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PN AAR 223

EGYPT  
USAID POPULATION SECTOR ASSESSMENT  
1982

VOLUME 1: POPULATION SECTOR ASSESSMENT

A Report Prepared By:

Mr. W. PARKER MAULDIN, Team Leader, Senior Scientist,  
The Rockefeller Foundation, New York City  
DR. H.T. CROLEY, Population and Family Planning  
Consultant, Monterey, California  
MR. LENNI KANGAS, Population Program Advisor, Bureau  
for the Near East, AID, Washington, D.C.  
MS. ANN LEONARD, Information and Communication  
Consultant, New York City  
DR. GEOFFREY McNICOLL, Deputy Director, Center for  
Policy Studies, The Population Council, New York City  
DR. EMMANUEL VOULGAROPOULOS, Professor of International  
Health, School of Public Health, University of Hawaii,  
Honolulu

During The Period:  
MARCH - APRIL 1982

Supported By The:  
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT  
(ADSS) AID/DSPE-C-0053

AUTHORIZATION:  
Assgn. No. 582139

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## ABBREVIATIONS

AID	Agency for International Development
AUC	American University, Cairo
CAPMAS	Central Agency for Public Mobilization and Statistics
CBR	Crude Birth Rate
CCC	Child Care Center
CCR	Collaborating Center for Clinical Research
CDC	Cairo Demographic Center
CDR	Crude Death Rate
CDSS	Country Development Strategy Statement
CEOSS	Coptic Evangelical Organization for Social Services
CFPA	Cairo Family Planning Association
CRS	Commercial Retail Sales
CYP	Couple Year of Protection
EFCS	Egyptian Fertility Care Society
EFPA	Egyptian Family Planning Association
FAO	Food and Agricultural Organization
FOF	Family of the Future
FP	Family Planning
FPA	Family Planning Association
FPIA	Family Planning International Association
FRG	Federal Republic of West Germany
FY	Fiscal Year
GOE	Government of Egypt

HIPH	High Institute of Public Health
IDA	International Development Authority
IDRC	International Development Research Center
IEC	Information, Education, and Communication
IFRP	International Fertility Research Program
IMR	Infant Mortality Rate
IPAVS	International Project of the Association for Voluntary Sterilization
IPPF	International Planned Parenthood Federation
ISELS	Institute of Society, Ethics, and the Life Sciences
ISSR	Institute of Statistical Studies and Research
ISSDS	Integrated Social Services Delivery System
IUD	Intrauterine Device
KAP	Knowledge, Attitude, and Practice
LE	Egyptian Pound (Monetary Unit)
MC	Monthly Cycle
MCH	Maternal and Child Health
MCRA	Married Couples of Reproductive Age
MIS	Management Information System
MOE	Ministry of Education
MOH	Ministry of Health
MOSA	Ministry of Social Affairs
MRS	Medical Representatives
MWRA	Married Women of Reproductive Age
NAS	National Academy of Sciences
OB/GYN	Obstetrics and Gynecology

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OC	Oral Contraceptive
ODA	Overseas Development Administration
ORS	Oral Rehydration Salts
PDP	Population and Development Project
PDPAC	Advisory Committee of the Population and Development Project
PFPB	Population and Family Planning Board
PIACT	Program for the Introduction and Adaptation of Contraceptive Technology
PIL	Project Implementation Letter
pt.	Piaster (100 piasters = LE1.00)
POP/FP	Population and Family Planning
RAM	Repair and Maintenance
RAPID	Resources for Awareness of Population Impact on Development
SDC	Social Development Center
SHIP	Sharkia International Project
SIS	State Information Service
SRC	Social Research Center
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
U.N.	United Nations
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Emergency Fund
USAID	United States Agency for International Development
VSC	Voluntary Surgical Contraception
WFS	World Fertility Survey
WHO	World Health Organization

VOLUME II

ANNEXES

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## I. INTRODUCTION

Egypt's population size will have passed the 45 million mark in September, 1982, and is growing by about 100,000 per month, 1.2 million each year. Today, Egyptian experts estimate that the growth rate hovers stubbornly around 2.8 or 3.0 percent per annum, a rate, which, if not lowered, would cause a doubling of population size in only 25 years, or one generation.

Not more than four percent of Egypt's land can reasonably sustain cultivation, a fact that continues to reinforce the ancient adage that "Egypt is the Nile and the Nile is Egypt." With half the population agrarian-based, Egypt already has one of the highest population densities for cultivatable land in the world. To lend a note of urgency to the situation, Egypt is the only country in the world where the rate of population growth has increased by over 40 percent in the past 10 years.

The Agency for International Development has provided assistance to the Government of Egypt in the population sector since September, 1977. Total obligations from USAID for the population and family planning program have reached \$67.5 million with \$23 million of this amount spent as of March, 1982. Although these funds represent substantial amounts, it has only been during the past two years that USAID-provided resources have actually become engaged through the Ministry of Health's and the Population and Family Planning Board's programs for delivering services, conducting training, providing commodities, undertaking information and educational campaigns, and supporting measurement efforts to determine program progress.

Because 1982 is the final year of the original project, the USAID mission in Cairo requested an outside team to visit Egypt to determine "lessons learned" over this five-year period and to identify and recommend to USAID a blueprint of activities that might be supported over the next five years. The team assembled in Cairo on March 1 and remained through April 11, 1982.

Staff members of the Population and Family Planning Board (PFPB), the Ministry of Health (MOH) and their colleagues in the nine governorates, 49 villages and 56 clinics which we visited were always gracious, gave generously of their time and offered their full cooperation in explaining their activities and programs to us. Others in the public and private sectors were equally helpful and we greatly appreciate their many kindnesses and assistance.

## II. DEMOGRAPHIC AND ECONOMIC DIMENSIONS

### A. Demographic Overview

Egypt's population quadrupled between 1900 and 1980. In the early decades of the century, population growth fluctuated between one and two percent per year. The growth rate steadily increased under a secular mortality decline beginning in the 1940s, reaching about three percent per year in the mid-1960s. A gradual fertility decline then began, dropping the rate of increase to 2.1 percent by 1972. In the most recent decade this fertility decline has halted, and, in terms of the crude birth rate, reversed. The growth rate of Egypt's population is again close to its historic peak.

In 1982 the population will grow by about 1.2 million persons, of which some 800,000 will be added in urban areas (including more than 300,000 to Greater Cairo), and 400,000 to rural areas. Continued rural-urban migration gives a marked differential between urban and rural growth rates (3.4 percent per year urban as against 1.5 percent rural), although most of city growth is now a consequence of the natural increase of city-dwellers themselves.

Overall Fertility and Mortality. Annual estimates of crude birth and death rates are available from registration data, which in Egypt, unlike most developing countries, are comparatively complete. A study by the Central Agency for Public Mobilization and Statistics (CAPMAS) in cooperation with the U.S. National Academy of Sciences (NAS) Panel on Egypt estimates completeness at above 95 percent for registered births, 88 percent for deaths. The official birth and death rate estimates for 1981 are 38 per thousand and 10 per 1,000 but these figures are not adjusted for underregistration. The actual rates could well be one or two points higher. CAPMAS, in June, 1982, advised the team that "provisional" figures for births in 1981 were approximately 90,000 fewer than in 1980. This obviously is an encouraging sign. If subsequent analysis by CAPMAS confirms these provisional data, it may signal a possible downward trend in Egyptian fertility.

While crude vital rates are obviously relevant for aggregate planning purposes, the measures that better reflect people's actual reproductive behavior are the total fertility rate (roughly, the number of children born to the average woman through her childbearing years under the prevailing pattern of fertility) and the infant mortality rate and expectation of life at birth. Egyptian data here are less adequate and timely. Total fertility was estimated to be 5.5 children per woman in 1975-76, down from 6.7 in 1959-60 (census-based estimates calculated by the CAMPAS/NAS Panel), a decline of 18 percent. There are more recent national estimates of total fertility (the as yet unanalyzed retrospective data from the 1980 Egyptian Fertility Survey should yield estimates

for the late 1970s). It is possible that total fertility has continued to decline in the post 1976-period, with the observed rise in the crude birth rate a result of shifts in the population age distribution (or vagaries in registration coverage). Any such decline is likely to have been small, however, and the total fertility rate as of 1982 fairly confidently can be taken to be above 5.0.

On the mortality side, the CAPMAS/NAS Panel estimates for 1976 put the infant mortality rate at 116 per 1,000 births and life expectancy at 55 years. (Under-registration of infant deaths is substantial, particularly in Upper Egypt, where mortality is well above the national average, and hence these estimates incorporate significant census-based adjustments.) Mortality improvement over 1960-77 has been about a 30 percent drop in infant mortality and a rise of about six years in life expectancy. Adult mortality, however, remained nearly constant over this period -- for example, there was no discernible change in expectation of life at age 10.

Regional Fertility Differentials. An important characteristic of Egyptian fertility is the strong pattern of regional variation. The 1976 total fertility estimates are as follows:

	<u>Urban</u>	<u>Rural</u>
Cairo and Alexandria	3.9 (20%)	----
Lower Egypt	5.0 (13%)	6.0 (32%)
Upper Egypt	5.6 (10%)	6.8 (25%)

(Numbers in parentheses are the percentages of the total population in each category.)

The average woman in Cairo and Alexandria has three fewer children over her reproductive life than does the average woman in rural Upper Egypt, two fewer than women in rural Lower Egypt, and one fewer than women in other urban areas of the country.

Proximate Determinants of Fertility. A valuable first step in understanding the forces governing fertility in a population is to identify the immediate biological and behavioral factors that hold fertility below its biological upper limit. The principal factors are postpartum amenorrhea (a delay in menstruation) associated with breastfeeding, the practice of contraception, and reproductive life spent in a non-married state. (In many populations induced abortion is a significant fourth factor.) In Egypt, the fertility decline in the 1960-76 intercensal period was attributable both to a rise in average age at marriage and the greater use of contraception that lowered fertility within marriage. The urban-rural differential in fertility seems to be almost wholly related to higher contraceptive use in the cities -- there is only a small urban-rural difference in marriage ages, and the appreciably shorter duration of breastfeeding in the urban population, other things being equal, would make urban fertility higher than rural.

Data on rates of contraceptive prevalence in Egypt are somewhat confusing. (CAPMAS is embarking on an USAID-funded study aimed at reconciling certain apparent inconsistencies in prevalence estimates.) The Egyptian Fertility Survey (Feb.-Mar.1980) estimated current prevalence to be 24 percent of married women at reproductive ages, ranging from virtually zero use in rural Upper Egypt to above 40 percent in urban governorates and the other urban areas of Lower Egypt:

	<u>Urban</u>	<u>Rural</u>	<u>Total</u>
Urban governorates	43	---	43
Lower Egypt	41	18	24
Upper Egypt	33	4	13
All Egypt	40	12	24

The PFPB-Westinghouse survey, conducted nearly a year later (Nov. 1980 - Jan. 1981), but in rural areas only, gave a significantly higher average rural use-rate: 17 percent (as compared to 12 percent). It is most likely that the difference is spurious, and results from questionnaire and procedural differences between the two surveys. More than half the discrepancy is in use-rates of methods other than pills and IUDs.

The method mix of Egyptian contraception shows a strong predominance of pills over IUDs and other methods. The Egyptian Fertility Survey data (1980) on use-rate by method are as follows:

	<u>Urban</u>	<u>Rural</u>	<u>All Egypt</u>	<u>Percentage Method Mix</u>
Pill	27.0	9.0	16.0	68%
IUD	7.0	2.0	4.0	17%
Others	7.0	1.0	4.0	15%
All Method	41.0	12.0	24.0	100%

Future Population Growth. Egypt's National Strategy Framework for Population, Human Resource Development and the Family Planning Program issued by the Supreme Council for Population and Family Planning in 1980 (see Annex III F) sets as its fertility goal a reduction of about 20 points in the crude birth rate by the year 2000 (i.e., from the current rate of approximately 40/1000 to 20/1000). The goal would correspond to achieving by that year a total fertility rate of close to three children per woman. If this target were approached gradually over the next two decades the population then would have reached about 60 million. The contraceptive prevalence rate consistent with this fertility goal for 2000 would be around 60-65 percent users among married women of reproductive age.

As the years pass without significant progress in fertility reduction, that target becomes less realistic. Virtually all recent projections of Egypt's population (CAPMAS, U.N., World Bank), for example, adopt what now can be seen as too low assumptions about

fertility rates in the early 1980s and therefore probably understate the future pace of population growth. The most plausible projection of those available to the team was the high variant of the UN's 1980 Population Assessment, giving the following numbers (rates refer to the five years preceding the date):

	<u>1980</u>	<u>1990</u>	<u>2000</u>	<u>2010</u>	<u>2020</u>
Population (millions)	42.1	53.7	67.2	82.7	98.9
Growth rate (percentage)	2.6	2.4	2.2	2.0	1.7
Birth rate (per 1000)	39.0	34.0	31.0	27.0	24.0
Death rate (per 1000)	13.0	10.0	9.0	7.0	7.0
Total fertility rate	5.2	4.4	4.0	3.4	3.0

Major future accomplishments in family planning program performance and in other areas of population policy could, of course, change this picture for the better.

The difference between this UN projection of total fertility reaching 4.0 by 2000 and the Supreme Council's implicit target of 3.0 is a difference between limited and substantial success in population policy. Total population in 2000 in the latter case would be only about 10 percent less than under the former, but the growth in population from 1980 to 2000 would be about 18 million, rather than 25 million. Also, a much larger proportionate reduction would be felt in the population at young ages, soon translating into a greatly eased burden of labor absorption. Even a total fertility rate of 3.0 is, of course, well above the so-called replacement level of fertility (the level which, when age-distribution effects work themselves out, will finally halt population growth) and will still result in a natural increase exceeding one percent per year.

#### B. Implications of Continued High Fertility

It would be redundant in this report to analyze the implications of continued rapid population growth for Egypt. The gravity of the demographic situation is fully recognized by USAID and is a major theme of the Country Development Strategy Statement. The annexes to that statement and other USAID and World Bank supported analyses offer graphic sectoral studies of the consequences of conservatively-projected population growth for education, housing, urban infrastructure and amenities, food needs, and employment. Domestic political repercussions from policy failures in these areas, traceable to rapid population growth, would be extremely serious. The costs in human welfare terms are potentially enormous.

As the population projections discussed earlier show, the tangible benefits from fertility decline are slow in coming. In the first decade, the primary education sector would begin to benefit from a smaller pool of new students and there would be some easing

of the burden on health and other services. But for the economy as a whole, future entrants to the labor force over virtually the rest of this century are already born. The numbers of new families that will be seeking housing in this period are similarly already determined.

This built-in lag of impact is one reason for the near-absence of a political constituency for a strong population policy: other problems always appear more urgent. Nothing that population policy can do now can lessen the massive task of training and finding productive employment for the 20 million young people 15 years of age or less who today constitute 45 percent of Egypt's population. Policy achievements of the next few years will be felt around the turn of the century, and few governments spare much attention for problems that will occur 15-20 or more years in the future. Planners, who typically apply a discount rate above five percent in computing the present value of project benefits, can easily reduce the apparent payoff of population programs to near insignificance in comparison to many alternative allocations of effort and resources.

Yet such conventional reasoning is highly inadequate to address the issue of rapid population growth. One of the principal gains from progress in slowing fertility would be generation of a climate of optimism about Egypt's long-term future -- both nationally and internationally. This probably would have tangible effects in terms of encouraging long-term investment, both domestic and foreign, in the Egyptian economy as well as intangible benefits for the development effort in general. With the demographic treadmill slowed, there would be more justifiable confidence that the other major problems of national development also can be overcome.

Another kind of gain should be implicit in achievement of low fertility: the administrative and organizational competence evidenced by the capacity to bring individual fertility behavior into line with national demographic interests should be a strong positive factor in promoting economic growth and the wide distribution of its benefits. Such complementarity with other aspects of the development effort is a prerequisite of a humane and effective population policy.

It has been possible, until recently, to argue that the Government of Egypt has been less concerned about Egypt's population problem, or less impressed by its seriousness, than have the various donor agencies. The inclination to assume that aggregate population growth can be accommodated by expanded irrigation and land reclamation, peopling the Sinai, or labor export, is still strong in some circles (see Al-Ahram articles, Annex III F), however insupportable these views are in economics and arithmetic. The present report, however, has been prepared at a time when there are strong indications that Egypt's top leadership is committed to more energetic action in this sphere.

### C. Reasons for High Fertility in Egypt

The fertility patterns in any society are the outcome of factors deeply embedded in its social structure, culture and economy. The brief analysis of fertility determinants given here attempts to separate out the most important of these factors in the case of Egypt, inevitably in a simplified manner, so as to contribute to an assessment of policy alternatives.

At the family level, the main factors underlying the maintenance of high fertility in Egypt appear to be the following:

- (1) High fertility yields significant economic advantages to many families, especially through male children. There are few counter-prevailing social pressures toward low fertility.
- (2) Women's particular fertility interests reflect the need for sons to improve their subordinate position in the family, especially in the early years of marriage.
- (3) There is a high level of ignorance and misinformation about effective and safe methods of contraception, and an inefficient distribution system for contraceptive supplies and services.
- (4) In addition to these specific factors, the cultural values of the society, developed under and reflecting earlier conditions of much higher mortality, provide a broad array of direct and indirect supports for continued high fertility. Such values, for example, sustain early female marriage and in some measure restrict the degree to which fertility is perceived to be an object of deliberate choice.

These reasons are not fully independent of one another. Moreover, there is no conclusive empirical basis for assigning weights on their comparative significance in explaining Egyptian fertility. Qualitative judgments can be made, however. From a policy standpoint, the comparative amenability to change of these various factors is an equally important consideration. We consider each factor briefly in turn.

Economic Supports for High Fertility. There is little hard quantitative evidence in Egypt on the economic costs and benefits of children to parents -- a conspicuous weakness in Egyptian fertility research. All indications are, however, that in rural areas children fairly easily earn their keep from an early age. Labor opportunities in agriculture and in the

informal sector are plentiful and moderately well paid by adult standards (and are not necessarily incompatible with school attendance); basic food costs are very low; marginal housing costs are probably unrecognized; opportunity costs for the mother are slight. The same may also be true for the urban poor with the important exception, for many, of housing costs. In both rural and urban areas the cost of education, nominally free but inevitably entailing many incidental expenses, would be appreciable for families with strong ambitions for their children. The urban middle class, in particular, is likely to feel these costs because for it the balance of obligations between parent and child has shifted decisively in the child's favor.

In traditional patriarchal and extended families, the cost of children to parents may be immaterial in that child care costs are widely shared. However, in residential terms at least, nuclear families are increasingly the norm, thus weakening this lineage role. (Its importance remains in sustaining significant status differences between the sexes.)

Even if individual families benefit from high fertility, local communities may suffer as increasing densities put stress on land availability, government services and public amenities. In many countries, both historically and in the contemporary world, an outcome of such situations has been the emergence of community-level social pressures on individuals or families to regulate marriage or fertility. Two reasons seem to preclude such a result under present conditions in Egypt. First the high degree of centralization in the system of public finance leaves local administration with little fiscal or budgetary responsibility, hence the downward pressure on fertility behavior that might result from the community having to bear the costs of rapid population growth are lost. Secondly, the face-to-face neighborhood groupings that would be most likely to exert social pressures affecting behavior to the perceived interest of the community appear to have little or no role in Egyptian society. Research on the nature of Egyptian social organization between the family and the lowest administrative units--village council areas and kisms -- is very limited; hence possibilities of mobilizing "natural" community groupings to achieve population and development objectives cannot be assessed.

In many Egyptian communities, particularly in rural areas, it is likely that the conflict of interest just described does not apply. With opportunities for labor migration, the national and even the wider regional economy provides for any individual community a nearly limitless source of labor income, enriching the community sending workers as well as individual families. The costs of such transfers, in depressed wages and urban crowding for example, are

dispersed and those immediately experiencing them cannot do anything about it, individually or collectively. The massive government price subsidies for food and fuel are another reason why individual communities may not benefit necessarily from controlling demographic costs--here, though, the chief beneficiaries are city dwellers. The subsidy policy in effect means that the vast resources absorbed by this program are spent on accommodating a growing population with minimal leverage applied to limiting that growth.

The overall picture of the economics of fertility in Egypt, then, is one in which for the most part, neither individuals nor communities could improve their lot in the short run by lowering fertility. The intricate mass of transfers that characterize any open, developing economy and the specific price distortions that have grown up in Egypt prevent the social costs of high fertility from being directly felt by most families. Indirectly, of course, the costs indeed are being borne by the society now, and will continue to be borne in the future.

The Position of Women. In societies in which a married woman is subordinate to both her husband and her husband's family -- especially her mother-in-law -- having children, particularly sons, may be almost the only route by which she can improve her status. This reality, making for early and high fertility, generally outweighs interest in spacing births and limiting family size on the grounds of health or increased personal opportunities. A typical pattern of change over time in this family structure is for gradual strengthening of the conjugal bonds and weakening of lineage bonds induced by forces such as education, secularization, and acceptance of media-supplied images of modernity. Accompanying such a change is a greater degree of status equality between the sexes, a narrowed age gap at marriage and, it is argued, a change in the relationship between children and parents -- i.e., increasing parents' obligations to their children while eroding the children's obligations to the family. This new family structure supports low fertility.

Egypt, conventionally categorized into Upper and Lower, urban and rural, straddles an appreciable range of this stylized continuum. In comparison to many other countries in the region it shows a somewhat later female age at marriage, generally higher status of women (at least among the elite) and a larger proportion of nuclear family households. But there is little doubt that the persistence of traditional family patterns is an important independent factor shoring up high rural fertility.

Contraceptive Knowledge and Access. By one measure, preferences revealed through behavior, demand for contraception in Egypt is very limited. Only 24 percent of married women of reproductive age use any form of contraception (12 percent in rural areas), despite existence of a nationwide distribution system. As found in many other countries, however, low prevalence of contraception use in Egypt coexists with high levels of approval of contraception and

with stated family size ideals and desires that are well below predictable achieved sizes. For example, the 1980 PFPB-Westinghouse survey of reproductive-age women in rural Egypt gave the following results:

	<u>Upper Egypt</u>	<u>Lower Egypt</u>	<u>All Egypt</u>
Want no more children (%)	43.0	65.0	55.0
Ideal family size	4.1	3.2	3.6
Desired family size	3.5	2.8	3.1
Approve using contraception (%)	70.0	89.0	80.0

While such data are difficult to interpret and cannot be simply translated into demand for contraception, there clearly is a large scope for raising the current level of prevalence of contraceptive use.

Evidence of the wide extent of misinformation in the population about contraceptive effectiveness and side-effects is given by the 1980 State Information Service (SIS) Baseline Survey. Other non-monetary costs of fertility regulation that presumably also are impeding contraceptive use -- poor clinic service, spot shortages of supplies, variable quality of supplies and so on -- are described below.

That use-rates of 30-40 percent can be obtained in rural settings (three times current levels) by intensive efforts to energize the family planning delivery system and to overcome ignorance and misinformation about methods is suggested by isolated experience both in Egypt and elsewhere. (The Family Planning-Health Services Project designed in Matlab Thana in Bangladesh is the best-documented example. Use-rates above 30 percent also were attained in one village council area in the Menoufia project.) The obstacles to reaching such rates throughout rural Egypt -- and with them a birth rate below 30 per 1,000 -- probably cannot all be removed by more effective family planning programs and information, education and communication (IEC) efforts. The important observation here, however, is that there does not seem to be a demand ceiling constraining program achievements at the present time.

Cultural Supports for High Fertility While high fertility can in large measure be explained in terms of economic interests, family patterns and the costs of effective contraception, these tangible factors are modulated by the society's cultural values. The salience of fertility as an object of decision-making, attitudes toward various methods of birth control, concepts of female status and roles, the strength of obligations felt toward various family members, all in part culturally-rooted, may be important independent forces determining fertility levels and patterns. A degree of confusion in the minds of many Egyptians about the teachings of Islam

on family planning also may be relevant factor. How cultural change works in altering fertility is poorly understood and influencing it, to the extent this is within reach of government policy, would be likely to call for concentrated effort over an extended period. As a constraint on policy options and as a reality governing policy effectiveness, however, these dimensions are undoubtedly significant in Egypt as elsewhere.

#### D. Outlook for Fertility Decline in Egypt

By many accounts rural Egypt is currently experiencing fairly pervasive socioeconomic change, and it would be surprising if fertility patterns were not influenced by this. (Information on year-to-year fertility trends in Egypt is restricted to total numbers of births and crude birth rates. Trends since the 1976 census in total fertility or in patterns of age-specific fertility are not known at this time.) Specific sources or reflections of change include the inflow of consumer durables, by no means only to the cities, that has accompanied the "open door" policy; the greatly expanded opportunities for migration of skilled and unskilled workers, both within Egypt and abroad; the impact of remittances by migrant workers, bringing new capital into many villages and new routes of social mobility; a trend toward blurring urban-rural distinctions with the growth of a large nonagricultural rural labor force and improvements in transport between village and town; and the reach of film and radio into the countryside and of television into many households even in remote hamlets.

What has been the demographic response? The short and long answer is that we do not know. The careful, detailed village studies that could detect early signs of change in fertility attitudes and in the proximate determinants of fertility are too few to give any broad-based indications. Observed fertility differentials, such as those by education of mother, are not striking for most of the population, although they are consistent enough to point the way for one strong direction of population policy, namely increasing school attendance, particularly for girls.

In urban areas, the same lack of information holds. Here an important future source of change may be shifts in the design and scope of the major food and fuel subsidies necessitated by the burgeoning costs of supporting these programs. Increases in the cost of living resulting from reduced subsidies could, in theory, be offset by increased incomes and the consequent greater discretionary income could lead to a substitution effect, lessening the demand for children. How any change would work out in practice, and its precise distributional impact and effect on fertility incentives, would again call for research that does not now exist.

A conservative but defensible conclusion would be that the social and economic changes taking place in Egypt, in part influenced by population growth, are likely to generate downward pressure on fertility, especially but not only in urban areas. It is conceivable that a fertility decline could "take off" in the near future -- for example, in the manner that apparently occurred in Thailand. However, no one can be confident of such an outcome in Egypt. The economic and structural supports for high fertility that were noted earlier will take time to erode and the pace of any resulting fertility decline may be quite slow. This is clearly the more appropriate assumption on which to base new policy action.

Assessing the demographic effect of a serious effort to upgrade contraceptive delivery systems in Egypt and their associated communication and outreach activities is a somewhat more straightforward task. We have seen that the demand for contraceptives at current, highly subsidized prices and at existing levels of quality of service is fairly weak. Experience elsewhere, and in the isolated local success stories that can be found in Egypt, suggest that demand can be greatly strengthened by correcting widespread misinformation about methods, by widening the choice of methods, by improving the quality of clinic services and providing outreach programs, and by encouragement of commercial distribution channels. Our conviction that contraceptive prevalence rates in Egypt can be markedly increased by such measures is the basis for the broad emphasis of this report on family planning.

The third set of factors that will govern the outlook for fertility decline in Egypt are policies (not necessarily with a primarily demographic objective) that alter the cost of children to parents or that promote trade offs of "quality" for quantity. Achievements in raising enrollment rates in primary education, especially for girls, we shall argue are particularly important here. Another area warranting careful investigation is the possibility for generating local community consensus and action around demographic issues, drawing on social rather than economic pressures. For example, the concept of community incentives related to family planning program achievement merits testing.

### III. POPULATION POLICY AND STRATEGY

#### A. History and Present Status

The political commitment of Egypt's top leadership to pursuing a policy of slowing rapid population growth historically has been weak and has evolved more slowly than in most major developing countries.

In 1953, the new government established a National Committee for Population Problems to undertake studies in demography and population with the objective of making recommendations on population policy. By 1955, the Committee had established and supervised eight family planning clinics in Cairo and Alexandria using the facilities of voluntary social service organizations. No publicity was allowed and women heard about these clinics only by word of mouth. In 1957, the Committee acquired non-governmental status and was called the Egyptian Association for Population Studies, although financing continued through the Ministry of Social Affairs. This later became the Egyptian Family Planning Association and was followed by the founding of the Alexandria Family Planning Society in 1962.

More than two decades ago, President Nasser expressed his negative views about family planning in a 1959 interview with the Christian Science Monitor:

I am not a believer in calling on people to exercise birth control by decree or persuasion. Instead of teaching people how to exercise birth control, we would do better to teach them how to increase their land production and raise their standard. In my opinion, instead of concentrating on birth control, we would do better to concentrate on how to make use of our resources. We live in and make use of only 4% of the area of our country. The rest is neglected and desert. If we direct our efforts to expanding the area in which we live instead of concentrating on how to reduce the population, we will soon find the solution.

The above quotation is included because similar views continue to be expressed in Egypt today. The same reluctance to acknowledge "the population problem" is again being demonstrated by a remarkable number of economists, planners and political leaders, as can be seen in the series of articles that appeared in the newspaper Al-Ahram in March 1982. (Translations of these articles are included in Annex III F.)

Only a few years later, however, the National Charter promulgated in 1962 signalled a new recognition of the issue and may be regarded as the beginning of a national population policy.

The (population) increase constitutes the most dangerous obstacle that faces the Egyptian people in their drive towards raising the standard of production in their country in an effective and efficient way. Attempts at family planning deserve the most sincere efforts by modern scientific methods. (The National Charter, 1962.)

In November, 1965 the Supreme Council for Family Planning was established by a presidential decree. It was headed by the prime minister and composed of eight ministers and the head of the Central Agency for Public Mobilization and Statistics. In 1966, an Executive Board of Family Planning was established and entrusted with launching a national family planning program through Ministry of Health facilities. Meanwhile, the Egyptian Family Planning Association undertook the coordination of private, voluntary efforts with support from the Ministry of Social Affairs and the International Planned Parenthood Federation.

In 1973, the national population policy changed direction when the Supreme Council adopted "The Socio-economic Approach to Fertility Reduction." This approach stressed the role of socio-economic variables in affecting fertility and sought to manipulate nine factors simultaneously. These were: (1) raising the standard of living of the family; (2) education; (3) employment of women; (4) mechanization of agriculture; (5) industrialization of the countryside; (6) reduction of infant mortality; (7) social security; (8) information and publicity; and (9) specific services including family planning.

Although spokesmen for Egypt's population program denied that family planning ranked ninth on the list of priorities, the way the policy was presented at that time certainly gave that appearance. We suspect that it was perceived that way by others in the country as well, including those such as governors and governorate health directors who were charged with its implementation.

Throughout his term in office, President Sadat also chose not to give prominence to population issues or to the need to slow Egypt's high rate of population growth. It appears that although he may have been aware of trends and projections in future population size,

he believed that the proper government response was more development in terms of land reclamation, new towns and industrial growth. Certainly, official economic plans through at least 1980 reflected this approach while being silent on the need for and feasibility of reducing population growth as a way of enhancing economic development.

In 1975, population policy was further modified and called the "Development Approach to the Population Problem." This approach attempts to define the problem in its entirety, viz., rapid growth, maldistribution, low literacy, etc. This policy gives the community the responsibility for implementing population and family planning policy, an action which we believe was a sound move despite inherent difficulties in implementation.

Despite a recognition by the Population and Family Planning Board in 1979-80 that more specific actions and priority needed to be given to greatly improving the provision of family planning services -- although still within the framework of enhanced local community participation and development -- no special support was forthcoming from the nation's top leadership. For example, although the government funds population and family planning indirectly through several ministries and agencies, the budget of the PFPB is only approximately LE 3 million\* per year (a wholly insufficient amount given the task) and there is no line item budget for family planning in the Ministry of Health. Other evidence of the lack of top-level concern during these years included the absence of any directive to cabinet ministries to give population issues special attention and the specific failure within the Ministry of Health, up to the present time, to assign priority attention to providing family planning services.

Finally, the "National Strategy Framework for Population, Human Resource Development and the Family Planning Program" was promulgated by the Board in December 1980. This document, which appears in Annex III F, is also comprehensive in scope, but gives more specific attention to the need for improving family planning services which now receive emphasis by being the first of three programmatic areas discussed in the section on program strategy.

It is against this background of nearly 30 years of official disinterest by Egypt's political leadership about population issues that President Mubarak's statements of February 13 and May 3, 1982 should be taken into account. Addressing a meeting of cabinet ministers and economic planners, the President stated "we cannot

\*About \$3.6 million @ LE.83 = U.S. \$1.00, March 1982.

ignore the fact that the current rate of population increase will hinder our efforts to achieve development, will dissipate our hopes for improving the quality of life for every Egyptian and limit our ambitions of preventing a deterioration and aggravation of our situation. We will not accept this. . . . It is sufficient to point out that if population growth continues at the current rate, our population will total 70 million by the year 2000 and this number will double again 25 years later. We must consider these facts with all seriousness because they will directly affect our ability to provide food, clothing, housing, jobs, health, education and culture to each Egyptian citizen."

On May 3, the President again repeated his concerns about the negative impact which Egypt's high population growth is having on economic development. At that time, he was quoted as saying that "Egypt needs to develop a practical approach to solving this aggravating problem instead of focusing on theoretical solutions that are difficult to implement."

For the first time, an Egyptian president has spoken out, publicly and forcefully, on the need to slow the country's rapid population growth. Obviously, this has provided a strong, politically legitimizing influence and a sense of urgency to deal with the problem. If this important expression of political will and commitment is sustained, the stage finally will be set for implementing a vigorous, national fertility control effort.

#### B. Population Goals and Targets

The Egyptian population/family planning program, quite properly, has set demographic targets since 1973. Setting such goals and targets in terms of crude birth rates, population growth rates, contraceptive prevalence and population size is an essential and logical element in planning any national fertility control program.

Today, two observations about how this was done and the consequences stand out in sharp relief. First, the targets set in 1973 were highly ambitious and, in hindsight, unrealistic. Second, desirable as the goals may have been there was a totally inadequate attempt to mobilize the necessary resources in terms of budget, political commitment, management and training to achieve them. A brief review of these earlier targets set by the Supreme Council for Population and Family Planning in 1973 illustrates these points:

- (1) Reduce the crude birth rate from 34/1,000 in 1972 to 24/1,000 in 1982. (We estimate the birth rate as being close to 40/1,000 in 1981.)

- (2) Reduce the annual population growth rate from 2.1 percent in 1973 to 1.1 percent in 1982. (In 1981 the growth rate was estimated at 2.9 or 3.0 percent, representing a very substantial increase of over 40 percent since 1973!)
- (3) Population size not to exceed 41 million in 1982. (Egypt's population size, as reported by CAPMAS, passed the 44 million mark in November, 1981.)
- (4) Prevent the crude death rate from exceeding 13/1,000. (This has been achieved. The crude death rate is estimated at 10 or 11/1,000 in 1981.)
- (5) Increase the number of users of family planning services from 540,000 in 1972 to 2.5 million in 1982 -- an increase in contraceptive prevalence from 16 to 35 percent. (Based on the 1980 Egyptian Fertility Survey, prevalence was 24 percent, implying 1.7 million contraceptive users, or shortfall of 800,000 users.)

As readily can be seen, none of the targets set in 1973 was achieved with the exception of the reduction in the crude death rate. Indeed, Egypt today is further away from achieving its population goals than it was nearly a decade ago when these objectives were set by the Supreme Council. Had these ambitious goals been achieved on schedule, Egypt's expected population projection for the year 2000 would have been approximately 50 million rather than the 65-70 million now anticipated.

#### Present Target and Goals

The National Strategy Framework issued by the Supreme Council in December, 1980 calls for an "optimum population growth rate" to be achieved primarily through lowering birth rates. Specifically, the crude birth rate is to be reduced "by 20 points," i.e., from 40/1,000 to 20/1,000 by the year 2000. This is to be done by increasing the prevalence of contraceptive use among married couples of reproductive age.

The contraceptive prevalence targets set by the Population and Development Project (PDP) for the family planning clinics in its twelve governorates range from 7 to 11 percent. Although this does not take into account those people who obtain contraceptives from pharmacies, these targets are much too low if Egypt is to attain its goal of one-tenth of a percentage point per year reduction in its growth rate. Not only must the prevalence rate be much higher than now targeted but it will have to increase by almost 2.5 percent each year if the hoped for one-tenth of a point per year reduction in the growth rate is to be achieved.

### C. Observations and Conclusions

As pointed out in Chapter II, a reduction of about 20 points in the crude birth rate by the year 2000 would correspond to achieving, in less than two decades, a new norm for completed family size or a total fertility rate close to three children per married couple. Also, it would require an increase in contraceptive use among reproductive age couples from today's 24 percent to 60 percent or more. According to the 1976 Census, total fertility was estimated at 5.5 children and, presumably, is still near that number in 1982.

For fundamental reasons related to the future course of Egypt's development, we agree that this is a proper, although ambitious, goal. At the same time, recent program performance provides little confidence that prospects of achieving this new target are much better than were the prospects of achieving similar goals set in 1973. The record of other developing countries that have decided, with determination, to achieve comparable reductions in birth and growth rates, does indicate that there is reason to believe that these new objectives can be achieved (see Figure 1). To do so, however, will require a major and sustained political commitment and a vastly reinvigorated and restructured family planning service delivery system, two key elements that are discussed in detail in Chapter VI of this report.

#### IV. THE EGYPTIAN FAMILY PLANNING PROGRAM

The family planning program in Egypt is carried out by a combination of public and private agencies and through the country's approximately 5,000 commercial pharmacies. Today, most of these providers of family planning services are recipients of AID support in terms of commodities, training and funding of some portion of local costs. In this section, we present a brief overview of the major public and private delivery and support programs operating today. (More detailed reports on these programs can be found in Annex II.)

##### A. Ministry of Health (MOH)

Over 80% of all centers providing family planning services are managed by the Ministry of Health within a health care pyramid of four levels. At the base are the rural health units and rural health centers which provide basic curative and preventive services. At the next level is the district general hospital where more specialized care of outpatients and inpatients is provided. The general hospitals at the governorate level provide care through all medical specialties. At the top of the pyramid are the university hospitals and teaching institutions in Cairo, Alexandria and in other governorate capitals.

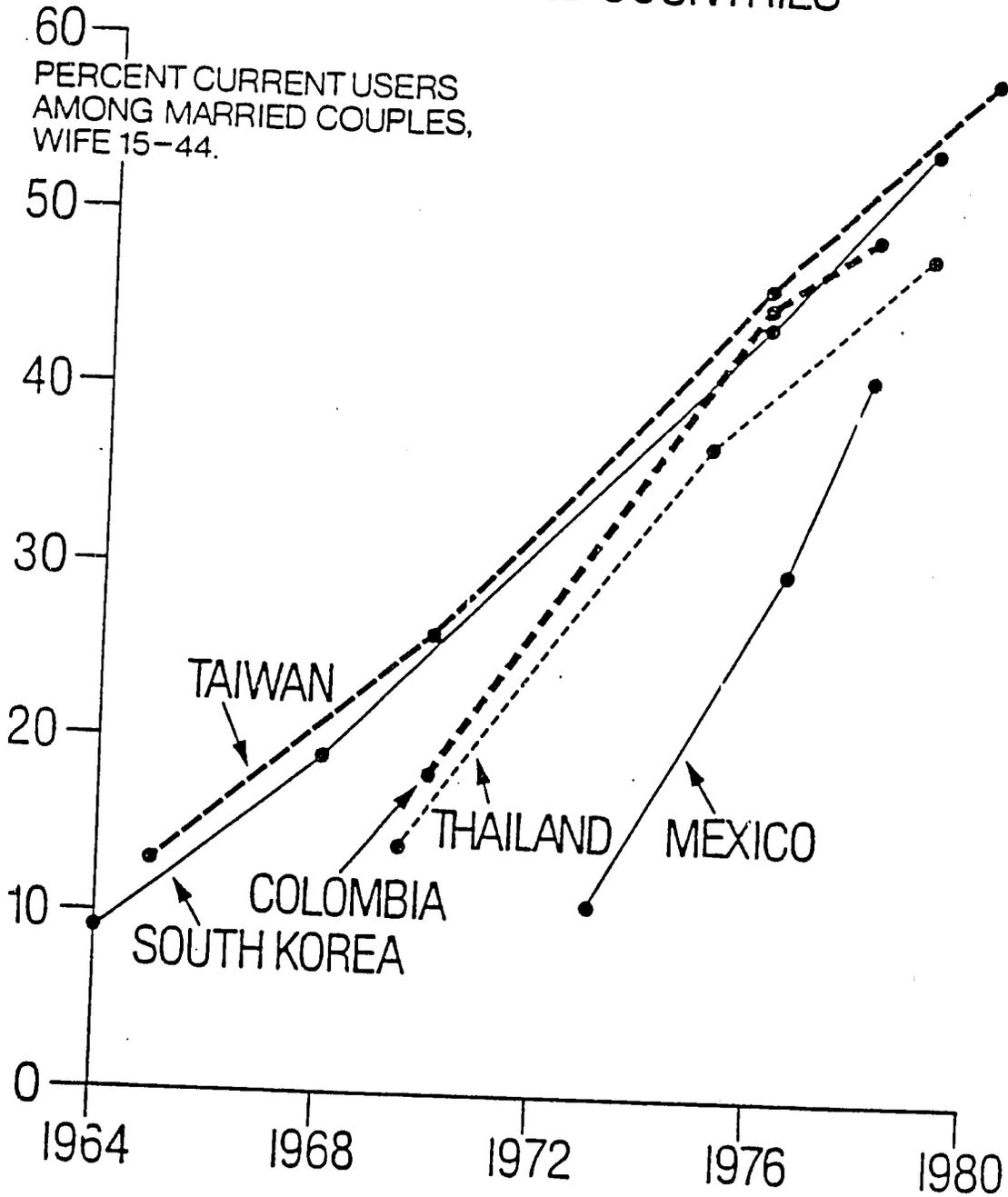
The distribution of health facilities in rural areas has continued to improve. The health network is designed so that there is a facility within 3 km. of every village with a population over 3,000. There is an average of one facility for every 9,200 rural people. Following is the number of each type of Ministry of Health facility as reported by the 1982 USAID Health Sector Assessment.

Rural Health Units	1,898
Rural Health Centers	549
Rural Health Hospitals	41
MOH Centers	238
Polyclinics, District Clinics	148
Urban Health Centers	61
General and District Hospitals	173
Obstetric and Pediatric Hospitals	3
MOH Total	<u>3,111*</u>

\* This figure will be used throughout this report (frequently rounded off at 3,100) as the number of MOH facilities providing family planning services. Other sources report figures from 3,200-3,300 and the actual number may fall somewhere within this range. The USAID Health Assessment report, however, is the most recent estimation.

Figure 1

# GROWTH IN CONTRACEPTIVE PREVALENCE, 1964-1980, FOR SELECTED COUNTRIES



The MOH family planning services delivery system is clinically-based and physician-dominated. Therefore, the physician's attitudes, knowledge, and skills are major factors in recruiting and maintaining satisfied contraceptors. Under MOH policy, oral contraceptives require a doctor's prescription and only physicians are authorized to do IUD insertions. (Oral contraceptives can be purchased at pharmacies without a prescription, however.) Theoretically then, almost all contraceptors using government facilities should come into contact with a physician. Yet, until this time, family planning has not been a part of the curriculum of the nation's medical schools or of nurse training institutes. A number of laudable steps now are being taken by the MOH to remedy this situation. These include (1) a training program for house officers (interns); (2) a pre-service training program for graduating physicians about to be assigned to one-year positions in Ministry of Health clinics; (3) an in-service training program for physicians currently working in MOH/family planning units; and (4) a clinic refresher program, now being developed, that will involve sending out trained teams in mobile units to visit MOH facilities.

The MOH receives a significant amount of international donor assistance in support of its family planning program, principally from USAID and the World Bank. The Ministry, however, does not have a line item budget for family planning which we view as a serious shortcoming.

The World Bank Second Population Project within the MOH is part of a joint effort by the Bank, the British Overseas Development Administration and the Government of Egypt to develop a primary health care, MOH and family planning outreach program in seven governorates. Sixty-five percent of Bank funds are earmarked for construction of training and health centers. An extensive training program for nurses, dayas (traditional birth attendants) and other outreach workers is an important part of this project. Contraceptives will be resupplied to users during home visits.

The West German Government is providing support to upgrade facilities and to increase acceptance rates for health and family planning services in Sharkia Governorate.

USAID support to the MOH includes assistance to the rural and urban health projects and the integrated social service delivery programs (Menoufia and Beni-Suef). AID also provides contraceptive supplies and funding for MOH family planning administration, training and the renovation of Al-Galaa hospital. In addition, funding for a number of other AID-supported population/family planning activities is channeled through the MOH.

B. Ministry of Social Affairs (MOSA)/Egyptian Family Planning Association (EFPA)

The MOH is not the only ministry involved in delivery of family planning services. The Ministry of Social Affairs also plays an active role through its support for the 499 clinics of the Egyptian Family Planning Association. (Official service statistics reports regard EFPA clinics as belonging to the MOSA. For purposes of consistency, this report also regards them as MOSA clinics while recognizing the essential private and voluntary agency character of the EFPA.)

The EFPA was founded in 1957 under the name Egyptian Association for Population Studies. In 1962, it became the Egyptian Family Planning Association. It is a loose federation of governorate-level family planning associations which have been active in keeping family planning before the public, providing training for family planning workers, and operating clinics.

The Cairo Family Planning Association and the Alexandria Family Planning Association are particularly active members of the EFPA. The Cairo Association was responsible for establishing the urban, commercial retail sales (CRS) distribution program which has now become the Family of the Future project. The Alexandria Association has established a first-class training facility, the Alexandria Family Planning Training Institute, which specializes in the training of trainers and serves the needs of a wide variety of Egyptian agencies both public and private.

