.who.int/rbm/CountryProfiles-egy.htm

WHO, UNICEF, UNFPA, and the World Bank, 2005, *Maternal Mortality in 2005*.

World Bank, 2007, *Egypt Poverty Assessment Update*.

World Bank, 2007, *World Development Indicators 2007*.