C. Observations on the Ministry of Health and Ministry of Social Affairs Family Planning Programs

A number of conclusions and observations can be drawn from the following four tables on service statistics. (They are grouped according to major contraceptive service providers.)

- The Ministry of Health's 3,111 clinics and hospitals currently provide contraceptive services to less than five percent of Egypt's 7.1 million married couples of reproductive age (Table 1).
- While the MOH has 87 percent of the clinics, these provide only 67 percent of the contraceptive services in the public sector (Table 4).
- The 499 MOSA/EFPA clinics represent 13 percent of the total MOH/MOSA clinics, but manage to provide about one-third of public sector contraceptive services (Tables 1 and 4). Stated differently, this 13 percent of all clinics provides family planning services to half as many clients as the entire MOH system.

Table 1

COMPARISON OF REPORTED CONTRACEPTIVE SERVICES  
AMONG SERVICE ORGANIZATIONS, ACCORDING TO METHOD,  
JANUARY-JUNE, 1981

Organization	No. (000s) and Percentage of Users by Organizations and Percentage by Method				Total No. Users (000s)	Percentage Of All Users	Prevalence Among Married Couples of Reproductive Age
	Pills	IUD	Condoms	Other (Foam, Cream, Diaphragms)			
Pharmacies	358 (50%)	.4	108 (72%)	40 (67%)	506	45%	7.0%
Ministry of Health	243 (34%)	81 (41%)	11 (7%)	5 (8%)	340	30%	4.8%
Ministry of Social Affairs (EPA)	109 (15%)	54 (27%)	4 (3%)	3 (5%)	170	15%	2.4%
Family of the Future (FOF)	-	62 (31%)	27 (18%)	12 (20%)	101	9%	1.4%
<b>TOTAL USERS</b>	<u>710</u>	<u>197</u>	<u>150</u>	<u>60</u>	<u>1,117</u>	<u>100%</u>	<u>15.6%</u>
Method Distribution	(64%)	(18%)	(13%)	(5%)	100%		

Note: FOF condoms are mostly distributed through pharmacies

Sources: PFPB Family Planning Service Statistics, January 1982, pp. 11 and 43

Table 2  
 TOTAL CONTRACEPTIVE SALES (000s) TO USERS THROUGH ALL  
 SOURCES OF DISTRIBUTION, JANUARY-JUNE, 1981

	<u>Pills</u> <u>Cycles</u>	<u>IUDs</u>	<u>Condoms</u>	<u>Diaphragms</u>	<u>Cream</u>	<u>Foam</u> <sup>1</sup>
All Family Planning Units	2,300 (50%)	68	770	1	2.7	11
Pharmacies	2,320 (50%)	.2	5,390	1	8	93
Family of the Future	--	<u>31</u>	<u>1,300</u>	--	--	<u>31</u>
TOTAL	<u>4,620</u>	<u>99</u>	<u>7,460</u>	<u>2</u>	<u>11</u>	<u>135</u>
Factor (to calcu- late users)	÷ 6.5	x 2	÷ 50	x 2	÷ 6	÷ 2.5
Users (000s)	711	198	149	4	2	54
Method Mix.	64%	18%	13%	.4%	.2%	5%

<sup>1</sup> Foam packets of 20 tablets each.

<sup>2</sup> Percentages rounded.

Source: PFPB Service Statistics, January, 1982, p. 43

Table 3

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ESTIMATE OF MARRIED COUPLES OF REPRODUCTIVE AGE (MCRA)

MID-1979 TO MID-1983

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<u>Year</u> <u>(Mid-point)</u>	<u>MCRA</u> <u>(000s)</u>	<u>Annual</u> <u>Increase</u> <u>In MCRA (000s)</u>
1979	6,746	---
1980	6,949	203
1981	7,157	208
1982	7,372	215
1983	7,593	221

Note: The number of MCRA is estimated from the 1981 figure in the source below, assuming an annual increase of 3 percent.

Source: Family Planning Service Statistics for January-June 1981; Population Family Planning Board, published January 1982, p. 45.

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Table 4  
MOH AND MOSA FAMILY PLANNING SERVICES  
RELATIVE TO NUMBER OF CLINICS

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	<u>Number Clinics</u>	<u>Number Users (000s)</u>	<u>All Clinics</u>	<u>Services</u>
MOH	3,111	340	86%	67%
MOSA (EFPA)	499	170	14%	33%
TOTAL	3,600	510	100%	100%

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- There has been virtually no increase in the number of oral contraceptive users obtaining their supplies from the MOH over the past ten years.
- In areas where MOH physicians have recently been trained to insert IUDs, e.g., Alexandria and Gharbia, a significant increase in IUD insertions has occurred. This provides encouraging evidence that there remains an unmet demand for intrauterine contraception.
- MOSA/EPFA clinics provide 40 percent of all MOH/MOSA clinic IUD insertions.
- Despite the better performance of MOSA clinics compared to MOH clinics, the entire network of 499 clinics services only 2.4 percent of Egypt's eligible population of married couples of reproductive age.
- MOSA/EPFA total reported family planning users were approximately 170,000 in 1981 (Table 1.)

Presently, the MOH and MOSA/EPFA report providing services to 510,000 or 7.2 percent of Egypt's married couples of reproductive age. It should be noted, however, that given the net addition of over 200,000 eligible couples each year, this increase will exceed the number of couples currently served by the public sector within only three years (Table 3).

Only 75 percent of MOH clinics reported their service statistics during the six-month period, January to June 1981. It appears furthermore, that no special attempt is made to correct delinquent reporting with the result that the performance or non-performance of one-fourth of the MOH service network is unknown. Unless this elementary deficiency is corrected, efficient management of the program will remain impossible.

#### D. Population and Development Project (PDP)

The rural Population and Development Project, which began in 1977 with UNFPA funding is implemented through the Population and Family Planning Board (PFPB). It was designed to achieve population objectives through the promotion of village-level social and economic activities in conjunction with upgrading family planning services and increasing the availability of contraceptives.

At the heart of the PDP system is the local PDP advisory committee situated in a "mother village," the seat of a village council representing about five satellite villages (averaging a total population of 30,000). The advisory committee is comprised of

government appointed members and recognized opinion leaders. USAID and UNFPA currently support the PDP equally in twelve rural governorates with 525 PDPACs providing coverage to about 15 million rural people.

Visits were made by team members to about 40 PDP villages and numerous meetings were held with Board and PDP personnel. The Board is to be complimented for getting the PDP organized and personnel in place in a relatively brief period of time. In addition to the staff at the central level there are 12 chief regional coordinators, about 100 district coordinators, 525 village advisory committees (PDPAC) composed of about 20 members each, and the "raayda refiya" (rural pioneers) who are the outreach development and family planning workers. The two key elements at the village level are the emphasis on local involvement and decision-making through the advisory committee and taking the family planning program to the home through the raaydas.

Despite the importance of the raaydas there have been difficulties in recruiting and keeping them because of the low pay (a maximum LE 8.00 per month depending upon performance) and the unrealistically high expectations for them as indicated in the raayda's job description. (See Annex III F). Many of the raaydas are young women who take the job until a better one comes along. Studies of the raayda by PDP have been candid in their conclusions indicating the need for better selection, training and supervision. The raayda remains a "volunteer" (i.e., not a regular government worker) because the Board does not want to create another large cadre of civil servants. However, consideration is being given to increasing the salary as a means of attracting and keeping raaydas.

The PDP attempts to accelerate some aspects of socio-economic development while recognizing that overall development depends to a great extent upon the national economic situation. This is done through interest-free loans (maximum of LE 10,000) for economically productive projects and grants for the improvement of social services. To date, this has been a rather diffuse undertaking because funds available do not allow an intensive effort. As of December 1980, only 149 loans had been made and 369 grants provided to village councils. The average loan was for LE 4,000 and the average grant was for LE 350. If family planning services are to be tied to socio-economic development, and if contraceptive prevalence is to rise as a result of such development, there needs to be a stronger linkage with other socio-economic development programs that have much greater assets. USAID resources channeled through the Organization for Development of Egyptian Villages ("ORDEV") would seem to offer such possibility.

There is an overlap between the PDP's family planning activities and those of the MOH since all family planning units in PDP villages are MOH facilities. The 1978-80 PDP achievement report states that in 1979 the prevalence rate for MWRAs was 12% for PDP areas as compared to 5% in the non-PDP areas of the same governorates. In the following year, with more village councils incorporated into the PDP, the population covered in PDP areas increased by 80%. The prevalence of contraceptive use increased in both PDP and non-PDP areas--an increase to 18% for the PDP areas and an increase to 6% for the non-PDP areas. While it is gratifying that the PDP units are performing better than the non-PDP units and better than the national average, the prevalence rate still must increase substantially if Egypt is to reach the goal it has set for a reduction in the population growth rate.

#### E. Integrated Social Services Delivery System - Menoufia

Another attempt to improve the family planning delivery system is the Menoufia Integrated Social Services Delivery System Project (ISSDS), which began in early 1979 with USAID support. Designed as a three-year action-research program for promoting family planning, health and social welfare services through an integrated development approach, it covered a rural population of more than two million people in 302 villages. The project is a joint effort of the local administration of Menoufia Governorate, the Governorate's Departments of Health and Social Affairs, the Ministries of Health and Social Affairs, and the Social Research Center (SRC) of the American University in Cairo.

Operationally, the project consists of four components: (1) action; (2) training; (3) family planning and health interventions; and (4) research. The SRC had the primary responsibility for the latter two components but was also much involved in all aspects of project implementation in order to allow the SRC "to serve as a catalyst to the Governorate of Menoufia," i.e., the research elements were to support the service elements of the project.

The very ambitious action-research project has been referred to as an expansion and replication of the "38 village household distribution study" carried out by the SRC in Menoufia Governorate from 1976 to 1978. Although initial household distribution of contraceptives also characterized this 302 village study, it also involved an attempt to upgrade the family planning, health and social services of the whole governorate. The extent to which this was achieved is not known because final reports on these services were not available when the team visited Egypt.

Preliminary survey data, however, indicate a contraceptive prevalence rate of 18.2% in October 1980 and 19.7% in February 1981. These rates are in marked contrast to a prevalence rate of 10% for the governorate reported in the PFPB's service statistics (including distribution to pharmacies) for the first six months of 1981. In either case, these data suggest that the ISSDS intervention has had minimal effect on increasing contraceptive use.

This conclusion has implications for Beni-Suef where the PDP and the SRC will join forces "to bring these two approaches together in such a manner that a synergistic result is obtained." The SRC will be responsible for evaluation, part of which will be six mini-surveys to get results to the program managers and administrators as quickly as possible. If this is to be done, the SRC will have to develop new ways of analyzing and reporting data quickly so they can be used to evaluate and modify the Beni-Suef program.

F. Family of the Future (FOF)

Family of the Future is a commercial retail sales program begun by the Cairo Family Planning Association in 1979. Today, it is a separate, private, non-profit family planning program registered with the Ministry of Social Affairs receiving its funding from USAID. The FOF project utilizes retail networks to extend the subsidized distribution of contraceptives by increasing awareness of and demand for family planning services, and by establishing a supply system which makes contraceptives readily available through commercial outlets (pharmacies) and physicians' offices.

Condoms, foam tablets and copper T and copper 7 IUDs are sold directly to doctors, hospitals, and pharmacies through FOF's six medical representatives and two distributors. Additional promotion is accomplished through an energetic advertising campaign and through the activities of a force of some 100+ volunteers. Summer camps, rallies, promotions at major sports events and contests are utilized to increase awareness, make discussion of contraception socially acceptable and to promote FOF products. The success of the program in the greater Cairo area has led to an expansion of FOF activities to include Alexandria, the Eastern Delta and parts of Upper Egypt. FOF also plans to add an oral contraceptive to its product line in the near future.

Tables 1 and 2 show FOF sales for only the first six months of 1981. Data from FOF for the entire 1981 calendar year, however, show the following:

	<u>Sales</u>	<u>Equivalent Users/Year</u>
IUD	71,500	71,500
Condom	1.7 million pieces	17,000
Foam Tablets	1.72 million tablets	17,200
TOTAL USERS		<u>105,700</u>

If the estimate of 1.1 million total users in Table 2 is approximately correct, the FOF is providing contraceptive commodities to 10 percent of all family planning users, a major achievement for an organization barely three years old. With supply problems largely resolved (FOF ran out of condoms in August 1981), FOF expects to double sales in 1982.

FOF is reaching a large segment of the population that prefers to obtain contraceptives through private pharmacies and physicians. Their approach to the physicians in private practice and to pharmacies is proving successful in large measure because both doctors and pharmacists can make a modest profit by handling FOF commodities.

In sum, the social marketing approach adopted and implemented by the Family of the Future organization provides an important complement to government-provided contraceptive services.

#### G. State Information Service (SIS)

The State Information Service established an information, education, and communication (IEC) section for population and family planning in February 1980. Support for the project was provided by USAID and work was carried out under a contract with the University of Chicago's Social Development Center. The Center provided the services of a full-time consultant to assist in developing the program. This person now is a direct consultant to the SIS.

The SIS project has produced many materials that have been instrumental in making family planning a subject of widespread discussion in Egypt. The program began with a general awareness campaign. It has now moved into campaigns that feature the five contraceptive methods available in the Egyptian family planning program and that show the effects of rapid population growth on education, housing, health, etc. The SIS produces films, TV and radio spots, and printed materials and arranges for full-length TV and radio programs on population/family planning subjects. It also has produced a wide range of promotional items which are distributed during regional promotions carried out by staff of the SIS's 50 regional information centers. A baseline study was done at the beginning of the SIS project to determine Egyptians' knowledge of and attitudes towards family planning. A follow-up survey is now being carried out for the SIS by CAPMAS.

The SIS has clearly demonstrated a capacity to produce a large volume of materials. It also has provided training in population/family planning IEC both for its own staff and for staff of other agencies and has been able to activate many of the 50

regional SIS information centers in support of the family planning program. These are all important accomplishments to the credit of the project's small, hard working staff. However, not surprisingly, given the newness of the project and the task at hand, there is considerable room for improvement in a number of areas.

Although there is more cooperation today between the SIS and other family planning agencies than when the project first began, much remains to be done. One critical area where cooperation is far from optimal is distribution of materials. The SIS can produce materials, and it has taken steps to help ensure that its staff deliver materials to the offices of other ministries and family planning agencies, but at this point distribution breaks down. In the more than 50 clinics visited by the team, there are few, if any, SIS materials to be found. Posters, booklets and films stacked and stored in corners of district, governorate, and central offices are useless.

Testing of materials before deciding on volume production and distribution needs more attention. Insufficient staff resources and time constraints have severely limited the pretesting of SIS materials to ensure that they are culturally relevant to the intended audience and not just acceptable to central office program staff. For example, the current campaign poster depicts the "ideal" two-child, nuclear family. Some testing was done to determine suitable costumes for the three versions of the posters produced (urban, Lower Egypt, and Upper Egypt) but no testing was done to determine whether the concept of the nuclear family is something with which Egyptians, particularly rural Egyptians, can identify.

There also is a need to improve the quality of materials. To date there has not been much of an attempt to reach beyond the "usual" suppliers of artwork, copy, scripts, etc., to seek new talent and fresh ideas, particularly from the private sector.

#### H. Egyptian Fertility Care Society (EFCS)

The Egyptian Fertility Care Society was founded in 1974 during a national conference on surgical contraception held at Assiut University. Initially, its emphasis was on voluntary sterilization and it has received support from the International Project of the Association for Voluntary Sterilization (IPAVS) to establish a university-based voluntary surgical contraception training program in eight university medical schools.

The EFCS has maintained an office in Cairo since September 1979. Since then, it has become active in broader areas of family planning. It was instrumental in preparing plans for the house officer training program now being implemented by the Ministry of Health and it is also developing a manual on family planning for

clinicians. The EFCS publishes bimonthly bulletins for doctors (in English) and pharmacists (in Arabic). It holds regular, day-long seminars for physicians in hospitals in various governorates and carries out special programs to inform opinion leaders from different segments of the population about the health hazards of high parity and the importance of family planning. The EFCS is also doing a series of TV programs on the health hazards of high parity.

The EFCS is a small agency whose projects generally have been done well and quickly despite limited staff resources. Given prevailing attitudes, it is doubtful that there will be much more the EFCS can do in the area of voluntary sterilization besides maintaining and upgrading university, research-based programs. The Society is seeking a broader role to play in the family planning field and its expertise and contacts could be well utilized in programs for medical practitioners and health delivery personnel and in the area of applied research.

### I. The Role of Pharmacies

As can be seen from Tables 1 and 2, pharmacies are playing a vital and expanding role in providing contraception. For the period January-June 1981, pharmacies provided one-half of all oral contraceptives and 90 percent of condoms (if FOF distribution is included) to Egyptian users of these two methods.

Many people clearly find it more convenient to go to pharmacies than to clinics and undoubtedly that trend will continue. As pointed out in the USAID-funded Futures Group study of the role of pharmacies in providing primary health care (1982), rural Egyptians in particular see the pharmacist as an important person to consult about their health care problems. Part of this attitude results from people perceiving the pharmacist as a professional member of the health care community and also as a local resident concerned about the welfare of his/her friends and neighbors. Additionally, the pharmacist's advice is free while a physician's advice might be costly. Finally, pharmacies typically are open for long hours, including evenings and often holidays as well. This means they are more accessible to clients than a doctor or nurse in a clinic where hours are limited and the waiting time is often long.

Since pharmacists are among the leading providers of family planning services in Egypt today, it is important that they know more about contraceptive products and how to counsel their customers effectively as to their use. Two efforts in this direction are now going on. The Family of the Future commercial distribution program focuses on pharmacies for delivery of its products. It provides information to pharmacists through its medical representatives and distributors and also holds family planning seminars for pharmacists. The Egyptian Fertility Care Society has begun publishing a bimonthly bulletin for pharmacists, in Arabic, on

family planning which now is sent to approximately 5,000 pharmacies throughout the country. It is designed to reach both pharmacists and their assistants. Both these efforts are important and should continue. In addition, consideration needs to be given to providing client materials to be distributed by pharmacists, including materials that can be understood by illiterates.

Since pharmacists are busy people, there must be some incentive provided for them to devote more time and effort to promoting contraceptive products. The Futures Group study indicates that the profit margin on most pharmaceutical items is relatively small, given the Government controls on pricing. Ways to provide a more significant inducement to encourage greater participation by pharmacists in the family planning effort need to be investigated and tried. One approach, of course, would be to allow more flexibility in contraceptive pricing and larger markups since many people are prepared to pay higher prices for such commodities. An effort to more actively involve pharmacists in the national program could have an important effect on increasing contraceptive prevalence in Egypt.

## V. POPULATION POLICY RESEARCH IN EGYPT

Efforts to initiate or speed a decline in fertility in any population are based on explicit or tacit assumptions about people's knowledge of and attitudes toward fertility regulation, about existing economic and social supports for large family size, and about the political and administrative feasibility of alternative kinds of policies and programs. The same is true of interventions aimed at other kinds of demographic goals--influencing internal migration, for example. Many of these assumptions are grounded in the three decade of accumulated experience of such efforts, both successes and failures, around the world. But the distinctive characteristics of the cultural and socioeconomic setting in any given country necessitate a close examination of the validity of policy assumptions in each particular setting. Both in influencing initial policy design and in assessing progress and proposing mid-course corrections, a strong, locally-based research program is a vital part of an effective response to population problems.

A recently published annotated bibliography on the population of Egypt lists over 3,000 studies in Arabic, English, and French. The 1976 Census and several large-scale household surveys in the last decade provide data sets covering demographic and socioeconomic characteristics and family planning attitudes and practice. An elaborate and comparatively effective registration system yields timely records of vital events down to the lowest administrative units. Small-scale, ad hoc surveys by individual researchers are an additional source of data.

Despite this quantitative richness, there are some conspicuous weaknesses in these data and analyses as a basis for population policy. These include:

- In-depth, focused anthropological studies of family and community behavior and of local-level economic and institutional change, either in rural or urban areas, are very few. (Some of the work sponsored by the Social Research Center of American University is the chief exception.) There are two serious consequences. First, while there is a widespread belief that villages throughout Egypt are undergoing significant social change, there is little empirical basis for assessing any resulting prospects for rapid demographic change. Whether, and if so to what extent, rural Egypt is in a sense being "primed" for the kind of fertility decline now under way in much of East Asia and Latin America is one of the big questions that should be absorbing and directing the attention of social scientists in the population field. And as a second consequence, those concerned with the design and content of the family planning effort lack basic information that would help to determine program emphases and to identify obstacles to success.

People's perception of public and private sector services, the actual experience of clients, the nature and strength of demand for birth control, and insights into how to enhance demand, are all topics that lie largely beyond the reach of conventional survey research.

- A remarkable degree of uncertainty exists about the level of contraceptive use in Egypt. The detailed information on methods from the World Fertility Survey questionnaire employed in the 1980 Egyptian Fertility Survey, not yet fully analyzed, should shed new light on this question. Again, intensive research in a small number of communities would greatly help in the assessment of survey results--for example, on "folk" methods of birth control and on the question of whether responses to survey questions on modern contraceptive use have any systematic bias.

- The centralized administration of the family planning program in rural areas has narrowed the scope for local experimentation with variation of inputs, different cost structures for supplies and services, different staff incentive schemes, and so on. Major new opportunities for imaginative operations research could be exploited under more flexible arrangements. (Operations research in the PDP and Menoufia projects are significant exceptions, but studies of alternative designs of basic service delivery schemes are notably lacking.)

- The experience of other developing countries in population policy and family planning programs is not being systematically sifted and scrutinized by Egyptian researchers for lessons that could be helpful to Egypt. The countries with potentially most to offer in this regard are far outside this region. For example, both the Matlab household delivery experiment in Bangladesh and the administrative design and reporting system of the Indonesian family planning program offer potentially important insights that may be of value in the Egyptian setting. Other relevant experience could be drawn from a number of East and Southeast Asian countries.

- At the broad sectoral level, studies of the consequences of population growth, and of the implications of alternative feasible trajectories of such growth, are in large measure an activity only of foreigners--in particular, World Bank and USAID. That the straightforward but relatively unsophisticated projections of the "RAPID" model should be surprising to top Egyptian leaders is an indictment of local policy research; so, too, is the continued wide currency of the view that massive population decentralization, expansion of cultivated areas, and construction of desert cities are alternative strategies to fertility reduction. Despite gaps in knowledge, there is a need for a thorough analytical survey of population and development relationships in Egypt, pulling together established findings in a coherent, policy-relevant framework.

The reasons for these deficiencies should be sought not in the caliber of researchers (many of whom have a well-deserved international standing) but in the research environment. In Section VI F below we make a number of recommendations for support measures that could be taken to improve this situation.

## VI. FOLICY AND PROGRAM RECOMMENDATIONS

### A. Political Commitment

The political commitment of Egypt's top leadership to population issues until very recently, has been weak. The Government of Egypt has a stated population policy and a program to reduce rates of population growth, but that program has been ineffective. In the absence of a strong political commitment, it is our assessment that the program will continue to be ineffective, and that Egypt's stated demographic goal of reducing population growth will not be realized.

President Mubarak's speech of February 13, and his additional comments on May 3, 1982 have captured the attention of policymakers and opinion leaders, and have focused national attention on the population issue. If the President continues to maintain an interest in population matters, and if he assigns high priority to reducing the rate of population growth, there is promise and a reasonable expectation that the population program can be energized both in the public and private sectors.

Political commitment can take various forms, but the following are two examples of steps that would signal such a commitment.

1. The President could continue to indicate his commitment to the importance of slowing population growth both through speeches and with announcements and specific directives to his senior officials.
2. The President also could assign responsibility for implementation of the population program and family planning to the governors, and require a quarterly report from them on accomplishments, plans, and constraints.

With a commitment along these lines, we recommend that USAID provide very substantial financial assistance to the program. Without such a commitment, however, we believe that the chances of developing effective population activities in the near future are poor and under such circumstances we believe the USAID could invest its funds better elsewhere. We also note that a lack of strong political commitment to greatly strengthen population activities would have far-reaching negative implications for Egypt's social and economic development.

### B. Energizing the Family Planning Delivery System

In the public sector, Egypt enjoys the important advantage over most other developing countries of having a well-established health infrastructure of 3,600 clinics, health centers and hospitals which are well located and adequately staffed. Despite this advantage, the government's health services have not, for a variety of reasons, given priority to providing family planning services.

Today, after 16 years of official program experience, government clinics (approximately 3,100 Ministry of Health clinics and 500 Ministry of Social Affairs-Egyptian Family Planning Association clinics) provide contraceptive services on a continuing basis to only seven percent of Egypt's 7.3 million reproductive age, married couples. In rural Egypt, the prevalence of contraceptive use attributable to government services is estimated at only six percent, although that figure is not precise because one-fourth of all clinics do not report their performance. Service statistics, furthermore, show little improvement over the past decade.

It is unlikely that performance can be improved by exhortation alone; instead, a number of organizational changes should be considered by both the government and USAID as either conditions precedent or as new program elements that should be agreed upon during negotiation and before signing of a new, multi-year project agreement for population and family planning support. These include:

- a) Establishment of a special department exclusively concerned with family planning within the Ministry of Health which would be headed by a highly capable and action-oriented undersecretary of health for population and family planning.

This unit, which should have a staff of ten or twelve professionals, would manage logistics and supply, training, field supervision, the medical aspects of contraception, and evaluation and planning. In addition, and in close collaboration with the Population and Family Planning Board, it would work cooperatively with other concerned ministries including Social Affairs, Education, Youth, Agriculture and Wakfs.

It is our conclusion that the present MOH staff consisting of only three senior officers concerned with family planning, although well-qualified and dedicated, is simply too small to manage a genuinely national effort and the large amount of government, USAID and other donor resources available to it.

- b) At regular intervals, say every three or four months, a meeting of governorate directors general of health should be convened to compare family planning performance among governorates, review problems and constraints and share new ideas for improving program performance. In this regard, we wish to note our strong endorsement of the Minister of Health's plan to devote a day exclusively to family planning matters with undersecretaries and directors general in the near future and believe this can serve as an important first step to giving the program greater priority and visibility.

- c) Because most of the personnel in the 56 clinics we visited were not aware of their annual family planning target, did not know if they were doing well or poorly nor how their performance compared with other clinics, and did not know how to calculate contraceptive prevalence rates, we recommend that USAID seek agreement with the MOH and PFPB to:
- 1) Revise the present target system so that each health unit is given a realistic target in terms of increasing prevalence of contraceptive use. (The present goal of reducing the nation's growth rate by 1/10th of one percentage point each year should be kept; at the field level, it could simply be presented in terms of increasing prevalence. The target would call for a 2.5 percent increase in prevalence each year.)
  - 2) Instruct supervisors to inform health units regularly of their target and how well they are performing compared to other units and compared to their own previous performance in terms of both prevalence and improved method mix.
- d) The present incentive system was intended to reward family planning workers for their efforts, but because of the way it is administered, it no longer serves that original purpose. Payments, for example, are received anywhere from 6-15 months after the reported activity took place, making it impossible for workers to associate it with job performance. Also, there is widespread, general lack of understanding and a great deal of misinformation about how the incentive system is supposed to work.

We agree with the many Egyptian officials we met who argued that the incentive system should be revised. A straightforward approach would be simply to let clinic staff keep all or most of the income received from contraceptive sales and divide this among the staff at the end of each month. Adopting this procedure would mean that workers would be rewarded quickly in direct proportion to their accomplishments. It would be readily understood by all and the elaborate financial accounting procedures associated with the present scheme could be eliminated. Staff now involved in financial accounting could be reassigned to the more useful task of analyzing and reporting clinic performance by each district and governorate instead. Adoption of this procedure would require a change or exemption from the Ministry of Finance regulation that now withholds or deducts a portion of incentive income as tax.

This would also require abandoning the present system of using "sales" receipts to order new contraceptive supplies. Instead, supplies would be provided at no cost to clinics at two-month intervals in such a way that clinic stocks would never drop below a two-month supply, with each replenishment bringing levels up to a four-month supply.

A related option would include a system of periodic awards to those clinics that perform best when compared to similar units and when compared to their own previous performance. These awards could be paid out of the regular incentive fund or from special monies made available for this purpose by the GOE or USAID. Such incentive payments to service providers, we believe, would do much to reinvigorate program operations.

### C. The Role of Governors

Parallel with these organizational changes within the Ministry of Health and the governorate health service system would be comparable organizational changes that would place greater responsibility and accountability on the governors for family planning and population program performance.

Consistent with the gradual evolution of the public administration decentralization process set in motion more than three years ago, which gives governors both greater authority and responsibility for health and social services, a number of steps should be considered to involve governors more directly in program implementation. These would include:

- Assignment of clear responsibility and accountability to governors by the Office of the President for improving family planning program performance.
- Periodically, at say quarterly intervals, governors should report to the President their program progress in terms of prevalence and registered birth rates so that this can be compared with their previous performance and so that comparisons can be made among governorates themselves. If the Office of the President would then congratulate the best performing governorates and, similarly, inquire why the more poorly performing governorates were not doing better, this process would have a salutary impact on program performance.
- Within each governorate, the governor's bulletin or newsletter should include a section on population and family planning that would provide:
  - a. news about population and family planning activities;

- b. new directives about family planning;
- c. a listing of the 10 units which performed best during the past three months along with a summary of innovative approaches used; and
- d. announcements of annual or semi-annual awards, and prizes for outstanding performance to the staff responsible.

-- Experimentation should begin soon with application of a system of community, or even governorate-wide, development incentives to those governorates which do best in improving family planning program performance. The linkage here with other USAID-supported rural development activities, specifically Basic Village Services and Development Decentralization projects, should be tailored in such a way so that best performing governorates might receive, for example, a 10 or 20% increase in development assistance related to increases in contraceptive prevalence.

A variation of this approach, although perhaps less easy to manage, would be to implement already planned development activities first in those areas that have performed best in family planning. If, for example, rural road construction already has been budgeted, the idea would be to construct roads first in those areas that have done best in family planning and make village council leaders and others aware of the fact that they are the beneficiaries of this rescheduling because of their family planning program performance. Such an approach would not entail any additional cost to the development budget.

-- Governors should be encouraged to propose additional ways in which the family planning program can move forward more rapidly. In support, USAID should consider making available a special fund to respond quickly to their proposals so that practical operations research and experimental trials on this front could begin soon. Such allocations could be jointly administered by the Government and USAID.

It is our judgement that actions along the two parallel lines discussed above involving both the Ministry of Health and the role of governors would be timely and would do much to energize a service delivery system that has yet to prove responsive to meeting goals and targets set by the Supreme Council for Population and Family Planning.

## VII. RECOMMENDATIONS TO IMPROVE THE DELIVERY OF FAMILY PLANNING SERVICES.

### A. Training

Officially the Egyptian family planning program is a clinic-based program with the Ministry of Health having major responsibility for delivery of services. In practice, a large number of contracepting Egyptians obtain their supplies through pharmacies, private physicians and clinics, or EFPA facilities. One of the main reasons that the MOH program has been so ineffective is that the doctors and nurses charged with delivery of services have received little or no training in family planning prior to being assigned to work in MOH facilities. In an attempt to improve performance, the MOH is now undertaking a number of ambitious initiatives to provide training for physicians at the intern, per-service and in-service levels. (These programs were described briefly in Section IV and are reported in greater detail in Annex I.C.)

Despite these new programs, there are many other steps that can be taken to improve the quality of services through training efforts. Some of these include:

1. A training program in contraception and family planning for private practitioners inasmuch as large number of Egyptians obtain medical services from private physicians. Such a program might best be carried out by a private agency with medical expertise such as the Egyptian Fertility Care Society or Family of the Future.
2. Training programs also should be extended to other service providers. Family planning should be included in the curriculum of nursing institutes and practical training should be provided to nurses already stationed in clinics and health centers. Training also should be provided for the dayas and raayda refiya in basic concepts of reproduction, correct usage of family planning methods, and side effects.
3. Nurses should be trained to do IUD insertions. this is particularly important for parts of Upper Egypt where women do not want to be examined by a male doctor. It also could increase the effectiveness of the program since nurses do not rotate in and out of rural clinic service as frequently as physicians.
4. All service providers should receive training in interpersonal communications skills as well as technical aspects of family planning so that they could better motivate their clients to accept and use the family planning method of their choice.

5. We endorse the Board's idea that a cadre of raayda refiya be developed as "master trainers". They would be a small group selected from among the brightest and most dedicated of the raayda. After receiving specialized training, they would work with the PDP and the MOSA to carry out raayda training activities throughout the country. The training program should focus on a few key areas of work, particularly family planning, and should not be overloaded with peripheral activities.
6. It is strongly recommended that training materials and procedures be standardized so that all trainees receive the same basic content. In addition, teaching methods should be modified to allow for greater participant involvement. This could be done through the introduction of problem-solving techniques and by increasing opportunities for in-clinic experience during training programs.

#### B. Private Sector Emphasis

Worldwide experience in family planning programs has demonstrated that greater contraceptive use can be achieved more rapidly by involving both the public and private sectors than by reliance primarily on either one. Egypt, also, is demonstrating this fact. The government and USAID are to be commended for encouraging private pharmacies and private organizations such as the Egyptian Family Planning Association and the Family of the Future to deliver contraceptive services. The following table gives impressive evidence of the role played by the private sector.

PERCENTAGE OF PRIVATE SECTOR-PROVIDED FAMILY PLANNING SERVICES

	<u>Pills</u>	<u>Condoms</u>	<u>IUDs</u>	<u>% All Users</u>
Pharmacies	50%	72%	-	45%
EFPA	15%	3%	27%	15%
FOF	-	<u>18%</u>	<u>31%</u>	<u>9%</u>
TOTAL	65%	93%	58%	69%

As can be seen from the above table, almost 70 percent of Egypt's contraceptive users obtain supplies from the private sector. Whereas most of our suggestions deal with ways to improve public sector performance, there remain important areas where additional private sector activities could usefully contribute to a strengthened family planning effort. These include:

1. Private physician training. As mentioned above, organized efforts to train more private physicians (and those government physicians who also have private practices) to insert IUDs should be more vigorously pursued.

2. Field worker training. Although this is primarily the responsibility of the MOH, there is enough work to be done in this important area to engage, on a larger scale, the Alexandria Family Planning Training Institute. The enormity of the training requirement suggests that assistance in this vital activity be energetically sought from private sources so they can quickly share a larger part of the training load.

3. Information, education, and communication. Despite large-scale USAID support to the State Information Service for IEC activities and materials development, little or none of this has reached clinics and fieldworkers who actually serve people. Although support to central agencies such as SIS should continue, there is also room for involving private sector resources in creative design, materials production, and mass media campaigns dealing with family planning. Given the great need for informative, understandable and reliable educational materials at the village and clinic level, it might be appropriate to engage, on a contractual basis, a private marketing or advertising firm in Egypt to work in this area.

4. Pharmacies. Egypt's 5,000 or so private pharmacies already are playing an impressive role in providing contraceptives. Further, the useful interaction between the Family of the Future program and pharmacists stands out as an example of private sector activity which, of course, should be further encouraged and supported. Over time, continued training for pharmacists will be required and should be supported by USAID.

Recognizing that a sizeable segment of the public prefers to obtain supplies from pharmacies and that a significant proportion of customers would be willing to pay somewhat higher prices for various products, it would appear useful to permit experimentation with more flexible pricing for some brands of contraceptives to determine if overall sales would increase. Higher markups than presently permitted by government regulations would encourage pharmacists to promote contraceptive products more energetically. The kind of experimentation with flexible pricing discussed here could be tried on a localized basis--not nationwide--to learn what works before considering wider application.

5. Contraceptive production. USAID's plans to assist a joint Egyptian-U.S. pharmaceutical firm to increase its production capacity for oral contraceptives is sound. Although the assessment team did not carefully examine production issues, we endorse this move in the belief that greater production capacity is needed and that private sector production also can lead to greater private sector promotion of contraceptive use.

6. Evaluation of Service Statistics. We note that USAID is considering supporting a project involving Price-Waterhouse and the Delta group in developing a more streamlined system for analysis and reporting of service statistics. This is another example of how private resources can be engaged to provide essential and timely services to the family planning program.

7. The Family of the Future. This impressive activity clearly deserves continued support from USAID. The government, and particularly the ministries of health and social affairs which have encouraged FOF to expand its private sector service role, are to be commended for adding this dimension of dynamism to the Egyptian family planning scene. Although IEC efforts to date have made important strides, especially through mass media, there are still important areas that require attention. The following is a summary of recommendations to strengthen the IEC effort.

C. Information, Education, and Communication (IEC)

1. The largest gap in the IEC program is at the clinic and client level. There are few, if any, materials in clinics for use by staff in explaining reproduction, contraceptive methods and their side effects, and no materials to give to clients. There is a particular problem with client materials because a large percentage of Egypt's population, particularly women, are illiterate. Therefore, existing publications on methods are of no use to most of the target audience. It is recommended that:

- a) Priority be given to development of print materials for illiterates that could be given out by raayda refiya and other extension workers during home visits and by clinic staff in order to reinforce verbal presentations and increase the impact of each interpersonal interaction. The capacity to design, test, and produce such materials should be developed in Egypt and made available to programs seeking to reach people at the grass roots level with specific family planning material--information not well suited to delivery by the mass media. Possible resources for such activities include Family of the Future, the Alexandria Family Planning Training Institute and private marketing/advertising firms.
- b) A number of training programs for physicians now are getting under way but it will be some time before the impact of these efforts can be realized on a wide scale. There is an immediate need for simple, standardized materials for clinic staff. These should include a manual on reproduction, contraceptive methods and side effects that is understandable to doctors, nurses, midwives, social workers and paraprofessionals and some simple, inexpensive

charts to be used in support of oral presentations that could be widely distributed and would supplement use of the more expensive magnetic boards now in use. In addition, the bimonthly bulletins for doctors (English) and pharmacists (Arabic) published by the Egyptian Fertility Care Society should be continued. Similar bulletins for nurse/midwives and possibly for social workers and raayda refiya also should be considered.

2. A lot of data are gathered at all levels of Egyptian family planning programs. However, little of this information ever filters back down the line to inform the various units "how we're doing" in relation to other segments of the program and in relation to targeted goals. Therefore, it is recommended that:

- a) Family planning programs, such as PDP and MOH, consider developing in-house bulletins to be distributed on a regular basis that will inform various program units of their performance in relation to other units.
- b) Consider providing the services of a consultant with expertise in information dissemination to look at how information flows (and does not flow) within various family planning agencies. Many program staff at both the central and governorate levels never see reports, papers or service statistics generated by their own agencies or those sent to them from external sources. For example, as of March 1982, few people outside the Population and Family Planning Board had received or read the March 1981 CAPMAS report on the Egyptian Fertility Survey of 1980. Likewise, few people had seen the results of the PFPB - Westinghouse contraceptive prevalence survey published a year earlier. The consultant could determine if there are some reasonable interventions that could improve this situation.

3. Interpersonal communications skills are of paramount importance to family planning motivators and service providers, particularly nurses, raayda refiya and dayas who are front line outreach workers. Ongoing efforts to provide training in face-to-face communications skills should be strengthened.

4. Both the SIS and FOF should continue their mass media efforts but now more stress should be placed on better testing of materials. These programs also should be encouraged to reach out to tap new sources of talent to assist in production of materials, particularly in the private sector.

5. Information programs for opinion leaders should be increased in order to strengthen support for the family planning program at all levels of the society. The planned use of the "RAPID" presentation in governorates is a useful step in this direction.

6. The PFPB should continue and strengthen its efforts to coordinate the IEC efforts of the various family planning programs in order to increase effectiveness and reduce duplication of effort. At this time, some key staff in the Ministry of Health, the Board and SIS seem unaware of each other's activities.

A small population education program has been operating in the Ministry of Education (MOE) for the past eight years. USAID has provided limited funding to this project to support annual summer workshops in Alexandria. Given the current status of this activity within the MOE and the staff commitments of the USAID Population Office, it is recommended that there be no major expansion of USAID assistance for population education activities at this time. However, it is suggested that USAID consider continuing some limited support, such as funding the summer workshop, but leaving major assistance to other international agencies (UNFPA, World Bank).

In the event that the concept of "sector support" gains momentum, then USAID might wish to consider using such a mechanism in the population education area, provided that the MOE came forward with a comprehensive workplan for program implementation coupled with a plan for rigorous, periodic outside evaluation.

## VIII POPULATION POLICIES BEYOND FAMILY PLANNING

The earlier section on the reasons for high fertility in Egypt could well be expanded into a detailed rationale for population policies in a wide variety of areas aside from the family planning program and its related IEC activities. In the Egyptian setting, however, we strongly believe that in the near future, population policy attention should be sharply focused rather than spread, and that policies need to be simple, self-evident in their objectives, and easily monitored in their performance. In other words we fully share the view expressed by President Mubarak on May 3, 1982:

"Egypt needs to develop a practical approach to solving this aggravating problem instead of focusing on theoretical solutions that are difficult to implement."

Our recommendations are of that kind:

- first, a strong push toward achievement of effective and universal primary education should be supported on demographic as well as development grounds (expanding female enrollment is a logical prime component of a series of measures directed at improvement of women's status);
- second, possibilities for drawing on existing community solidarities in promoting consensus and action on demographic goals warrant careful exploration;
- we suggest that the above recommendations be carried out before serious consideration is given to fine-tuned anti-natalist incentives and disincentives;

### A. Primary Education

The single policy action outside the area of family planning and IEC activities that we believe would be most valuable in bringing down Egyptian fertility is expansion of basic, formal education. Both the current much lower enrollment rates for females than for males and the larger empirical association of female education with lowered fertility argue for greater initial attention to raising female school enrollment.

While there is already more than adequate justification for a strong commitment to this goal, the demographic arguments provide a further rationale. (We thus endorse the policy emphasis set out in the 1981 World Bank report on Population and Human Resource Development in Egypt, as against the contrary view of a lack of a fertility-depressing effect from greater female education argued by Kelley, et. al. on the basis of their recent analysis of the 1979 Rural Fertility Survey.)

The percentage of females and males enrolled in primary school in the late 1970's and the percentage of Egyptians age 10 years and over who are illiterate (from the 1976 census) are shown below:

In Primary School		Illiterates Age 10 and Above	
Female	Male	Female	Male
56%	84%	71%	43%

Less than two out of five primary school students are girls, a proportion that has hardly changed over the last decade. In Upper Egypt the proportion is only 30 percent, and adult illiteracy reaches 80 percent.

The proportion of women in the population with completed primary education is so low that inferences about the quantitative demographic impact of much higher female school enrollment cannot readily be drawn from cross section differentials. (The latter are modes, once fertility is standardized for age and marital duration.) The stronger argument is based on the prospect for a major improvement in women's status that success here could yield, and for the kinds of changes in family relationships that were mentioned earlier in the discussion of the reasons for high fertility. The issue of expanded support for primary education of girls has special relevance to USAID given the Agency's capacity to provide major resources for this activity over the next several years.

The kinds of program effort that are recommended are measures to energize the "delivery system" for primary education analogous to those earlier suggested for the family planning program. One helpful step would be to ensure widespread awareness of female enrollment rates and encourage use of these rates as a performance indicator, both among governorates and among districts or village council areas within governorates. Indeed, the same necessity for top-level government commitment, efforts to motivate regional and local government action, and delegation of accountability to the governorate level as were proposed for the family planning program equally apply here.

While expansion of female education can well stand on its own merits as a USAID program emphasis, it could also be seen as one component of a coherent effort to address the supports for high fertility rooted in Egyptian family patterns. Other plausible components for consideration by the government, if not USAID, would include encouragement of greater labor force roles for women and attempts to raise female age at marriage.

## B. Community-Level Population Policy

USAID has supported GOE moves in the direction of decentralization of government functions and assignment of greater revenue-raising authority to local government. Genuinely decentralized local finance (at present far from Egyptian reality, as the reports of the National Urban Policy Study, for example, attest) can be a powerful force in creating awareness of demographic costs in a community and stimulating local initiatives to contain them.

A somewhat analogous option for "community-level" population policy to work also may exist at the true community level--individual villages or hamlets in rural areas and shiakha in cities. These are loose settlement groups averaging several thousand persons, often with strong social cohesion, but no formal role in the society. (Both representative and administrative functions operate only at the higher level of village and council area and kism.) The possibility of drawing on existing community solidarities to promote consensus and action on demographic goals is virtually unexplored in Egypt, but offers distinct if limited promise as a policy route. A systematic effort should be made to assemble or generate information on this subject and to assess its policy implications. The PDP program has some ambitions in this regard which merit design, funding and experimental trials.

## C. Rationalization of Subsidy Programs

The economic effects of the elaborate programs of food and energy subsidies in Egypt have been extensively analyzed, and USAID's Country Development Strategy Statement and Annex on this subject provides a comprehensive review. The main conclusions are: 1) the benefits of the programs accrue predominantly to the urban population; and 2) the subsidies represent an average (as of 1979) of about 40 percent of estimated total household expenditures among urban households and 50 percent of expenditures for households in the lower half of the urban household income distribution. (Since in Egypt, as in most developing countries, there is a positive correlation between household size and household expenditure, the distribution of impact by expenditures per person is somewhat more weighted toward poorer households.) In effect, then, the urban population has been largely insulated from the rapid increases in international prices of energy and food (principally wheat) since 1973. There is unanimity of views among donor agencies that a rationalization of these programs is essential--resulting at a minimum in their benefits being focused on low-income households and their burden on the national budget being brought under control. Pressure to this end is being brought on the GOE by the World Bank and USAID.

A virtually unexamined dimension of the subsidy programs is their possible demographic impact. The subsidies contribute, for example, to the overall urban bias in Egypt's development strategy, which plausibly has speeded rural-to-urban migration. To a degree, subsidies may also insulate parents from bearing a large share of the social costs of their fertility. The plausibility of such a link is apparent and means that parents are less likely to take into account the costs of raising additional children when making fertility decisions. Such reasoning underlies moves in a number of countries to restrict the number of children covered in future ration cards to, say, three per family.

National economic realities, combined with sustained pressure for rationalization by the international donor community, eventually are likely to persuade the GOE to face the political costs of dismantling the subsidy programs in favor of an alternative, more focused and controllable, income support scheme. Any substantial consequent rise in the cost of living is likely to put additional pressure on urban families to lower fertility. The precise treatment of family size in any such program redesign is, of course, potentially significant in influencing urban fertility and in signalling government commitment to low fertility. In the case of the ration card limitation, we see an explicit coupling of these two programs, one already highly sensitive and politicized. We believe this coupling carries a serious risk of damaging broader population policy interests and recommend the USAID not advocate making such adjustments for the purpose of advancing population policy objectives. The economic rationale for more realistic pricing policies is sufficiently compelling and there is no need to link this with possible fertility outcomes.

## IX. RESEARCH ISSUES

Recommendations on AID activities aimed at improving the knowledge base for population policy in Egypt are directed at improving the institutional environment for research and at indicating some specific subject areas where research should have high priority.

### A. Institutional Environment

Problems making for low productivity in population research in Egyptian institutions are well known. At the main public institutions, low salaries force most research staff into multiple jobs and lead to an emphasis on contract research and consultancies yielding hurriedly-prepared, narrowly-construed products. Data processing facilities are typically poor and there are few public-use data sets (a problem for training in quantitative analysis that has results analogous to the "hands-off" training of medical students). It is hard to detect much sense of a research frontier in the population community, although the projects commissioned by the PFPB's Research Office do represent an effort toward a coordinated research strategy. Some of Egypt's best population scientists are working abroad or in the private sector.

Our recommendations on measures to counter these conditions and mobilize the best population research talent in addressing the problems ahead are the following:

- USAID should continue as a funder of the research program of the PFPB at approximately the present level. The Board's Research Office could be given more flexibility in timing the disbursement of funds to subcontractors to enable it to maximize incentives for timeliness and quality of research products.
- USAID should be open to proposals for direct project support on subjects of strong mutual interest from institutions such as the Social Research Center of American University and the Cairo Demographic Center, with a byproduct being the upgrading of their data processing and other core facilities.

--  
USAID should use its good offices with CAPMAS to encourage an "open door" policy with respect to secondary analysis of population survey data by Egyptian researchers.

- As a major innovation in the organization and funding of population research in Egypt, USAID should seriously investigate establishing a new research program. It would be aimed at recruitment of top Egyptian population scientists presently having multiple jobs or working outside the country, for limited-term (1-3 years) secondment to Egyptian research institutions such as PFPB, the Social Research Center of the American University, Cairo, the Institute of Statistical Studies and Researches and the Cairo Demographic Center, on specific full-time research assignments. Desirable characteristics of such a program would include: administrative distancing from USAID and from the GOE to allow competitive salaries and flexible supervision (ensuring quality of performance through informal pressures rather than through contract compliance); overall management in the hands of a scholar of international stature; sufficient coordination of research content to build a cumulative knowledge base; and a program size and identity able to confer prestige and sustain high morale.

#### B. Priority Research Areas

Egypt has both a wealth of research on population (certainly in terms of simple, quantitative effort) and a comparative dearth of information and analysis on a significant number of issues where detailed knowledge would ideally be needed to provide a sound basis for policy. Some important research issues are implicit in earlier recommendations on the family planning program and IEC activities. Other issues the team found to be poorly researched or virtually uninvestigated include the following:

- Changes in the proximate determinants of Egyptian fertility other than modern contraception: specifically, breastfeeding practices, age of cohabitation, marital stability, "traditional" or "folk" methods of contraception, and induced abortion. In a predominantly pill-based family planning program, as in Egypt, possibilities for interaction effects between contraception and lactation also deserve close attention.
- Interpretive analysis of how family planning services appear from the client's or potential client's perspective. (The PFPB has begun to undertake studies of this kind.)
- Focused anthropological or quasi-anthropological studies of how government programs (health, education, family planning) actually operate at the local level. A single, excellent example of this genre is available, but several more such efforts are needed to capture regional variation and the urban situation.

- Investigation of the net economic costs of children among families of different socioeconomic status and urban or rural location. (Do food subsidies offset de facto costs of education? At what ages do earnings cover consumption? What is the likely effect on family costs if ration-cards were limited to, say, three children?)
- Changes in the status of women in rural society. What are the forces making for change, and what is the pace of change?
- Relationships between the Village Council and its constituent villages: How does that interaction really work? How do satellite village residents view Village Councils? What are the analogous relations between Kism and Shiakha in cities?

In addition, preparation of an overall analytical survey of population and development in Egypt, perhaps consisting of a loosely coordinated series of sectoral studies, could, if really well done, be an important contribution to sound development of population policy. USAID should consider sponsoring such a study, possibly through collaboration between appropriate Egyptian and American research institutions.

## X. SPECIAL RECOMMENDATIONS FOR CONSIDERATION BY USAID

### A. Model Urban Family Planning Program

As Egypt is becoming increasingly urbanized more attention needs to be given to improving the implementation of urban family planning services. The FOF has made an excellent start in the commercial distribution of contraceptives and with its awareness programs, but no attempt is being made to provide outreach services nor to relate promotional activities to the provision of family planning services in neighborhood facilities.

Therefore, we recommend that USAID provide support to the Cairo Family Planning Association (CFPA) to develop a model urban family planning program in Cairo and to do this in cooperation with the FOF. These two organizations should be able to work cooperatively with each other as the FOF developed out of the CFPA and the boards of the two organizations have the same chairperson.

### B. Coordination of Development Activities

USAID is now funding a wide range of development activities in both rural and urban areas. In rural areas, programs like Development Decentralization and Basic Village Services in collaboration with the Organization for Development of Egyptian Villages reach down to the village level. These programs have significantly greater resources than the PFPB's Population and Development Project. It would be highly useful if USAID could encourage better coordination between these efforts so that they become mutually supportive. For example, funds earmarked for village projects might be allocated in such a way that they would be supportive of PDP efforts. Those units that are making significant progress with their family planning efforts would be given priority for receipt of project funds for social and economic activities. In return, the PDP village-level organizational structure could be used to support other development activities. Such a strategy would maximize results from program expenditures and would go a long way towards avoiding needless duplication of effort.

### C. Staffing

The four-person professional staff of the USAID Population Office (three American and one Egyptian) is hard-pressed to manage the current \$67 million population portfolio. Day-to-day administration cuts down on in-country travel and on time that can be spent working with their Egyptian counterparts. There is also insufficient time to think about new program directions, develop new activities and improve management of current assistance efforts.

It would be to the advantage of the Population Office if one or two additional direct hire AID population officers could be assigned to the Mission. Another alternative would be to develop a technical assistance contract and/or to make more use of Egyptian professionals in AID activities. Areas that particularly merit more attention include training, logistics management and analysis of service statistics.

EGYPT  
USAID POPULATION SECTOR ASSESSMENT  
1982

VOLUME II: ANNEXES

Report Prepared By:

MR. W. PARKER MAULDIN, Team Leader, Senior Scientist,  
The Rockefeller Foundation, New York City  
DR. H.T. CROLEY, Population and Family Planning Consultant,  
Monterey, California  
MR. LENNI KANGAS, Population Program Advisor, Bureau for the  
Near East, AID, Washington, D.C.  
MS. ANN LEONARD, Information and Communication Consultant,  
New York City  
Dr. GEOFFREY McNICOLL, Deputy Director, Center for Policy  
Studies, the Population Council, New York City  
DR. EMMANUEL VOULGARPOULOS, Professor of International Health,  
School of Public Health, University of Hawaii, Honolulu

During The Period:

MARCH - APRIL 1982

Supported By The:

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT  
(ADSS) AID/DSPE-C-0053

AUTHORIZATION:  
Assgn. No. 582139

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## A. MINISTRY OF HEALTH

### Organization

Since 1977, the Ministry of Health has organized as follows for the delivery of family planning services:

(1) Department of Family Planning

- headed by a director general and theoretically has responsibility to coordinate family planning activities of the MOH.

(2) High Committee for Family Planning

- this committee is chaired by the Minister of Health.
- other members include under-secretaries from ministries involved in family planning related activities, the Chairman of PFPB and the Senior Advisor of Family Planning Affairs.

(3) Senior Advisor on Family Planning Affairs

- The Advisor reports directly to the Minister of Health.

(4) Board of Consultants on Family Planning Affairs

(Technical Advisors Committee)

- This Board has the responsibility to advise the MOH on all matters regarding FP as requested.

The MOH uses the following mechanism to implement jointly financed projects with multilateral, bilateral and non-governmental agencies:

(1) A Coordinating Committee headed by the Senior Advisor for Family Planning Affairs is established for each project. The Committee includes the first undersecretary of MOH, the Director General of the FP department and the executive director of the project. The role of the committee is overall coordination.

(2) Executive Director - responsible for implementing the project, is responsible to the Coordinating Committee and acts as liaison between the committee and various units involved in execution at the central and governorate levels.

At the Governorate level supervision of FP/MCH activities are the responsibility of one unit under the Director General of Health Services. At the District level the supervision responsibility is with the Director of Health Services.

### Population Projects

The following are projects managed under this system:

- (1) First Population Project (World Bank)
  - home visiting program.
  - constructing and equipping nine general health centers, polyclinics, one training center.
  - purchase of 150 multipurpose vehicles.
- (2) Second Population Project (World Bank/ODA)
  - six governorates and two districts of Cairo.
  - national information and population education program, contraceptive supplies, integrated social service family planning delivery system.
  - training for MCH/FP.
  - emphasis on prevention and home visiting program of nurses.
  - increase number of health units and upgrading training centers.
- (3) Pilot Project, Federal Republic of Germany (F.R.G.)
  - International Islamic Center for Population Studies at Al-Azhar University.
  - upgrading family planning services in 21 rural health units/centers.
  - Alexandria, Sharkia and Dakahlia.
- (4) Rural Health Project (USAID)
  - four governorates, Beheira, Dakahlia, Fayoum and Assiut.
  - improve rural health services including MCH/family planning.
- (5) Urban Health Project (USAID)
  - improve urban health services in MCH/FP and nutrition.
  - five zones of Cairo Governorate (Helwan; South, West, North and East Cairo).

- community involvement and home visits.
- training all categories of health professionals.
- outreach program.

In addition, funding for the following activities is routed through the MOH although responsibility for implementation may rest with other agencies.

#### Family Planning Project (USAID)

- contraceptive supplies.
- integrated social services delivery system - Menoufia, Beni Suef.
- MOH family planning administration.
- training.
- Al Galaa Hospital.
- SHIP.
- SIS.

#### Discussion and Recommendations

There is now an opportunity to revitalize family planning services provided by MOH and a number of activities are underway that can contribute significantly to expansion and enrichment of the family planning program.

1. The various training programs for medical graduates, for clinic personnel, special IUD training programs and the like offer an opportunity to provide uniform instruction and reference materials and the issuance of directives.

2. Perhaps we should note that the number of family planning acceptors and users receiving services through governmental clinics has been more or less constant for about 10 years. This is the case despite the rapid increase in the number of married women of reproductive age.

There is adequate staff in most health centers and units to provide much more information to potential family planning clients than is now the case. Many units have no posters on display, no simple booklets to show to a client, and to form the basis for explaining family planning and the various methods of contraception.

There also needs to be more out-reach activities involving nurses, assistant midwives, and the doctors themselves.

3. The family planning effort is a large one that requires reaching the minds of millions of persons. In our view, the MOH

central staff is simply too small to cope with the needs of the program. MOH has able and dedicated people, but the organization is neither sufficiently integrated, nor of a size, to accomplish the many tasks that are required.

4. Units in the field don't know whether they are doing well or poorly; they don't know whether they are doing as well as their neighbors; and many don't know whether they are doing better or worse than last year.

We recommend that a system of rapid feedback be instituted that would give them information on:

- the yearly prevalence rate as a result of their activities.
- a ranking of units in their district, and perhaps in their governorate.
- highlighting the 10 units in the country, and in the governorate that have the best performance record.

We also recommend that a selected number of units be given an award/prize for best performance annually, or perhaps semi-annually.

5. We think it would be very useful if the Minister of Health was to indicate that MOH gives priority to family planning, and this could be done by asking the undersecretaries/directors general of health to report to the Minister personally once each quarter on family planning performance. Staff could receive reports from the governorates and then rank the governorates in two ways:

- overall performance, expressed in terms of prevalence rates.
- performance during the last reporting period as compared with performance in the previous reporting period.

Top priority must be given to the supply and distribution of contraceptives. Contraceptive shortages and/or non-availability continue to disrupt the family planning program.

6. The MOH should seek a higher level of coordination between the Ministry and other family planning programs.

## B. LOGISTICS

### Contraceptive Supply and Distribution

Oral contraceptives are manufactured in Egypt by El-Nil and CID pharmaceutical firms but the active ingredients and the packaging

materials are imported. All other contraceptives are manufactured abroad and imported. Donors supply most of the active ingredients and the imported contraceptives to the Population and Family Planning Board without charge.

The Board takes the responsibility for getting the supplies through customs and pays the in-country handling and transportation charges for the pill ingredients (which are given free to the manufacturer) and the contraceptives manufactured abroad which go to the Egyptian Pharmaceutical Trading Company (Egydrug) for distribution. The manufacturer receives from the Board three piasters for each cycle of pills produced and Egydrug receives half a piaster for each cycle distributed. It is estimated that this is about one half of the cost of manufacture and distribution. Similarly the 3.5 piaster wholesale price for one cycle is divided so that the manufacturer receives three piasters and Egydrug one-half a piaster. As about 40% of the pills manufactured are distributed to pharmacies, a loss is suffered on the remainder of the cycles which go to the family planning clinics. For the first six months of 1981 it is estimated that this loss would be about L.E. 68,000 for the manufacturers and L.E. 11,300 for Egydrug.

The pharmacist's share of the profit on the Cu T, which he sells for L.E. 1.00, and the condoms, which he sells 3 for 5 pt., is 30%. Egydrug receives 10% of the retail price and the remaining 60% is returned to the Board to be used as incentives for FP workers (according to Dr. Sami Hafez of Egydrug). Based on the distribution figures for the first half of 1981, about L.E. 90,000 would have been returned to the Board for these two contraceptives, but only L.E. 120 would have been from the sale of Cu T's. (The latter is due to the limited number of IUD's distributed to pharmacies through the Government program).

For all other contraceptives the pharmacist receives 25% of the retail price; Egydrug 10%; and 65% is supposed to be returned to the Board. During the first half of 1981 the Board should have received L.E.12,100 for the sale of foam tablets; L.E.1162 for creams, and L.E.323 for diaphragms. Therefore, the total that the Board should have received for the sale of contraceptives for this time period would have been L.E.103,585.

The MOH health units sell contraceptives for the same price as the pharmacies. They obtain them from a MOH warehouse and send the equivalent of the retail price of the contraceptives obtained to the district health office. Some districts forward this money to the governorate level health office where it is used to purchase replacement contraceptives to supply the governorate's MOH warehouses. Other districts, especially if they are near an Egydrug

warehouse, purchase the replacement stock directly rather than sending the money on to the governorate health office.

Egydrug is responsible for the initial distribution of contraceptives. It has one central warehouse and six other warehouses scattered throughout the country. These six serve a holding more than a distribution function as the central warehouse cannot handle all of the supplies, especially bulky items such as powdered milk. There are 36 branch warehouses which serve a distributary function. Egydrug vehicles transport the commodities to the warehouses and branches and from the branches to the MOH governorate warehouses. From there they are distributed to MOH district warehouses (however not all districts have warehouses). Apparently each FP clinic must send someone to the MOH warehouse to obtain contraceptives.

After receiving an initial supply of contraceptives, each health unit is limited in its purchase of contraceptives by the amount of money it has received from previous sales. This system does not allow for any expansion of supplies and this has been the main barrier to FP clinics stocking Cu T's. This problem is in the process of being overcome as 50,000 Cu T's are being distributed on a consignment basis to the clinics. As they are sold replacements can be purchased.

Retail contraceptive prices:

Nordette and Microvlar OC	32 pt./cycle
All other OC	5 pt./cycle
Condoms	3 for 5 pt.
Foam tablets	20 for 20 pt.
Delfin cream	25 pt. for initial kit. 20 pt. for replacement.
Cu T L.E.	1.00
Lippes loop	10 pt.
Diaphragm	50 pt.

FP clinics are supposed to maintain a three month supply of contraceptives but this sometimes is difficult to do as they are limited to the amount with which they were supplied initially unless clinic staff are willing to pay for additional supplies out of their own pockets. The MOH warehouses are supposed to maintain a six month supply.

The zonal (district) contraceptive warehouse visited by a team member had an adequate supply of pills and condoms. At the rate of distribution for the previous year there were enough pills for two years and enough condoms for more than six months.

## Record Keeping

A variety of forms are utilized by the FP clinics but the main one used for compiling service statistics in the MOH units is "Tay Aleph Tamania" (TA8) which is to be completed at the end of each month. On one side is printed the different types of contraceptives and columns are provided to enter the supply present at the beginning of the month, the amount received during the month, the amount distributed, and the amount on hand at the end of the month.

The other side of the TA8 form provides space for the names of clinic workers, their job classification, marital status, basic salary and allowances. This does not relate to service statistics and those at the Board who compile the statistics think it would speed up the final reporting of service statistics if these two forms were separated. If the service statistics side could be completed in triplicate one copy could go directly to the Board, one to the MOH in Cairo, and one to the governorate health office. At present the form is sent to the Board via the district health office, the governorate health office, and the FP department at the MOH. At least some if not several clinics are without the TA8 form and have to draw their own. Not only is this a laborious task, it increases the possibility of omissions and inaccuracies and may delay submission. Apparently it is up to each governorate to print its own forms. It is estimated that enough forms could be provided to all units by the Board for LE. 2,000.

At each level (district, governorate and central) statistics are compiled. At the district and governorate level at least seven forms are completed. These forms report on:

- 1) Population, births, deaths, IMR, and sale of loops and pills by type of health unit. This form has a place for a comment by the governorate director of pharmacies. One example: "The governorate has enough contraceptives to last six months."
- 2) Status of MOH warehouses sent every six months. Contraceptive supplies at beginning of month amount received, amount distributed, amount at end of month. A column is provided so that this can be compared with the same time period for the previous year for the different types of contraceptives.
- 3) Same type of information as above but totaled for health units every three months.

- 4) Pills: continuing users, new users, drop-outs.  
Loops: It wasn't clear what information is reported.
- 5) Inspection visits by different supervisors and by types of health units.
- 6) "Logbooks." Number of units that completed forms, didn't complete forms, and didn't have forms. (Not sure about the latter). This is done by a supervisor.
- 7) Activity of those responsible for follow-up of clients.  
Done by a supervisor.

These forms and the TA8 forms are sent to the FP department at the MOH for compilation of national statistics. After the FP department obtains the information it needs from the TA8 forms they are to be forwarded to the Board. The service statistics for the FP units are based on compilation and analysis of data from this form.

Service statistics were compiled and published by the Board on a monthly basis but beginning with 1981 this was changed to a six month report. The report for Jan.-June 1981 is available. The data received are never complete because there are always some units that do not report. As of now (April 1) the Board regards the data as complete through December 1981. The cut-off point seems to be reached when 75% of the units have reported. Seventy days is the average length of time it takes the TA8 to reach the Board. Thirty days is regarded as desirable.

Once completed the Board's service statistics are sent to the following:

PFPB department heads  
FP department MOH  
Governorate health departments via FP dept.  
EFPA  
Governorate FP associations via EFPA  
CAPMAS  
Cairo Demographic Center  
Statistical Institute, Cairo Univ.  
International Islamic Center for Population Studies and Research,  
Al Azhar Univ.  
UNFPA  
USAID, and  
Possibly others.

The FP department does some elementary analysis to obtain the CBR, CDR, IMR and ratio of deaths to live births. The results of these analyses and compilations are sent to Dr. Bermaw, General Director of Planning, MOH. There seems to be considerable duplication of statistical compilation by the MOH and the Board that could be eliminated. Also, it seems that the statistics compiled by the FP department have a very narrow distribution.

Egydrug reports to the Board the contraceptive distribution figures to pharmacies and to MOH warehouses, by governorates, although the table in the service statistics report refers to this as distribution to FP units.

### Incentives

Initially family planning was not part of the regular MOH health services. Some of the clinic personnel were to provide family planning services three days a week in the afternoon after regular clinic hours. To compensate them for this they received the equivalent of what the clients paid for pills (10 pt.) and L.E. 1.00 for each IUD insertion. This was divided among the staff.

With time family planning services became part of the regular health services and although the original justification for the incentive no longer existed, the system continued. It was modified so that people at the district, governorate, and MOH level received some of the clinic incentive money. However, it does not seem to serve as a motivational force: 1) because of the long delays in payment of the incentive; 2) because of the small amount received by the clinic staff; and 3) because some people with little or no relation to FP receive incentives.

Because of conflicting information about percentages it is difficult to determine exactly how the system is supposed to work, but the following is probably correct in outline although it may be wrong in some of the details.

The funds available for the incentive system are the monies collected by clinic staff from the sale of contraceptives and the L.E. 60,000-80,000 the Board has available to pay for IUD insertion. Initially each clinic forwarded contraceptive receipts to the MOH and, eventually, got 100% of it back as an incentive plus L.E. 1.00 for each IUD inserted. However, now they are supposed to receive only 65% (possibly 70%) of the money.

Ten per cent remains at the MOH level where part is used to pay those "ten or so people who have done the work" and the remainder is

dispensed at the discretion of the Minister. It is estimated that the amount available at the central level is about L.E. 25,000 per year.

There are at least two versions of what is supposed to happen after that:

- 1) It might be easiest to illustrate the first version by starting with L.E. 1000. It would be divided as follows:

L.E. 100 (10%)	would stay with the MOH.
L.E. 900	would go to the governorate health office.
L.E. 90 (10%)	would remain there.
L.E. 810	would go to the district health office.
L.E. 162 (20%)	would remain there and
L.E. 648 (65%)	would go to the health units for distribution.

- 2) The other explanation is that 10% remains at the MOH level. 20% goes to the governorate health office where it is divided equally among the district health offices and the governorate office. This leaves 70% for the clinic staff.

There should be a standard formula for dividing this at the health unit level but this information is not always communicated. In one clinic it was divided as follows:

1) Clinic physician(s)	35%
2) Social Worker	15%
3) Nurse	15%
4) Pharmacist	10%
5) Midwife	10%
6) Clerk	5%
7) Two servants	5% each

Assuming a total annual incentive of L.E. 250,000 the average per clinic would be L.E. 42 or, based on the above distribution figures, from L.E. 2 to L.E. 15 per employee per year. Not much of an incentive.

Some of the problems with how the system works are illustrated by the experience of one clinic. When asked when the last incentive was received, no one knew because it had been so long ago. A statement for the payment of L.E. 141.37 on 22 September 1981 was found. Seven months had elapsed since it was received. Neither the time period covered nor the basis for the payment were given.

Five months elapsed between this payment and the one just prior to it for L.E. 89.95 dated 28 April 1981. It stated that this was for pills sold from Nov. 1980 thru March 1981 and IUD's inserted from Nov. 1979 thru Dec. 1980. In other words, in the case of the IUD's, as much as 17 months elapsed between the time of insertion and receipt of the incentive. With such a time gap, this system not only doesn't function as an incentive, but it becomes very difficult for the clinic staff to know if they are receiving the amount deserved. However, by getting the monthly sales and insertion figures for these time periods it was possible to calculate the approximate base for the incentive payment: L.E. 142.80 for the loops and L.E. 45.50 for the OC's for a total of L.E. 188.30. Sixty-five per cent of this, or L.E. 122.40, should have been received rather than the L.E. 89.95 that actually was received.

This type of comparison is not completely justified because the basis for the incentive is the equivalent of contraceptives purchased plus L.E. 1.00 for each loop inserted rather than the sales to clients. However, the two figures should be somewhat comparable as over a period of time purchases and sales should balance out. Clinic staff don't seem to have any idea about what they should receive. They just accept it. And, as indicated for the 22 September 1981 incentive check, there was no reference to the time period covered nor type of contraceptives sold so there was no way of checking on the appropriateness of the payment.

No reference was made to the sale of condoms in the 28 April 1981 statement yet condoms were sold during the time period covered. At the governorate health office we were told pills referred to condoms and pills, but this seems unlikely.

The head of family planning at the district health office visited, who was a recipient of FP incentive, said the district health director made the decision about how the incentive money would be divided but never informed the staff of how the decision was made. She said she thought incentive checks arrived about twice a year.

The governorate health office had received an incentive check at the end of December 1981 for almost L.E. 6,000 which covered the April-August 1981 period. Twenty per cent of this was for "supervision". This was divided into equal parts for the districts and the governorate health offices, i.e. the governorate received the same as one district. Checks were supposed to be sent to the districts on 25 February, but the one we visited didn't receive it until 22 March. The district director was to receive L.E. 40 and

the deputy director L.E. 30. The remainder was to be divided among district level health personnel in whatever manner the director deemed appropriate, thus confirming as policy what we had been told at the district offices.

### C. TRAINING OF PHYSICIANS FOR FAMILY PLANNING

(While the following section focuses on physician training, recommendations for training of nurses are included in several sections.)

#### Background

The Egyptian physician at the present time is the key person in the delivery of family planning services. Estimates on the number of physicians registered with the Egyptian Medical Syndicate in 1980 were about 43,547 with a total of approximately 35,000 in active practice. Of this total 15,500 were employed by the MOH, 4000 by other governmental and public sector agencies, 4000 were house officers, 4500 were in the armed forces and 3000 were full time in the private sector. Approximately 5000 physicians were graduated in 1981 as compared to 3,500 in 1976 and 1,695 in 1970. The number graduating from nine functioning medical faculties in 1982 is estimatee at 5500. Recently measures have been taken to reduce the number of medical students by 10% yearly. However the number of yearly graduates will stay between 5000 and 5500 for the foreseeable future. The MOH is required to absorb at least 2500 to 3000 graduates yearly. The present ratio of physicians per population is about 1/1000.

After a six year course of study and one year internship, all medical graduates have obligatory service in the Ministry of Health for four years. Two out of three physicians spend at least one year of obligatory service in the rural health service. The others (those who score highest on written examinations) can compete for fellowships and other specialized training opportunities. At the completion of the year's obligatory service in the rural health service the physician has the option of staying in the rural health service, persuing a residency in a Ministry of Health hospital, or entering another area of activity within the Ministry of Health.

Medical education in Egypt does not prepare the graduate to function effectively in the facilities of the rural health service. It has been patterned after the early European tradition where lecturing is the main teaching methodology. Discussions, problem solving exercises and group activities allowing dialogue with professors and students are for the most part nonexistent.

Added to this system are the consequences of the Government's policy to completely subsidize medical education. The result is enormous enrollments with classes of several hundred students each. Access to meaningful laboratory and clinical experiences are limited. The curriculum is curative oriented, hospital based and technology centered. Until quite recently little was introduced into the curriculum that might orient the student to consider community needs. Except for reproductive physiology little time is devoted to family planning, population dynamics, contraceptive technology and health consequences of rapid population growth.

### Training Programs

The Ministry of Health and the Population and Family Planning Board have for sometime recognized that the training of physicians, nurses and other health unit staff has been inadequate in preparing them to effectively provide family planning services. Consequently, they have actively supported the development of practical, short term training programs in family planning through governmental and private agencies in various parts of Egypt.

In early 1981, the MOH was instrumental in initiating the development of four major competency-based training programs in family planning that are nation-wide in scope and hold the promise of reaching all newly graduating physicians yearly as well as those who are already functioning in MOH health units. These training programs form a framework for a sequential training activity that could, within five years following active implementation, involve in these four programs the majority of physicians providing family planning services through the more than 3000 MOH health units and the family planning clinics. Since the family planning program in Egypt is a clinic-based program, dominated by physicians and other medical staff, and also because at this time IUD insertions require a physician's intervention, the implications of the nationwide training programs for physicians currently planned and underway are overwhelming.

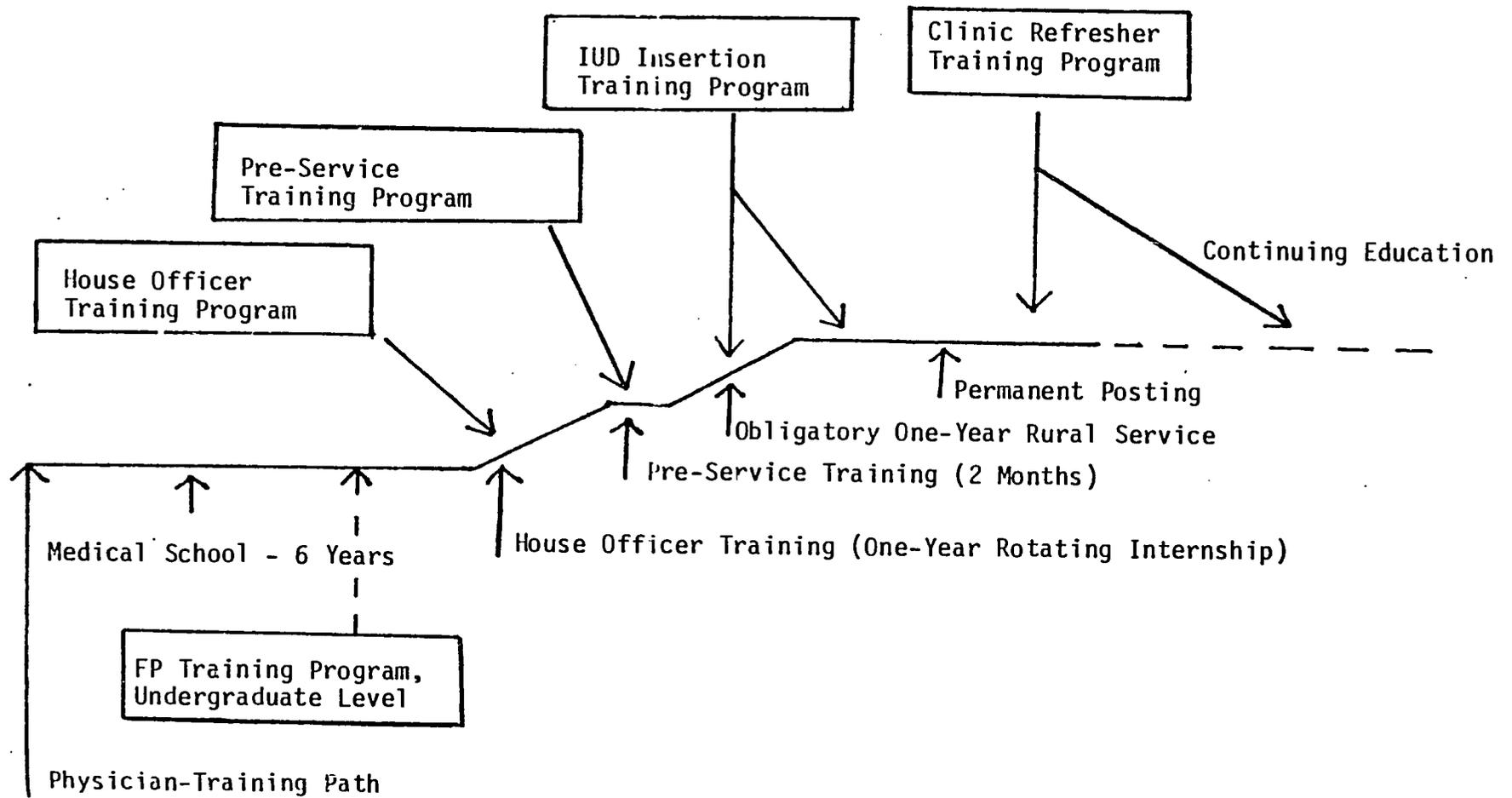
### Family Planning Training For House Officers

Every year approximately 3000 newly graduated physicians rotate through university and MOH teaching hospitals during the one-year compulsory internship (7th year medical training). Two months of this year are spent in the departments of obstetrics/gynecology. The family planning training program will be incorporated into this period and will consist of a theoretical and a clinical component. The one week theoretical component will include a review of

PLANNED SEQUENTIAL TRAINING FOR PHYSICIANS

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reproductive physiology, contraceptive methodology, management of side effects of contraception, management of infertility and other family planning related subjects. The two week practical component will involve practice of IUD insertion on pelvic models during the first week and IUD insertions and diaphragm fittings on clients in MOH family planning clinics and university hospitals during the second week.

A manual will be developed by a board composed of the heads of ob/gyn departments from all universities under the auspices of the Egyptian Fertility Care Society and will be given to each trainee. It will serve as a reference guide. At the end of training, an IUD insertion kit will be supplied to each unit staffed by a physician who has participated in this training program.

The training program will be carried out in the ob/gyn departments of the following hospitals:

1. University Hospitals
  - (1) Cairo University
  - (2) Ain Shams University
  - (3) Alexandria University
  - (4) Al Azhar University Medical Faculty for Men
  - (5) Al Azhar University Medical Faculty for Women
  - (6) Mansoura University
  - (7) Zagazig University
  - (8) Assiut University
  - (9) Tanta University
2. MOH Teaching Hospitals  
19 hospitals
3. MOH Teaching Hospitals in Cairo
  - (1) Ahmed Maher Hospital
  - (2) El Mounira Hospital
  - (3) El Galaa Hospital
  - (4) El Sahel Hospital
  - (5) Manshiet El Bakry Hospital
4. MOH Teaching Hospitals in Alexandria
  - (1) Dar Ismail Hospital
  - (2) El Gomhouria Hospital
  - (3) Ras El Teen Hospital

Management and coordination of this program is the responsibility of the manpower development department of MOH under the guidance of a

committee composed of:

- The director general of the manpower development department.
- The general director of planning department.
- Two physicians assigned by the director general of manpower development.
- Four administrators assigned by the director general of manpower development.

In addition there is a Steering Committee composed of representatives of all government agencies with interests in the project. Its function is planning the activities, follow-up, and evaluation.

The following are recommendations aimed at increasing the effectiveness of this training effort.

- (1) This is a major undertaking which theoretically can reach all medical graduates yearly. The program will involve all the university and MOH teaching hospitals and a number of clinics which will serve as centers for practical training. Although the target group are newly graduated physicians, the opportunities for training and motivating nursing and other paramedical staff during these program activities are enormous and should be capitalized on. Materials (e.g. the manual) developed for this training program could easily be modified and used for the training of nurses and other staff. The manual will contain a synopsis of all subjects covered in the training, practical guidelines for the use of contraceptives including contra-indications, and illustrations on appropriate procedures.
- (2) The complex nature of technical management and control of finances for this activity may impede its rapid implementation. Efforts are required to readily effect a transfer of funds to the governorate levels and to the universities. A standardized format for financial transfers and program management at the governorate levels needs to be developed. An orientation activity that explains the program for directors general, directors of teaching hospitals and heads of departments of Ob/Gyn would be useful to assure standardization in quality, sharing of resources and problem solving.
- (3) A similar program appropriately designed to train nurses in family planning should be developed and conducted at the high

institute of nursing in Cairo and Alexandria. Yearly graduates from these two institutes number about 500. Graduates are employed as head nurses and teachers at the Ministry of Health post-secondary technical and secondary technical nursing schools. In addition efforts should be initiated to introduce other courses and activities into the programs that increase understanding of the population problem. Family planning also should be included in the curriculum of the 128 secondary nursing technical institutes which are attached to hospitals. The yearly graduating class from these institutes is estimated at about 4000.

In view of the prevailing strategy to involve nurses more actively in recruiting and maintaining contraceptives through outreach programs and to eventually participate in IUD insertion, planning for the development of these programs should be given highest priority.

#### Pre-Service Family Planning Training

About 50% of the physicians that graduate from Egyptian medical schools each year are assigned to rural health units throughout Egypt for one year. A two month general pre-service training program has been provided to these new graduates at training centers in Cairo to orient them to the Rural Health Service. In 1980, pre-service training in Cairo was discontinued and this responsibility was shifted to the governorates.

Implementation of this training at the governorate level has not been evaluated but there seems to be a consensus among the MOH officials interviewed that it could be improved. Up until the present time the training has devoted little or no attention to family planning services. Hence there is a major need to incorporate the subject. The Pre-Service Family Planning Training Program is being developed to meet this need. It will train approximately 700 governorate level physician trainers and administrators throughout Egypt over a five year period. The first phase, to be conducted over a period of 30 months beginning August 1982, will train about 240-280 trainers from 10 governorates. Trainers will acquire the necessary skills to train physicians to provide family planning and MOH services within the framework and constraints of the rural health system. For example, in addition to providing basic training in family planning services, it is planned that the trainers will be able to instruct the pre-service trainees in management and administration of rural health centers and units and in development of an outreach program of home visits to be conducted by the nurses, midwives and social workers. The development of an active outreach program by the staff of rural health centers and units is essential in motivating family planning

acceptors, maintaining contraceptive users and delivering health and family planning services.

The trainers training will be conducted at the High Institute of Public Health in Alexandria. This is the only post-graduate, multi-disciplinary public health training institution in Egypt and in the region. The Institute has developed a Rural Health Field Training Center in Abbis II village on the outskirts of Alexandria. Training will be conducted in two stages. The first stage of three weeks will be conducted at the Center in Abbis II and will include development of skills in planning, organizing and implementing a training program for family planning and MCH services for rural health centers and units. Training methodologies will be an integral part of the program. A major outcome will be a plan for a training program to be conducted in the trainees own governorate.

The second stage will take place in the training center of each governorate. The trainers will implement their planned program under the supervision of Institute staff. This stage will last two to three weeks and will include practical training in family planning skills such as IUD insertions.

The estimated number of trainers for pre-service training at the governorates include:

Directors general of rural health	25
District health officers	139
Senior physicians in urban MCH centers	224
Senior physicians in rural training centers of the World Bank	8
Physicians in urban health offices	150
Obstetricians in MOH district hospitals	162
Total	<u>708</u>

The training schedule for this program over a 30 month period includes two sessions per year at the Abbis II Center with of about 60 to 70 trainees per session from 10 governorates. Second stage training then will be conducted in each of the 10 governorates. In summary, between 240 to 280 trainers will be trained over a 30 month period. Expansion of training to cover the remaining 15 governorates is intended following successful completion of the present program.

#### The Rural Health Training Centers (Abbis II)

The High Institute of Public Health has developed a Rural Health Training Center at Abbis II under a collaborative agreement with the

Department of Health in Alexandria which manages the center. The center has been used as a base for students from the NITW to receive field training in the surrounding communities. The nature of the field training is dependent on the yearly "theme", integrating all the Institute's departments. For example, this year's theme is the "Effect of the Environment on Family Health". The Department of Family Health which is responsible for the development of the Center is also conducting special training for their students at the Center emphasizing Family Planning and MCH services. The Department has been active during the past two years in conducting KAP surveys in the communities served by the Center. Information from these surveys has been used to develop operating procedures for the Rural Health Center, job descriptions for the Health Center physicians and staff, family folders for patient record keeping and an outreach program using the nurses, midwives and social workers to provide family planning and MCH services to the surrounding communities. The Department's experience following these surveys and review of the Center's activities has identified the following specific areas in need of improvement if the center is to provide more effective family planning and MCH services to the surrounding communities and serve as an effective training center:

1. Management of Health Center
  - job descriptions for physician and staff
  - record keeping
  - pharmacy control
  - health education
  - contraceptive supply
2. Training of Staff
  - basic skills
  - communication
  - health education and prevention
  - management
3. Outreach Program
  - nurses

The Department of Family Planning is presently attempting to deal with these required improvements and has conducted a training program for the clinic staff in September/October 1981.

In addition, a community outreach program for FP/MCH services in Abbis II village was established in February 1981. The program initially put emphasis and priority on visits to families eligible for family planning services such as families with two or three children. The visits were carried out by nurses and social workers who were

instructed to "diagnose" the family situation and attitude before introducing the subject of family planning and contraceptive use. Before the pilot outreach program was initiated, the Department staff found it necessary to train the clinic nursing staff in basic nursing procedures and practical procedures including record keeping and recording events in the family folder.

The visiting load was left up to the judgement of the home visitors and resulted in three or four visits per outreach worker per day. During the initial phase, a daily meeting was held with the nurses following their home visits to discuss the day's activities, problems and actions to be taken. The visitors have consistently reported positive attitudes towards family planning held by the villagers. Initial assessments of the activity indicate a remarkable enthusiasm within the nursing staff in dealing with the families, performing basic procedures, motivating acceptance of family planning and other health measures, and counseling referral to the health center when required.

The Department of Health also has prepared four self-instructional modules related to family planning for the forthcoming pre-service training activity on (1) oral contraceptives, (2) intra uterine devices, (3) breast feeding, and (4) other contraceptives. These materials have been pre-tested in the governorates of Assuan and Port Said.

A newsletter "Family Health and Family Planning" has been developed (January 1981) and distributed to approximately 500 participants who have undergone training at the Abbas II Center. The newsletter is written in simple English and the first issue contained the following articles: "A limited KAP study helps before starting activities in family planning"; "Reaching mother at home"; "Diarrhea kills our children, In what way ??"; "Oral rehydration to save children"; "A challenge against traditional birth attendants."

It is recommended that this newsletter be institutionalized at least on a bi-monthly basis and distribution should be expanded to all physicians in the Rural Health Service, training centers and MCH centers in addition to all the participants of Abbas II training. It should be expanded to include space for readers to write in requesting advice on matters related to family planning and MCH services. An estimated distribution of 5000 copies would cover the needs indicated above. It would complement the physicians' bulletin now being published by the Egyptian Fertility Care Society. It would serve to provide continuing education to the rural physicians following their pre-service training and also would create a network for communication for individuals experiencing similar problems.

Additional recommendations for the pre-service training program include:

- (1) In order for the Department of Family Health to carry out these activities, major emphasis and priority effort is required to identify and train young faculty and staff within the Department to assume specific program responsibilities. Faculty and staff should be identified for short term training in teaching and training methodologies, management of rural health services, contraceptive technology, family planning and population dynamics.
- (2) Other select faculty involved in this program should make visits to well known training institutions in southeast Asia (Indonesia and Thailand) in order to observe training methodologies developed by training institutions dealing with rural communities and family planning using self-teaching, non-directive learning approaches.

Training of MCH/FP Physicians in Traditional Contraceptive Use, IUD Insertion and Diaphragm Fitting.

The increasing demand for IUD's has created a pressing need to rapidly systematize and expand training for physicians in IUD insertion as well as in traditional contraceptive use and diaphragm insertion. A training program was initiated in May 1980 to conduct six training programs yearly in four governorates: Alexandria, Gharbia (Tanta), Sharkia (Zagazig) and Menia. Each training program involves 20 participants for a total of 120 physicians in each governorate. Thus, over a two year period, approximately 960 Egyptian physicians would be trained. The program was initiated in Alexandria and followed with programs in Tanta. Thirteen training programs have been conducted in each. Three programs were conducted in Zagazig before management difficulties suspended further training. Training has not yet been initiated in Menia. In total about 520 physicians have been trained thus far. Plans are underway to initiate training in Assiut, which will serve as a regional center for Upper Egypt, and in Dakahlia within three months.

At the present time the duration of program is 13 days and includes practical training, lectures and seminars. At the end of the training the participants are expected to:

- Have improved their knowledge and understanding of:
- The population problem in the world and in Egypt.
  - Current concepts regarding pre-natal care, childbirth and post-natal care.

- Care of the newborn with diarrhea and dehydration.
  - Relationship of breast feeding and family planning.
  - Methods of contraception and appropriate choices.
  - Evaluation of family planning services and activities.
2. Have developed skills in the use and insertion of IUD's
  3. Have developed attitudes conducive to motivating family planning acceptors and understanding of socio-cultural factors affecting contraceptive use.

A typical list of lecture and seminar topics is as follows:

- Population problem in Egypt and the world.
- Evaluation methods of the family planning activities.
- The physiology of pregnancy and the natural methods for birth control.
- National population and family planning policies.
- Chemical hormone methods: types, chemical composition, indication, side effects and proper utilization.
- The social and economic factors affecting fertility.
- Antenatal care of pregnant women.
- The diaphragm and local contraceptives.
- Child care: management of diarrhea and dehydration among children.
- The statistical data used and required.
- Seminar about medical registration in family planning.
- IUDs: types, indication, side effects and proper utilization.
- Seminar about IUDs.
- Surgical methods and laparoscope: kinds and criteria of utilization, periodical examination for early detection of cancer of the cervix (Pap Smear).
- Check-up of regular patients and choosing the suitable methods for birth control.
- Means of communication, education and information.
- Evaluation and discussing the program.

Trainers are recruited from the departments of obstetrics and gynecology of the university hospitals as well as from the MOH teaching hospitals. Practical training is conducted in the hospitals and selected MCH centers.

Participants are recruited from the rural health centers, rural units and other MOH units. Management of the program is the responsibility of the undersecretary and/or director general for health services of the governorate.

At the end of the training program each trainee is given an IUD kit, IUD's, and diaphragms and educational material. It is intended that the trainers and consultants involved in the training will make consultation follow-up visits to the trainees' site of work for further guidance. A recording and reporting system for contraceptive methods and prevalence and a register of trainees has been established.

Recommendations For In-Service Training:

- (1) There are about 3600 health units (private and government) providing family planning services and only about one-fourth have the capacity to insert IUD's. A reasonable target within the next two years would be to double the present capacity for training from 500 per year to the level of 1000 physicians per year until all units providing family planning services have the capacity for IUD insertion. A maintenance training capacity level of 500 trainees per year thereafter would cover retraining requirements and physicians who would not have received IUD training in the projected House Officers Training in Family Planning program scheduled for implementation in July 1982 (see below).
- (2) Approximately 3000 physicians are in private practice full time or are involved with MOH and other governmental agencies in activities that would not normally involve them in IUD training. A specific training program for this group is required and can probably best be coordinated by one of the private voluntary agencies with technical expertise and training experience such as the Egyptian Family Planning Association, the Egyptian Fertility Care Society or the Family of the Future.
- (3) Upper Egypt has special problems regarding IUD insertions. A training program for nurse-midwives in IUD insertion would be useful and feasible at the medical faculty of Assiut University.
- (4) A review of the current training program has identified some areas requiring improvement. Ob/Gyn specialists recruited as trainers have different perceptions regarding family planning services, contraceptive use, issues related to appropriate choice of contraceptives, and the MOH policies and practices. For example, team members observed one round table discussion led by three Ob/Gyn specialists. Each one urged upon the trainees his preferred method of contraception in spite of the fact that their opinions may have been at

variance with the accepted MOH policies. In addition the unstructured nature of the presentations resulted in grossly misleading statements in terms of current knowledge and facts regarding contraceptive use, indications and contra-indications.

This underscores the importance of developing standardized training materials covering the major topics discussed, such as a manual for trainees. This manual could serve as a reference document when these trainees return to their unit. It could also serve as the core curriculum around which seminars and informal discussions could be structured.

- (5) It would also be useful to hold orientation sessions for trainers prior to conducting the program in order to review the major objectives of the training and make them aware of prevailing MOH policies and procedures governing the provision of family planning services.
- (6) In order to stimulate trainee participation, a problem solving "mini-workshop" format could be incorporated into the training structured around problems regarding family planning services encountered by the trainees in their health units.
- (7) Another subject for special attention within the problem solving context is how to improve the recording and reporting system and its implications.

An improvement and rapid expansion of this training program could have an immediate impact on increasing the numbers of IUD acceptors and should continue to receive priority support.

#### Clinic Refresher Course in Family Planning

Work on this program was initiated in May 1981. It is designed to provide training to medical and support staff in the more than 3,000 Ministry of Health (MOH) facilities and 500 public sector clinics which provide family planning services. The purpose of the training is two-fold: 1) To increase the knowledge of clinic staff in methods of communication and education with special reference to family planning services and contraceptive use; and 2) To increase the acceptability of family planning services provided by the clinic staff.

The program will be directed by the MOH and will be developed in collaboration with the State Information Service. It consists of three parts:

1. A three-hour, pre-programmed refresher training course for

all health staff.

2. Establishment of a central training team which will pilot test the course and train governorate training teams.
3. Establishment of 25 governorate training teams which will present the course to all health facility staff in Egypt.

The Clinic Refresher Course is designed to prepare the health unit staff technically and psychologically to assume increased responsibility for providing family planning information and related counselling. Five films are being prepared covering on following major themes:

- (1) Physiology of reproduction.
- (2) Methods of contraception.
- (3) Introduction to the problem of side effects and what to tell clients about them.
- (4) Techniques of counselling clients for family planning.
- (5) Questions most often asked about family planning by clients.

The films are being made in Egypt and are in Arabic. The health unit physician will be trained to participate in the presentation. The entire course will last three hours but can be divided into smaller discrete sections.

A central training team will be established to train governorate level training teams. Teams will consist of an MOH physician, a health/adult education specialist, an administrator, and a driver/operator of mass media equipment.

Each governorate training team will have the following equipment and materials:

- (1) Vehicle (van) fully equipped for audio-visual presentations and electrical power generating capacity to run equipment.
- (2) Films for the recorded portions of the refresher course, 16mm projector and screen.
- (3) Plasticized, ten page flip chart with stand explaining to clients the male and female reproductive systems and contraceptive methods.
- (4) A supply of one-sheet leaflets on all contraceptive methods available in Egypt to be distributed to clients.

- (5) A supply of one-sheet leaflets explaining each contraceptive method.
- (6) A set of posters illustrating all contraceptive methods to be put on the walls of health facilities.
- (7) A display of contraceptives.
- (8) Copies of a fact book on family planning including chapters on contraceptive methods.

The course will be field tested by the central training team and three governorate teams in 10-15 health facilities in September 1982.

Technical assistance for the development and production of material is provided by the Social Development Center of the University of Chicago.

Recommendations:

The majority of the physicians and health unit staff in facilities which provide family planning services have been inadequately trained to provide effective family planning services. The clinic refresher program holds the promise of supplying this training and assisting in the development of skills that will allow the health unit staff to more effectively reach and communicate with their clients. The program places a heavy administrative/management burden at the governorate level to maintain equipment, supplies, training materials and schedules.

The following recommendations are made concerning this activity:

- (1) Coordination be effected with rural health services management in order to plan for the timely introduction of additional interventions to this training process covering other MCH problems directly affecting infant/child mortality. However, this should not be attempted however until the delivery/training system is in place and functioning at least in the three test governorates.
- (2) The temptation to overload this training program with messages other than those specifically geared to increase contraceptive use will be great and should be resisted until the system establishes the fact that it can carry out the family planning content. A system of gradually adding on could then be developed starting with oral rehydration. A dialogue should begin with management of the Rural Health Project (USAID assisted) in order to consider initial integration demonstration

efforts in select rural health centers and units in the four governorates, Behera, Dakahlia, Fayoum and Assiat, which will come under this program.

Recommendation regarding the coordination of USAID assisted Training Programs in Family Planning

These programs represent a major effort and will require the active coordination of the universities, private voluntary agencies and other government bodies working with the Ministry of Health. On a day to day basis, effective management of these training activities will require the establishment of a separate coordinating/management unit for family planning training within the appropriate division of the MOH relating directly to the donor agency which supports these program. The need to involve and contract for a wide range of technical assistance, both foreign and domestic, in the implementation of these programs necessitates that the coordinating management unit be able to respond rapidly and with flexibility and also be able to readily collaborate with private and other governmental bodies. Because these training activities are nationwide, a central coordinating body with appropriate representation also would be useful in maintaining standards and evaluation. Decentralizing management to the governorate levels with the establishment of a governorate level training committee to organize, manage and evaluate training in each governorate is essential. This committee should be chosen from among the following governorate officials:

- Director Training, MOH
- Director of Population and Family Planning
- Director of Family Planning Association
- Director of Training, MOSA
- Director of Training, MO Manpower and Training Directorate
- Population Education Officer, MOE
- Director Training, Youth Directorate
- Director Training, M. of Information.

Technical assistance for these activities is being provided by USAID and is estimated to total approximately \$4 million over a 5 year period.

Clinic Refresher

PIL\* #26

Time Frame: April 25, 1981 to Oct. 15, 1983 (30 months)

Technical Assistance: Social Development Center, University of Chicago

Budget: \$1,976,176

Family Planning Training for House Officers

PIL\* #38  
Time Frame: 30 mos May 1981  
Technical Assistance:  
Budget: \$607,819

IUD Training

PIL #17  
Time Frame: May 1, 1980 - 2 years  
Budget: L.E. 429,860

Pre-Service Training

PIL #28  
Time Frame: 30 mos - Feb. 1982  
Budget: \$620,728

Ship

PIL #27  
Time Frame: May 1981 - April 1982  
Budget: L.E. 184,000

Other Training Of Physicians By the MOH

Additional training for physicians to improve their capacity to provide family planning services has been developed and coordinated through the Office of the General Director, Department of Family Planning, MOH. These programs have been conducted in Sharkia, Dakahlia, and Alexandria with assistance from the West Germany government. Approximately 14, two-week courses have been held since 1979, training approximately 300 physicians. This office has also participated in the training of house officers in Alexandria and, in collaboration with the International Islamic Center for Population Studies at Al-Azhar University, in training of central trainers and MOH staff at Al Galaa Hospital. Since 1979 ten two-week courses have been conducted training about 300 physicians. Support also has been provided to the Health Improvement Association enabling the Association to conduct two IUD training courses of two days duration for physicians working with the MOH and the Family Planning Association in Cairo.

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\* PIL - Project Implementation Letter

Sharkia International Project (SHIP), International Islamic Center For Population Studies and Research, Al-Azhar University

The International Islamic Center established the SHIP Project in May 1981 in Abu Kir and Hehea districts of Sharkia Governorate covering about 50,000 people. The Project will serve as a coordinating and referral center for basic health and social services provided by satellite units. The services will include MCH and family planning, first aid and emergency care, social welfare, community development, and collecting vital statistics. The Center will provide training opportunities for undergraduate medical students, pre-service training, and post-graduate training in community medicine and family planning. Approximately 600 undergraduate medical students will receive two weeks training yearly at the Center in community medicine and family planning. Post-graduate training will involve about 200 trainees for one week yearly in the house officer training category and in the pre-service category.

Training for Surgical Contraception

Gynecologic laparoscopy and mini-laparotomy training is available at all university hospitals during the basic post-graduate training leading to the M.Ch. in obstetrics and gynecology. A standard requirement recently introduced into the curriculum is a separate family planning course and questions on family planning are now being included on the examination for the M.Ch. degree in Ob/Gyn.

The Egyptian Fertility Care Society (EFCS) has developed a training program in gynecologic laparoscopy in eight university hospitals. Approximately 80 trainees have been certified since 1980 through the Society-sponsored program. Laparoscopes have been provided to all university hospitals and to certain MOH hospitals such as Al-Galaa, Om Elmasreyeen in Ismailia and Menoufia, and mini-lap kits have been provided to the health units served by the trainees. A repair and maintenance (RAM) center for laparoscopy equipment has been established in Assiut. Support for these activities has been provided by the International Project of the Association for Voluntary Sterilization (IPAVS).

The EFCS produces a bi-monthly bulletin on family planning, in English, that is distributed to about 5,000 physicians through the computerized distribution system of Al-Ahram newspaper. The Society also holds scientific seminars for physicians and carries out a variety of IEC activities.

Recommendation: The EFCS has been active in promoting surgical contraception. It is an affiliate of the Egyptian Medical Association and is strongly connected to the leadership of the Association of

Obstetricians and Gynecologists and departments of Ob/Gyn in the university medical schools and the Society was instrumental in developing the training program and educational material that will be used in the house officer training programs of the MOH. The EFCS has the capacity to develop and implement a wide range of training programs in family planning for physicians and its expertise should be utilized by the MOH.

#### Pathfinder Fund of Egypt

Through its collaboration with the Family Planning Association of Alexandria the Pathfinder Fund has established a clinic in Alexandria that provides training in family planning services and IUD insertions by private physicians.

D. INFORMATION, EDUCATION AND COMMUNICATION (IEC)

Amendment 4 to the USAID Family Planning Project (November 1981) states that:

With multi-tiered service and supply networks being established nationwide, there is an obvious and corresponding need for a well articulated mechanism to stimulate demand at all social levels of people who are (or soon will be) of reproductive age. This is the mission of the Information, Education and Communication elements, ranging from the mass media's central GOE messaging from Cairo, and such reinforcement as can be gotten from governorate levels, to the sensitization and enlightenment of local leaders on population matters, and, finally, the face-to-face motivation that can be effected door-to-door in rural and village settings.

Since 1978, when IEC was added to the Project, AID has obligated \$7.5 million for this element.

In the last few years there has been a tremendous increase in IEC efforts in support of family planning. The following is a review of some of the major IEC efforts operating today:

1) State Information Service (SIS) Population IEC Project.

The SIS project began its first, full-scale mass media campaign in January, 1980. Since then it has produced a wide range of materials such as print, radio and TV ads, TV and radio programs with a family planning theme, films, pamphlets, booklets, posters and other promotional items. It also carries out local promotional activities and organizes conferences and training activities. A detailed description of the SIS program can be found in Annex II D.

2) Family of the Future.

Family of the future has an active IEC program aimed at: (1) promoting FOF products to the general public; (2) promoting the sale of FOF products by pharmacies & private physicians; (3) informing the general public about family planning. The IEC strategy has both mass media and interpersonal communication components. Both are given almost equal weight in the FOF approach.

a) Interpersonal Communication. FOF's interpersonal communications approach aims at two audiences:

(1) Health professionals. These people are reached through FOF's medical representatives (MRs). The MR's task is to promote FOF products but, in addition, to educate pharmacists and physicians about the products.

(2) General public. The general public is reached through FOF's 100+ volunteers. These are mostly college graduates waiting for assignments in government offices. They receive no salary but get money for travel, expenses and bonuses. They work mainly by:

(a) Setting up rallies for various groups (factory workers, soldiers, clubs, etc.) that feature a speaker on one or more family planning topic. Promotional materials are given away at these rallies. The featured speaker is usually an physician, but there may also be a religious leader, educator or other professional. Experience shows that generally the physician is sufficient.

(FOF Director Effat Ramadan states that once you begin to talk about health issues, interest in religion takes a back seat. People are interested in their health and well being first).

(b) House-to-house visits. Volunteers make visits to talk to people about family planning. They are not allowed to distribute contraceptives. This is against the law. They do give out information and suggest where contraceptives may be obtained.

b) Mass Media

FOF has effectively used the mass media to promote its products. Both studies done by FOF and the SIS baseline survey show that there is an increasing awareness of FOF products among the general public. Currently FOF promotes the following products: Tops condoms, Amaan foaming tablets, Copper T, and Copper 7 (Gravigard). It is planning to promote an oral contraceptive in the near future.

FOF must submit their ads to a committee for approval before they can go on the government controlled TV and radio. This has been a problem since the ruling panel has not allowed them to link their product names to the products' function -- e.g., you can mention Tops, but you can't mention what it is! FOF has gotten around this by use of indirect advertising -- sponsoring programs dealing with family planning and mentioning products by name.

During 1981, FOF placed the following ads:

Television	Indirect	280 (on 2 channels)		
Radio	Indirect	665 (on 5 channels)		
Print	Direct	Dailies	80	
		Weeklies	79	239
		Monthly	49	
		Other	31	
		Indirect	Dailies	27

In 1982, FOF will introduce two new products: Golden Tops, a higher priced condom in a new package, and Nordette oral contraceptives. Large-scale promotions of these products are planned in addition to continued advertising of existing products. A media plan has been developed for FOF by Porter-Novelli advertising agency under FOF's technical consultant contract with Triton.

FOF has developed some print materials. They have their own version of the Rafaat Kamal booklet on "How Not To Get Pregnant" (SIS also distributes this booklet but with another back cover). They are thinking of redoing it as a series of pamphlets. They have a small brochure on methods and some more technical pieces on the IUD for clinicians and pharmacists.

FOF has also developed a lot of promotional materials: football scorecards, paper hats (usually handed out at football games), plastic cups, etc. They have also developed product display units for pharmacies.

c) IEC Research/Market

FOF is developing its own in-house capacity for message and materials testing. They primarily make

use of their volunteers who gather data through such things as the pharmacy intercept study carried out in fall, 1981. This study recorded client attitudes about FOF products and family planning in general. They have also begun to use focus groups (small, homogeneous groups selected as representative of different audiences) to test messages and materials. Plans call for an expanded research program in the coming year.

3) Population and Development Project (PDP)

PDP has developed a number of materials to support personnel at various levels of its organization. For example, they have produced two handbooks for raayda refiya. They also were publishing a regular PDP bulletin but this was discontinued due to lack of funds.

The basic communications emphasis in PDP is on face-to-face communication. They carry out numerous training programs to develop the interpersonal communications skills of their personnel. They are using the Macmillan Visual Learning System (magnetic boards) in both their training and outreach activities.

4) Ministry of Health.

The MOH does not have its own communication program. However it has been responsible for production of some materials (e.g., a slide set) and is now overseeing production of the films that will be used in the Clinic Refresher Training Course. It will work with the SIS on development of print materials for this course.

The World Bank Project within MOH is involved in an outreach program. They are using the magnetic boards in this program as part of their training activities. Apparently they are also planning to develop orientation materials. They do not seem to be aware of the materials prepared by PDP and SIS.

The MOH has a materials development and production center on Roda Island. The Roda Center was financed by WHO although it is now operated by MOH. It is situated in a new facility and has modern equipment for production of slides, tapes, films, video and print materials. Most of its work is in support of nurses training programs. It has

done a few materials for family planning. The facility appears to be underutilized.

5) The Egyptian Fertility Care Society (EFCS).

The EFCS has a small but active IEC program. They hold frequent seminars for physicians and opinion leaders and have developed a series of TV programs that address the health hazards of high parity. With support from PIACT and the IFRP, they are now publishing bimonthly bulletins on family planning for doctors (English) and pharmacists (Arabic) which are widely distributed throughout the country.

Awareness of Family Planning in Egypt

Data collected in the SIS Baseline Survey (1980) brought some interesting information to light. For example, the survey clearly showed a high level of awareness of family planning among the 2,000 people interviewed (the survey attempted to get a representative sample of male/female and urban/rural) as indicated in the following table. It is particularly interesting to note that when people were asked to spontaneously name family planning methods, "injections" were the third most frequently cited method and "female sterilization" the fifth most frequently mentioned even though neither method is a part of the national family planning program.

Table 1.  
Percent of Respondents  
Who Had Ever Heard of Specified Methods of Contraception

Method	Total	Male	Female	Cairo/ Alex.	Other Urban	Rur
Oral Pill	98	97	98	100	100	96
IUD	74	66	82	90	87	62
Injections	55	52	59	57	62	53
Diaphragm	26	21	31	39	33	18
Vaginal Tablets	13	14	12	21	19	7
Creams, Jellies	12	10	13	19	14	7
Condom	37	40	34	61	55	20
Female Sterilization	35	34	35	44	47	25
Male Sterilization	18	23	11	25	23	21
Rhythm	21	24	18	40	35	7

The survey also revealed that the majority of respondents either "approved strongly" or "approved moderately" of family planning.

Table 2.  
Percent of Respondents Who "Approve Strongly" or  
"Approve Moderately" of Family Planning, by Sex and Urban-Rural Residence

Respondent	Average	Approve For	
		Spacing	Limiting
Male	89	89	88
Female	93	93	94
Cairo/Alexandria	91	90	93
Other Urban	93	94	93
Rural	89	90	89
Total	91	91	91

However the survey also pointed up two areas of major concern in terms of program implementation in Egypt: people greatly underestimate the reliability of modern contraceptive methods:

Table 3.  
Perception's of Reliability of Modern Contraceptive Methods

Method	Very Reliable	Moderately Reliable	A little Unreliable	Very Unreliable
Oral Pill	52	23	21	4
IUD	40	25	29	6
Injections	46	33	16	5
Diaphragm	29	30	33	8
Vaginal Tablets	27	22	44	7
Creams, Jellies	25	26	35	14
Condoms	28	23	37	12
Female Sterilization	81	12	5	2
Male Sterilization	75	16	6	3
Rhythm	20	20	35	25

They have exaggerated fears about the effects of contraceptives on health.

Table 4.  
Perceptions of Contraceptive Safety

Method	Very Safe	Moderately Safe	A little Unsafe	Very Unsafe
Oral pill	13	12	45	30
IUD	24	16	39	21
Injections	47	24	20	9
Diaphragms	41	21	23	15
Vaginal Tablets	47	16	27	10
Creams, Jellies	53	19	24	4
Condom	72	9	13	6
Female Sterilization	68	10	10	12
Male Sterilization	61	14	7	18
Rhythm	87	8	3	2

#### Information Needs and Recommendations

The largest gap in the IEC program seems to be at the clinic level. There is little, if any, material in clinics to be used by staff explaining reproduction, contraceptive methods and side effects and materials to give to clients. There is a particular problem with client materials because a large percentage of Egypt's population, particularly women, are illiterate. Therefore, existing publications on methods are of little use to most of the target audience. It is therefore recommended that:

1) Priority attention be given to development of print materials for illiterates. A quick way to get something into people's hands would be to reproduce the 8-10 principal messages from the Macmillan magnetic boards and being widely introduced throughout the Egyptian program. The pictures could be reproduced on newsprint to make small pamphlets on reproduction and the different methods. If done in black and white, they could be reproduced for about 5¢ per copy. The price of color reproduction should be checked out

well to see if, given the large print run, it would be economical to reproduce the colors as used on the boards themselves. (Studies show Egyptians tend to prefer bright colors.) These pamphlets could then be given out by raayda refiya when they make home visits. They would reinforce the information given by the raayda for both the acceptor, by reminding her how to use the method correctly, and for the undecided by allowing them to discuss the contents of the pamphlet with family and friends. Research done by PIACT in Mexico has not only shown that women given pictorial materials to take home after a verbal presentation retain knowledge longer and with greater accuracy, but also that they enjoy sharing the materials with friends and neighbors since they can tell the story from the illustrations. These materials could also be given out in the clinic by all members of the health team.

2) The capacity to develop, test and produce simple pictorial materials for illiterates should be developed so that the various programs can reach people at the grass roots level with specific family planning information (information not well suited to delivery by the mass media). Such a capacity should be developed by people who are in touch with and have empathy with the target audience and kept away from middle class bureaucrats who think they understand what poor urban and rural audiences want and need to know. The expertise of Egyptian anthropologists who have considerable experience with the target audiences could be called upon. More importantly, those actively involved with the illiterate audiences, such as the raayda refiya, should be used in the actual testing of materials because they are known and trusted by the community. The final decision as to what messages and illustrations are used must always rest with the target audience. When developing materials for non-literates, the opinions of "experts" should be systematically ignored.

Two possible venues for this type of activity are the Family of the Future and the Alexandria Family Planning Training Institute. Family of the Future has begun an active program to test product recognition and messages through use of small "focus" groups and intercept studies. Mr. Effat Ramadan has been opposed to client materials on the grounds that they are useless to people who don't read. However, he is not opposed to the idea of print materials for illiterate audiences. The idea of expanding his market research capability to include this type of expertise might be explored.

Mrs. Salha Awad at the Family Planning Training Institute in Alexandria is interested in developing a small cadre of raayda refiya that could become "master trainers". They could then go around the country both training other local trainers and assisting in development of training programs. If such a group were organized, a logical extension would be to also give them training in how to test simple materials at the grassroots level. They would work in conjunction with materials developers and artists, but they should be participants in developing the concepts as well as in testing messages and visuals materials. They could become a resource that could be used by a variety of different programs, e.g., SIS and PDP.

3) A number of training programs for physicians are now getting underway. Before the impact of these training efforts can be realized on a wide scale, there is a need for some simple, standardized materials for clinic staff. There is a tremendous amount of misinformation circulating in Egypt, not only among the general public but within the health community as well. A standardized manual could make a real contribution towards spreading correct information about family planning. These manuals should include information on traditional methods, outline correct usage of these methods and emphasize that they can be reliable when used correctly. Numerous copies of the manuals should be made available to every clinic providing family planning services so that they can be readily accessible to all staff dealing directly with clients.

The SIS has printed a pamphlet for pharmacists and clinic staff on methods. They also have shorter, less detailed booklets and flyers suitable for a more general but literate audience. Copies of these materials need to get out to clinics in large quantities. Distribution should be the responsibility of MOH, PDP and other appropriate agencies. If MOH or PDP feel that these pamphlets need to be improved, then they should work with SIS by providing suggestions for revised editions. SIS might want to consider establishing a medical review committee to routinely review materials on medical subjects or they might retain the services of a medical expert on a consultant basis. In the meantime, the existing materials need to be disseminated because what is available out there now is nothing at all.

There should also be some simple charts to be used in support of oral presentations. These would be inexpensive charts that could be widely distributed and would supplement use of the more expensive magnetic boards.

4) The Egyptian Fertility Care Society began publishing bimonthly bulletins for doctors and pharmacists in January, 1981. These bulletins should be continued. In addition, similar bulletins for nurse/midwives and possibly for social workers and raayda refiya should be considered.

#### Intra and Inter-Program Communication Recommendations

A lot of data are gathered at all levels of Egyptian family planning programs. However little of this information ever filters down the line to inform the various units "how we're doing" in relation to other segments of the program and in relation to targeted goals. The following recommendations are addressed at improving the situation.

1) Family planning programs, such as MOH and PDP, should develop in-house bulletins, produced on a regular basis, that will inform various program units of their performance in relation to other units. The need for such a communication system has been noted at several places in this report as critical to improving program performance.

The bulletins could be prepared at the governorate level. In addition to data on performance they could include notices of awards for highest levels of achievement, news about program innovations and general information on population and family planning. The publications could make good use of photos and other graphics to make them appealing to their audience.

2) It is also suggested that consideration be given to providing the services of a short term consultant with expertise in information dissemination to look at how information flows within and between various family planning agencies. Many program staff never seem to see reports, papers or service statistics generated by their own agencies or those sent to them from external sources. It would be the role of the consultant to determine if there are some reasonable interventions, such as "packaging information" in a particular format, that would allow important knowledge to get into the hands of those who need to know.

#### SIS Population IEC Project Recommendations

At the present time, the SIS is the major player in the IEC field in Egypt. Most of AID's assistance for IEC goes to this project. In the two years that the current program has been under way, SIS has accomplished a lot. (See Annex II D for an idea of the broad range of activities being carried out.)

There was a lot of criticism of the program when it first got underway. Critics lambasted the artwork, the symbol, the messages. However it should be kept in mind that before SIS there really wasn't much in the way of IEC activities in Egypt. When looking at this project it must be remembered that the SIS: (1) has produced a lot of materials; (2) has in a large part been responsible for making family planning almost a household word; and (3) has proven that you can talk about family planning, including contraceptive methods, via the mass media without any backlash. There is no doubt that the SIS project will continue to play an important role in the Egyptian population and family planning program for some time to come, and it is encouraging to see that there is beginning to be some coordination between the SIS and both the private and public sector programs.

Now that SIS has institutionalized its population IEC project and the unit has had two years of experience in development, production and distribution of materials, it may be an appropriate time to begin to think more about the quality of the products rather than the quantity of materials produced. There is a danger of overplaying the awareness angle to a point where people begin to turn off to an all-to-familiar family planning entreaty. The project now might begin to put more time and effort into the construction of future campaigns. It may also want to consider developing some "mini" campaigns aimed at particular subsections of the population.

The SIS is currently working to strengthen its 50 regional information centers. As part of this effort, some funds are to be provided to these units for local campaigns. This is a direction that should be encouraged and could produce some excellent results.

Some other suggestions relating to the SIS project include:

1) It would be helpful if the SIS were able to devote more time to pretesting materials. Their small, four person, research department is involved not only in pretesting but in campaign monitoring. This involves extensive travel throughout the country. It would be useful if additional staff could be made available for the research unit in Cairo. It would also benefit the program if some pretesting capacity could be developed in a few of the larger regional offices. This would allow materials to be regularly sent out for pretesting and then returned to Cairo. Local staff might also be able to take over some of the monitoring activities thus reducing the amount of travel required by central staff. This should result in more culturally appropriate materials that will appeal to a broader audience, particularly the rural and urban poor.

2) The SIS has no in-house capacity to design or produce materials. All work is done outside and frequently is carried out by the production departments of newspapers, TV or radio companies. The campaigns could benefit from some new ideas in terms of artwork, messages, etc. Therefore it is suggested that SIS endeavor to cast a wider net for good talent. This could involve use of private agencies. The SIS could also make use of materials developed through other agencies. For example, some excellent family planning posters have been produced through programs of the Alexandria Family Planning Training Institute and the Ministry of Education's Population Education Project. Some of these posters could be duplicated and distributed or some of the artwork could be utilized in other aspects of the campaigns. Some of the participating artists also might be engaged to work on future SIS projects.

Another possible source of new materials could also serve as an SIS media event. Art competitions for school children on national themes are common in Egypt and Egyptian children are known for their colorful and imaginative paintings. SIS could organize competitions on a population theme first at a district or governate level. Prizes could be awarded and finalists would compete in a national contest. Again prizes could be awarded and the awards ceremony would make an excellent media event. The winning paintings could then be reproduced by SIS for widescale distribution.

3) The technical assistance contract with the Social Development Center, University of Chicago, expires October 15, 1982. Consideration should be given to providing some further technical back-up to the program.

This might possibly be done through Temple University, Cornell or another appropriate contractor with development communications expertise.

4) A follow-up study to evaluate the impact of the SIS campaign to date is now underway. The data have been collected by CAPMAS. There now appears to be some confusion as to how the results will be analyzed. It is hoped that these difficulties can be worked out as soon as possible so that the analysis can go forward and the SIS can make use of the results in future program planning. The SDC should be encouraged to get the results published as quickly as possible (it should be noted that there are still some volumes from the 1980 Baseline Survey yet to be published.)

#### Additional IEC Recommendations

1) Consideration might be given to development of some cassette recordings for use in clinic waiting rooms. To make these appealing to both clients and clinic staff, some information on family planning, nutrition, health, etc., could be interspersed with music and other entertainment. A series of cassettes should be produced so that there is some variety. Popular songs, including the family planning song that has become a "hit" could be used. Cassette technology is simple, easy-to-use and maintain, and playback equipment is relatively inexpensive. These cassettes could be produced through SIS or possibly the PDP.

2) Some experiments in the use of video-tape have been carried out in Egypt. At this time it is not recommended that video-tape become a major emphasis within the IEC program. This is an advanced technology. Equipment is expensive and there is no capacity for maintenance outside of major cities and even there it is probably limited. It is also questionable how the equipment would hold up given conditions in rural areas. There might be some limited use of video tape for training activities within active centers such as the Alexandria Family Planning Training Institute.

3) The Visual Learning System developed by Macmillan is now in use in Egypt. This has proven to be a popular means of presenting information on family planning and health that reinforces presentations by trainers and service providers. The kits are expensive and are made up of a large number of individual pieces. It is suggested that the durability of these materials be carefully monitored to see how they withstand dust, dirt and continuous handling. In some of the kits it is difficult to return the pieces to the right "envelopes". Therefore, they get mixed up. Notice should also be taken to see if pieces frequently are lost. If this proves to be the case, consideration might be given to reducing the number of pieces incorporated in each segment of the system.

4) Interpersonal communication is a vital element in the Egyptian program. On-going efforts to promote and improve face-to-face communication

skills should be encouraged. In addition there is a need for more and better on-the-job supervision and encouragement. Special attention should be given to supporting the role of the raayda refiya as an important resource for family planning. Also now that the days are again "legitimate", they should receive training in face-to-face communication in order for them to become more effective motivators.

5) The Family of the Future program has an active IEC component. Through their technical assistance contract with Triton, they have received assistance from Porter-Novelli advertising agency on the development of their marketing and research capability. A communication plan for 1982 has been developed which appears to be a comprehensive media design that will serve to increase FOF's expertise in the IEC area. It is recommended that this external consultant assistance continue to be provided to FOF as it expands both its product line and its geographical reach. FOF has recently begun an innovative research program. It is hoped they will continue to refine this capability and disseminate the results of their studies to other agencies working in the field.

6) Information programs for opinion leaders need to be increased in order to strengthen support for the family planning program at all levels of the society. The recent series of articles on population appearing in Al-Ahram (See text in Annex II F) clearly show that there is anything but a consensus as to the existence of a population problem in Egypt.

7) The PFPB should continue its efforts to coordinate IEC efforts of the various family planning programs in order to increase effectiveness and reduce duplication. While there now appears to be greater cooperation among programs than previously existed, there is still a long way to go. Besides encouraging coordination at the central level, it is important that regional staff of family planning programs (SIS, MOH, PDP, etc.) work more closely together to gain maximum program impact.

#### E. POPULATION EDUCATION

A small population education unit has been operating in the Ministry of Education (MOE) since 1974. It has a regular staff of two (one member has just left for the Sudan and has not as yet been replaced) and works with designated liaison officers from each curriculum area (social studies, home economics, Arabic, religion, math and science). The project has been involved in:

(1) identifying areas of intervention for population education topics within the curriculum;

(2) preparing curriculum guides for the primary and preparatory levels;

- (3)preparation of a curriculum guide for teacher training institutes (these are the secondary level institutes that prepare primary school teachers);
- (4)production and distribution of 23 booklets for teachers and supervisors on major concepts of population education, teaching methods and evaluation.
- (5)operation of a year-long correspondence course in population education for interested teachers and supervisors;
- (6)carrying out a two-week summer workshop each year at the Alexandria Family Planning Training Institute;
- (7)printing and distributing a quarterly population education bulletin to workshop participants and those enrolled in the correspondence course.

The project has a very dedicated staff but limited resources that have allowed for training of only a small number of teachers and supervisors at the national level and production of only 2,000 copies of each of its publications. A workshop for art specialists resulted in some excellent posters on population topics. These are being reproduced by the project in a booklet. Forty copies of the booklet are being sent to each MOE zone. However they are not producing any of the actual posters which would make wonderful displays in schools that generally lack any visual materials.

To get this program moving would require interventions within the MOE to secure a real commitment at the level of the Minister and then to establish support within the MOE to make population education a priority subject. This would allow for implementation through teacher training at the local level, complete integration of population concepts into the curriculum and, most importantly, inclusion of questions on population education in the national examinations given at each level in order to insure that the subject actually is taught in the schools.

The Population Office of USAID/Cairo has an excellent, but small staff who are already carrying a heavy workload. It is the opinion of the Assessment Team that the staff work required to develop and maintain the necessary linkages with the MOE to support the development of a major population education project are beyond the present staff capacity. Therefore the Team makes the following recommendations.

#### Recommendations

- (1) No major expansion of AID assistance for population education activities at the present time.

- (2) AID consider continuing some limited support for the Population Education Project, such as the summer workshop, but leave major funding to the international agencies.
- (3) If the concept of "sector support" gains momentum, USAID might wish to consider using such a mechanism in the population education area. This would require submission by the Ministry of Education of a comprehensive work plan with carefully conceived outputs, e.g., training, curriculum revision, printing, etc., and would include arrangements for rigorous, outside evaluation.

**Annex II Population/Family Planning Projects:  
Team Reports**

## A. SERVICE STATISTICS

Several general observations about estimates of contraceptive prevalence must be made. There is some confusion over estimates of prevalence, as mentioned in the main report, with the Egyptian Fertility Survey of 1980 reporting 11.7 percent prevalence in rural areas and the later PFPB-Westinghouse survey of December, 1980 showing a significantly higher use rate of 17.1 percent. Table 1, based on data in the Board's Family Planning Service Statistics report, January-June 1981, shows prevalence attributed to major contraceptive providers at 16 percent. But this is not precise because it is based on reports from 75 percent of all clinics. In addition, and because of problems in estimating IUD retention, service statistics arbitrarily do not take into account IUDs inserted in previous years and merely include insertions of the previous 12 months and assume an IUD retention of one year. Even if IUD retention rates beyond one year are low, this likely results in underestimating the prevalence of IUD contraception.

Considerable effort has gone into compiling the service statistics, but it is unfortunate that there has been very little analysis and interpretation of the data and, because of the delays involved in obtaining reports from the field, it is not possible for the PFPB to publish the statistics until six to twelve months after the data are generated.

There is much useful information in the six month report for the planner and evaluator, but it is not known to what extent and by whom this information is used. For example, contraceptive prevalence targets have been established from the governorate down to the FP unit, but has the actual performance been compared with these targets, and if so, what action has been taken in the case of these units, districts, or governorates that have not achieved their targets? The six month service statistics do show the target population, estimated users, and percent of achievement of the target for the PDP and non-PDP areas. However, this is not reported for the remaining two-thirds of the population. Has the importance of pharmacies in providing contraceptives (45 percent of all users) been noted and what effort is being made to enhance the pharmacists' role? Why does the average EFPA clinic account for more than three times as many users as the average MOH FP facility? These and many other questions develop out of a relatively superficial analysis of the service statistics. A more detailed analysis would raise, and might answer, further questions. However, before such an analysis takes place it would be necessary to correct some of the reported data and to resolve or explain inconsistencies.

All of the prevalence rates have to be doubled because they were calculated using a denominator that reflected twelve months of use rather than six. The denominator used in calculating the number of pill users should be 6.5 rather than 13; 50 for condoms rather than 100; 0.5 for IUDs rather than 1.0, etc. The foam tablets present a special problem because the packages sold through the clinics contain 20 tablets and those distributed by FOF contain 12. As it is not the number of tablets but the number of packages sold that is reported it is necessary to multiply the FOF sales by 12/20 to get the equivalent number of packages of 20 tablets. Once this is done the FOF sales can be added to the clinic sales and the number of users calculated by dividing by 2.5 rather than 5.0 as was done by the PFPB in determining the number of foam tablet users. The assumption is that five packages (100 tablets) provide one couple year of protection (CYP). Therefore, 2.5 packages (50 tablets) would provide six months of protection.

The PDP tables (pp. 53-65 in the six month report) have one column headed "Other" which refers to contraceptives other than pills and IUDs. This is not a useful categorization because the method of calculating prevalence is dependent on the type of contraceptive. One person said that this referred to condoms only, but this seems unlikely as other tables show that foam tablets, diaphragms, and creams were sold in several of the PDP governorates.

The service statistics report gives a total of 4,310,906 (see Tables 11 and 12) married women of reproductive age (MWRA) for the twelve PDP governorates, but only 2,744,793 in the PDP areas and 245,577 in the "non-PDP areas." The total for the latter two (2,990,570) is only 60 percent of the total MWRA for the twelve governorates. Why there is this discrepancy is not known. It is possible that as the PDP and "non-PDP" areas are rural, the remaining 40 percent of the MWRA live in urban areas. If so, one would expect the prevalence rate in the PDP areas, i.e., rural, to be less than the 11.2 percent for the total population of the twelve governorates, but at 13.4 percent, it is higher. The rate for the "non-PDP" areas is only 2.4 percent. (Table 11)

Another reason for questioning the service statistics is the indication that more IUDs were inserted in the PDP areas of the twelve PDP governorates (57 percent of the population) than for the governorates as a whole! (Table 13) Two of the extreme examples of this were Gharbia, where 14,000 IUD insertions were reported in the PDP areas but only 3,724 for the total governorate (which includes the PDP areas), and Beni-Suef, where the comparable figures were 6,044 and 366.

Table 1

COMPARISON OF REPORTED CONTRACEPTIVE SERVICES  
AMONG SERVICE ORGANIZATIONS, ACCORDING TO METHOD,  
JANUARY-JUNE, 1981

Organization	No. of Users (000s) and Percentage by Method				Total No. Users (000s)	Percentage Of All Users	Prevalence Among Married Couples of Re- productive Age
	Pills	IUD	Condoms	Other (Foam, Cream, Diaphragms)			
Pharmacies	358 (50%)	.4	108 (72%)	40 (67%)	506	45%	7.0%
Ministry of Health,	243 (34%)	81 (41%)	11 (7%)	5 (8%)	340	30%	4.8%
Ministry of Social Affairs	109 (15%)	54 (27%)	4 (3%)	3 (5%)	170	15%	2.4%
Family of the Future (FOF)	-	62 (31%)	27 (18%)	12 (20%)	101	9%	1.4%
TOTAL USERS	<u>710</u>	<u>197</u>	<u>150</u>	<u>60</u>	<u>1,117</u>	<u>100%</u>	<u>15.6%</u>
Method Distribution	(64%)	(18%)	(13%)	(5%)	100%		

Source: PFPB Family Planning Service Statistics, January 1982, pp. 11 and 43.

Table 2  
TOTAL CONTRACEPTIVE SALES (000s) TO USERS THROUGH ALL  
SOURCES OF DISTRIBUTION, JANUARY-JUNE, 1981

	<u>Pills (MC)</u>	<u>Loops</u>	<u>Condoms</u>	<u>Diaphragms</u>	<u>Cream</u>	<u>Foam<sup>1</sup></u>	
All Family Planning Units	2,300 (50%)	68	770	1	2.7	11	
Pharmacies (EPTC)	1,400 (30%)	.2	5,390	1	8	93	
Producing Companies Through Pharmacies	920 (20%)	--	--	--	--	--	
Family of the Future	<u>--</u>	<u>31</u>	<u>1,300</u>	<u>--</u>	<u>--</u>	<u>31</u>	
TOTAL	<u>4,620</u>	<u>99</u>	<u>7,460</u>	<u>2</u>	<u>11</u>	<u>135</u>	
Factor (to calcu- late users)	÷ 6.5	x 2	÷ 50	x 2	÷ 6	÷ 2.5	Total Users (000s)
Users (000s)	711	198	149	4	2	54	1,118
Method Mix%	64%	18%	13%	.4%	.2%	5%	100% <sup>2</sup>

<sup>1</sup> Foam packets of 20 tablets each.

<sup>2</sup> Percentages rounded.

Source: PFPB Service Statistics, January, 1982, p. 43

Table 3  
 CONTRACEPTIVE SALES THROUGH ALL FAMILY PLANNING UNITS,  
 JANUARY-JUNE, 1981

	<u>Pills (MC)</u> <u>(000s)</u>	<u>Loops</u> <u>(000s)</u>	<u>Condoms</u> <u>(000s)</u>	<u>Diaphragms</u>	<u>Cream</u>	<u>Foam<sup>1</sup></u> <u>(000s)</u>	<u>No. Users</u> <u>(000s)</u>
MOH	1,582	40	537	780	1,480	8	340
MOSA	710	27	219	280	1,190	4	170
Other	<u>11</u>	<u>.6</u>	<u>13</u>	<u>--</u>	<u>--</u>	<u>—</u>	<u>3</u>
TOTAL	<u>2,303</u>	<u>68</u>	<u>769</u>	<u>1,060</u>	<u>2,670</u>	<u>12</u>	
Factor	÷ 6.5	x 2	÷ 50	x 2	÷ 6	÷ 2.5	
No. Users (000s)	354	136	15	2	.4	5	512

Source: PFPB Family Planning Service Statistics, January, 1981, p. 11.

<sup>1</sup> Foam packets of 20 tablets each.

Table No. 4

CONTRACEPTIVE USE ATTRIBUTED TO GOVERNMENT CLINICS  
AND HEALTH CENTERS - MOH & MOSA

AS OF JUNE, 1981

	<u>National</u>	<u>Cairo</u>	<u>Alexandria</u>	<u>National Excluding Cairo and Alexandria</u>
No. MCRA (000's)	7,157	988	449	5,720
No. F.P. Users (000's)	564	179	60	325
Prevalence of Contra- ceptive Use	8%	18%	13%	6%

Source : Family Planning Service Statistics for January - June, 1981;  
Population Family Planning Board, published January 1, 1982  
p. 45.

Table No. 5

ESTIMATE OF MARRIED COUPLES OF REPRODUCTIVE  
AGE (MCRA) MID 1979 TO MID 1983

<u>YEAR (MID-POINT)</u>	<u>NO. MCRA (000's)</u>	<u>ANNUAL INCREASE IN MCRA</u>
1979	6,745	--
1980	6,947	202
1981*	7,157	210
1982	7,370	213
1983	7,590	221

\* Source: Family-Planning Service Statistics for January - June, 1981;  
Population Family Planning Board, published January, 1982, p. 45

Note: The number of MCRA is estimated from the 1981 figure in the above  
report assuming an annual increase of 3 percent.

Table No. 6

MINISTRY OF HEALTH CONTRACEPTIVE USERS (in 000's)  
REPORTED AS OF JUNE, 1981

	<u>PILLS</u>	<u>IUDs</u>	<u>CONDOMS</u>	<u>OTHER</u>	<u>TOTAL</u>	<u>PROGRAM PREVAL</u>
URAL	197	54	8	1.5	258	3.6 ?
URBAN	46	27	2.5	1	76	1.1
TOTAL :	243	81	11	3	338	4.7%

Table No. 7

MINISTRY OF SOCIAL AFFAIRS CONTRACEPTIVE USERS (in 000's)  
REPORTED AS OF JUNE, 1981

	<u>PILLS</u>	<u>IUDs</u>	<u>CONDOMS</u>	<u>OTHER</u>	<u>TOTAL</u>	<u>PROGRAM PREVAL</u>
URAL	76	12	2	1		
URBAN	33	42	2	3		
TOTAL :	109	54	4	1	168	2.3%

Table No. 8

TOTAL MOH AND MOSA CONTRACEPTIVE USERS (in 000's)

TOTAL :	352	135	15	4	506	7%
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SOURCE : Above data derived from Family Planning Service Statistics for January - June, 1981; Population Family Planning Board, published January, 1982, p.11.

- note: 1) Estimates of Pill use were obtained by dividing the 6 months distribution by 6.5.
- 2) Estimates of IUD use were obtained by multiplying the reported 6 months distribution from clinics by 2 for an annual estimate.
- 3) Condom usage was derived by dividing total pieces distributed by 5.
- 4) Program Prevalence - the percentage of Married Couples of Reproductive Age (MCRA) using contraception with supplies or services from MOH and MOSA clinics was calculated by :  $\frac{\text{No. Users}}{\text{MCRA - 7,157,000}}$

Table No. 9

COMPARISON OF CONTRACEPTIVE SERVICES PROVIDED BY THE  
MINISTRIES OF HEALTH AND SOCIAL AFFAIRS, BY METHOD.

REPORTED AS OF JUNE, 1981

<u>PILLS</u>	<u>IUDs</u>	<u>CONDOMS</u>	<u>OTHER</u>	<u>TOTAL</u> <u>USERS</u>	<u>PROGRAM</u> <u>PREVALENCE</u>
69%	60%	73%	75%	67%	4.7%
31%	40%	27%	25%	33%	2.3%
					<hr/> 7.0%

Table No. 10

MOH AND MOSA FAMILY PLANNING SERVICES  
RELATIVE TO NUMBER OF CLINICS

	<u>Clinics</u>	<u>% All Clinics</u>	<u>% Services</u>
MOH	3,209	87%	67%
MOSA (EFPA)	<u>499</u>	<u>13%</u>	<u>33%</u>
TOTAL	3,708	100%	100%

Table 11

POPULATION AND DEVELOPMENT PROJECT  
COMPARISON OF PDP AND NON-PDP AREAS

Governorate	Married Women of Reproductive Age		Cycles of Oral Contraceptives Distributed By Clinics		Oral Contraceptive Prevalence Rate		Number of IUDs Inserted		IUD Prevalence Rate		Number of Condoms Distributed		Total Prevalence Rate**	
	PDP	Non-PDP*	PDP	Non-PDP	PDP	Non-PDP	PDP	Non-PDP	PDP	Non-PDP	PDP	Non-PDP	PDP	Non-PDP
Damietta	78,371	--	99,471	--	19.5	--	0	--	0.0	--	0	--	19.6	--
Dakahlia	325,997	75,136	214,761	15,780	10.3	3.2	1,970	193	1.2	0.5	15,391	1,706	11.5	3.7
Sharkia	346,368	58,548	161,358	8,600	7.2	2.3	776	70	0.4	0.2	2,413	2,515	7.6	2.5
Kalilyubia	188,323	--	134,206	--	11.0	--	4,979	--	5.3	--	25,706	--	16.3	--
Gharbia	352,672	--	307,665	--	13.4	--	14,000	--	7.9	--	736	--	21.3	--
Kafr El-Sheik	165,943	19,518	110,955	1,312	10.3	--	3,202	--	3.9	--	0	--	11.2	--
Behera	309,325	45,779	76,617	3,282	3.8	1.0	519	56	0.3	0.2	7,190	489	4.0	1.2
Giza	211,424	--	220,311	--	16.0	--	6,090	--	5.8	--	2,396	--	21.8	--
Fayoum	159,678	--	110,290	--	15.4	--	1,477	--	2.7	--	10,757	--	18.1	--
Beni-Suef	150,056	--	83,342	--	8.5	--	6,044	--	8.1	--	3,482	--	16.6	--
Menia	225,063	46,596	132,860	2,229	9.1	0.7	1,710	32	1.5	0.1	28,050	1,280	10.6	0.8
Assiut	231,773	--	53,227	--	3.5	--	60	--	0.1	--	10,877	--	3.6	--
TOTAL	<u>2,744,993</u>	<u>245,577</u>	<u>1,705,063</u>	<u>31,203</u>	<u>10.1</u>	<u>2.0</u>	<u>40,827</u>	<u>351</u>	<u>3.2</u>	<u>0.3</u>	<u>106,998</u>	<u>5,990</u>	<u>13.3</u>	<u>2.3</u>

\* Blanks (--) indicate that all rural areas are in the PDP.

\*\* Condom prevalence rates by governorate were so low that they were not calculated.

Source: PFPB, family planning statistics, January 1982, pp. 54-65.

Table 12

NUMBER OF MARRIED WOMEN OF REPRODUCTIVE AGE (MWRA)  
AND CONTRACEPTIVE USERS IN PDP/NON-PDP AREAS  
COMPARED WITH TOTAL MWRA AND USERS  
IN EACH OF THE TWELVE GOVERNORATES  
WITH PDP PROGRAMS

<u>Governorate</u>	<u>Married Women of Reproductive Age</u>		<u>Contraceptive Users</u>	
	<u>Total for Each of the Twelve Governorates</u>	<u>Total PDP/NON-PDP Areas</u>	<u>Total for Each of the Twelve Governorates</u>	<u>Total PDP/NON-PDP Areas</u>
Damietta	112,897	78,371	24,084	15,304
Dakahlia	545,766	401,133	52,578	40,136
Sharkia	514,835	404,916	60,240	27,938
Kaliyubia	318,008	188,323	54,392	31,134
Gharbia	446,362	352,672	81,298	75,348
Kafr el-Sheik	269,799	185,461	31,594	23,676
Behera	499,642	355,104	43,732	13,596
Giza	501,642	211,424	65,018	46,122
Fayoum	210,602	159,678	19,656	20,138
Beni-Suaf	203,431	150,056	13,634	24,980
Menia	368,231	271,659	37,702	25,452
Assiut	319,691	321,773	23,130	8,680
TOTAL	<u>4,310,906</u>	<u>2,990,570</u>	<u>507,058</u>	<u>352,504</u>

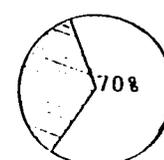
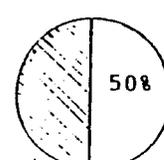
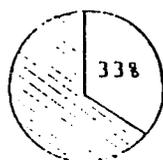
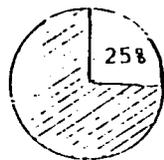
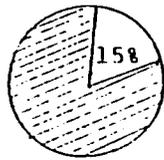
Source: PFPB Family Planning Statistics, January, 1982,  
pp. 45 and 54-65.

Table 13  
 COMPARISON OF TOTAL DISTRIBUTION OF CONTRACEPTIVES  
 TO PHARMACIES AND BY FP UNITS  
 WITH REPORTED DISTRIBUTION BY FP UNITS  
 IN THE PDP AREAS OF THE TWELVE PDP GOVERNORATES

<u>Governorate</u>	<u>IUD</u>		<u>Oral Contraceptives</u>	
	<u>Totals For</u> <u>Governorates</u>	<u>PDP</u> <u>Areas</u>	<u>Totals For</u> <u>Governorates</u>	<u>PDP</u> <u>Areas</u>
Damietta	287	0	121,989	99,471
Dakahlia	3,370	1,970	330,203	214,761
Sharkia	3,450	776	264,120	161,358
Kaliyubia	4,171	4,979	202,195	134,306
Gharbia	3,724	14,000	403,704	307,665
Kafr el-Sheik	1,527	3,202	171,512	110,955
Behera	3,634	519	212,821	76,617
Giza	5,583	6,090	176,825	220,311
Fayoum	536	1,477	106,414	110,290
Beni-Suef	366	6,044	68,983	73,342
Menia	768	1,710	212,605	132,860
Assiut	564	60	100,840	54,227
TOTAL	<u>27,980</u>	<u>40,827</u>	<u>2,372,211</u>	<u>1,696,163</u>

Source: PFPB Family Planning Statistics, January, 1982,  
 pp. 43 and 54-65.

Family Planning Users



Birth Rate

40

37

33

25

18

Growth Rate

3%

2.7%

2.3%

1.5%

1.0%

Double

23 years

26 years

30 years

45 years

70 years

The same situation prevailed for oral contraceptives in three of the governorates. The reported total number of cycles sold in the PDP areas of Giza, Fayoum, and Beni-Suef was 403,943 cycles, yet only 352,222 cycles are reported as being sold throughout the three governorates and Giza is primarily urban. It should be kept in mind that figures for the total distribution of contraceptives includes distribution of pharmacies. One would not think that distribution to pharmacies would be included in statistics for the PDP areas. The following table provides a comparison of the data for the PDP areas and those for the non-pharmacy sources of contraceptives.

<u>FP Units</u>	<u>IUD</u>	<u>Cycles of Oral Contraceptives</u>
PDP	40,827	1,696,163
MOH	22,621	1,079,647
EFPA	5,078	493,501
Other	<u>281</u>	<u>4,930</u>
(Total: MOH, EFPA, Other)	(27,980)	(1,578,078)

In one sense there are no PDP family planning units. There are only PDP areas where FP services are offered through the facilities of the MOH, and possibly the EFPA, a few other units, and the outreach workers (raaydas) employed by the PDP. So this creates a mystery as to how the figures for the PDP areas can exceed the total distribution of IUDs and pills through the three types of units indicated in the table. It could be that the clinics do not record the contraceptives distributed by the raaydas, but this is unlikely, as the clinic is the source and, as indicated earlier, in some cases the PDP distribution figures exceed the total distribution for the governorate. This is even more dramatic when the PDP figures are compared with those for the MOH.

The table on page 43 of the six-month report which, according to its title shows the distribution to users for the first six months of 1981 by the FP units, pharmacies, Egydrug, FOF, and the manufacturers of oral contraceptives, is mislabeled. What it actually shows is the distribution to pharmacies by Egydrug and the manufacturers, distribution by FP units to users, and the distribution by FOF, most of which goes to pharmacies. This may be

a minor distinction, but it does imply that FOF, Egydrug, and the manufacturers distribute to users and that data are available for sales by pharmacies. Data are available only for sales to pharmacies. Presumable sales to pharmacies would be similar to sales by pharmacies, although some pharmacists complained that they had foam tablets because they were forced to take them and they were not trying to sell them.

It is unfortunate that most of these discrepancies were not discovered until after the assessment team left Egypt. Someone will have to explain or resolve these differences before the service statistics can be used to evaluate the family planning effort.

#### B. FAMILY OF THE FUTURE

The urban based Family of the Future (FOF) is one of several commercial retail sales (CRS) programs operating around the world which utilizes retail networks to extend the subsidized distribution of contraceptives to individuals who may not otherwise be reached. The Egyptian CRS activity was launched in June 1979 by the Cairo Family Planning Association as the Community Based Family Planning Services program with initial support from the International Planned Parenthood Federation. It subsequently was renamed Family of the Future and became an independent private agency. USAID began funding the project in September, 1980.

The purpose of the project is: 1) to increase awareness and demand for family planning services; and 2) to establish a supply system which makes contraceptives readily available through commercial outlets and physicians offices.

Condoms, foam tablets, and Cu T and Cu 7 IUDs are distributed and sold directly to doctors, hospitals and pharmacies. Initially most of the distribution to pharmacies was done through a private pharmaceutical distribution company, but the FOF is gradually taking over direct responsibility for this function through its sales force of six medical representatives and two distributors. Additional promotion is accomplished through vigorous advertising campaigns and the activities of a force of 100+ volunteers. More than 50,000 civilians and soldiers were reached through rallies in 1981. Contests in the media, summer camps, rallies, and promotions at major sports events are utilized to increase awareness, to make discussion of contraception socially acceptable, and to promote FOF products.

Less than three years since it began and a year and a half after

it started receiving AID support, the FOF is firmly established in the Greater Cairo Area and is planning its expansion to Alexandria, the Eastern Delta and Upper Egypt. Even before the expansion some of its products have found their way into these regions.

The couple years of protection provided by the sale of contraceptives in 1981 was almost double the 1980 figure. A 50% increase in contraceptive sales is anticipated for 1982. This would seem to be a rather modest estimate considering the geographical expansion and a media budget that will more than double to LE.600,000.

Some of FOF's innovations have provided competition for other family planning programs, e.g., the Government is considering packaging its condoms individually like FOF's Tops brand, rather than selling them in plastic strips because people seem to prefer packaging. This may increase clinic sales. FOF has shown that the widely held view that Egyptian men will not use condoms is false. In fact, the FOF ran out of condoms in the spring of 1981 because the demand was underestimated.

Although the FOF is off to a good start and is expanding, it is completely dependent upon AID. The Cu 7 is purchased by FOF with AID funds. All other contraceptives are provided to FOF by AID without charge. Since pricing of most contraceptives is fixed by the Government, FOF's profit margin is limited. For example, condoms and foam tablets are wholesaled below cost; the CU T just about at cost; and the Cu 7 above cost. The revenue that has been generated from the sale of contraceptives is being retained by FOF pending a decision about how it will be utilized. The 1981 revenue from the sale of contraceptives was LE.189,341.

In their paper on 1981 accomplishments FOF estimated the cost of their contraceptives as LE.219,000 but this seems much too low. Based on AID dollar figures for the purchase of contraceptives, and FOF's estimates in their proposed budget for the cost of packaging the expenditure would be \$299,467 and LE.44,726 or the equivalent of LE.404,800.

No one expects FOF to be self-sufficient immediately so AID should continue to support FOF and the FOF should not be hampered by insufficient funds in achieving its desirable objectives. However, in anticipation of that day it would be desirable if FOF kept a separate set of records showing the actual unit cost of each contraceptive. This would help to identify "winners" and "losers" and might affect program planning.

Related to this is the need to calculate the unit cost of certain expenditures related to the sale of contraceptives. This should include the cost of the contraceptive, the packaging, and the media cost for promotion. As indicated earlier FOF is not a profit making organization and its prices are regulated by the Government, but this type of calculation would assist the FOF in evaluating the cost effectiveness of the promotion of its products. Calculating the cost per couple years of protection would further refine this type of evaluation.

#### C. THE STATE INFORMATION SERVICE (SIS) POPULATION IEC PROJECT

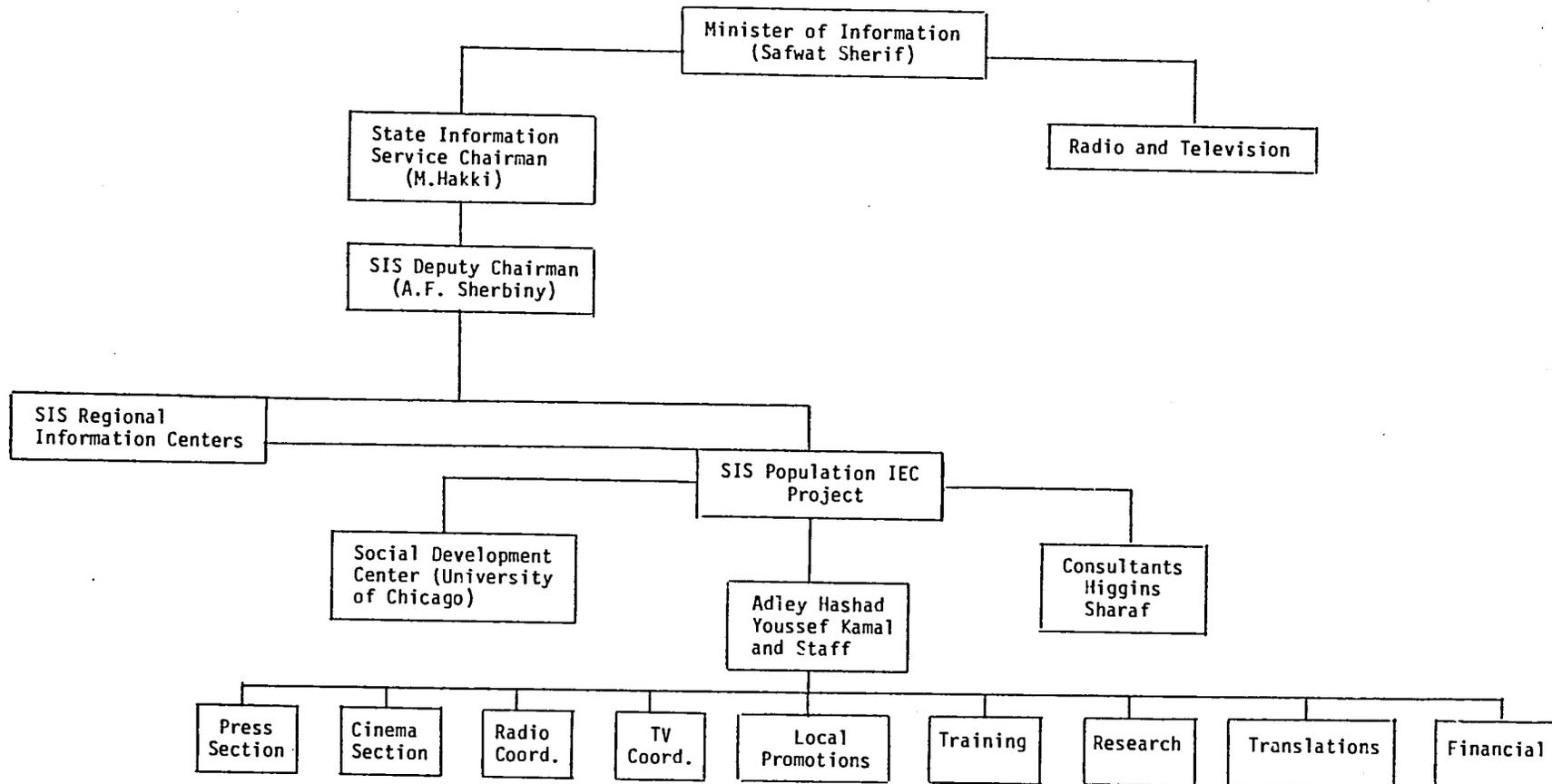
Plans for a major population IEC effort to be carried out by the State Information Service first began to be formulated in 1978 when a consultant team visited Egypt to work with USAID and the Ministry of Information on the program. Subsequent to their visit David Piet of AID worked on development of the project which resulted in the awarding of a technical services contract to the Social Development Center of the University of Chicago to assist SIS with project design and implementation. While some materials were produced during the 1978-79 period, the major campaign did not begin until January 1980 when the SDC began work with the SIS. A full-time consultant, Mr. Robert Higgins, was provided by the SDC.

Administratively the population IEC project is a part of the State Information Service which comes under the Ministry of Information. The current Minister of Information, Mr. Safwat Sherif, is also the head of the national TV and radio broadcasting authority. The project is headed by the Chairman of SIS, Mr. Mohamed Hakki, and is under the day-to-day direction of the Deputy Project Director, Mr. Adley Hashad. Mr. Mohamed Sharaf is a full-time consultant to the project as is Mr. Higgins who is now employed directly by the SIS. Originally the project was housed in the SIS offices but it rather quickly outgrew the available space so separate facilities were leased on Tahrir Square where the group is now headquartered.

#### Development of the Project

Plans for implementation of the SIS project called for an initial baseline survey of knowledge, attitudes and practices of Egyptians relative to family planning. This survey was to have preceded the media portion of the program. However, delays in implementing the survey resulted in interviewing going on after the initial media effort had already begun. Therefore, responses may have reflected exposure to the media campaign.

STATE INFORMATION SERVICE POPULATION IEC PROJECT



The SDC carried out the survey and analyzed the data collected in conjunction with the Social Research Center at AUC. Nine volumes on the results have been published to date. Some additional volumes have yet to be completed.

In the meantime, SIS launched its first mass media campaign: "Look Around You, We Have a Population Problem". This campaign involved use of radio and television, billboards, posters, etc. It was followed by a campaign with the theme "Small Families Live Better" and promotion of the national family planning symbol. During this period SIS developed a lot of promotional items for distribution including key chains, pens, tea trays, plates, coasters, calendars, etc.

The SIS also began to carry out promotional campaigns throughout the country. These campaigns called upon the 50 SIS regional Information Centers to assist in carrying on promotional activities at the local level. (Each unit now has at least one staff member responsible for family planning). Training programs were also begun to increase the skills of project staff in IEC activities and to educate SIS staff at the central and local levels about population and family planning. Selected staff also have been sent off each year to attend training programs at the University of Chicago and other U.S. institutions.

During the first year of operation the campaign succeeded in getting a lot of attention. A great deal of this attention was in the form of criticism as to the quality of ads, themes, etc. However, even the criticism served to focus attention on the subject of population and family planning; and, most importantly, it demonstrated that you could mount a major media effort on the subject and not cause any backlash.

The second year of the project, SIS planned to launch a campaign that would feature the five methods available in the national family planning program. The theme of the campaign was to be "The Choice Is Yours". However, during 1981 a new Chairman was appointed to head the SIS. He was formerly the Egyptian ambassador to the Vatican and he was not an enthusiastic supporter of family planning. He felt that ads featuring contraceptive methods were "too sensitive" to be aired before the public. The high level of momentum gained during the first year of the project therefore began to ebb until it almost reached a complete standstill in the summer of 1981.

In the fall of 1981, Mohamed Hakki took over the chairmanship of

the SIS. He was formerly Minister of Press Information in the Egyptian Embassy in Washington D.C. His background is in public relations and journalism and he is a strong supporter of the family planning program. He has indicated that he considers the population IEC project a priority effort and that he is interested in upgrading the quality of messages and materials produced. His appointment has brought an upswing in the level of activity within the project. The methods ads are now appearing in the press, on TV, in the cinema and are being featured in various promotional efforts -- with no negative reaction from the public.

#### Plans for 1982

A workplan for 1982 has been adopted. It calls for expenditures of approximately \$3.3 million for the IEC effort. The monies will be used for:

(1) Medja. This will include production of TV and radio advertising, development of TV and radio programs with a population/family planning theme, production and distribution of films, advertising in newspapers and magazines, print materials, signs, billboards, kiosks, travelling exhibitions and special exhibitions. (\$1,985,000).

(2) SIS Regional Center Activities. Funds will be used to upgrade local offices, encourage program activities and for establishment of a "model" office in Beni Suef (this is being done in conjunction with the joint PDP/SRC initiative about to begin in this governorate). (\$285,000).

(3) Training, Research and Evaluation. In-country training activities will be for SIS staff and some IEC persons from other ministries. Overseas training will be provided for selected staff along with English language training at AUC. (\$ 255,000). Support will be provided for the research unit which monitors the SIS campaigns and does some pretesting of materials. The funds are mostly used for travel costs. (\$30,000).

(4) Administrative Costs. Rent, utilities, miscellaneous personnel costs, office supplies and equipment, reference materials, vehicles and executive travel come under this heading. (\$289,500).

(5) Consultants and Technical Support. The services of Mr. Higgins and a secretary; media, editorial and training consultants; institutional technical assistance; workshops, conferences and symposia fall into this category. (\$296,000).

## SIS Activities

Television. SIS spends an average of LE 20,000 per month to produce television programs on the country's two national channels. These include panel discussions and interviews and are incorporated into programs on health, family, women, and labour. In 1982 the SIS plans to introduce a social drama (five 40-minute episodes). An analysis of the media schedule for February 1982 showed 17 programs aired on Channel 5 and five on Channel 9 for a total of 22 family planning related programs. SIS also runs ads on television. Commercial time is donated by the Egyptian Government.

Estimates of households with television are as high as 50%. Surveys carried out by SIS monitoring teams consistently show that most people hear about or remember hearing about family planning from television.

Radio. Radio has an even greater reach than television. SIS spends an average of LE 13,000 per month on radio programming. Again commercial time is donated by the Government. Most radio programming is done through interviews and discussions on programs with titles ranging from "The Islamic Magazine" to "Good Morning Cairo". SIS also produces radio dramas. Seven have been done to date and more are planned. Each series runs for one month, 15 minutes per day. Programs are prepared by the radio network. The scripts are approved by SIS.

In January 1982, SIS aired 34 hours and 26 minutes of family planning related programming. Twenty-three programs were aired on local networks, 8 on the cultural network and 11 on the general network for a total of 42 programs. Since programs are repeated at varying intervals, there were actually 268 family planning broadcasts. Length of the programs ranged from one minute to 60 minutes.

Press and Magazines. Print ads are an important element in the family planning IEC effort. Ads are developed to support campaign themes and for special occasions such as New Years or Mothers Day. An average of LE 16,000 per month is spent on ads in newspapers and magazines. In February, 1982, SIS placed 31 quarter to full-page ads in 21 newspapers. Most are national papers, but ads were also placed in local papers in Beni Suef, Qena and El-Minia. Thirteen ads were run in 11 magazines in February. These ranged from half to full-page spreads in publications dealing with radio/TV, youth, religion and public opinion.

Posters and Print Materials. Posters have been developed for each campaign. Approximately 500,000 of each are printed and distributed throughout the country. Smaller, self-adhesive versions of each poster are also produced. The current poster, "Small Families Enjoy a Quiet and Orderly Life", showing the two-child, nuclear family, has been produced in three versions: urban, fellahin (Lower Egypt) and Saidi (Upper Egypt) reflecting different dress for each region. A special poster for the Ministry of Health showing the five methods has also been produced. Three new SIS posters will be done in 1982. Special posters for use by other ministries are also planned.

SIS has developed a number of print materials. These range from the Rafaat Kamal booklet "How Not To Get Pregnant" (which they are planning to reissue with a new cover) to method-specific booklets and pamphlets for pharmacists and clinic staff to football score cards and prayer cards for Ramadan. In 1982 they will produce a series of booklets on the impact of population on education, food production, health services, labor and housing. At the request of the Ministry of Information they will also publish a 400-page book for use in a televised literacy course. They also are to work with the MOH on preparation of materials for use in the clinic refresher program.

Film. Thirteen family planning films have been produced so far. They range from 2 to 15 minutes in length. Most of the short films are motivational. Longer films have been produced on contraceptive methods and two feature model clinics. One film, "Hassanein and Mohamadien" is based on a song of the same name, with a family planning theme, which has become something of a "hit" throughout Egypt. The song is also played on the radio and has become a hot item on the bootleg cassette market. A sequel to the song is planned. A new film series is now being produced that will focus on the impact of population on education, food, etc. The pamphlets noted above will be another part of this awareness campaign.

Films are made available in 16mm and 35mm. They are aired on TV and are distributed to the SIS regional centers. Two copies are kept for use by the centers and the rest are distributed to offices of other ministries and to cinema houses.

Signs and Billboards. In 1982, SIS will increase the number of billboards in use from 50 to 80. In addition they will construct three electrically illuminated billboards in Cairo and Alexandria. They have also produced 2,000 metal signs with the family planning

symbol for display outside MOH FP/MCH centers. Additional signs will be produced to cover all 3,000+ MOH units.

Traveling Exhibits. Two portable exhibit units will be added to the program. They will be permanently mounted in mobile units and will include projection equipment. They will be sent to cities and towns throughout the country for use during local promotions, fairs, etc. Portable kiosks also will be produced and distributed to selected SIS Information Centers.

Local Activities in SIS Centers. SIS has been encouraging greater participation by local information units in the family planning campaign. During 1982 they will begin a program to upgrade the regional centers. Funds will be provided to physically improve the offices and to purchase needed equipment. They also will make available to each unit, depending on the size of the center, from LE 1,000 to 4,000 for locally developed information activities. Individual plans and budgets will be submitted to SIS, Cairo for approval. A special effort will be made in Beni Suef where a major new family planning program is about to get underway. SIS also is providing each unit with a small library on population and communication. A larger reference collection is being developed in the main office.

Local Promotion. SIS carries out local promotions in various governorates throughout the year. These usually last from 4 to 5 days and begin with a "kick-off" attended by local dignitaries (frequently including the governor). Cairo staff work with local SIS units to put up posters, give out materials to pharmacies and clinics, show films and give away promotional items to local residents. Fifteen local promotions have been scheduled for the period March-July, 1982.

At a recent promotional "blitz" in Helwan, the following materials were distributed:

- 20,000 methods booklets
- 3,000 methods pamphlets
- 400 posters
- 600 tea trays/plates
- 200 methods pens
- 1,000 symbol stickers

From time to time SIS staff has a team from their research department "monitor" the area before and after a promotion (a sample of 40 respondents -- 20 male and 20 female) to measure the effect of the promotion.

Training. SIS regularly conducts training courses in population, family planning and communications for its own personnel and for some IEC staff of other ministries. Overseas training also has been provided on a regular basis. This is mostly short-term training but some personnel have been enrolled in degree programs (Chicago and Cornell). A special course for staff researchers is planned for 1982 that will include use of an Apple computer.

Conferences. SIS occasionally holds conferences or seminars for various groups. A symposium on contraceptive methods was held in February, 1981. An international symposium on development communications is in the workplan for 1982.

#### Future Activities

SIS is currently developing a series of campaigns based on the RAPID report. These include the production of films and print materials on the effects of population on education, food, health services, labor and housing. The various segments will be launched one at a time. Newspaper articles and ads will also be a part of each campaign. The films will be shown on television. After this series is completed, SIS plans to go back to the methods again. Under consideration for future campaigns are: (1) husbands and wives should talk about planning their family; (2) raising the image of nurses; (3) promotion of the role of the pharmacist; and (4) motivation for hard to reach groups.

#### Production and Distribution of Materials

SIS has no in-house capacity to produce materials. SIS comes up with story lines, ad copy, and design ideas. These are then presented to various media committees for review. Committees for radio, TV, film and print are made up of SIS staff, specialists from the media and representatives of population/family planning programs. All work is then done outside on a bid basis. A lot of work is done by the newspaper, magazine and broadcast organizations that actually run the finished materials. Some work goes to private agencies or producers.

Most of SIS' distribution is done through the regional units. Quantities of materials are sent to these units. Local staff then distribute materials to offices of other ministries in the area. How effective this distribution is depends on the motivation of the staff in the particular office, and once the materials are handed over to other agencies, SIS has no control over their use. The central office and the centers try to work in cooperation with other

agencies by supplying materials for specific activities. The centers also hold local lectures and public meetings in cooperation with other ministries. These involve speakers (a medical doctor, a sheikh and a teacher or social worker), film showings and distribution of materials.

### Evaluation

A follow-up survey to evaluate the impact of the SIS campaign has just been completed by CAPMAS. This survey will have a sample of 3,000 (the baseline survey had 2,000), half male and half female. There will be 247 questions on the survey instrument (90% are the same as appeared on the baseline). The exercise is designed to: (1) make a before and after comparison of awareness and knowledge; (2) explore sociological and socio-psychological correlates of family planning acceptance in order to better define target audiences and media strategy; and (3) assist in planning for new family planning programming. The survey will cover: family life background, value of children, awareness of Egypt's population problem, awareness and attitudes towards family planning, contact with family planning, knowledge and use of contraceptive methods and social characteristics of respondents and their spouses.

There are still some unresolved questions concerning analysis of this data that make it difficult to predict when the results will be made available.

Additional discussion of the SIS Population IEC Project and recommendations are included in the Program Section of this annex dealing with Information, Education and Communication.  
(See Annex I.D)

#### D. THE EGYPTIAN FERTILITY CARE SOCIETY (EFCS)

The Egyptian Fertility Care Society was founded in February 1974, during the first National Conference on Voluntary Surgical Contraception, at Assiut University. At that time, only a small, select group of dedicated Ob/Gyns were involved. Progress was slow because of the religious and political environment.

The Society has held annual meetings each year. In 1975, it began receiving support from the International Project of the Association for Voluntary Sterilization (IPAVS). In 1978, the EFCS program was expanded to include a university-based voluntary surgical contraception (VSC) training program in eight university medical schools. A grant of \$95,150 was made by IPAVS for this purpose and to cover the cost of opening a permanent office for the Society in Cairo.

The EFCS headquarters was opened in September 1979, and since then the Society has become increasingly active. The training program in surgical contraception procedures has been developed and began operation in early 1981. Basic materials and guidelines for this program have been developed.

The EFCS is headed by an honorary executive director, Dr. Ezzeldin Osman Hassan. The position of full-time medical administrator was held by a very competent physician, Dr. Mamdouh Wahba. Dr. Wahba returned to private practice as of Jan. 31, 1982 and the Society is still seeking a replacement for him. The quality of the medical administrator will greatly affect EFCS's future activities since it is a small organization that places heavy responsibilities on the few staff members.

Besides organizing the sterilization research programs in the medical facilities, EFCS has also been active in promoting better training of physicians in all aspects of family planning. The Society regularly presents scientific seminars for already graduated physicians. This activity is supported by IPAVS and has staff support from MOH. They held 10 such seminars in 1981 and four in 1982.

The EFCS was instrumental in preparing the training program for house officers (interns). However, the Ministry of Health decided to implement the program through its own auspices. It is scheduled to begin sometime this year. The program will provide didactic and practical training to all interns as they rotate through Ob/Gyn and allow one or two IUD insertions. This program is in both private and MOH facilities. The EFCS is preparing a family planning manual -- possibly to accompany this training. This manual could be adapted for training of nurses or other paraprofessionals.

With the support of PIACT and the IFRP, the Society is producing bimonthly bulletins for physicians (in English) and pharmacists (in Arabic). The bulletins feature short articles, in simple prose, on family planning methods and related topics. They include photos, cartoons and other illustrations. They are distributed through the Al-Ahram distribution network and are sent to rural health centers and village pharmacies as well as to facilities in metropolitan areas.

The EFCS also has an IEC program supported by IPAVS. This program began in April 1981. It includes seminars for opinion leaders and television programs on the dangers of multiparity. Both activities have been carried out on schedule. Six seminars for

opinion leaders have been held in the last year, and a seventh took place on March 18, 1982.

- (1) Aswan (two participants have since become ministers -- Health and Wakfs\*).
- (2) The Shoura Assembly.
- (3) Damanhour.
- (4) Luxor.
- (5) Port Said.
- (6) Rotary Club members.
- (7) Mansoura (18/3/82).

Twelve TV programs on the hazards of high parity have been produced. Dr. Rafaat Kamal, a journalist & EFCS Board member, is gathering feedback on these programs.

The IEC program is now due to be evaluated by an external consultant who will recommend program activities for the coming year.

The EFCS seems anxious to broaden the scope of its activities beyond voluntary surgical contraception. Many of its current interests and activities are already in the broader field of family planning. The topic for its next annual conference in June will be "Health Aspects of Fertility Control and the Population Problem in Egypt". This will be the first annual conference where surgical contraception will not be the featured topic.

To date the EFCS has proven to be capable of getting the work done, when it is supposed to be done. They have excellent contacts within the medical community and their board members are active in many other family planning programs.

Their expertise could be further drawn upon in the important area of physician training and possibly for training of nurses and paramedical personnel as well.

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\* Minister of Wakfs has just been appointed Grand Sheikh of Al-Azhar.

A.

PREVALENCE PROGRAMMING:

A TOOL FOR FAMILY PLANNING TARGET SETTING AND PROGRAM MANAGEMENT  
IN EGYPT

I. Target Setting and Program Performance Management. To some extent, field staff are translating demographic targets and measuring program performance in terms of the concept of prevalence of contraceptive use among married women of reproductive age (MWRA). At the same time, however, much confusion exists at the implementation level among many field workers, clinic staff and community program managers about how to distinguish between "cumulative new acceptors" and "current users" (or prevalence). As a result, inadequate attention is given to increasing the number of actual contraceptive users. Too often, the recruitment of new acceptors assumes nearly exclusive priority while follow up actions are neglected.

Related to this is the almost universal and serious underestimation at governorate, marqaz and village council levels of current population size and the present number of eligible couples. Typically, program managers are relying for both on 1976 census figures, which are now five years out-of-date and understate both population size and the number of eligible couples by approximately 15 percent.\*

The concept of quantifying demographic goals in terms of growth rates, future population size and service delivery targets is well established in the Population Family Planning Board, the Ministry of Health and other key government ministries and is generally understood by lower echelon staff. Furthermore, the family planning services delivery program is now in that state of evolution and early maturation which makes possible a further refinement toward the implementation of "prevalence programming."

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\*Assumes a 2.8 percent annual growth rate, 1976 to 1981. By 1982, the 1976 figures would have increased by 18%.

Field visits have revealed that prevalence concepts are moderately well understood and in some instances used in measuring program performance. Almost always, the concept is quickly grasped by supervisors when it is explained to them. The receptivity by technical people in Cairo has likewise been highly positive.

Chart No. 1 shows the correlation between the crude birth rate and population growth rate with the prevalence of contraceptive use. This single and relatively simple concept is applicable to all levels of analysis and target setting - national, governorate, district or marqaz, and village. It can be applied to any political subdivision, "catchment" or coverage area and will serve as a powerful tool for program management permitting easy comparison of program performance among geographic areas and among field workers while also displaying the status of current use and future goals. In the absence of a perfectly functioning vital registration system, prevalence measurement provides a totally adequate substitute for a more elegant service statistics reporting system.

## II. The Correlation Between Prevalence of Contraceptive Use, Population Growth Rates and Crude Birth Rates

The chart showing the correlation between prevalence of contraceptive use and the crude birth rate is designed for use by field workers, their supervisors and program managers at all levels in the service delivery organization. The same chart can be used at national, governorate, marqaz and village levels.

The scale at the bottom is the "prevalence rate" which means the percentage of eligible couples of reproductive age who, at any one point in time, are practicing contraception. As you will note, in Egypt today, approximately 23 percent of eligibles are using contraception and the crude birth rate is 38 or 39/1000. To reach replacement level fertility or a "net reproduction rate of one" (NRR = 1), it will be necessary for about 70 percent of eligibles to be contraceptive users which will result in a crude birth rate of about 10/1000. For present purposes, it is assumed that the crude death rate at that time would be roughly 10/000 and that births would equal deaths.<sup>1</sup>

The chart can be used to measure progress in increasing the percentage of continuing users of contraception and in setting goals for field worker achievement, village achievement and district targets. For example, if a village or district today is at 13 percent prevalence, a goal of 18 or 20 percent could be set for the

next year and progress toward achieving that can be measured at quarterly intervals.

If the prevalence "worksheet" is correctly filled out, the present confusion in the reporting system between "cumulative new acceptors" and "current users" will be straightened out to everyone's benefit. Furthermore, by adopting "prevalence programming," field workers will begin to emphasize the need for increasing continuing users as opposed to merely recruiting new acceptors with a resultant greater fertility reduction payoff. Also, there will be a "natural shift" toward promoting more effective methods as field workers realize that it is easier to "maintain" a continuing user who has an IUD or who has accepted voluntary sterilization than one who requires a regular resupply of pills or condoms.

One of its most useful features is that it allows a reasonably accurate comparison of performance among geographic areas. This should prove particularly helpful to program managers and supervisors in village council and district offices who will be able to easily and routinely identify both high and low performance areas. In the case of low performance, extra supervision or refresher training can be mobilized; in high performance areas, supervisors can learn what are the key ingredients to program success so these lessons can be applied elsewhere.

Along the sloping line, prevalence should be periodically plotted, say at intervals of three or six months. The mark indicating prevalence should be dated so progress during time intervals can be measured and tracked. These plots can be adjusted on the basis of prevalence surveys when such survey results are available.

The chart includes assumptions on the crude death rate (CDR) and the crude birth rate (CBR). Subtracting the CDR from the CBR gives the population growth rate shown on the left vertical scale.

Prevalence programming deals in a practical way with estimates and projections of contraceptive use and the effect of these on crude birth rates and growth rates.<sup>2</sup> Despite some inherent lack of preciseness, application of the concept provides a more realistic and accurate picture and tracking method for measuring program performance than most management information systems (MIS) used in large-scale family planning programs worldwide today. This is especially true when there is no complete vital registration system and when newly designed MIS efforts are not yet fully operational.

Furthermore, it lends itself to local application without the need to pass performance data from lower to central levels and back again. All the calculations can be simply done with inexpensive electronic hand calculators without sophisticated computers and computer programming.

In situations like Egypt where a more sophisticated MIS may not be nationally operational for some time, the application of prevalence programming concepts can fill an important interim need for performance measurement, target setting and evaluation.

III. Prevalence of Contraceptive Use Worksheet Instructions and Methodological Note. The comments below match the number on the worksheet.

1. Estimate mid-1981 population by using an average annual growth rate of 2.8 percent, applied to 1976 census data. This can be easily and quickly done on a typical electronic hand calculator by first entering 1.028; pressing the "times" button or the "X"; then enter the 1976 population figure and lastly; pressing the "equals" button or "=" five times (for five years) to produce the population size estimate for 1981.

2. To determine the estimate of eligible couples of reproductive age, simply divide the 1981 population size by 6. In Egypt, given its age structure and early age of marriage, it turns out that eligible or married couples of reproductive age (MCRA) represent about 16 to 17 percent of the total population. Dividing

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(1,2) Changes in birth rates, of course, are caused by other factors than prevalence of contraceptive use. Such factors include increasing age of marriage, changes in fecundity, duration of reproductive unions, etc. Despite this, however, the correlation between prevalence and the crude birth rate remains reasonably accurate.

by "6" is easier for field workers. The calculation for married women of reproductive age (MWRA) is identical. (The advantage of "MCRA" is that it includes the other half of eligible and potential contraceptive users, namely men.)

3. Pill Users: Average number of pills distributed per month; Determine this by calculating the average number of cycles distributed per month during the previous three months. Because field workers and clinics often distribute two or three monthly cycles at a time, taking the average monthly distribution or "off-take" for the previous three months will be more accurate than only using the previous single month's distribution figure.

4. Condom Users: Assume a frequency of intercourse of 10 per month (which could also allow for modest wastage); divide the total number of pieces of condoms distributed the previous month by 10. As with the estimate of monthly pill users, a more accurate estimate would be obtained by taking the average monthly distribution over the previous three months.

5. Cumulative Vasectomies: Simply add all the vasectomy cases in your area or jurisdiction since male sterilization has been offered. Because vasectomies have only been available for the past few years or so, it is not necessary to subtract from the total cumulative figure those few cases where the wife has passed beyond age 45 and can be presumed to be no longer fertile.

6. Cumulative Tubal Ligations: As with vasectomies, all all known ligation cases in your area since this method was first offered. Be sure to include ligations done by mobile teams or voluntary organizations on women living in your service area, but only count them once.

7. IUD Users: To estimate current ISU (including copper "T") users, complete the following table:

Multiply the number of insertions during each period or year by the percentage figure for that period to give the number of current users. Total the bottom line of current users and enter on worksheet.

8. Injectables: Because most injectables provide 3 month's protection, add the curmulative number of injections given during the past three months and enter the total.

9. Foam: Estimate the number of foam or Neo-Sampoon users by counting the number of women who were given foam or Neo-Sampoon the previous month.

10. Diaphragm: Estimate the number of women using cervical caps or diaphragms by data from clinic or survey records. If the data are not available, use the cumulative prescriptions of these methods over the past 12 months.

11. For the total number of users, add items #3 through #10.

12. Prevalence, which means the percentage of eligible couples using contraception at any one point in time, is determined by dividing the number of users (#11) by the number of eligibles (#2). This gives you the "prevalence rate."

13. As a final step, put a mark along the sloping line directly above the point where your prevalence rate falls on the bottom line. Put today's date by that mark so you will be able to track changes in prevalence over time.

14. Note: If the registration of births and deaths in your area is reasonably accurate, calculate the crude birth rate by dividing the number of births in 1980 by the 1980 population size:

$$\frac{\text{No Births}}{\text{Population size}} = \text{CBR} - \text{for the Crude Birth Rate} - \text{CBR.}$$

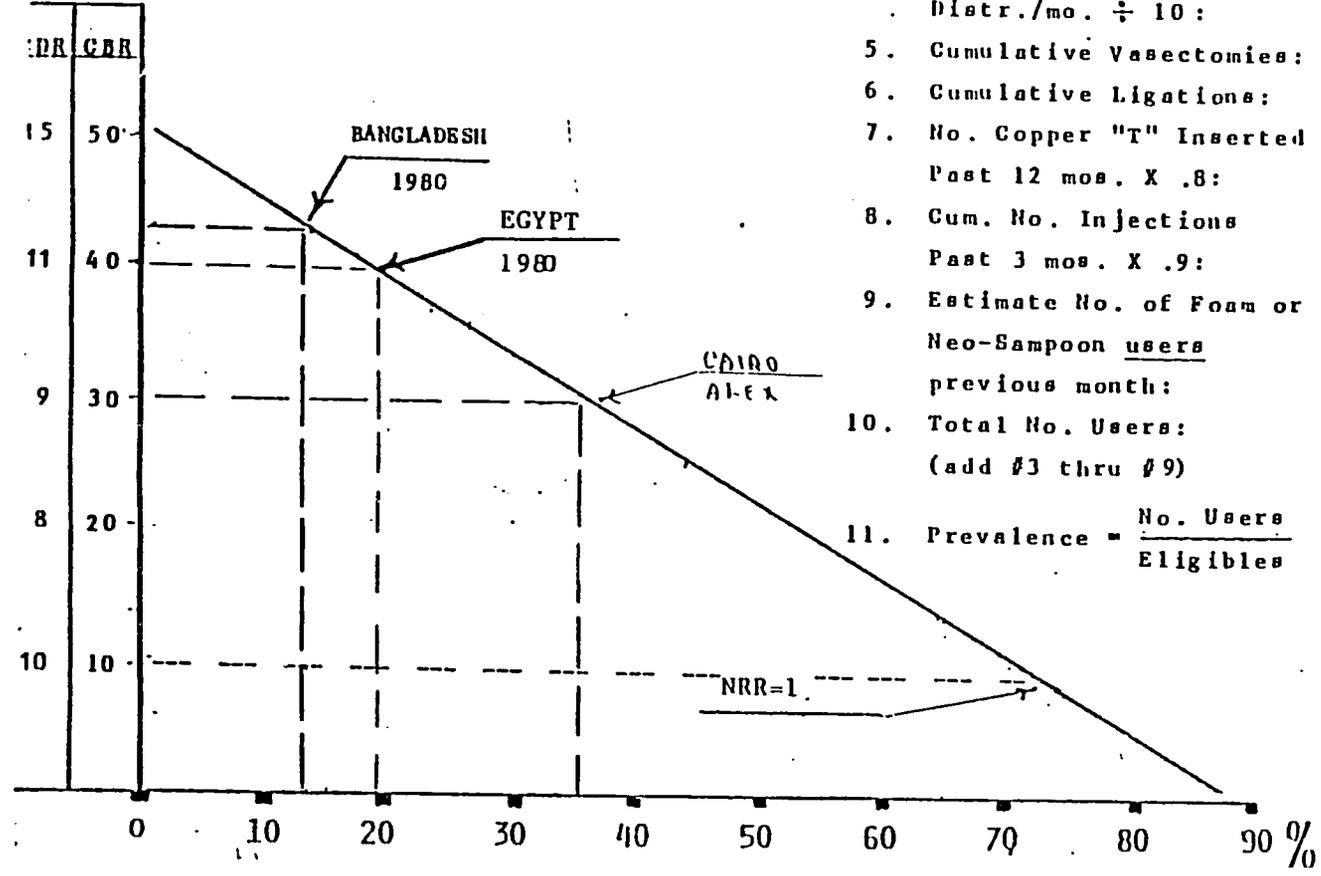
Place a mark on the chart where the line opposite the CBR matches the prevalence rate on the bottom scale. This mark may or may not be exactly on the sloping line, but it should be close to it.

RELATION BETWEEN PREVALENCE OF  
CONTRACEPTIVE USE AND POPULATION  
GROWTH RATES, CRUDE DEATH RATES  
AND CRUDE BIRTH RATES

-106-

PREVALENCE OF CONTRACEPTIVE USE

1. 1981 Population Size: \_\_\_\_\_
2. 1981 Eligible Couples  
= Population  $\div$  6 \_\_\_\_\_
- \*\*\*\*\*      \*\*\*\*\*      \*\*\*\*\*      \*\*\*\*\*      \*\*\*\*\*
3. Avg. No. Pills Distr./mo.: \_\_\_\_\_
4. Avg. No. Pieces Condo  
Distr./mo.  $\div$  10: \_\_\_\_\_
5. Cumulative Vasectomies: \_\_\_\_\_
6. Cumulative Ligations: \_\_\_\_\_
7. No. Copper "T" Inserted  
Past 12 mos. X .8: \_\_\_\_\_
8. Cum. No. Injections  
Past 3 mos. X .9: \_\_\_\_\_
9. Estimate No. of Foam or  
Neo-Sampoon users  
previous month: \_\_\_\_\_
10. Total No. Users:  
(add #3 thru #9) \_\_\_\_\_
11. Prevalence =  $\frac{\text{No. Users}}{\text{Eligibles}}$  \_\_\_\_\_



% ELIGIBLE COUPLING  
 USING CONTRACEPTIVE

08

YEAR	1981	1980	1979	1978	1977	TOTAL
Number Insertions						
Est. % Now Using	100%	80%	60%	50%	30%	
Current Users						

Multiply the number of insertions each year by the percentage figure for that year to give the number of current users. Total the bottom line of current users 1981 - 1977 and enter on worksheet.

# IMPLEMENTATION OF FERTILITY CONTROL PROGRAMS IN DEVELOPING SOCIETIES

Figure 2  
INTER-RELATIONSHIP FERTILITY CONTROL PROGRAMS  
AND DEVELOPMENT - MODERNIZATION

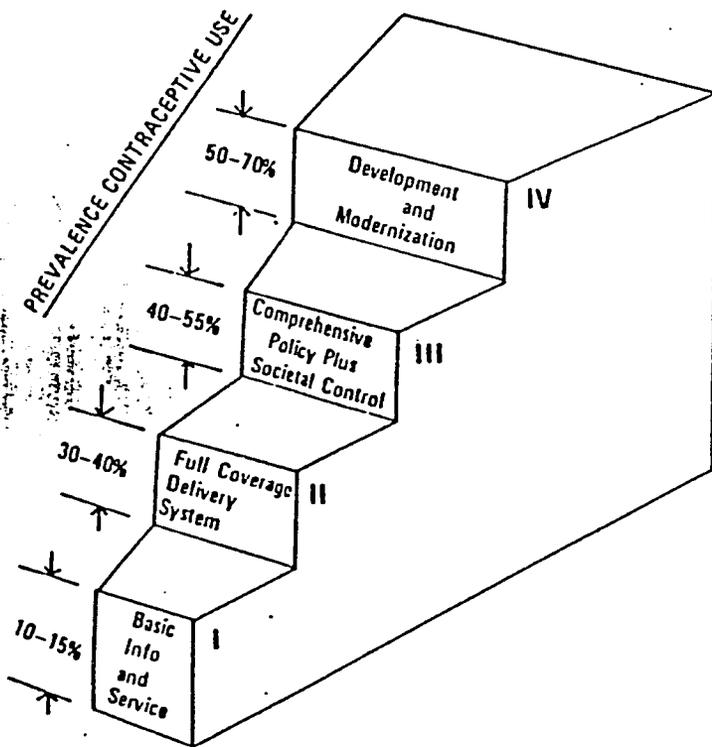
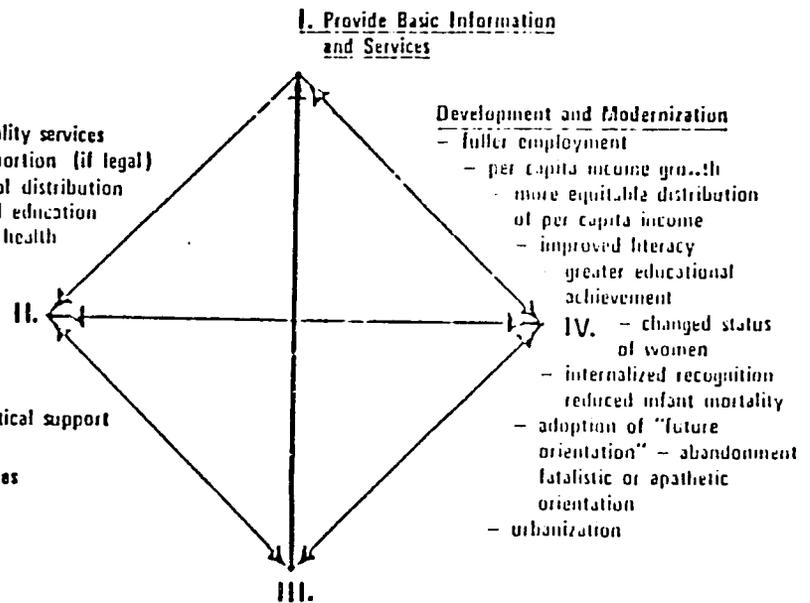


Figure 1  
Stages of  
Fertility Control Programs Against  
the Backdrop of Development and  
Modernization

### Full Coverage Delivery System

- universal access to quality services
  - use all methods plus abortion (if legal)
  - commercial and non-clinical distribution
  - sophisticated information and education
  - integration with maternal child health
- Improved level general public health services
  - good administration
  - quality evaluation
  - "soft" population policy
  - adequate budget and political support
  - incentives
  - village centered services



### Comprehensive Program with Increased Societal Control "mutual coercion by mutual consent"

- adoption of "comprehensive" population policy
- wider use of incentives; for individuals, groups, communities
- legal changes, e.g. raised age of marriage
- access to social services according to fertility behavior
- sustained political support
- dynamic leadership
- link to other development activities

### Development and Modernization

- fuller employment
- per capita income growth
- more equitable distribution of per capita income
- improved literacy
- greater educational achievement
- changed status of women
- internalized recognition reduced infant mortality
- adoption of "future orientation" - abandonment fatalistic or apathetic orientation
- urbanization

LENNI W. KANGAS  
Agency for International Development

# SPECTRUM OF EXTERNAL INFLUENCES AFFECTING FERTILITY BEHAVIOR

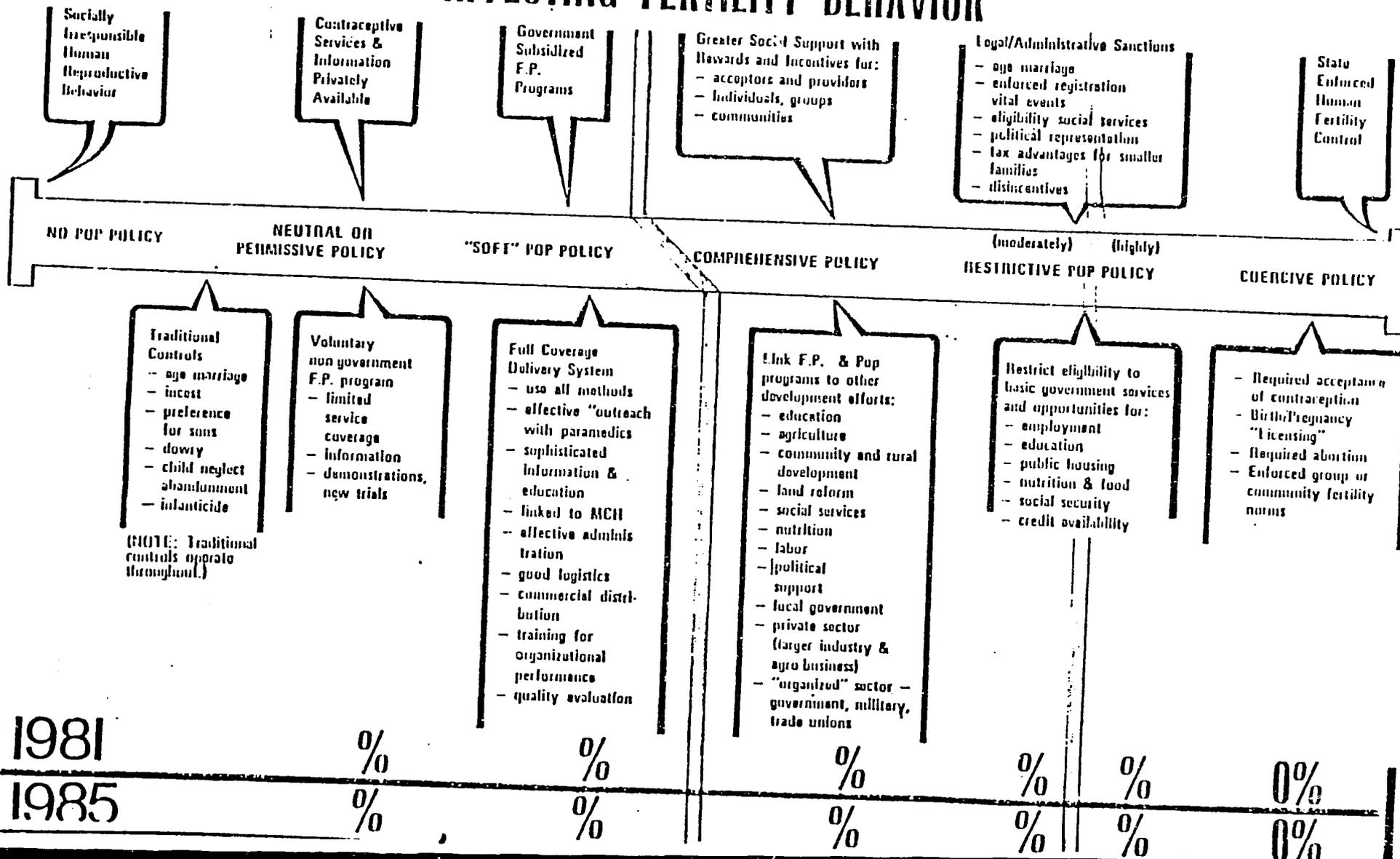
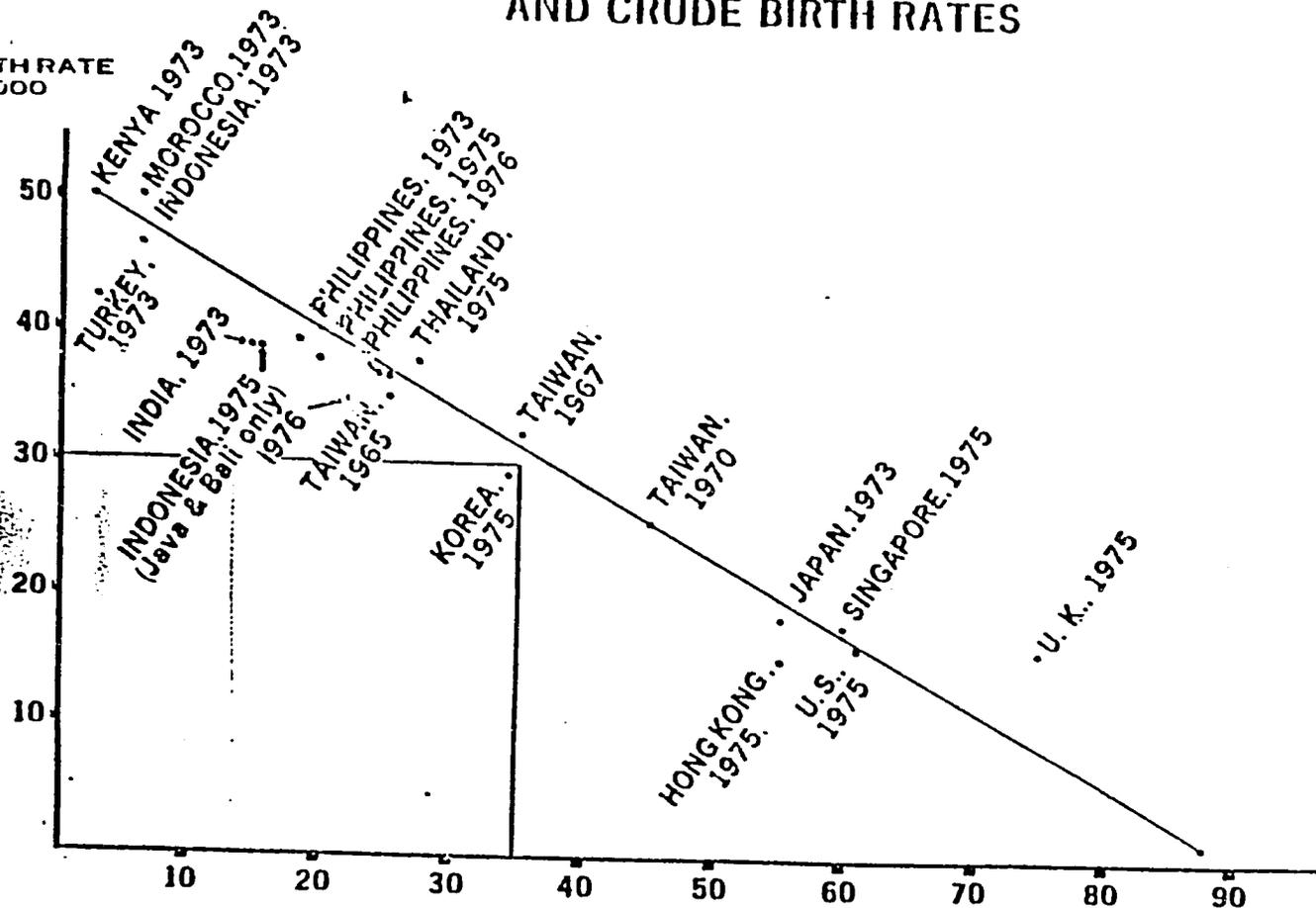


Figure 4  
CORRELATION BETWEEN PREVALENCE RATES  
AND CRUDE BIRTH RATES

CRUDE BIRTH RATE  
PER 1000

48



\* NOTE: A CONTRACEPTIVE PREVALENCE RATE OF 35% RESULTS IN A CGR OF APPROXIMATELY 30/1000. (SEE TAIWAN 1967) THIS GIVES RISE TO THE "35-30 RULE" ALSO A TWO-POINT INCREASE IN PREVALENCE CORRESPONDINGLY RESULTS IN ROUGHLY A ONE POINT DECLINE IN CGR.

PREVALENCE RATE (% OF  
COUPLES MARRIED OF  
REPRODUCTIVE AGE (15-49)  
USING CONTRACEPTIVES)

## B. OUTLINE OF DETERMINANTS OF EGYPTIAN FERTILITY

### I. SUPPORTING HIGH FERTILITY

#### A. History of High Fertility

1. Has served Egyptian peasantry well for centuries - because high mortality roughly equalled high fertility, especially infant mortality
2. Norm of large family size means:
  - a) protection against hostile neighbors
  - b) agricultural labor
  - c) social & economic security in old age
  - d) income from family members migrating to cities & abroad
  - e) proof of virility

#### B. Islamic Culture/Religion

1. Fatalism, God's will, "Allah will provide."  
Don't tempt fate by interfering with God's will
2. Male-dominated family and social structure
3. Low status of women
4. Confused public perceptions whether religion for or against birth control
5. The international dimension: Without political rapprochement with conservative Arab states, GOE wants to avoid criticism from them for promoting fertility control

#### C. Low Educational Status

1. Mass doesn't understand macro population problem/predicament - imperfectly understands micro problem at family & community level
2. Majority cannot understand insidious nature of population growth - concept of momentum of growth, the already accomplished "radical" change in mortality since 1945

3. Little tradition of critical thought among majority
4. Severe neglect of female education (73% of females ages 10-14 years in two recently sampled rural areas of Uppeer Egypt - (including Assuit) were illiterate today!)
5. Populace easily swayed by fantasy propoganda that all will be better - new towns, new lands, new jobs - or cynical about promises government

D. Economic and Social Influences

1. Lack of economic/social mobility
2. Low incentives for "deferred consumption" and saving for the future, e.g., children's education
3. Many (majority?) living now within "zero sum game"
4. Personal initiative inadequately rewarded. One "gets ahead" through family influence, friends and relatives, or fate
5. Above circumstances reinforce fatalism and lack of "future orientation" - the notion that one can influence your future welfare
6. Dilemma: large family size & high fertility is economically rational behavior at micro or household level: ultimately disasterous at macro/nation-state and community level

E. Family Variables

1. High economic value of children
2. Psychological rewards from large family size - proof of fertility, manhood, womanhood
3. Emphasis on early marriage - removes dependent female from household, assures virginity (esteemed by Muslim religion), and increases exposure to child-bearing.
4. Few alternative female roles other than child-bearing/rearing. Limited male employment opportunities and rapid growth labor force will continue to suppress female labor force participation;

5. Woman's hold on man tied to continuous child-bearing - fear of divorce/abandonment
6. Tradition of extended vs. nuclear family
7. Folklore re: reproduction/contraception/abortion,

F. Absence of Unequivocal Fertility Control Policy plus Government Policies that Indirectly Support High Fertility

1. Top political leadership unconvinced about existence & implications of population problem
2. Government technocrat community likewise unconvinced or ambivalent.
3. Subsidies for food, energy, and housing and higher education obscure real costs of having children
4. Failure to enforce laws on compulsory school enrollment, child labor and minimum age of marriage
5. Free university education and technical education - parents not forced to save for children's education
6. Guaranteed employment of technical school and university graduates by government
7. Lack of credibility of many government services - in health (underutilization) education also?  
  
Distrust & suspicion of government intentions/services, e.g., BCG vaccination, oral rehydration and family planning programs.

G. Weak Family Planning Service Program

1. Lack of availability of effective, safe, inexpensive means of contraception
2. Low level public knowledge of where, how, why and safety of contraception
3. Weak central staff in Ministry of Health charged with program implementation

4. No capacity to disaggregate family planning information and services to discrete audiences of land owners, landless, urban/rural, educated and illiterate

## II. SOCIAL/ECONOMIC CHANGES SUPPRESSING FERTILITY

- A. Urbanization - lack of housing, limited child labor opportunities
- B. Migration - to cities, abroad - broadens horizons, increases wealth, fosters small-scale entrepreneurship
- C. Inflation - costs more to feed, clothe, house and educate children
- D. Income growth/consumerism/materialism
- E. Moderization: travel, electrification, television, radio
- F. Land fragmentation among heirs
- G. Agrigultural mechanization - displacement of child labor
- H. Increasing educational levels (? examine evidence)
- I. Labor force changes, increasing female participation
- J. Improved status of women, new laws on women's status

## III. INSTITUTIONAL CHANGES THAT COULD REDUCE FERTILITY

- A. Strong government Commitment to fertility control
- B. Implementation of a vigorous fertility control service program
- C. Massive, sustained public information/education campaign
- D. Introduction of Societal control & social/legal support measures
  1. Taxes
  2. Incentives/disincentives
  3. Removal subsidies
  4. Instill sense of community participation

IV. DETERMINANTS OF FERTILITY AMENABLE TO CHANGE

<u>Determinant Category</u>	Importance/ Weight of Determinants (10=High;1=low)	10= High; 1= Low		Number Years Before Affects Fertility	Political/ Adminis- trative Feasibility	Population/ Family Plan. Program Priority
		Degree of Government Influence	Degree of Donor Influence			
<b>A. <u>Governmental</u></b>						
1. Adoption Comprehensive Population Policy; Top-Level Political Support	8 (Program not likely to move without this)	10	3	2 years minimum	6	8
2. Implement vigorous FP Service Delivery	6-7	8	5	2 years minimum	7	10
3. Maintain massive, sustained information/education program	8	8	6	3-4 years	8	9
4. Introduce Societal Control & Social/Legal Support Measures For Lowered Fertile	6 (overall; impor- tance increases overtime).					
a. raise/enforce marriage age	4	8	2	3 years	4	4
b. enforce compulsory school enrollment	6	8	2	7-10 years	5	5
c. reduce food, education subsidies	4	9	4	2 years	4	6
d. restrict public housing eligibility	3	9	1	5 years	3	3
e. limit guaranteed employment	5	9	1	5+ years	3	3
f. enforce child labor laws	6	7	1	3-5 years	5	6
g. reduce subsidies for child raising	3	9	1	6 years	5	2
h. incentives/disincentives - for individuals, communities, governorates	6-7	9-10	5-6	3-4 years	7	7

<u>Determinant Category</u>	Importance/ Weight of Determinants (10=High;1=low)	10= High; 1= Low		Number Years Before Affects Fertility	Political/ Adminis- trative Feasibility	Population/ Family Plan. Program Priority
		Degree of Government Influence	Degree of Donor Influence			
<u>B. Economic/Social</u>						
1. Inflation	5	4	2	5-10 years	2	1
2. Urbanization	6	3	0	"	3	2
3. Migration						
a. to cities	6	3	1	"	2	3
b. abroad	5	3	1	"	3	1
4. Increase income growth	6	4	2	4 years	4	2
5. Improve equity of income distribution	7	5	2	10 years	3	2
6. Agricultural mechanization- displace child labor	6	8	5	6 years	7	6
7. Increase female school enrollment/continuation	7	9	5	12 years	6	5
8. Land fragmentation	5	2	1	5-10 years	2	1
9. Favorable credit to contra- ceptors/those limiting family size	4	8	3	2 years	3	2
10. Tax treatment favoring smaller families	4	8	2	3 years	6	4
11. Raise educational levels	6	4	2	10 years	5	3
12. Rural Electrification	4	7	4	4 years	7	6
<u>C. Cultural</u>						
1. Religiosity	6	3	0	5-7 years	2	1
2. Family Variables	3	2	1	"	1	1
3. "Modernization"	7	4	2	"	3	1

C. FIELD TRIPS

1. Abou Soud Public Health Center, Cairo and Torah Health Center, March 4, 1982

Dr. Moshira and Dr. Hashad, MOH. and two Assessment Team members visited two clinics in the greater Cairo area on Thursday, March 4, 1982.

Abou Soud Public Health Center

This health center is located in a congested urban area near the "City of the Dead" in Cairo. Center staff said they serve a population of about 90,000 and claimed the density was approximately 100,000/kms<sup>2</sup>.

The center was constructed in 1978, presumably with funds from the first World Bank population loan (\$5.0 mil.). It is clean, spacious and well-functioning. Staff includes 13 physicians, 2 dentists, and 25 nurses and nurse midwives.

Daily patient load is about 300. When we arrived 80 or so patients, mostly women and children, were present. By 11.00 a.m., almost all patients had been served and the center was nearly empty.

Dr. Karim, the center director, said diarrhea among children, family planning, and environmental sanitation are their leading health problems.

MOH and school health services are free; other services are provided for a 10 piaster fee (about 10 cents U.S.).

Family Planning Services In 1981, the MCH Unit distributed 1,522 monthly cycles of pills (as compared to 1,923 mc in 1980), inserted 149 IUDs (86 in 1980), and distributed 796 condoms (units).

In terms of FP users per year, the MCH unit served:

<u>Method</u>		<u>Users</u>
Pills:	$\frac{1522}{13} =$	117
IUD:	$149 \times 85\% =$	126
Condom:	$\frac{796}{100} =$	8
Total:		251 FP Users

In addition, the "public health unit" at the center also supplies oral contraceptives. In 1980, this unit distributed 3,600 monthly cycles of pills, sufficient for 277 users for one year.

Only the Lippes size "A" loop was available. Dr. Karim believed the copper oxide in the copper "T" would damage the fetus if pregnancy occurred with the device in situ. Dr. Moshira explained that this is not true. The center's pharmacy had only four boxes (@ 100 pieces each) of condoms in stock. This shortage of condom supplies most likely explains the minimal distribution of condoms from this center. There were ample supplies of pills and IUDs and staff reported no outages during the past 12 months.

Comment:

With 300 visits per day, this obviously is a busy health center. Nevertheless, it's family planning case load, with only 276 users served through the MCH clinic (plus, perhaps, an equal number through the public health clinic, is extremely light.) If the catchment population is 90,000, then there are approximately 15,000 MCRA (married couples of reproductive age). At best, 500 or so obtain family planning services from this center or roughly only 3.3% of all eligibles.

Reportedly, there are 30 or 40 private clinics in the area and undoubtedly a number of pharmacies which may partly account for the reduced FP case load. Note that fewer monthly cycles of contraceptives were distributed in 1981 than in 1980 (1522 vs. 1923) by the MCH unit.

Torah Health Center (5 km south of Maadi)

This center also was constructed in 1978 with World Bank funds. Staff includes 10 physicians, 8 nurses, 4 midwives and 2 social workers. Three physicians work in the MCH clinic, two female and one male. The facility is clean and well maintained.

Dr. Fawzia, the center director, said they served a population of approximately 50,000 living in a 9 km square area. Center staff attend about 40% of all deliveries in the area and handle 4-45 deliveries per month. The infant mortality rate, derived from registered deaths, was around 120 to 130/1000.

Patient visits average 70 per day. Oral rehydration is offered with "very good results" according to Dr. Fawzia. They are using both the UNICEF provided ORS and a locally manufactured mixture.

Family Planning Services

Services provided by the Torah Health Center and the local pharmacy we visited are shown below:

	<u>Torah Health Center</u>	<u>Pharmacy</u>
Pills:	150 users	600 users (sells 30 MC/day)
Condoms:	60 users	120-150 users (sells 10 units/day- "Top )
IUD:	160 (1981)	30 per year (cu T)
Total:	<hr/> 370 users	<hr/> 750 users

With a 50,000 population size, there are approximately 8,300 MCRA. If one assumes the clinic serves 500 (allowing for IUD insertions in earlier years), it is serving 6% of MCRA whereas this one pharmacy serves 9% of MCRA.

The center inserted 15 Cu T in February, 1982 which women purchased at local pharmacies for L.E. 2.00 each. The center sells Neo-Sampon for pt. 20, but only sold one tube last month. The price is to be reduced to pt. 10 next month.

Clinic staff accept private patients after 2:00 p.m. each day. IUD insertions are provided for L.E. 1.00 for the Lippes loop and L.E. 2.00 for the Cu T. Dental patients are charged pt. 50 for each procedure, e.g., extraction, cavity repair, etc.

Family planning incentive payments received last year were:

Physician:*	L.E. 50
Nurse:	L.E. 15
Midwife:	L.E. 15
Social Worker:	L.E. 15
Pharmacist:	L.E. 15

\* Not determined wheter all doctors or only MCH doctors received the LE.50.

Dr. Fawzia said they were able to obtain contraceptive commodities in excess of the value of their monthly "sales". All agreed there was a heavy paperwork burden associated with handling money from sales, depositing it, keeping records and the annual incentive.

During the past three years, a number of measles cases appeared despite children having had measles vaccinations. Dr. Fawzia suspected it might be a new strain that was resistant to the vaccine. The other possibility is that the vaccine was defective.

Dr. Fawzia reported that environmental sanitation had improved during the past three years. She showed a great deal of enthusiasm for her work in Torah, remarking that she "loved this place". She also said that local residents readily volunteer to repair clinic facilities without cost when they break down. Obviously, she enjoys excellent rapport with the community.

Comment:

The Torah Health Center should be considered as a site for more intensive FP outreach activities, possibly a trial of "prevalence programming" involving local pharmacies. Signs of solid community rapport were impressive. An operations research activity enlisting center staff on how to double contraceptive use in their catchment area would be likely to produce good results. Also there are, attractive possibilities for expanding the combined "public-private" FP service combinations if clear goals were established for increasing contraceptive prevalence in the catchment or service area. Other pharmacies should be visited to learn about their sales of pills, condoms and IUDs.

2. FIELD TRIP TO BENI-SUEF, MARCH 9, 1982

Three teams from the Population Assessment Team visited Beni Suef on March 9, 1982. Dr. Helmi Bermawi of the Ministry of Health and Ms. Laura Slobey of USAID were also part of these groups. The following report is on the visit of one team to PDP headquarters, one urban health unit, one rural unit in a PDP village, a pharmacy and the local Ministry of Health Statistical Office.

PDP Program

The population of Beni Suef is 1,258,351. There are 38 PDP units in the governorate covering 211 villages. There are eight rural coordinators; 126 raayda Rifeya. The director of PDP in Beni Suef is Mr. Mohamed Kamel.

PDP has conducted training for various levels of personnel and for local leaders such as workers' representatives and imams. They have also provided English language training and training in knitting. Twenty trainers have been taught how to use the magnetic boards, 83 raayda have been trained in face-to-face communication, and 52 PDP staff have attended SIS training programs.

#### Urban Health Center

This center, on the edge of urban Beni Suef, serves about 58,000 people. It is an outpatient clinic. There are 6 physicians, 17 nurses and 13 midwives. Two doctors are trained to insert IUDs, including the director, Dr. Kalsoum.

There were 158 births in the area in Feb. 1982; 92 were attended by center staff. They do 60% of deliveries. Daily case load is 50-60 in outpatient clinic, 20 in MCH.

In 1981, they inserted 72 IUDs (all Lippes Loops), 3,500 condoms were distributed (they are currently out of condoms) and 1,619 cycles of OC's. They don't distribute foam, cream or other methods. The director says the people in her area aren't well educated so they can't use these methods (an opinion disputed by findings in the next village visited). The prevalence formula was used to show the director and other staff present the low percentage of potential users being reached. She said the first thing needed is to raise the age of marriage in order to shorten the period of fertility. She said the midwives discuss family planning after childbirth. Apparently they aren't very convincing. They did have some family planning stickers on the walls.

#### Tazmant Village

This is a PDP village - a mother village with a rural health center. There were lots of family planning posters, including what appeared to be locally produced materials, and lots of charts on the walls. There is one physician. He now has three trainees with him. There are four nurses, four midwives and six raayda. The doctor estimates he inserts two IUDs per month: in 1981 he inserted 10. He has 300 regular users of the Kromex cream! He is very sold on it and apparently has done a good job promoting it as a safe and easy-to-use method. He said that he was concerned because they are no longer going to stock Kromex (on investigation it appears to be a problem of registering the product in Egypt and steps are being taken to make its use legal). Contraceptives on hand included 100 condoms, 10 loops, 150 cycles of OC's (120 Primovlar and 30 Anovlar) and 17 Kromex cream.

The doctor said there were 700 births in the area in 1981 and that most were attended by dayas. He had a good supply of Oralyte. He said he used it often and found it helpful. Most common health problems of children are colds in winter and diarrhea in summer.

Tazmant had a significantly higher prevalence rate than the urban clinic, but still it was only about 11%.

#### Pharmacy

On the way back from Tazmant the group stopped at a local pharmacy. The pharmacist said he regularly stocks five different OC's. He said Anovlar and Microvlar are the most popular brands. He estimated sales per month at 120 cycles. He stocks both the graviguard Cu7 and the multiload IUDs. He sells about 22 per month. Condom sales (Tahiti) are 300 per month and foaming tablets (Larfam and Neo-Sampon) are 50 per month. He doesn't stock creams because they don't sell.

A visit was also made to the MOH office in Beni Suef. The tables that follow are based on the information provided by the head of the statistical department.

#### MOH District Supply Stations

##### Supplies of contraceptives:

###### Central warehouse:

Pills	4,673
IUDs	338
Condoms	7,948

###### Stock in Health Facilities (as of 2/1)

Pills	34,708
IUDs	773
Condoms	19,593
Kromex	5,000
Other	228

###### Stock in 7 Distribution Centers (apx.):

Pills	20,000
IUDs	200
Condoms	5,000

Statistics:

Population	1,258,351	(1981)
Births	53,482	
Deaths	15,165	
Infant Deaths (under 1 year)	3,308	

3. FIELD TRIP TO MENOUFIA MARCH 10-11, 1982.

Two Assessment Team members visited Menoufia accompanied by Dr. Saad Gadallah and several of his colleagues including Samiha El Katsha, Samira Shehata, Esmat Kheir.

We visited a number of villages in the morning, were received by the governor before lunch, and had extended discussions about the design and operation of the project in the evening, with emphasis on the household contraceptive distribution system, the oral rehydration project, and training. There was also some discussion of evaluation and of the Beni Suef project. Most of the readers of this report will be familiar with the Menoufia project and, therefore, this field trip report will only sketch the highlights of our discussions, plus a few notes on nine of the villages visited by team members.

Household Distribution: One of the major elements in the Menoufia program was visits to each household to discuss family planning with women in the household and to offer three cycles of pills to women who expressed an interest in contraception and/or were willing to take the pills. For women who were less than three months postpartum, or who were lactating and had not resumed menstruation, foam tablets (Neosampoos) were offered. During the first year, 1978-79, three districts were to be covered then three the second year, and the remaining two the third year. (This brief report will not attempt to describe the socio-demographic survey, the mini-surveys, the establishment of district committees, and the like.)

Dr. Gadallah said that he would have preferred three rounds of household distribution during the first year rather than a single round, after which users and persons interested in using contraceptive methods had to visit a health clinic, a pharmacy, a private doctor, or private family planning association. Also, the Social Research Center would have preferred follow-up visits to those who accepted supplies at the time of the initial, and only, household visit. This feature was not built into the design, presumably because of budgetary constraints. In our view this is a

major weakness in the design of the Menoufia project. Many professionals, and we believe an overwhelming majority, would expect little or no increase in prevalence rates following a single household visit (one would expect a temporary rise in prevalence, followed by a decline). Other aspects of a program might, of course, lead to an increase in prevalence, but a single household visit does not seem to be a promising approach to an increase in the prevalence of contraceptive use.

Household Oralyte Distribution: A program to distribute oral rehydration salt (Oralyte) to all households having children 0-4 years of age was undertaken in the first year of the program. Canvassers informed mothers about the value and use of oral rehydration, and each family with a child less than 5 years of age was offered two packages of Oralyte, a one-litre plastic bottle, instruction when and how to use the Oralyte, and instructions to go to the nearest health unit when additional supplies were needed. Initially, women who had participated in the household distribution of contraceptives were the canvassers who offered Oralyte.

The SRC staff says a number of mistakes were made in the initial distribution of Oralyte:

- Neither the village leaders, physicians, nor the villagers were informed about the project.
- Distributors of contraceptives were not viewed as credible sources of medical information. There was distrust of those seeking to prevent births who then began to discuss how to save the lives of babies.

The second approach used was to hire and train a separate group of canvassers who were not identified as would-be-preventers of births. Female university graduates were used as canvassers. Also, a village meeting was held by the head of the local unit, the physician, and the social worker to discuss with villagers various action programs with special emphasis on the oral rehydration project. This approach appeared to work well, but it was time consuming. Therefore a third approach was used.

The third approach was to provide supplies to the local health unit and one other designated location (typically at a volunteer's home) in the village. Villagers were informed about the availability of supplies and were encouraged to pick them up at specified times. Members of the oral rehydration distribution teams were available to explain to individual participants the ORS treatment. Two significant problems developed during this phase of the project: (1) after the first announcements about the program,

so many women came for information and supplies that the staff could not cope with the crowd, and (2) the canvassers were not familiar with the social structure in the villages and created resentment because of lack of attention to "first" families and to groups that did not like to be brought together because of past animosities.

The fourth approach was a small group approach which focussed on informing local leaders, including physicians, and then organizing local committees which were given the responsibility for carrying out the project. Following the process of community preparation and before starting the distribution, the committee assigned persons (usually the raayda refiyas) to visit 20 households each day and invite mothers of children less than five years of age to go the following day to the health unit or depot to receive the ORS package. Mothers responding to this invitation were divided into groups of about ten and were given instructions and supplies of Oralyte. This approach is reported to have worked very well, with 97% of the target population responding positively.

Training: A major part of the project was the training of personnel associated with health, social activities, and family planning so as to upgrade their knowledge and performance. This activity was the responsibility of governorate personnel with technical assistance from SRC. There were both general and specialized training programs.

The General Training Program: It was planned to train one doctor, two nurses, and a clerk from each health unit, the director, social worker, rural development worker, nursery supervisor, and the officers of the community development society from each social affairs unit and the heads of village units and councils. The general training program was designated to cover: (1) available health and social services and their relationship to family planning; (2) population policy and developments needed to solve the population problem; (3) physiology of reproduction, the various contraceptive methods including their use and effectiveness, and the treatment of sterility (4) population and family planning communication and education; and (5) family planning programs and their relationship to the economic and social situation. Trainees were divided into groups of 25. SRC reports that they were able to get good and respected instructors, primarily from Cairo, and were able to get the trainees to participate in the sessions by asking questions and entering into the discussion. Training was given for five days over a two week period.

Specialized Training Courses: Specialized training course were held for:

- Doctors.
- Nurses.
- Health unit clerks.
- Social sector personnel.

The details of these programs are included in reports by SRC and need not be repeated here.

SRC concludes that there is a need to create local teams of trainers drawing on personnel from the districts and the governorate. There is a particular need for more training of nurses, and also for the social sector. Similarly there is inadequate supervision.

Supervision is inadequate in most programs and should be given much more attention. We suggest that simple check lists be worked out for each level of supervisors and, of course, that supervisors be supervised until they learn to be supportive of personnel in the various units rather than acting as inspectors.

Governor Abdul Monseif Husein, a sociologist, was transferred from another province to Menoufia about five months ago. He described the governorate as being a very limited area with high density. It is not adequate to solve the population problem through diffusion of information and family planning, but it is also necessary to open up new lands. Also, there is considerable migration from the province. He noted that it is preferable for migrants to go to an adjoining province than to the Sinai. He said that one needs to institutionalize the small family norm in order to reduce fertility, adding that this is difficult at present. He suggests that it probably is best to concentrate on the health aspects of family planning and on child spacing at the present time.

We asked about the feasibility and desirability of social support measures such as more education for girls, raising the age at marriage. The governor responded that he would support such measures, and suggested that the age at marriage for girls might be raised from 16 to 20. There should be more education for girls, and also more educational opportunities. He said that the recent speech by the President in which he emphasized the significance of rapid population growth was very important and that the Population Conference now being planned should have come before the Economic Conference.

We also asked about the desirability and feasibility of rewarding villages that have relatively high prevalence of contraceptive use by giving them priority for development projects that are being planned. We pointed out that there are two advantages to such a program, namely, it doesn't cost anything additional, and it rewards villages for good performance in family planning. The governor thought this would be a good incentive and could be implemented.

We also asked about:

Community incentives: The governor feels that these are much better than individual incentives; moreover, he has funds that could be allocated to such a program if some outside funds could be made available.

Newsletter: To give news about family planning, including directives, and performance of best units, possibly combined with a reward to the best performing units. The governor said they have a governorate newsletter covering a variety of topics, and that family planning/population items would be included.

We stressed that governors could be very helpful to a family planning program, and cited the Indonesian experience. He said that Egypt has been divided into eight planning zones and that four governorates are included in the zone of which Menoufia is a part. This would be a good group in which to discuss such matters. The governors of the planning zones meet quarterly. This group has a direct line to the Ministry of Finance, and Abdul Husein said this could be a very effective mechanism.

He noted that he has a number of problems, including inadequate educational facilities for girls, limited opportunities for employment in agriculture-particularly for women, too rapid turnover of doctors in health and family planning clinics, lack of a training center for continual in-house training and retraining, prohibition by the Ministry of Health on the use of injectables, and the lack of vans for transporting supplies and presenting audiovisual materials to different groups.

The governor asked whether we would support family planning programs. We replied that our government was very much interested in assisting Egypt in a number of sectors, and that we attach great importance to population. We described the purpose of the mission, and concluded by saying that the major job was of course one that Egypt must carry out, and that this requires commitment, including

political commitment, and resources. We stressed the need for better planning, training, supervision, and service. We added that if those things could be accomplished, we would be very surprised if our government did not make substantial contributions to assist their programs.

The following health facilities were visited in Menoufia:

Combined Units

1. Bai el Arab
2. Batanoon
3. Esto Bary
4. Meet Berrah
5. Shanawan
6. Shubrah Bekherun

Health Units

1. Begarem
2. Meet abu El Kom
3. Meet Mesoud

The structure of each type of unit is the same, although there are variations in the number of hospital beds (most having 14 beds, but a few having 20), the staffing pattern, and the activities. Most combined units have a nursery, sewing classes, knitting classes, training in and manufacture of rugs, woodworking of varying degrees of sophistication, and beehives for production of honey. Some have sizeable poultry operations, cattle raising, sometimes for breeding, and more often for slaughter. Some also have primary schools located on the premises. A few have a sizeable number of employees engaged in manufacture of uniforms, for example, for the Army and for nurses.

For the most part these seem to be quite useful activities that impart practical skills to girls, young women, boys, and young men. Some very young boys were engaged in production activities, as well as a few very young girls, and the use of child labor left us with a sense of concern. Also, the number of young girls in classes where they learned sewing, embroidery, and crocheting was so large in relation to the size of the classroom that they were sitting too close together to permit any level of efficiency. Overall, however, we were favorably impressed with these efforts to teach useful skills to both young girls and boys.

The combined units date from the mid 1950s and early 1960s, and the range of activities sketched above existed prior to the Menoufia project. However, the project has been well received and serves a useful, complementary role.

Family planning activities are also highly variable in the different units, although in the governorate as a whole they are all

too constant. The accompanying table shows that the prevalence of contraceptive use from activities of governmental family planning clinics has gradually increased from five percent in 1978 to seven percent in 1981, (8% in 1981, including an allowance for IUDs inserted in earlier years). However sample surveys conducted in 1980 indicate that the prevalence of contraceptive use was about double this figure in rural areas. Unfortunately, one comes away with the impression that the governmental family planning program is not yet well organized, and lacks a sense of high priority and urgency.

When workers were asked what could be done to improve performance they mentioned the need for a simple and, regular supply system, transportation for nurses and midwives so that they can visit nearby villages, training programs for dayas who, after all, attend almost all births in rural areas. We would add there is a need for training of clinic personnel, a feedback system so that they will know how well their unit is doing relative to other units, and relative to what it did last year, more display of posters, etc.

D. PROGRAMS/PROJECTS IN THE POPULATION SECTOR FINANCED BY GOE, AID AND OTHER DONORS.

UNFPA

PFPB population and family planning activities 1976-1980.

1. PDP: community based program in 12 governorates: Behera, Damietta, Kafr El-Sheikh, Gharbia, Dakahlia, Sharkia, Kaliubia, Fayoum, Beni Suef, Minia, Assiut. (USAID assists in the expansion of the project within certain village council areas not covered by PDP in governorates which it had already started.) The project aims at establishing self reliance at the village level for the implementation of national population policies.
2. Management, planning and evaluation activities of PFPB and coordination of planning activities of different sectors and central and regional levels.
3. Bio-medical research.
4. Socio-economic and action research.
5. Communication, education and training.

CAPMAS data collection and processing activities:

1. National Fertility Survey and Egyptian Fertility Survey, 1980.
2. Pregnancy Wastage and Infant Mortality Sample Survey.
3. Internal Migration Sample Survey.

Ministry of Agriculture and Irrigation, General Organization for Land Cultivation, Department of Community Development, Mariout, for the introduction of population and communication component in the land resettlement project. Supported by FAO funds. Started in 1975 and expired in 1979.

SRC/AUC: Research study on cultural values and population policy, a part of a global project of the Institute of Society, Ethics and the Life Sciences (ISELS). Started in 1975 and ended in 1978.

Ministry of Manpower and Vocational Training: socio-economic research on population and manpower needs in rural and urban areas.

World Bank: IDA

MOH

1. First Population Project: 1974-1979. Governorates of Kalyubia, Minia, Gharbia, and Assiut. Establishment of polyclinics, general health centers, pilot study for home visiting program and training component. Total cost \$11.38 million: IDA \$5 million.
2. Second Population Project: 1979-1983. Total budget \$60.3 million: IDA \$25 million, ODA \$8 million, GOE \$27.3 million.

UNICEF

1. Community based family planning project. Six areas were under EFPA: three urban deprived communities in Cairo, Aswan and Luxor, and three rural and semi-rural communities in Assiut, Sharkia and Menoufia; three areas under Land Reclamation Authority; South Tahrir, Mariot and East Delta. 1975-1978. Expenditure was about \$350,000.
2. Expenditure Educational Programs: through EFPA in Alexandria, Assiut and Aswan, 1979-1980.

WHO

1. WHO special program on human reproduction. Several research activities were funded on the safety and effectiveness of oral and injectable contraceptives and intra-uterine devices; the development of new and improved IUD's; methods for the determination of the fertile period; methods for regulation of male fertility; female sterilization; service research in family planning.
  1. AUC 1977-1978, \$14,950.
  2. Cairo University 1978-1978, \$5,700.
  3. Institute for Research for Tropical Medicine, Cairo 1977-1978, \$54,693.
  4. Alexandria University 1977-1979, \$56,290; 1978-1979, \$21,800.
  5. Assiut University 1977-1979, \$95,600.
  6. Strengthening of research capabilities at the Collaborating Center for Clinical Research (CCR), Shatby Maternity Hospital, Alexandria University 1977-1979, \$178,720.

7. Research Training Grants, nationwide. 12 grants in 1977-1978, \$116,343; 8 grants in 1978-1979, \$96,050.

USAID

1. Population and Family Planning Board: extension of PDP.
2. SRC/AUC: Menoufia Project.
3. MOH: El-Galaa Maternity Hospital; High Institute of Public Health; training IUD and diaphragm insertion in centers in Alexandria, Tanta, Minia, Zagazig.
4. The State Information Service.
5. Contraceptive Prevalence Survey: PFPB \$60,000, Westinghouse Corp. Health System \$82,000, USAID \$75,000.
6. Contraceptives. 1980-1981, \$10.9 million.
7. Family of the Future: EFPA/Cairo. Currently operating in Greater Cairo and reaching out to other urban areas. Also supported by IPPF.

ODA (Government of U.K. Overseas Development Administration)

Second Population Project: (see World Bank) Equipment for EFPA.

FRG (Federal Republic of Germany)

To MOH to upgrade the facilities and acceptance rates of health and family planning services.

1. Strengthening the Family Planning Department at MOH.
2. Al-Galaa hospital, in cooperation with International Islamic Center, for Population Studies and Research, Al-Azhar University.
3. In Alexandria, Dakahlia and Sharkia governorates 21 health units are being renovated and upgraded into rural health centers. Under a recent extension another 16 rural health centers will be covered within the three governorates.

International Project of the Association for Voluntary Sterilization: (IPAVS)

1. Egyptian Fertility Care Society (EFCS): a national association established to expand the national resources and assistance services for voluntary sterilization. 1975-1977, \$13,500; 1977-1978, \$33,650; 1978-1979, \$95,150.
2. EFCS to establish a nation wide training program in endoscopy, minilaparotomy and coloptomy nationwide. 1975-1977, \$77,500.

3. Misr Spinning and Weaving Hospital in Mehalla El Kubra, Gharbia governorate to incorporate laparoscopy services into the hospital family planning clinic. 1976-1978, \$6,643.
4. Boulak El Dakrour Hospital, Cairo, to expand female voluntary sterilization services to two outlying health centers and to train physicians in sterilization methods. 1978, \$17,122.
5. The National Institute of Cardiac Diseases, Cairo, to establish free female voluntary sterilization project. \$11,057.
6. Faculty of Medicine, Zagazig University, Sharkia governorate, to establish females voluntary sterilization including physicians training and rural information and education squad. 1978-1979, \$36,735; 1979-1980, \$25,890.

Family Life and Population Program, Church World Services

For family planning services of the Coptic Evangelical Organization for Social services (CEOSS) in rural areas of the governorates of Minia and Assiut supported by Family Planning International Assistance (FPIA). FLIPP/CWS 1978-1979, \$28,000; FPIA 1975-1979, \$112,055; 1980, \$49,422, Commodities for project estimated at \$43,590.

Family Planning International Association (FPIA)

Bishopric of Public Ecumenical and Social Services for nationwide raising and development of population and family planning consciousness among clergy and lay leaders of the Coptic Orthodox Church and to mobilize the church's parish level resources as channels of information and education about family planning. The project started in 1975 and in 1978-1979 a grant of \$89,289 and commodity assistance estimated at \$17,962 were awarded.

Ford Foundation

1. Assiut University, research and training in the interaction of disease and contraception 1977-1980, \$102,000 extension grant of \$6,500.
2. International Islamic Center for Population Studies and Research, Al-Azhar University, training and research in family planning and biology 1975-1976, \$25,000. Social research on population issues and problems, 1976-1978, \$30,000.

International Development Research Center (IDRC)

1. Cairo University to carry out clinical trials of copper IUD. \$14,440.
2. International Center for Population Studies and Research, Al-Azhar University, research on postpartum contraception, duration 3 years, total grant \$87,970, 1978-1979.

International Fertility Research Program (IFRP)

Research studies in the area of female sterilization, barrier methods, postpartum IUD's, quantitative menstrual blood loss, menstrual regulation, pregnancy termination, and maternity care monitoring at: (1) Medical School, Ain Shams University, Cairo; (2) El Hussein Hospital, Al-Azhar University, Cairo; (3) Kasr El Aini Hospital, Cairo University, Cairo; (4) Bab El Sharia Hospital, Cairo; (5) Boulak El Dakroun Hospital, Cairo; (6) Shatby Maternity Hospital, Alexandria University; (7) Misr Spinning and Weaving Company Hospital, Mehalla El Kubra, Gharbia; (8) Mobarrah Hospital, Assiut.

Pathfinder Fund

1. Department of OB/GYN of Ain Shams University, Cairo, a comparative sterilization Project, April 1977 - March 1978, \$31,390.
2. Mobarrah Hospital, Assiut University, to gather and analyze information on the traditional birth attendant (Daya). Total approved \$10,177, total disbursed \$8,376.
3. Provision of contraceptives and supplies Cairo, Alexandria and Assiut.
4. Family Planning Association of Alexandria for family planning registration and service project and to train 50 natural leaders to provide family planning information and education Oct. 1977 - June 1979, total approved \$36,315, total disbursed \$26,925.

Program for the Introduction and Adaptation of Contraceptives Technology (PIACT)

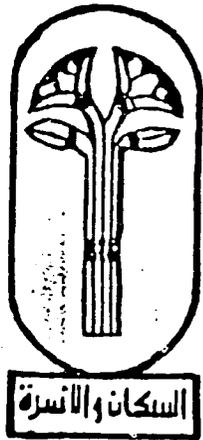
1. Assiut University, Dept. of Ob/Gyn, Country Program, Oct. 1978-Sept. 1979, \$5,000.  
Development of rural research networks in Upper Egypt, Oct 1978 - Dec. 1979, \$15,000.

- Workshop on research needs in population and family planning, Dec. 1978 - April 1979, \$5,800.
2. Family Planning Association of Alexandria: Developing contraceptive support material for illiterates and semi-literate rural acceptors, Oct. 1978 - Dec. 1979, \$6,000.
  3. University of Alexandria, management of injectable ammenoroea by temporary IUD insertion. Oct. 1978 - March 1980, \$2,200.
  4. National Organization for Drug Control and Research, Cairo. For quality control of contraceptive methods. May 1979 - Dec. 1980, \$25,000.

Rockefeller Foundation

1. Assiut University, studies on adaptation of contraceptive technology for local use, June 1977 - May 1978, \$24,940.
2. Institute of Statistical Studies and Research, Cairo University, research on childhood mortality in relation to fertility behaviour and attitudes. 1976, \$16,000.
3. Field studies of Contraceptive Implants (Norplant) in four Universities, 1980-83, \$310,000.

**E.1 ARAB REPUBLIC OF EGYPT  
THE SUPREME COUNCIL FOR POPULATION  
AND FAMILY PLANNING**



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**NATIONAL STRATEGY FRAMEWORK FOR  
POPULATION, HUMAN RESOURCE DEVELOPMENT  
AND THE FAMILY PLANNING PROGRAM**

**DECEMBER 1980**

NATIONAL STRATEGY FRAMEWORK FOR  
POPULATION, HUMAN RESOURCE DEVELOPMENT  
AND THE FAMILY PLANNING PROGRAM

December 1980

I. The Population Problem

The relationship between population problems and the state and process of development is now well-established. In a less developed country a high rate of population growth, maldistribution and adverse population characteristics place severe strains on the society's attempt to develop. Concomitantly, population trends are determined by the country's development performance. Population problems must, therefore, be tackled within the framework of overall national development plans. Egypt's population problem encompasses three interrelated dimensions: high growth rate, unbalanced spatial distribution and unfavorable population characteristics particularly in terms of health, education and the status of women.

In 1980, Egypt's population was estimated to be in the neighbourhood of 42 million and growing at a rate close to 3 percent annually. It is projected that the population will reach between 60 and 70 million by the year 2000. The crude death rate has declined consistently since the mid 1940s to reach approximately 10 per thousand by 1980. Fluctuating around 40 per thousand in the mid 1940s, the crude birth rate declined significantly from 1966 reaching 35 per thousand in 1972. This decline is attributed to an environment of intensive socio-economic change which started in the early 1950s continuing till the mid 1960s, the launching of a national program for family planning and the

war situation involving massive mobilization from 1967 to 1973. However, the birth rate is estimated to have risen again close to 40 per thousand in the late 1970s. This rise in the birth rate is a combination of numerous factors -- possibly a post 1973 War baby boom. High birth rates have resulted in a young age structure and therefore, a high child dependency ratio. Around 40 percent of the population is estimated to be under 15 years of age and for every 100 adults aged 15-64 there are approximately 75 children to be supported. The effects of Egypt's rapid population growth on its national development are profound and the need for an effective strategy to reduce fertility has become a necessity.

Egypt also suffers from extreme spatial maldistribution of its population. Over 99 percent of the population is concentrated in less than 4 percent of the total area of the country. The population density is more than 1000 inhabitants per square kilometer in some urban districts. The population is heavily concentrated in the Nile Valley and Delta because the desert currently does not support life. For this reason, agriculture and human settlements are competing for the same space. Currently the urban population represents 44 percent of the total population and more than one fourth of the population lives in Greater Cairo and Alexandria. A combination of push factors on the rural side and pull factors in urban centers continues to fuel a rural to urban migration stream. This worsens the rural/urban aspect of population maldistribution and results in a relative socio-economic inertia in rural areas as well as compounding the inability of urban centers to cope with their growing populations.

## II. National Policies

### A. National Development Plan

The National Development Strategy of Egypt (1978-1982) devotes the second chapter to the population problem and calls for four distinct lines of action:

1. A program which aims at achieving an optimum size for the population by reducing the population growth rate and developing the National Population and Family Planning Program within the framework of the comprehensive socio-economic planning process.
2. A program which aims at restructuring the population map of Egypt by establishing new communities in the desert, in particular the Western Desert, the coastal areas and Sinai.
3. A program designed to reconstruct the Egyptian village.
4. A program related to upgrading the productivity of the labour force that includes:
  - raising the level of skills;
  - linking education and training to the requirements of production;
  - creating the necessary employment opportunities.

### B. National Policy on Population and Family Planning

#### 1. Objectives

Within the overall development policy of the country, the National Population and Family Planning Policy aims at the attainment of the

following interrelated objectives:

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- a. An optimum population growth rate. This is to be achieved through lower birth rates, reduction of infant mortality and greater attention to the recent trends of emigration:
    - Lower birth rates are to be operationalized by the reduction of the crude birth rate by about twenty points by the year 2000 through raising the level of overall contraceptive practice among married women in reproductive age;
    - Infant mortality is to be further reduced through upgrading the efforts in the areas of health and sanitation;
    - Recent trends in emigration need to be thoroughly studied in order to facilitate the development of a comprehensive strategy.
  - b. A better population distribution to be attained through:
    - Slowing the trend of rural to urban migration in response to integrated development of the rural areas;
    - The development of Egyptian deserts and the creation of new settlements.
  - c. Improved population characteristics particularly in the areas of health, education and the status of women to be attained through promotion of continued and renewed efforts by various ministries and agencies.

## 2. Policy Directions

The first national population policy declared in 1965, centered on one aspect of the population

problem, viz., growth, and aimed at fertility reduction. A family planning program was developed as the instrument of this policy. It adopted a medical orientation, conforming with family planning programs in existence at that time.

Subsequently, the national population policy went through two successive stages of development. The second phase of the policy which was fully developed in 1973 can be called "The Socio-Economic Approach to Fertility Reduction". While fertility reduction was still the primary concern, the policy recognized the role of socio-economic variables in relation to fertility and identified nine factors as critical fertility influencers which have to be manipulated simultaneously. These are: the socio-economic standard of the family, education, the status of women (stressing participation of women in the waged labor force outside the agricultural and domestic fields), mechanization of agriculture, industrialization (with emphasis on agro-industries), infant mortality (with improvement of nutrition and sanitation as basic elements), social security, information and communication, and family planning delivery services.

The third and present population policy phase which started in 1975 may be called the "Development Approach to the Population Problem". It is an elaboration of the previous phase and has developed on the basis of a greater realization of the magnitude and implications of population growth, the limits within which it can be reduced, and a better understanding of both population and the socio-economic environment. This phase differs from previous policy phases

in defining the population problem in its entirety, in terms of growth, distribution and characteristics.

The policy relates population activities to the three hierarchical levels of the country's administration, the central, governorate and community levels. The policy takes the community as its platform for action and programs are designed to transfer the responsibility for implementing population and family planning policy to the local administration and community. In this respect, efforts capitalize on the recent law decentralizing the government's responsibilities.

### 3. Institutional Framework

The Supreme Council for Population and Family Planning is the overall national institution for population activities. The Council is presided over by the Prime Minister who currently delegated the Minister of Health to chair the meetings.

The Council includes in its membership the Ministers of Education, Social Affairs and Security, Agriculture, Planning, Labor Force and Training, Culture and Information, Local Government, Wakfs (Religious Affairs), Youth, the President of the Central Agency for Public Mobilization and Statistics, and the Chairman of the Population and Family Planning Board. It also includes four ex professo members appointed by the Council for a period of two years. The First Lady of Egypt, Mrs. Jehan El Sadat is a member of the Supreme Council. Four governors are invited in rotation to attend the meetings

of the Council.

The Population and Family Planning Board is the Council's technical body which assists it in the planning, programming, monitoring, coordination and evaluation of policies and programs. It has a bureau in each governorate.

Three committees were formed by the Council: (i) a higher committee for Information, Education and Communication (IEC) chaired by the Minister of Culture and Information, which coordinates IEC activities in population and family planning; (ii) a committee of first undersecretaries of institutions represented in the Council which assists the Population and Family Planning Board in interagency planning and programming and oversees the execution of the Council's decisions in their sectors; (iii) a field monitoring committee chaired by the First Lady of Egypt.

Implementation of national and sectorial programs has become the sole responsibility of governorates and local government institutions. A Population and Family Planning Regional Committee is formed in the image of the Council in each governorate and is headed by the governor. There is also a governorate subcommittee for IEC activities. According to the new law for local government, population and family planning is an integral responsibility of elected councils in governorates, cities, and villages.

The Egyptian Family Planning Association coordinates and supervises all voluntary family planning activities. The director of this association is currently a member of the Council.

### III. Program Strategy Framework

This program strategy is basically in relation to population growth and more specifically to fertility reduction. With regards to population distribution and characteristics, intensive studies and research are needed in order to further develop distribution and characteristics strategies. The national population and family planning program encompasses three interrelated programmatic areas primarily directed towards achieving the policy objective of reducing the birth rate by twenty points by the year 2000 through raising the prevalence rate of contraceptive practice.

The three programmatic areas are:

- A. Upgrading family planning services integrated into relevant health and social activities.
- B. Institution of community based socio-economic programs of development conducive to family planning practice.
- C. Strengthening educational, population education and IEC programs which aim at fertility behavior change, institution of the small family norms, and widespread contraceptive practice.

#### A. Family Planning Services

This program area aims at attaining the policy goal of increased prevalence rate through efficient delivery of health and social care related to family planning practice. As an immediate goal it seeks to capture the potential population desiring and willing to practice

family planning. It has two major components: health/social and family planning services and contraceptive availability. In addition, achievements in this program area will contribute to improved population characteristics, particularly in terms of health and the status of women.

#### 1. Health/Social and Family Planning Services

The health/social infrastructure consists of government health and social units and voluntary associations integrating family planning services in their activities. The original services in which family planning is being integrated include primary care, mother and child care, and a wide range of socially related activities such as day care centres, social security services, literacy programs, women clubs and productive family projects. Together, health, social and voluntary association units constitute a firm basis for family planning services.

Projects and activities in both rural and urban areas are designed to raise the efficiency of service units by improving physical facilities, upgrading the skills of social, medical, paramedical and auxiliary personnel, extending facilities to deprived or overcrowded areas, and improving management, supervision and community involvement. The program will give special attention to the involvement of private doctors and pharmacies. A number of research and pilot projects also aim at the design of innovative approaches and more efficient systems of health/social/family planning delivery services.

In rural areas the strategy focuses upon the increased effective use of contraceptives, the

expansion of services into deprived areas, and the encouragement of activities by voluntary associations. In urban areas, where the use of contraceptives is higher, the strategy is to strengthen specialized services and to facilitate the work of voluntary organizations.

Priority will be given to projects aiming to:

- a. Increase coverage of the population through outreach programs in both rural and urban areas.
- b. Upgrade physical facilities of service units.
- c. Upgrade the system of registration and of the processing and publication of vital data and family planning service statistics.
- d. Institute adequate training facilities and upgrade training programs for social, medical, paramedical and auxiliary personnel and outreach workers.
- e. Improve sanitation including refuse disposal, provision of fresh water supply, and programs designed to decrease infant mortality and morbidity including health education.
- f. Increase coordination between government, voluntary and private activities.
- g. Upgrade management of service units and improve supervision.
- h. Promote the active participation of private doctors and pharmacists in family planning.
- i. Further integrate family planning with related health and social activities.
- j. Strengthen all voluntary organizations, especially the Egyptian Family Planning Association in order to have more active roles in family planning efforts.

## 2. Contraceptive Availability

Contraceptive availability is a critical component of the program. The aim is to provide more efficient and widely available family planning services for parents who decide to limit their fertility through the smooth and adequate provision of a contraceptive product mix within easy reach of the population at nominal prices. These contraceptives are dispensed primarily through over 4000 government and voluntary units and recently through over 5000 private pharmacies which have been included in the organized program. In addition some conventional contraceptives are dispensed through outreach programs and commercial channels.

Priority will be given to the following areas of supply and distribution:

- Creating reasonable stocks to avoid shortages.
- Making available a better method mix.
- Providing more outlets.
- Developing outreach contraceptive distribution programs.
- Increasing transportation capacity.
- Assuring adequate warehouse space.
- Training stock-keepers.
- Mechanizing data.
- Developing promotion techniques.

### B. Community Based Population Oriented Socio-Economic Development Programs

Whereas family planning programs are large:

responsive to behavioral changes, community based population oriented socio-economic programs aim at inducing or even precipitating behavioral changes consistent with the small family norms and family planning practice. These programs are distinguished from general developmental activities in a number of ways: (i) they are population oriented, meaning that they are selective in promoting a number of factors identified as being strong influencers of population trends; (ii) the social and economic activities they promote are ultimately measured in terms of population objectives; (iii) they are community based meaning that they seek popular participation in target setting, activity design and management of such activities; (iv) they are not alternatives to family planning programs but rather include health/family planning services as one of their main components.

Projects within this program area aim to contribute to fertility reduction through a number of interrelated projects simultaneously attempting to: raise the quality of health/social/family planning services, improve the status of women through functional literacy programs and greater participation in waged economic activities, promote small scale and cottage industry, improve sanitation, promote mechanization of agriculture, facilitate access to urban areas, institute cultural activities, and promote information and communication through community institutions such as mosques and youth clubs, and through community outreach workers. At the same time, the activities are designed to contribute to the improvement of population characteristics and to a better spatial distribution by making the rural village a more suitable place in which to live.

An overall activity in this program area is the upgrading of the managerial capabilities of local councils and local officials who have the responsibility of designing and implementing projects in their communities as well as mobilizing community participation. A number of projects have been designed over the past few years and are now gaining momentum.

Priority will be given to projects aiming to:

- Strengthen ongoing projects.
- Expansion to nationwide coverage, including extension on a pilot scale to satellite villages and hamlets and to desert and coastal communities.
- Strengthen the components related to sanitation, upgrading the status of women, and literacy, especially women's literacy.
- A greater coordination of inputs provided by various ministries and agencies.

#### C. Education, Population Education and IEC Programs

##### 1. Education

The policy considers education as a critical parameter of the population program since it aims to raise the quality of human resources and is a strong influencer of population trends. In this respect, priority will be given to projects which aim to:

- Absorb all children in school age.
- Promote basic education (combining primary and intermediate levels as compulsory stage).

promote the education of women.

promote functional education and training in technical skills adapted to national needs.

upgrade and expand day care centres and staff them with puericulturists.

expand the use of audio-visual and modern educational aids.

promote research on the interrelation between ill development and national needs.

### Population Education

Population education will include in and out school programs. Present activities of inschool population education consist of relevant changes introduced by the Ministry of Education in thericula of primary, intermediate and secondary schools, and inservice teacher training.

Priority will be given to projects aiming to:

tend and strengthen the present inschool population education program and inservice teacher training.

introduce population education in basic education schools.

introduce population education in faculties of education.

introduce population education in faculties of home economics.

introduce population education in faculties of medicine and schools of nursing.

encourage the Supreme Council of Universities to assist universities introduce population education in different faculties.

- Encourage universities to offer diplomas in population and development.
- Integrate population education in literacy programs.
- Promote research on population education.

### 3. Information, Education and Communication (IEC)

IEC activities aim at creating and maintaining public awareness of the ill effects of rapid population growth on both national development efforts and family well-being, motivating individuals to adopt the small family norm, informing and educating the target population on contraception, overcoming adverse social reactions and misinformation, and maintaining a dynamic momentum for leadership and program personnel.

In a recent reorganization, the Supreme Council for Population and Family Planning entrusted the coordination of all IEC projects and activities to a high committee presided over by the Minister of Culture and Information. This committee prepared a national plan for IEC activities which has been approved by the Council.

IEC programs endeavor to: reinforce the role of mass media (television, press and radio) at the national level in conjunction with the institution of regional television and broadcasting facilities; involve the active participation of various institutions such as the Ministries of Social Affairs, Culture and Information, the Supreme Council for Youth, Labor Force, Agriculture, Wakfs (Religious Affairs), reinforce the role of voluntary organizations in IEC programs, give greater emphasis in community based programs

to the role of community outreach workers in home visiting; develop local community IEC programs with indigenous efforts; and experiment with action research communication programs.

Priority will be given to projects which aim to:

- Sustain and upgrade mass media IEC activities and promote their geographical diversification.
- Promote face to face and group communication as a main responsibility of community and voluntary institutions coordinated with the upgrading of training programs for IEC personnel with special emphasis on the training of community leaders and outreach workers in face to face communication.
- Create greater interaction among face to face, group and mass communication.
- Involve the active participation of the Ministry of Culture and Information.
- Promote workers education in the industrial sector.
- Promote IEC in youth programs.
- Promote the active participation of the Ministry of Wakfs (Religious Affairs).
- Involve the active participation of the Ministry of Agriculture.
- Reinforce the role of voluntary organizations in IEC activities.
- Experiment with action research communication programs.
- Promote research on IEC.

#### IV. Support Activities

##### Leadership

Committed leadership is a parameter central to the success of population programs. The Supreme Council for Population and Family Planning, having regained the momentum of its activities, is assuming an effective leadership role. However leadership commitment to population issues and activities need to be strengthened, and need to permeate more effectively the government structure especially the descending hierarchical orders. Priority, therefore, will be given to activities which can strengthen leadership commitment at all levels.

##### Policy Formulation and Planning

The national strategy in this area is:

(i) to strengthen the interrelation between population and social and economic variables in sectorial short, intermediate, and long term plans, so that programs and activities under such plans would have a greater bearing on population trends; and (ii) to support governorate and local planning of population activities. Priority will be given to projects aiming to:

- Establish and/or strengthen population analysis units in planning departments of ministries and local government.
- Promote training programs on population dynamics for personnel in these units.
- Undertake research on the interrelation of social and economic variables and on the development of integrated planning models.

### Social Development

While aiming to preserve the genuine cultural norms of the Egyptian society, the National Development Strategy and the Population Policy aim to induce social change and social mobility conducive to influencing population parameters.

In this respect the program strategy gives priority to projects aiming to:

- Expand coverage of social securities.
- Promote women's participation in all aspects of political, social and economic activities.
- Promote programs to meet children's needs.
- Increase the role of youth as change agents.

### Incentives

The use of incentives is another support activity. Priority will be given to projects aiming to:

- Give due consideration to social, educational, and economic incentives which enhance social mobility.
- Develop incentive systems to upgrade performance in activities related to all aspects of the population.

### Data

The strategy with regard to data as a support activity is to work towards the provision of consistent, accurate and timely data for the use of the population program, and for the use of project planners and managers.

Priority will be given to projects aiming to:

- Improve data collection and analysis at all levels of the data system with special attention to misregistration and underregistration of vital data, data on employment, education and literacy, the status and employment of women, emigration, and the effect of innovative projects upon contraceptive prevalence.
- Mechanize and computerize data and extend computer facilities to governorates.
- Upgrade and coordinate the facilities for training in population, demography and family planning.
- Upgrade skills of the personnel responsible for data collection at the community level.
- Introduce data collection, registration, and statistics as basic requirements for graduation in medical and paramedical institutions
- Early publication and dissemination of data.
- Wider use of surveys.
- Improve data on migrants and their characteristics.

### Research

The strategy of the research is to identify research needs and priorities, to coordinate and sponsor research projects, and to disseminate research findings to policy and decision makers.

Research activity priorities on population in Egypt will be in the areas of:

- Setting of program quantitative objectives.

- Action research aiming at the improvement of present systems of service delivery and the development of alternative new systems, with special emphasis on health/social family planning service delivery and IEC.
- Assessing new contraceptives and fertility control methods consistent with the socio-economic and health profile of the Egyptian population.
- The better understanding of the relationship between population and socio-economic variables at macro and micro levels.
- Population distribution, including rural-urban migration and urbanization. Priority is to be given to the development of a population spatial distribution strategy to the year 2000.
- Studies on migration, especially in relation to population policy.
- Development of an improved system for identification of research needs and priorities.
- Improvement of research management and encouragement of participation in population research by various institutes.
- Dissemination and better utilization of research findings.

#### Management

Management of population related programs and projects is an area which deserves increased attention to maximize the utilization of direct and indirect inputs in attainment of population objectives and targets. Management encompasses

a wide range of activities including support, planning, programming, statistical research, coordination, monitoring and budgeting. In a multidimensional sectorial approach such as the Egyptian dealing with its population problems activities have sectorial, intersectorial and interinstitutional dimensions.

Some management priority needs identified under the specific health formulation and planning, data and in addition, particular importance is given to projects aiming at improved cost inputs and their monitoring and evaluation at each institution.

Intersectorial and interinstitutional coordination, monitoring, and evaluation function of the Supreme Council on Family Planning. This function is reinforced. Particular emphasis will be given to continuous evaluation of policies and programs to assess their effects and that corrective measures may be taken in a timely manner.

Priority will also be given to the use of external assistance. The institutional meetings with external agencies and those already initiated will help in coordination and to insure the optimum utilization of external assistance.

- E.2. The National Training Plan: 1982-1986 (translation of PFPB Document issued December, 1981)

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#### Introduction

Egypt suffers from a population problem that has three dimensions:

1. Rapid population growth
2. Maldistribution of population
3. Low population characteristics: such as health, education, women position, etc.

Egypt's population was estimated in Nov. 1981 at about 44 million, in addition to the annual population growth rate of about 3%. It has been predicted that the population will reach 60-70 million in the year 2000. Also, Egypt suffers from the imbalanced population distribution since about 99% live on 4% of the lands, and the population density has reached more than 1000 per square kilometer

The development strategy of the period 1978-1982 stresses three work lines:

1. Achieving the ideal population growth rate by reducing the population growth rate .1% per year.
2. Re-distributing the population through establishing new

societies in the desert.

3. Raising manpower productivity through:
  - a) Improving labor force efficiency.
  - b) Linking education and training with production needs.
  - c) Providing the necessary employment opportunities.

Therefore, one of the goals of the plan is to improve the manpower performance on all levels. The plan aims at providing the trained labor in the field of FP/P, and also specifying the roles and responsibilities of the agencies and ministries participating in the training program.

1. Reasons for the National Training Plan:

1. The absence of coordination among FP/POP agencies with regard to training because of lack of role specification.
2. Shortage in trained FP labor.

2. Plan Goals:

1. Specifying roles and responsibilities among concerned agencies and ministries and establishing coordination among them in the field of training.
2. Providing cadres and leaders capable of executing FP/POP programs.
3. Improving efficiency of existing labor force and providing them with required information and skills.

3. Roles and Responsibilities for the Execution of the Plan:

1. The Supreme Council for Population and Family Planning
  - a) Coordinate training efforts among ministries and agencies participating in the National Plan.
  - b) Encourage ministries and agencies to enter training programs in their plans and budgets to achieve the National Plan.
2. Ministries and Agencies
  - a) Specify training goals, contents and assessment method.
  - b) Training centers and institutes to provide all facilities for training programs.
3. Governorates
  - a) Governorates are responsible for the execution of the

local and national programs within their areas through the governmental and private authorities in each governorate.

- b) The governorates have the responsibility of specifying training programs and their needs, goals, contents, methods and assessment on the local level.
- c) The governorates should be guided by the central program when executing the local program.
- d) Establishing coordination among the different authorities responsible for the execution of training courses.

#### 4. The Permanent Committee for FP Training

##### 1. The Coordination Committee

The Supreme Council appoints the members of this committee from among the trainers in the different ministries and agencies.

- a) Study plans of different ministries and agencies in order to coordinate among them to achieve plan goals.
- b) Make best use of the available facilities of different authorities to achieve plan goals.
- c) Put in a system to encourage participation in the training programs of the plan.
- d) Suggest basis and methods for assessment and follow-up connected with the goals of the plan.
- e) Study the reports prepared by participating authorities and put recommendations to help solving problems.
- f) Suggest training courses that the Committee may see should be added.

##### 2. Role of PFPB

- a) Coordinate training efforts of different ministries and agencies.
- b) Provide participants with different training materials.
- c) Prepare studies and researches related to training activities.
- d) Prepare and follow-up the trainers' training program in the ministries.
- e) Submit an assessment report of the training activities to the Supreme Council.
- f) Provide ministries and agencies with a list of experts and specialists in different fields related to FP.

5. Ministries and Agencies Responsible for Execution:

1. Ministry of Health.
2. Ministry of Health Education.
3. Ministry of Health Social Affairs.
4. Ministry of Health Agriculture.
5. Ministry of Health Manpower and Vocational Training.
6. Ministry of Health Culture.
7. Ministry of Health Local Administration (?).
8. Ministry of Health Wakfs.
9. CAPMAS.
10. EFPA.
11. The Supreme Council for Youth and Sports.
12. Broadcasting and TV Federation.
13. SIS.

6. Plan Approaches:

1. Training trainers from concerned ministries.
2. Training the following staff:
  - a) Medical services: doctors, pharmacists, social workers, nurses, medical visitors and clerks.
  - b) Information and advertising: religious leaders, workers leaders, youth, rural and urban raaydas, broadcasting, TV and journalism staff.
  - c) Management and Development: training, planning, research, follow-up and assessment staff.
  - d) Administrative staff in local administration: governors, general secretary, assistant secretary, village and town chairman, unit secretary's, public and executive leaders.
3. Include population and family planning material in the curriculum of the different colleges especially those directly related to FP such as the college of medicine and nursing schools. And also in the curriculum of all educational stages.

7. Facilities:

1.
  - a) Training Centers: Training programs are to be carried out

in the training rooms in each ministry and agency on the central level. These are:

1. Ministry of Education training center.
  2. Ministry of Social Affairs.
  3. Youth leaders centers in the Ministry of Youth.
  4. Ministry of Manpower and Vocational Training training center.
  5. Ministry of Agriculture training center.
  6. Training center in Omar Makram Mosque (Wakfs).
  7. Islamic Delegation City.
  8. Nile Information Centers.
  9. Broadcasting and TV training centers.
  10. Local Administration Secretariat training Institute.
  11. Youth Centers halls.
  12. MOH training centers in Cairo.
  13. Workers' Unions halls.
- b) In the governorates, training will be carried out in the training halls in the governorates and districts.
- c) 1. Research and Training Institute in Alexandria.  
2. Administrative Development Institute.  
3. National Planning Institute.
2. Trainers: The Board has previously trained 552 FP trainers who participate in giving lectures and leading discussions with a number of university professors and government executives. The Plan aims at preparing other cadres of FP trainers who will handle training in all sectors.
3. Training Assistance: Most training halls are not very well equipped with projectors and other training equipment. The Plan aims at providing training equipment on the central and local levels.
9. The Objective Basis of Plan Preparation:
1. We suggest that the National Training Plan be executed within a period of five years (1982-1986), i.e., 20% of the numbers listed in the Plan every year with an annual assessment of the training work on all levels.
  2. The Plan has concentrated on the training programs that can be executed by the different ministries and agencies, each in its own field, and which can help improve efficiency of the staff on the National Program for FP/P.

3. Ministries and agencies participating in the Plan are to allocate training money in their budgets every year to finance their training plans and the Ministry of Finance is to finance the ministries upon their request.
4. The training department in the Board is to prepare a study on the FP/POP positions within the national project and specify the training levels according to the nature of the positions.
5. The Plan aims at covering the shortage in training facilities and equipment by preparing a study on developing the training facilities.

10. "Outputs":

The Plan aims at improving the efficiency of the national program staff by:

- a) Providing the staff with new skills in the field of FP services.
- b) Changing the attitudes of the staff working in the field of FP information and advertising.
- c) Improving the efficiency of the administration, planning and development staff.
- d) Developing the educational materials related to FP in all educational stages.

11. Assessment and Follow-up System: to be carried out on three stages:

1. First Stage

- a) Following up the process of planning and assessing training programs.
- b) The training execution process; after and before training.

2. Second Stage: (short term assessment)

Measuring the extent of executing information and skills of the trainers after they return to work during 3 months after finishing the training.

3. Third Stage

Measuring the influence of training in order to develop the efficiency of trainers within one year after training.

E.3. OUTLINE OF JOB DESCRIPTION FOR THE RAAAYDA RIFEYA  
(translation of PDP document)

Family Planning

1. Participate in data and information collection activities.
2. Inform village women of family planning services at health units.
3. Escort the woman who uses family planning for the first time to doctor for check.
4. Home visits for MWRA for information and education in FP and repeat visit once a month.
5. Collect information on rumors and misconceptions circulating in the village and discuss them with Advisory Committee members to correct these ideas.
6. Distribution of contraceptives through visits.
7. Buy contraceptives for pharmacy if brand is not available at health unit.
8. Direct women who are not willing to go to health unit for IUD insertion to private doctors.
9. Explain with honesty to new acceptors possible preliminary side effects of contraceptives.
10. Visit dropouts to inquire for reason and try to urge them to continue.
11. Try to convince a larger number of women than the target number to practice family planning.
12. Identify mothers who were recently delivered by dayas for vital registration and concentrate on convincing them to practise family planning.
13. Recruit village women to attend lectures, religious discussions and movies.
14. Follow-up TV and radio programs on FP and pass on information to village women.
15. Register visits and number of acceptors at the registration books at the local unit.
16. With cooperation from head of village council develop a monthly plan to achieve the target population of the year to reduce birth rates by 1/1000 annually.
17. Keep in contact with women political representatives and women who have participated in income generating projects to continue their activities in informing other women about FP.

Health Care and Environment

1. Identify major sickness and illness in the village and collect information on their causes and preventive measures

- and educate women on preventive and curative actions.
2. Educate women to brush their teeth, personal hygiene and eye care.
  3. Educate women on sanitation issues and necessity of separating from animals and cattle.
  4. Urge women on importance of W.C. and clean water.
  5. Urge women to paint their homes and help them to carry it out.
  6. Motivate and help the youth to cover swamps.
  7. Motivate families to use vaccinations required.
  8. Educate villagers to go to health centers when feeling sick.

#### Mother and Child Care

1. Inform women of importance of pre-natal care.
2. Educate pregnant women on health requirements.
3. Inform mothers of proper food to eat to ensure continuity of breast feeding.
4. In case of artificial feeding educate mother on importance of sanitary measures.
5. Educate mother on importance of child bathing and keeping baby clean and taking care of his/her eyes.
6. Educate mothers of the danger of weaning in summer months and proper ways of weaning.
7. Make sure that mothers conform to dates of vaccination.
8. Inform mother of major causes of infant and child illness, i.e., diarrhea, eye diseases, and worms.
9. Educate citizens on importance of immediate registration of births and deaths.

#### Nursery and Child Care Centers (CCC)

1. Encourage child care centers.
2. Encourage parents to send children to CCC.
3. Organize mother visits to CCC.
4. Urge parents to continue paying fees and if unable help them to be exempted.
5. Encourage mother to periodically supervise CCC.
6. Follow-up of absentees for CCC.
7. Assist supervisor to follow-up absentees.

#### Girls Handcraft Centers

1. Identify school dropouts and encourage them to join centers.
2. Follow-up of absentees.
3. Encourage girls who complete their training to continue

- with income generating activities (sewing)
4. Help trained girls to locate clients.

#### Women Clubs

1. Inform women about meetings.
2. Supervise meetings.
3. Be responsible for registration and organization of meetings and activities.
4. Learn how to use equipment if available.
5. Follow absentees.

#### Income Generating Project

1. Cooperate with village head and women representatives to identify local materials to encourage female income generating activities.
2. Participate in recommending projects for women to utilize funds and loans available.
3. Follow-up of activities of women who already participated in some of these projects.
4. Educate women to utilize veterinarian services provided at the village for cattle, animals and poultry breeding activities.
5. Educate women on importance of cleanliness to poultry and animal husbandry.
6. Educate women not to slaughter female animals because they are valuable for reproduction.
7. Encourage women to invest part of income in poultry and rabbit breeding.
8. Train villagers to produce cheese and milk products.
9. Train villagers in food conservation methods.

#### Literacy Programs

1. Encourage and motivate female youth to become literate.
2. Organise with Advisory Committee literacy courses for girls and women.
3. Ensure continuity of these courses.
4. Follow-up of dropouts.
5. Use women's clubs to encourage literate females to utilize new acquired skill.

MUBARAK ADDRESSES CAIRO ECONOMIC CONFERENCE

[Speech by President Muhammad Husni Mubarak at the Expanded Economic Conference Held at the Central Mobilization and Statistics Bureau in Cairo on 13 February -- live]

[Text] In the name of the merciful and compassionate God, Mr. Conference Chairman, dear brothers: Ever since our noble people entrusted me with responsibility in these delicate circumstances, I have taken it upon myself to see to it that the priorities of national action agree with the supreme national interest in its comprehensive concept and that the activity of the legislative and executive authorities is directed toward the achievement of the people's interest, because this is the basic context of democratic rule, and this is the message borne by everyone who undertakes the trust of national struggle.

There is no argument that the consolidation of the basis of the national economy on sound principles is at the top of national responsibilities. If we want our beloved Egypt to be prosperous and strong -- and we have pledged to God to do that -- its strength must be based on a strong and sound economy, and we must work to achieve prosperity for the whole society and for the individuals who perform their national duty. It is our duty to achieve for them a free and dignified life that will make each one of them secure and confident about his present and future, looking toward the future with reassurance and optimism.

As we have agreed, national action is a levy that no citizen can disregard, neglect or leave to government departments to deal with as they wish while he stands as a spectator, sometimes satisfied and sometimes indignant. We all must participate in tackling this responsibility, because the matter affects us all. Any strengthening of the national economy directly benefits us. Consequently, it is necessary to have mass participation in discussing the methods and alternatives that can strengthen the production base, increase the rate of savings and investments, rationalize consumption, combat all forms of waste and achieve social justice by raising the standard of living of the toiling groups without expropriating the right of every honorable citizen to honest gain.

I have found that the period we are passing through is completely appropriate for comprehensively reviewing the Egyptian economy. We have accumulated much experience in all aspects of economic life, and our view has become clearer and more penetrating and our ambitions have become bigger and broader. We have also entered an era of peace, which will enable us to give greater attention to the process of rebuilding and construction.

Divine providence has given us new resources which should be exploited in a way that will achieve the greatest benefit to us and to the future generations of our children and grandchildren. Furthermore, we are embarking on a new 5-year plan for comprehensive development, for which we must lay down a clear strategy and agreed priorities.

For this reason, brothers, I have requested that some preliminary studies be made. These studies should be free of theoretical analysis and capable of practical implementation. This primarily requires concentration on finding solutions to problems we face in accordance with an agreed-upon priority.

You recall that I have called on anyone with views or experience to contribute to these efforts. The people's response has been magnificent and gives hope and reassurance. This phenomenon would not have emerged had the masses not been confident of the viability of this national mission and willing to shoulder its great burdens.

I then called for convening this conference, which includes the best economic minds in Egypt, so that views can interact and compete to serve the national interests. There will be no muzzling of views or restrictions on advice as long as we all proceed from our sublime loyalty to ancient Egypt and its glorious people and as long as the goal we agree upon is to achieve the legitimate interests of the individuals and the whole society and to enable every citizen to express his creative potential without limits.

*Population*

Dear brothers, we cannot forget that a sound economic development must not be content only with increasing the gross national product, but must seek to achieve another aim that is no less important — raising the individual's standard of living and improving the quality of life for every citizen. This requires that the population must be proportionate to the production of commodities and services and that the use of our resources must be optimal. Therefore, we must direct a long look at the population growth rate and consider the near and distant future, because this is the meaning of loyalty to the homeland and being true to ourselves. We cannot ignore the fact that the current rate of increase in population will hinder our efforts to achieve development, will dissipate our hopes for changing the quality of life of every Egyptian and confine our ambitions to preventing the deterioration and aggravation of our situation. We will not accept this.

We have pledged to God and the homeland that our progress in various fields will not stop, so that every citizen will feel that the present is better than the past and that the future will bring hope and promise. I do not want to speak much on this. It is sufficient to point out that if population growth continues at the current rate, our population will reach 70 million by 2000, and this number will double 25 years later. We must consider this fact with all seriousness, because it will directly affect our ability to provide food, clothing, housing, jobs, medicines, education and culture to each Egyptian citizen.

Perhaps it is proper to say that the total number employed in 1976 was 11.6 million people. This is expected to reach 24.1 million in 2000 and soar to 53.2 million people in 2025. The number of children in primary school will reach 12 million in 2000. This number was no higher than 6 million in 1976.

In housing, the population growth rate will require providing 8 million housing units by 2000 and another 7 million in the following 10 years. These figures are important indicators of our ability to meet development requirements and to raise standards of living.

Undoubtedly, you realize the aim of convening this conference and the task it must perform. In view of your experience, you are capable of defining the best method for conducting the discussions and dialogue at this conference. However, I would like to submit to you certain points and concepts that might assist you in achieving the aims and choosing the method of work.

1. The task you are carrying out does not start in a vacuum. It must be based on an objective evaluation of reality with all its positive and negative aspects. We must take into consideration strategic national goals and the distinguishing marks of the Egyptian experiment so that our work can be associated with and applicable in a genuine Egyptian environment.
2. This conference, which was preceded by several studies, is not the end of the road. It is a link in the chain of the intensified search for an integral picture of the development strategy and of the main lines of the coming 5-year plan. This conference is not expected to complete within a few days a discussion of the complicated economic problems and provide the appropriate solutions. Furthermore, it is unacceptable that the conference should wind up by issuing general recommendations which add nothing to our ability to confront our problems. What is required is to crystallize debate on the main lines which were the subject of discussion and to prepare for the continuation of study during the coming weeks with a view to laying down an integral framework for the development plan and proposing a specific strategy for its development. This must be coupled with detailed studies for implementation and available alternatives and options to implement economic policy in a way enabling the leadership, together with the legislative and executive organs, to compare these alternatives and choose the ones that will guarantee the maximum possible benefit at the least possible cost.
3. We hope that work at this conference and the committees that will evolve from it will be objective purely for the sake of God and the homeland, because the national interest hangs in the balance and because all of us face a historic responsibility. This is not a field for taking sides or for dissension. On the contrary, it requires collaboration, solidarity and appreciation of responsibility on the basis that the charting of the economic course is a matter that requires a unity of effort and action, although the road is open for varying exertions.
4. I hope the scope of debate and discussion will expand in the coming weeks to include other people who did not have the opportunity to participate in the activities of this conference. Egypt is full of outstanding experts and efficient persons who must not be deprived of discharging their duty in the national service.
5. Throughout the stages of discussion, we must remember that our sublime goal is to realize more happiness and prosperity for every citizen and to pave the way for all those who are capable of participating in the process of work and construction so that they can build a new edifice for Egypt that will recall the glories of its noble past.
6. It is necessary that we should provide economic stability on the basis that it is the essence of the rational economic policy and the main pillar for prosperity and progress. This demands that tremors and upheavals [at-tafarat] be avoided and that the change be restricted to the limited circle within which the economic reform is required in every stage of growth and development. It also demands the preparation of long-term plans that will not be affected by the change of persons and divergence of views. Everyone should be committed to these plans so that each person can predict the potentials available for economic activity. I want to make it clear that we welcome the intensification of economic activity by individuals and establishments in the coming period, even without awaiting the final results of the discussion. The aim of these studies is to intensify and not restrict action.
7. Our noble people are fully capable of shouldering the burdens of development and its requirements, so long as they are confident that a serious and sincere action is in progress and that this is not a question of slogans or of privileges monopolized by a few factions, but that this is a general national effort in which all participate according to ability and potential and from which we will reap the best of fruits. God grant you success in your work and guide you to what is good. God's peace and blessings be with you. [applause]

Al-Ahram, 5 March, 1982.

Al-Ahram opens the file of "population problem" and submits a "working paper" to the conference which was called for by the President.

The problem is imposing itself in a persisting and continuous manner. All agree on the need for a quick remedy but differ in descriptions and methods of handling the problem.

In more detail "Is the Egyptian population a problem?". Some of the experts reply : yes, it is individually and as part of a bigger problem which is the universal population explosion and the lack of resources in return, particularly food, to the extent that scientists are warning that a global starvation is on the threshold of the 21st century.

There is no solution other than reducing the rate of birth. Another team of experts say that population is not a problem as much as a case that needs handling and confrontation by developing and expanding resources because the problem is economical in the first place and not population. Moreover, population is a wealth and is the dearest we possess and should be invested in the best possible manner.

Which of these two is right? and is it possible to adopt one of these opinions and neglect the other? or that this would be a luxury we cannot afford and that we have to try all the routes in search of a better society. The issue - and we wish to call it the problem until we investigate all its aspects - became obvious since 1936 half a century ago and it is astonishing that both opinions are still valid .. one calls for reduction of the rate of birth and the other opposes the idea completely. In spite of the long period and efforts we did not yet reach a "solid" opinion. Perhaps this was the reason that made President Mubarak call for a conference to discuss the problem from all aspects in agreement with his policy to intrust "important matters" to experts in different fields for discussion and study on scientific basis and proposing solutions and alternatives. From this principle and in response to the President's wish, Al-Ahram, as in the case of the economical seminar, called for a seminar which covered several meetings and was attended by experts in several fields and the case was brought to discussion on scientific logical basis in a free and sincere manner supported by statistics and scientific facts and covered different viewpoints.

Dr. Mohamed Sobhi Abdul Hakim :

It is appropriate to start with a quick review to the history of our awareness of the population problem. It was in 1936 when the population of Egypt was between 15 to 16 millions only, where the first warning pointed to the population problem which will face Egypt. These warnings came from two professors one Egyptian and the other American. The Egyptian was our late professor Dr. Mohamed Awad Mohamed who published

a book titled "Population of our Planet". He ended the book with a chapter on population in which he stated that Egypt was approaching a population problem. The American was "Windel Kleiland", the professor of sociology in the American University who published a book in the same year titled "Population Problem in Egypt" and finished the book with a chapter titled "Does Egypt suffer from a population problem?". He was frank in answering his enquiry. Both professors in addition to publishing these books continued giving efforts in the same field. Dr. Mohamed Awad Mohamed faced some opposition from the Islamic religious scholars but he was behind the famous opinion issued by Sheikh Abdul Mejid Selim the "Mufti" of Egypt in 1937 which was the first Islamic official scholar opinion "Fatwa" approving family planning. Dr. Awad continued his efforts and extracted from the book of "Al-Imam Al-Ghazali" proofs that Islam is not against family planning even if only for the purpose of preserving female beauty.

As to the American "Windel Kleiland" he continued his efforts publishing several articles in American magazines in continuation to his book. These warnings were faint until the 23rd of July Revolution when many files were opened and several matters were brought to light. It was a blessing that the Minister of Social Affairs after the Revolution was a student of Dr. Awad and a specialist in population studies, Dr. Abbas Amar who decided to carry on the mission and established within the "permanent council for services" the national committee for population matters. "Egypt participated for the first time in an international conference on population held in Rome in 1954. Later the "permanent council for services" was cancelled and the "national committee for population matters" became the society of population studies, which carried out a number of scientific studies and researches including a pioneer field study under the supervision of Dr. Hanna Rizq and he studied the findings of the study over a period of two years in the center for population researches in "Benston" University and obtained by this research PhD in population and perhaps this was the first field study for fertility in the Egyptian society. Later the "society for population studies" became what is now known as the "General Society for Family Planning".

Until the beginning of the sixties the government was rather conservative in handling the problem of family planning in an effective manner because of the conviction that doubling the national income in 10 years is capable of dealing with any growth in population, until the "National Work Contract" was laid down in 1962 which included a famous paragraph which was considered the first step for the government to deal with the problem of population and family planning. Later in 1965 the supreme council for family planning was established and in 1966 the executive committee for family planning was formed to serve as technical secretariat to the supreme council. The basic philosophy was based on the medical approach on to basis: "encouragement and propaganda and the provision of family planning means and materials and make it easy to obtain." In 1972 work was initiated in the national policy for family planning to cover a period of 10 years with the aim to implement 9 principles on which this policy was based and which affects and governs population fertility in Egypt and thus may be able to face the problem in an effective manner. The new policy entrusted the executive committee for family planning with the task of laying the policies and plans and follow up and evaluation and removed from the committee all executive

duties. This policy aimed to reduce the rate of birth by 1 per thousand per year as the rate was 36 per thousand at that time and was aimed to reach 26 per thousand in 1982 the year in which the national policy was to be implemented. In 1974 the International Conference for Population was held in Bucharest and Egypt participated and the Conference dealt with the problem from the viewpoint of Development. It is worth mentioning that "Windle Klieland" stated that one of the important public figures in Egypt who was responsible for laying down policies said that he was looking forward to the day when the population of Egypt will reach 30 millions.

Looking into the trends of population growth in Egypt we can say that the population were about 10 millions and increased during half a century to reach 20 millions in 1950 and to 40 millions after 28 years only in 1978. In the first half of the century up to 1947 the rate of growth was from 1 to 2 percent and increased to 3 percent. Statistics of birth and mortality indicate that the rate of birth was stable with minor changes and it can be said that a slight decrease took place in the last 10 years. As to the rate of mortality it was around the figure 26 per thousand until the end of the first world war and decreased gradually to reach 10 to 11 per thousand. This leaves a big gap between births and mortalities accordingly adding to the population.

We now arrive to three inquiries :

- Are we actually facing a population problem ? if this is true what is its nature and dimensions in order not to exaggerate or underestimate the problem ? This is the beginning of the scientific diagnosis of the problem.
- If our awareness of the problem goes a long way back as well as our efforts, what were our goals and to what extent have we succeeded?
- We are applying planning and is it possible that planning covers family planning as well? Or is it an individual decision taken by the husband or wife? This leads to two levels of family planning one on the national level and the other on the family level, which means that a birth which may be a happy event to a family can be an unhappy event to the society. Can the planner handle this approach and play a role in making a social and cultural changes in the behavior of the family ?

Dr. Aziz El-Bindary:

In order to complete the figures the rate of birth reached 43 per thousand in 1965 and decreased by one per thousand per year until it reached 36.4 in 1972 and from 1973 increased to reach 40 or 41 per thousand but started to decrease from last year and we cannot judge whether this decrease will continue or will rise again. We can notice a decrease in the rate of birth during the economical difficulties in the thirties and during the first and second wars and in the 56th year and after the 1967 war although the decrease was negligible. The phenomena shows that after the unnatural decrease an increase occurred which actually happened after 1973 to compensate the decrease after

There are a number of reasons and assumptions for the decrease, e.g., the economical difficulties, psychological stress and the enlisting of men in the army. From 1967 up to 1973 the rate of marriage decreased to 7.5 instead of 10.6 and from 1973 increased to 10.6 and decreased once more.

I will discuss now the development approach of the problem which was adopted by Bucharest Conference in 1974 and wish to point out that Egypt has adopted this approach before the Conference. As to the questioners involved I would say that there is of course a population problem due to the fact that "there is an undesirable situation that can be changed in a fixed time". If we look into the population situation in Egypt the problem is quite obvious with the population reaching 44 million in 1974 and the density of population is 1000 per square km. which is considered as one of the highest in the world, e.g. "Bab El-Sharia and Khalifa" quarters in Cairo and "Customs" in Alexandria where the density is 140 000 per square km., with an average of nine complete families living in one room of 4 by 5 meters which results in social and many other problems.

Another problem of the population distribution which we see for the first time in Egypt and the history of humanity is that 60% of the population are below 20 years of age. In addition to the "population growth and population distribution" there is the "population characteristics" which are very low in the Egyptian population as illiteracy is officially 56% while in fact it amounts to 70% in spite of all the efforts made in the past 30 years. Illiteracy among females is 90% and the average life of the Egyptian is 56 years while it is 70 or 75 in other countries. Also the percentage of working women in the village is 12% while this percentage is about 50% in other advanced societies. Any solutions to the population problem require a long period of time to give results. For example if starting from tonight every family will control the number of children and have two children only which is the lowest possible, still the number of population will reach 60 millions by the year 2000. Accordingly, we can say that there are possible solutions but it needs a reasonable period of time.

As to the point of dealing with the problem by planning, I wish to point out that the decision to have children is an individual one and there is difference between developed countries and developing countries such as Egypt and where in the first the problem is "controlled" by individual decisions while in the latter the situation is "uncontrolled" by individuals. Planning can of course play a role in changing human behaviour and I believe this can be achieved in a short time under proper conditions and reasons.

A last question is why didn't we succeed until now? Is it because of the method adopted in facing population problem? and does the developing approach as a solution to the problem is the right approach or does it add to the problem? In my opinion this approach does solve the problem and should be reviewed giving special attention to the villages society which is the bigger portion.

Dr. Faisal El-Gansouri :

First of all I will not define it as a problem but I will define it the "population issue". From the point of view of planning as a means to economical development allow me to repeat the four dimensions of the case, the first of which is the population age composition, where we find 60% under 20 years of age and 43% under 15 years of age and these numbers are a burden on the family and are not productive and are considered "consumption" from the point of view of economical development. The second dimension is population distribution where inhabited area is 4% and in Alexandria and Cairo live 21% of the population, which results in problems which cannot be solved. The distribution is imbalanced and 55% of the population live in villages while 45% live in cities which are a burden on the villages, and according to the last statistics about the government support which amounts to 1600 millions this year we find that 70% goes to cities and only 30% to agriculture societies. Therefore, the development here is economical since cities are a burden on villages which produce to feed the cities. The third dimension is the population growth : the rate of growth is high and while it is expected in the best possible circumstances that the population will be 60-65 million in the year 2000 some say that we will be more than 75 millions which has a strong influence on a nation which imports its food, e.g., out of our total exports which amount to 3000 millions we consume 80% of that to import 6 commodities only which are wheat, flour, fats, meat, sugar and tea. In other terms we import food worth one third of our exports including cotton other than petroleum. Therefore, the population growth is a burden to consumption. The fourth dimension of the case which is the most important from the economical point of view is the imbalance between human resources and available natural resources, e.g., population increased over five times since the beginning of the century against 25% increase in agricultural land 0.15%. This proves that the case is very difficult and what has planning done in the past and what will it do in the future in this connection ?

Let us first ask : Is the population case the reason for the problems we are suffering now ? or is it a result of these problems?  
I believe that the population case in Egypt with all its problems is a result of Egypt's economical problems. It was not the reason behind these problems even though it started to become a reason for problems .. why and how?

When we look to the distribution of wealth, we find rich minority enjoying good life and a majority suffering and naturally these who suffer do not care and it makes no difference to them to have one or ten children as a zero to one equals zero to 10, while in the case of those enjoying life the division of income on two or three differs from seven or ten. For example, if we take the case of two brothers one living in a village and the other left the circle of "darkness and injustice" and is living in Cairo we find that the one living in the city is ambitious to give good education to his son like other people living in Cairo while the other brother who lives in the village does not care specially that children are sent to work in the fields and if a child dies he brings another. Therefore, we must say that the case involved is an economical problem and is not reason thereof

but in fact is a result to it, but it has become to be a reason with the increase in population and burdens and with the increase in consumption over production and we are depending on foreign imports and loans and started to feel the problem.

In order to conclude whether we can face the problem or not we must admit that the population case was not the reason for the problems circumstances that took place in the Egyptian society were the reason for it and we must point out that the imbalance in the distribution of incomes has led to this problem.. this is the real reason and not poverty!! There are developing nations which are supposed to suffer from population growth but because of the slight difference in incomes in these nations the rate of growth is normal because the difference in income when being reasonable gives people a feeling of justice and satisfaction and makes them care. There is a big difference between being poor and imbalance in the distribution of incomes. This imbalance creates the problem because of the careless attitude it plants in the individuals. The case is not the standard of income as a whole and the society with incomes varying between 20 and 100 differs from a society where incomes vary between 20 and 20000 in the latter case the 20 pound income people became careless of what takes place and accordingly the population problem is a result of the imbalance in the distribution of incomes.

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Attendees:

- President, Dr. Mohamed Sobhi Abdul Hakim, Head of the Consultative Council.
- Ibrahim Shokri, president of the Labour Party.
- Albert Barsoum Salama, Minister of State for Immigration Affairs.
- Dr. Kamal El-Ganzouri, Minister of Planning..
- Dr. Fouad Hashem, Minister of Economics.
- Sayed Zaki, Deputy to the National Assembly.
- Dr. Mohamed Helmi Morad, Deputy President of the Labour Party.
- Dr. Aziz El-Bindary, President of the PFPB.
- Dr. Mohamed Mahmoud El-Sayad, Member of the Arabic Language Council and Professor in the Faculty of Arts, Cairo University.
- Dr. Mokhtar Hallouda, President of CAPMAS.
- Dr. Abdul Rahman El-Naggar, Director of Mosques in the Ministry of Wakfs.
- Dr. Salah El-Din Namek, Ex-Dean of the Faculty of Commerce in

- Dr. Mostafa El-Gendi, Deputy of the Statistics Council.
- Dr. Mohamed Sayed Ghallab, Professor in the Institute of African Studies.
- Dr. Ramzi Zaki, Senior expert of the National Planning Institute.
- Dr. Hussein Ramzi Kazem, First Undersecretary of Organization and Administration Council.
- Dr. Ahmed Ali Ismail, Dean Assistant of the Faculty of Arts, Cairo University.
- Dr. Atef Mohamed Khalifa, Professor and Head of the Population Census Cairo University.
- Dr. Wedad Morcos from the National Center for Social and Criminal Researches.
- Nagwa Al-Wakil, Lecturer in the Faculty of Agriculture, Al-Azhar Uni.
- Hussein Enan, Deputy President of Broadcasting and TV.
- Ahmed Shokri, Representative of the Ministry of Social Affairs.
- Dr. Hassan Belal, Director of Information in the Ministry of Health.
- Mohamed Abdul Salam, Director of Population and Development in the PF
- Mahmoud Mourad, Al-Ahram Newspaper.

Al-Ahram, 3/12/1982

As we said last Friday, some experts are greatly annoyed by the population problem which they consider to be seriously threatening Egypt's security. At the same time, some other experts say that it is an important problem that cannot be solved only through family planning (birth control) but also through the overall civilizational development of all aspects; economic, agricultural, educational and social, taking into consideration that human beings are our greatest wealth and they should be best invested.

At the end of last Friday's discussion (see Dr. Sara Loza translation) Dr. Kamal El-Ganzouri, Minister of Planning, heated the argument by saying that the population situation in Egypt - with all its problems - is a result of the Egyptian economic problems and not a reason for these problems, although it has just started to be so. He said that the imbalanced income distribution led to the present situation because it was this distribution that put people in the circle of "Indifference" and poverty. He said that poverty is not a problem in itself; the problem lies in the feeling of injustice created by the mal-distribution of incomes and which made people stop to care.

But, poverty is no problem and is not the reason of population increase, how can we interpret the statistics that indicate that Egypt's population has doubled only one time (from 10 to 20 mil.) during the first half of this century whereas it has doubled another time during the last 28 years only to reach 40 mil. in 1978 although we were poorer in the first era than the second one and, moreover, there was no justice in income distribution ?

Dr. Ganzouri : From the technical point of view, and by analyzing figures, we find out that the reason behind the non-increase in population high growth rates in the first half of this century was caused by high deaths rates and it was God who handled the problem. But if we relate the population problem with the economic problem we find that it is not caused by the standard of living as a whole nor by poverty or poor resources but by the mal-distribution of income. That is why, while making development plans for the future phase, we are trying to avoid our mistakes of the past when we wanted to push the national economy as a whole regardless of where and for whom. We were concerned only with raising national production without thinking for whom? But if we put into our minds the task of transferring the people from the state of indifference to the state of care we will change our plans. For example, when we deal with industry what do we choose ? heavy or light industries? Also our dealing with the city must be different from the village. The starting point of the development plan is : How can we transfere more people from the state of

/ indifference to the state of care ? Therefore, when we plan now, it is time to forget about the sectoral attitude. Theoretically this attitude might be right, but we must ask : agriculture .. for whom? Who will work in it and who will benefit from it? This is no ideological issue. The fact is, in order that development can face the population problem in the coming years, this can not be done by new decrees or laws or by creating more organizations for FP but it can be done by a new philosophy for development that gives chance to the individuals living in the state of indifference to care and this to be reflected on the size of the family. This is the way and it is not religious or anything like that. As long as the man in the street is indifferent, he is not interested in the matter, tomorrow is just like today and "it doesn't make any difference". So when we plan for development we must put into consideration the 11 million people who work in the government and public and private sectors in addition to the 400,000 people entering the work market every year. How to make all these a productive labor .. make each one of them work, produce and earn enough money.

The right planning approach we are after now is to review planning lines and trends keeping in mind, on both the national and sectoral levels, the population problem.

Dr. Helmy Mourad : I always thought that the efforts and money spent on family planning are wasted unless we raise the living and civilizational standard of the majority of our people. This is the conclusion which the Bucharest Conference has come to in 1974 as well as other scientists such as the French economist Leroi Polier (?) who says that the higher the civilizational standard the less family members.

Dr. Sobhi Abdul Hakim : There is also the theory of Sociological Attraction (?) of the french sociologist Arcen Demos (?) who resembles the individual mounting the society scale to the oil in a lamp -- the higher he mounts the less he brings children.

Dr. Helmy Mourad : We can see this in our society where we can find natural tendency for FP among the educated. As was said before, this tendency exists naturally in the advanced rather than developed countries. So, I think that if FP money were spent on ...

Dr. Aziz El-Bindary : the budget is LE 103 millions for 5 years.

Dr. Helmy Mourad : .. it will be more useful if we spend it on raising the civilizational standard, for example on elimination of illiteracy which rate is still very high, if we do this we will be solving the problem more effectively because the individuals will be doing it upon their own will. But if we try to solve it by propaganda, as the case now, without anybody to listen and no tendency for comprehension, our efforts will lead to a contrary result. I draw your attention to a serious fact : who will be influenced by this propaganda ? and who will be benefited by the available methods of FP? It is the educated families i.e. those who are most capable of bringing up their children. As if we are reversing the situation, leaving the incapable families in their illiteracy and backwardness to bring more and more children while the capable families practice FP.

Then, the problem has a civilizational aspect and an economic aspect of which Dr. Ganzouri spoke concentrating on development planning not only to increase the production but also to a better distribution of its profits. In the villages we thought that electricity supply is the way toward development but most unfortunately there is no social or cultural care given to the village, not even any attempt to raise the standard of living. The village has become, after the migration of its inhabitants to work abroad, a consumptional rather than a productive unit.

The problem we are facing should neither be underestimated nor exaggerated. In this case, exaggeration is more dangerous than underestimation because this makes us consider it as an excuse for the collapse in civilizational development now happening. We should not hang all our mistakes on this problem and we should not put all the burden of underdevelopment on the backs of the people telling them, "you are responsible for the crime and you shouldn't criticize the government". I want that the government says that it feels the responsibility and asks the people to help it. The government should work in eliminating illiteracy and introduce FP concepts with it.

-Dr. Aziz El-Bindary: I wish to clarify the point of the LE 103 mill. The greater part of it is a \$ 60 mill. loan from World Bank and there is \$ 30 mill. allocated for medical and sanitary services as approaches to FP.

- Dr. Ganzouri: I have a comment on what Dr. Mourad said about illiteracy. Illiteracy is one of the approaches in the development planning, but I have not heard of any country that could eliminate illiteracy of grown-ups in the past 50 years. The right way to overcome illiteracy is through cutting its sources. We have changed the obligatory education period from 6 to 9 years. We say that schools absorb about 80% of the children in the obligatory education age but in fact the percentage is only 72%.

- Dr. Sobhi A. Hakim: One might think that the illiteracy problem is related to the population problem. But I would like to mention that, there was a field study about the factors affecting fertility changes in the Egyptian society. The study concluded that the birth rates among those who can't read and write and those who have primary education certificate is almost the same and that education starts to influence fertility behavior only after intermediate education and not before.

- Dr. Mostafa El-Gendi: Moreover, the mother who can read and write usually has more children than the illiterate mother because she can take more care of her children. Only after intermediate education the mother becomes aware of the problem.

The decrease in the birth rates from 1964 to 1972 has other reasons than the 1967 war, such as the use of pills and the raise in marriage age specially in urban areas. In 1980 a study proved that the average of births for women in the urban areas is 6.7 out of which only 5 children live and in the rural areas the average was 7 out of which only 4-6 live.

- Dr. Sobhi Abdul Hakim : We know that the high mortality rate in rural areas is one of the reasons of birth increase. That is why one of the nine goals of the national FP policy was to reduce infant mortality rates.

- Dr. Mostafa El-Gendi : The "Fertility in the Egyptian Society" study has also proved that one third of the women covered by the study have used pills and that 83 used loops but only 63 of these have continued using loops. Answering the question of "why did they stop using contraceptives?" 143 of the women said that they want to bring children, 553 said it was because of health reasons, 13 because of religious reasons and 20 because of husband being outside the country. We should expect an increase in the birth rates due to the improvement in the health services which will reduce abortions and deaths.

- Dr. Atef Khalifa : Education has a strong effect on births because it results in raising the standard of living and delaying marriages. Our study has proved that the marriage age is raised two years against each educational stage. Also, the educated wife is more capable of opposing traditions. The number of educated female contraceptors is almost double the number of illiterate users.

- Dr. Mohamed El-Sayed Ghallab : I would like to mention that population increase is not the result of underdevelopment but rather economic development. This happened in other parts of the world as well as in Egypt. But the demographic course which should take place after this did not happen in Egypt due to many reasons such as : the mal-distribution of wealth, the attitude of the feudal lords toward education, and even when an economic development took place a small minority had all its benefits. This is why the demographic course did not reach its end as was the case in Europe. The industrial development which took place after the 23rd of July Revolution was a response to the population problem and the consequent insufficiency of agricultural resources. But with our country being involved in wars, the planners had only the chance of making one plan (1960-65) and after that there was no planning. Now we ask "Can we make a quick population change?". The change, supported by all efforts, will not happen before 20 years, so shall we wait all this time? In my opinion, we should develop the existing population wealth and carry out the decisions made by the Bucharest Conference which means adopting the principle of development as the greatest national interest and start from the point of raising the individual's standard of living. Family planning will be achieved by social and economic development which creates the desirable intellectual atmosphere and behavior habits.

Albert Barsoum Salama : There is also a relationship between the population problem and the immigration of Egyptians outside Egypt. They would not immigrate if they can find a good work opportunity in Egypt. Immigration has become a constitutional right that can't be prohibited but we are trying to regularize it according to society requirements. The number of immigrants outside Egypt is 3 million who have transferred \$ 2866 mil. to Egypt last year. We are now undertaking some studies aiming at strengthening their ties with their country and encouraging them to invest their money locally.

Al-Ahram opens the file of the "population issue", exposing all facts and presenting a "working paper" for the conference proposed by the President.

The solution : through development and through technology.

Planning expert : utilize the advantages of increased population instead of resorting to inhuman solutions.

Chairman of CAPMAS: I call for forming a work group to devise a plan and to re-evaluate past activities.

Chairman of the Shura Council : Japan faced the problem by a program depending on abortion.

Chairman of PFPB : No, abortion was due to the American occupation. Japan's experience is fascinating. The Human Rights Declaration forbids interference in making decisions of husband and wife.

The dialogue is still continuing, expressing not only the views of its participating parties, but also various trends prevailing in the Egyptian scene. It also expresses universal theories related to the population issue, linking it to economic resources, especially food resources.

Through exchange of opinions of such a large group of experts, we can grasp the facts.

- Sayed Zaki : The problem of population increase is challenging Egypt nowadays due to imbalance between the population growth and the available resources. The work force is 11 to 12 million which means that the dependency rate is high. The PFPB has played a role .. though this role was less than what was expected, but we should not lay all responsibility on it since the overall cure of that imbalance requires efforts for development to convert citizens into a productive force. It also requires eradicating misconceptions and spreading education.

The Egyptian citizen, builder of ancient civilization, can plan a role in converting the population increase into a blessing. How can this be done ? We should benefit from the experiences of others like Japan, Thailand, Germany, Switzerland and India which has encouraged small industries aimed at export in order to increase the earnings of families and the state revenues as well. For instance, we don't cultivate but 2% of our land. It is true that the State encourages land reclamation, but allow me to say that the State says much but act little. Our country has many craftsmen, but there are several obstacles facing them. We pay millions to import clothes while we impose high customs duties on raw materials necessary for local industry. Our coasts extend along two great seas, but we complain of insufficient supplies of fish. Our villages have turned from production into consumption. We should exert efforts to...

Dr. Ramzi Zaki : I would like to restrict myself to the nature of the population as I see it. There are two trends in diagnosing such problem. Malthus stated that this problem is due to imbalance between the population and the resources. In formulating his theory, Malthus proposed the law of decreased , neglected the effects of scientific and technological progress and viewed population increase as a purely biological process, unrelated to social and economic circumstances. History proved the inaccuracy of such theory. The population problem is not just an imbalance between population and resources but an imbalance between population size and the extent of social and economic progress of a given country. Thus several problems result in the form of unemployment and shortages of food, housing and transport. If population increase occurs in an advanced, developed society, it would not be considered as a problem. Thus the population problem is a result of underdevelopment, not a cause for it.

Hence, it is wrong to consider population growth as an evil, since it supplies the most important element for production, i.e., the production manpower. It also provides a potential market upon which an integrated industry can be established. An effective demand for products can be guaranteed if there is an equitable distribution of income.

The trend aiming at planning families by all means is just an illusion because population is a slowly changing variable especially on the medium of short terms. Thus, we are surprised at suggestions of inhuman solutions which are sometimes forwarded, some of them calling for interfering by force of law to limit births, or for imposing an additional tax on parents who have a third child. Some solutions even call for sterilization of men.

- Dr. Sobhi Abdul Hakim : Who called for that?

- Dr. Ramzi Zaki : I do not remember who, but it was mentioned in some studies.

Dr. Sobhi Abdul Hakim : I am well aware of all writings in this respect and I don't recall that any Egyptian dared to call for that. It's totally out of question.

- Dr. Ramzi Zaki : I am generally opposed to the Malthusian trend which calls for solutions ranging from family planning and imposing penalties. However, I do not mean to underestimate the efforts exerted in the field of population and family planning in Egypt, but I am hinting to the danger of excessive optimism regarding the outcome of such efforts and that we have better search for the positive aspects of the relative abundance of population and to utilize it well.

- Dr. Sobhi Abdul Hakim : If we study the European experience in comparison with the Egyptian one, we find that the population growth here was moderate till the end of World War II. Although the birth rate was higher than it is now, the death rate was also high, compensating for the former. However, the death rate has fallen since the middle of this century to reach half of its previous level, hence was the population increase we are now complaining about. It is certain that the death rate, now about 10 or 11 per thousand, has come near the lower limit at which such rates usually become stable. But what about

or would they decrease ?

We are living now in Egypt amidst the period of transition or explosion which has begun since the end of World War II and which we seek to surpass in order to reach the stage of maturity. This necessitates interference and directional guidance.

Should we become pessimistic Malthusians ? Or should we become optimists ? We shouldn't exaggerate the problem nor play it down. According to the lowest projections, Egypt's population would be no less than 60 million by the year 2000. If we don't interfere the population would reach about 70 million. Thus, any efforts aiming at decreasing the population will contribute to development, especially since the issue is not just a balance between population and resources, but it is also a choice between the available and the desired standards of living, taking into consideration that such standard changes according to aspirations of the people.

Dr. Mokhtar Hallouda : In the European experience, progress was going side by side in development, health, education, etc. together with out-migration. As for Egypt, we have "imported" better health, but this has not been paralleled by better education, development or awareness of our problems. This calls for the necessity of planning for confronting this problem. I support the view that population and development are interrelated, so there is no use of arguing about "with which of them should we begin?" because I believe that such confrontation should have multiple approaches, e.g. development, population control, education, religious awareness or incentives.

-Dr. Ahmed Ali Ismail: The population growth has been discussed already, so I will concentrate on population distribution. It is well-known that the inhabited area is only 3.5% of Egypt's total population, i.e., 35,000 sq.km. out of 1 million sq.km., thus we find the population density to be high, sometimes so high that it leads to inhuman and non-permissible living conditions well below the decent standards we seek. For instance, the population density in some districts in Cairo, like Bab El-Sharia and Roud El-Farag, is more than 100,000 per sq.km. Cairo and Alexandria alone are housing more than 20.2% of Egypt's population. Cairo alone has 14% of this population and its population will reach more than 16 million in 2000. Egypt's population of 44 mil. have to share only 6 million feddans of cultivated land, i.e., one feddan for each 7.3 persons. This brings us to internal migration as one aspect of the problem. The cities represent "pull" centers and the solution would be the modernization of Egyptian villages so that the rural population may not leave their villages to the cities.

If we move to another aspect .. the balance should <sup>not</sup> be that between population and resources only, but also between population and the technological level, which is a resource in itself, as in the case of Japan. It is strange that Egypt, Japan and Germany have entered the era of industry at nearly the same time, yet we are now still depending on others for technology, which is one of the measures of social change and solution of the population problem. It is technology that will carry us into the twenty-first century.

- Dr. Mohamed Mahmoud El-Sayad : The plenty of natural resources is the measure of the nation's strength. However, these resources are valueless unless there exists the capable people who can utilize it. Thus, human wealth is no less important than economic wealth. It even determines the nation's present and future. We can judge any nation by the degree of progress or backwardness of its people. The plenty of Egypt's population has given it a leading role, but we should not judge by numbers but rather by quality. Japan has a population of 120 mil., has no natural resources, its agricultural production covers only 14% of its needs but still it does not suffer from population problem. We do suffer from such problem and we heard that the allocations for family planning exceeded 100 mil. pounds, but I wonder whether this aim can be achieved through advertisement. If we are still living on 4% of our land area, why shouldn't we cultivate and inhabit the remaining area? The problem of over-population is one of lagging behind the advances of our era, underdevelopment and inability to utilize modern technology.

- Dr. Mohamed Sobhi Abdul Hakim : In Japan's experience we should distinguish between economic and technological development on one hand and population growth which has not become slow. In the statistics of 1979 the birth rate was 14.3 per thousand and the death rate 5.9 per thousand, i.e., natural increase of 8.4 per thousand. This does not compare to the rapid growth rate in Egypt. There has been tremendous increase of births in Japan after World War II, so its government devised a harsh program relying on abortions which amounted to 1 1/2 mil. cases in one year. This program continued till Japan surpassed the explosive transitional period to reach population maturity. I am just mentioning this although no Egyptian would think of resorting to such method adopted by Japan.

- Dr. Aziz El-Bindary : I disagree with Dr. Sobhi since I am fascinated with Japan's experience and I find it similar to Egypt's. Egypt also tried three times to join the industrial revolution .. it may even be the first developing nation to try to do so since the rule of Mohamed Ali .. but it failed. Japan also tried several times until it succeeded. I think that it is wrong to look separately to the population and demographic experience on the one hand and the socio-economic experience on the other hand. It is also incorrect to describe Japan's family planning program as harsh, but rather the opposite is true. Japan resisted any attempt in that direction. I have spent 6 months there to study their experience. There has been a wave of abortions and increased illegitimate births as a result of the presence of American troops, so the government permitted abortion under medical supervision. Furthermore, Japan is very conservative in the use of contraceptives to the extent that the use of pills and IUDs is not allowed except under strict medical supervision. So, the most commonly used methods are the condoms and the cervical barriers. Confrontation of the population problem in Japan was carried out through the approach of development and progress when, after World War II, it found out that it could solve its problems if it could get ahead of other countries. Thus, it has chosen five fields, namely; electronics, optical instruments, brewing industries, rice growing, fishing and means of transport. Two years ago, Japan has devised its development plan for the next 25 years, thus setting an example of growth for other nations in the world, including Egypt to set their own development scheme

I'd also like to comment on what was said about family planning and limiting family size. Our aim is in line with the UN Human Rights Declaration which stated the right of each couple to have children according to their own choice without interference and their right to know the means enabling them to do so. Hence, our programs depend on spreading knowledge and making the methods available. We thought that as soon as we do this the birth rates would decrease rapidly. It may be because of this that Dr. Hallouda said that the strategies devised up till now have not succeeded .. I agree with this .. but why haven't they succeeded ? The basis were laid out the various authorities have not implemented them. So, we shouldn't blame but ourselves.

- Dr. Mokhtar Hallouda : As for the strategies devised, I cannot judge about them now but I think their evaluation is mandatory. Because of the fact that there is no specialized body for this, we cannot judge if these strategies are right or wrong, especially when we are in a period which necessitates an evaluation of all past occurrences.

Rough Translation of an Article from the Cairo

Newspaper Al Ahram,

May 4, 1982

President Hosni Mubarak held a meeting yesterday with experts on population and housing in Egypt to study the dangerous effects that overpopulation is having on the economy of the country and the social and economic sectors.

The meeting was also attended by a group of American experts who submitted a scientific study on other aspects of this problem. President Hosni Mubarak conducted the discussions, which lasted about 3 hours and a half. He declared that the purpose of this conference, called "Egypt Tomorrow" is to reach a practical means to solve the difficult problem of overpopulation.

The Secretary of the Information, Shofar Sharif, said that the President reiterated during the meeting that we have to exert every effort in order to put an end to the difficult problem of overpopulation which reaches at the present time a million and a quarter a year.

At the meeting the conferees saw a movie which showed the effect of population distribution in Egypt and the increased averages of population according to the different sectors of the country. Everything was done in a scientific way, using the computer. According to all these averages and the studies, Egypt will need 2 million rooms every year in addition to building more schools and universities and finding new sources of foods in order to meet overpopulation.

The Minister of Information also declared that these are fantastic numbers and figures and the study which was prepared by a group of American experts is indeed a worthy study to be taken into consideration and we should not allow the overpopulation problem to continue.

List of attendees, among them Mr. Marshall Green, Advisor to the Secretary of State, and Alfred Atherton, U.S. Ambassador to Cairo and Donald Brown, Chief of U.S., A.I.D. There was also a photograph of President Mubarak and nearby attendees.

Al-Ahram  
February 15, 1982 (translation)

### The Population Study

The Egyptian Population will double within 24 years. The population study received by President Mubarak and prepared by the Future Studies experts assigned by the Agency for International Development warned of the dangers of the high rate of population increase in Egypt in a manner which threatens the national development plans and explodes the problems of employment, education and services.

The President had requested a conference be quickly held to investigate the dangers stated in this important report and that this conference be held after his return from Oman.

Al-Ahram is publishing today on its third page part one of a report on the population in Egypt which will double in 24 years. The second part of the report will be published tomorrow.

Al-Ahram  
February 13, 1982 (translation)

### A Conference to Investigate the Population Increase

The economic editor of Al Ahram learned that President Mubarak requested that a conference be held on a later date to investigate the problem of the population increase in Egypt after his return from Oman.

The President received a few days ago a report showing the dangerous population rate of increase which is affecting the Economic Development Plan, public facilities and services and which absorbs all effort of prosperity and progress.

CAPMAS will arrange the conference and invites consultants and information people. All political party representatives will also be invited.

The complete study received by the President will be reviewed in the conference. Positive procedures to face this national problem is the aim of this conference. It is well known that Egypt's population increases by 1.3 million yearly.

## E.6. Population and family Planning Board's Framework for the Governorates

### Introduction

The population problem in Egypt is identified with three intervening aspects (dimensions) : population growth; distribution, and population characteristics. Therefore, when preparing the framework for the population plan on the three levels : central, governorate and local, we should take into consideration the before mentioned aspects. These can be treated through activities. The activities cannot succeed unless we take into consideration some points :

- Efficient management on the three levels.
- Coordination and integration among the activities of each plan and the three plans altogether.
- The importance of public participation, specially in financing.
- The planning process must be done from bottom to top, i.e., we only make a framework for a guiding plan that can help the governorates make their own plans while at the same time we are guided by some governorates plans for 1990, particularly Beheira and Alexandria.
- Using the persuasion approach rather than authority.
- Consider the activities priorities as set by the strategic framework of the national program for FP and population.

### The Proposed Framework of the Governorate Plan Includes:

- A final target for the plan.
- Direct targets.
- Factors (or sub-targets) to achieve these targets.
- The general activities that should exist in order to achieve these targets on the governorate level.
- The detailed activities of the organizations responsible for the execution of the plan.

### Assessment Team Comment

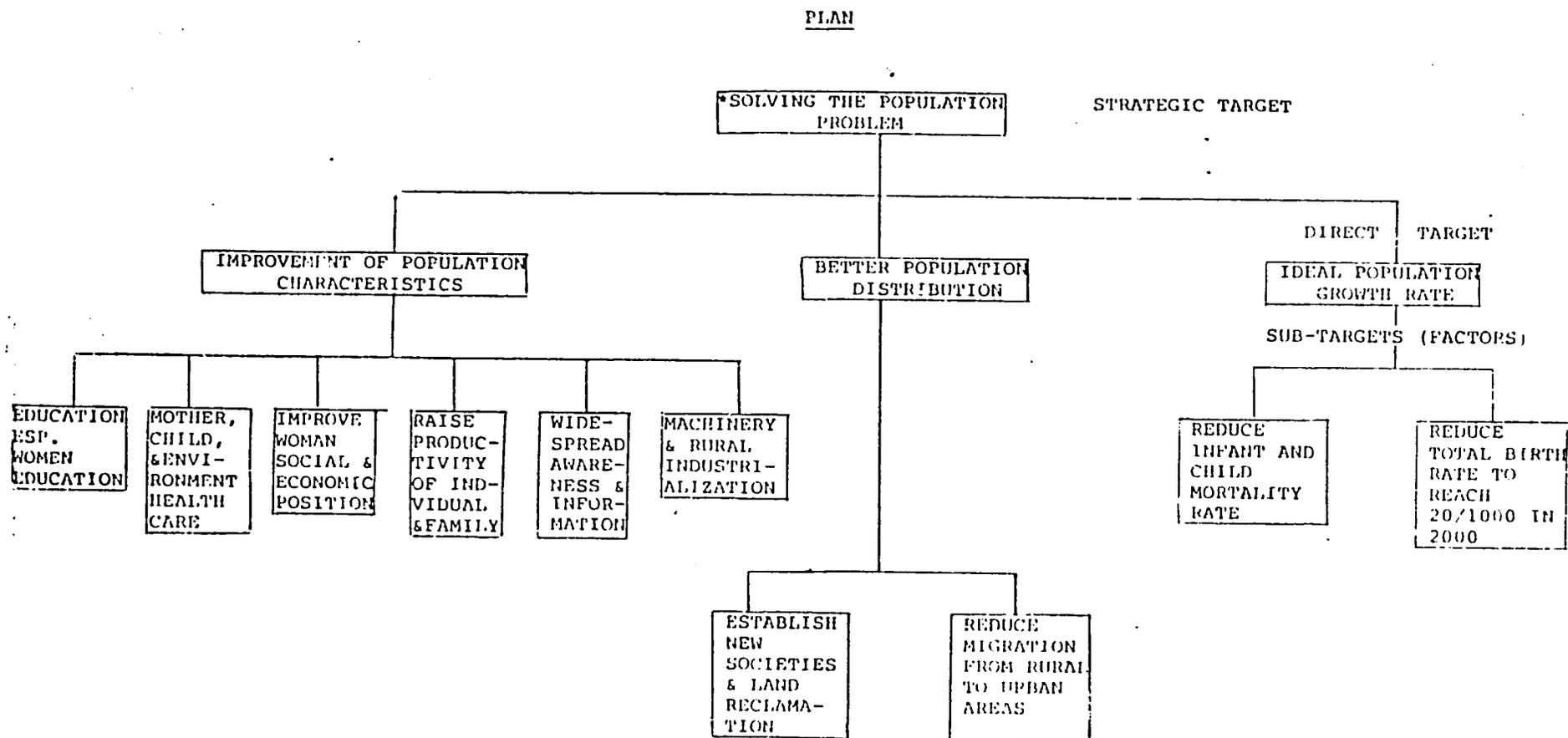
This very comprehensive framework prepared by the PFPB, and a similar one proposed for and sent to village councils, lists many desirable targets and factors. The next step would seem to be to establish priorities for the activities and to translate them into practical tasks that are capable of being carried out by the existing staff and within the existing facilities. It would seem that many of the activities cannot be implemented without a transfer of resources to the governorate or village council. If this is not possible those activities dependent upon the transfer should be eliminated.

PRIMARY FRAMEWORK

<u>OBJECTS</u>	<u>FACTORS</u>	<u>ACTIVITIES</u>
<p>Real Growth rate.</p>	<p>1) Reducing total birth rate to 20/1000 in the year 2000.</p> <p>2) Reduce infant and child mortality.</p>	<p>1- Increasing the number of contraceptive users among MWRA through :</p> <ul style="list-style-type: none"> <li>- Establishing more government and private FP centers.</li> <li>- Regular follow-up of FP centers.</li> <li>- Widespread information to convince the people of the importance of adopting the small family concept, create public awareness of the bad consequences of population increase and introduce contraception methods to target societies.</li> <li>- Increase contraceptives stock, establish new distribution outlets and warehouses, develop marketing and distribution method and train warehouse staff.</li> </ul> <p>2- Improve efficiency of service units which includes: providing materials and equipment, improving efficiency of social worker medical staff and nurses, training leaders, encouraging local societies to participate in the activities and encouraging research for better distribution methods of medical, social and FP services.</p> <p>3- Give special attention to Raidas and home visitors programs.</p> <p>1- Participate in improving general health through establishing sanitary drainage and clean water projects, vaccinations and establishing centers for maternal and child health care.</p> <p>2- Establish animal housing places in order to exterminate pollution sources which causes raise of infant mortality rate.</p> <p>3- Publicize health information among governorate residents especially parents and children.</p> <p>4- Increase the number of women and children benefited by food programs.</p> <p>5- Training of Dayas in Governorate health units on how to convince women get rid of bad health and food habits.</p>
<p>Better Population Distribution</p>	<p>1) Reduce migration from rural to urban areas.</p> <p>2) Land reclamation and establishing new societies</p>	<p>1- Improve means of transportation.</p> <p>2- Improve village services including medical, organizational, administrative and social services.</p> <p>3- Introduce non-traditional activities such as agricultural products industrialization which includes : meat, chicken, milk, oils, animal feed, etc.</p> <p>4- Develop the Productive Families project in rural areas.</p> <p>5- Encourage work in illiteracy elimination.</p> <p>1- Expand land reclamation projects and establish new societies provided with healthy houses, electricity and clean water</p> <p>2- Provide employment opportunities for the emigrants to the newly established societies so that they don't feel home sick.</p>

Improve Population Characteristics	1) Education, specially women education.	<ul style="list-style-type: none"> <li>1- Participate in vocational training and education projects.</li> <li>2- Absorbition of all children in the obligatory education age.</li> <li>3- Raise absorbition rate in all educational stages.</li> <li>4- Encourage work in illiteracy elimination.</li> <li>5- Strengthen and support population training programs and related research in all education stages.</li> <li>6- Usage of modern educational methods such as auditory and visual means.</li> <li>7- Invest school gatherings to convince students and parents of family planning and population concepts.</li> <li>8- Establish women classes to teach sewing, embroidery and knitting.</li> <li>9- Establish nurseries.</li> <li>10- Training service staff.</li> </ul>
	2) Mother, child, and environment health care.	<ul style="list-style-type: none"> <li>1- Concentrate on mother and child health care.</li> <li>2- Group vaccinations.</li> <li>3- Establish nurseries provided with health services.</li> <li>4- Publicize health information among mothers and children.</li> <li>5- Improve general health through sanitary drainage and clean water projects and mother and child health care centers.</li> </ul>
	3) Improve woman social and economic position.	<ul style="list-style-type: none"> <li>1- Establish mother and child health care centers.</li> <li>2- Establish women vocational training cent.</li> <li>3- Eliminate women illiteracy.</li> <li>4- Participate in employment of women in economic activities.</li> <li>5- Establish nurseries for working women.</li> <li>6- encourage children services programs such as film clubs and children clubs.</li> <li>7- Spread the Productive Families project.</li> <li>8- Participate in rural industrialization providing employment for women.</li> </ul>
	4) Increase productivity of individual and family.	<ul style="list-style-type: none"> <li>1- Training farmers on usage and maintenance of machines.</li> <li>2- Increase feddan production capacity of different crops.</li> <li>3- Establish vocational training centers.</li> <li>4- Expand agricultural machinery and provide agricultural machines and workshops.</li> <li>5- Improve services quality in the governor.</li> </ul>
	5) Wide-spread awareness and inform- ation.	<ul style="list-style-type: none"> <li>1- Convince health units visitors with FP aims through seminars, films, publicatio etc.</li> <li>2- Arrange school exhibitions and invest school gatherings and activities to convince students and parents with FP.</li> <li>3- Introduce modern education methods incl. auditory and visual means.</li> </ul>

<p>6) Agricultural machinery and rural industrialization.</p>	<ol style="list-style-type: none"> <li>4- Charge the Dept. of educational means with making health charts and slides.</li> <li>5- Arrange seminars, lectures, contests, publications ..etc., in order to create public awareness of the bad consequences of population increase.</li> <li>6- Provide information services such as cultural contests, plays, and art exhibitions in villages and schools.</li> <li>7- Arrange information caravans for youth in the villages and cities.</li> <li>8- Make personal and official contacts with individuals to convince them of FP.</li> </ol> <ol style="list-style-type: none"> <li>1- Provide agricultural machines.</li> <li>2- Training programs on usage and maintenance of machines.</li> <li>3- Vocational training.</li> <li>4- Increase feddan production capacity of different crops.</li> <li>5- Introduce more profitable crops instead of the traditional crops.</li> <li>6- Establish nurseries for the women working in agricultural and industrial integration projects.</li> <li>7- Expand land reclamation projects.</li> <li>8- Expand agricultural products industrialization.</li> <li>9- Training of agricultural engineers (male and female).</li> </ol>
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\* - According to strategy, the only quantitative target is reducing the total birth rate to 20/1000 in the year 2000.

- The object and sub-targets are deeply intervening and can not be definitely separated.