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# Country Development Strategy Statement

## FY 1986

## EGYPT

ANNEX E

POPULATION, HEALTH AND  
NUTRITION SECTOR STRATEGY



## APRIL 1984

Agency for International Development  
Washington, D.C. 20523

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CONTENTS

Page

I.	Introduction: Relative Importance of Current Policy Constraints	1
II.	Overall Goal	2
III.	Historical Worsening of Quality of Life	2
IV.	GOE Population Program	3
V.	USAID Population Sector Strategy	4
VI.	Constraints to Effective Fertility Control: other Necessary Remedial Actions	5
VII.	GOE Health Policy	8
VIII.	USAID Health Strategy	9
Table I.	Determinants of Fertility amenable to change	6

Egypt: FY 1986 CDSS Annex

POPULATION, HEALTH AND NUTRITION  
SECTOR STRATEGY

I. Introduction: Relative Importance of Current Policy Constraints

Historically, the GOE's policies have not been sufficiently vigorous in the population and health sectors. Presidents Nasser and Sadat never recognized that rapid population growth impedes economic development and many senior GOE economists and planners continue to favor long-term socio-economic development measures over specific family planning services. Government health services are under-financed, and over-extended in the direction of curative care and there has been insufficient recovery of service costs from patients.

Recently, signs of change in GOE policy directions in both the population and health sectors have emerged. At the conclusion of a National Conference on Population on March 29, 1984, President Mubarak announced the formation of a new National Council on Population over which he would personally preside. He pointedly said that "raising the standard of living" as the basic approach to addressing Egypt's population growth problem was an inadequate response and called for striking a balance between providing family planning services and implementing development programs. In addition, he called for a greater private sector role in collaboration with the government and urged political parties become more active in this national cause.

The GOE is expanding the role of the Government Health Insurance Organization (GHIO) to increase patient assumption of medical costs and there has been an expanded focus on preventive care. Central government expenditures on health were projected to more than double during 1982/83; even if this was fully achieved, the proportion of the GOE's current budgetary expenditures going into health and population activities (4%) would still be below international standards. Consequently, USAID project officers will emphasize increased GOE funding to permit adequate GOE counterpart contributions and we will be alert to ways of stimulating greater vigor in the GOE's health and FP programs to expand the benefits available from AID investments therein. We view the recent policy strides by the GOE in the population and health sectors as significant and, with the growing congruence between current USAID and emerging GOE policies, we are presently considering the health and population sectors as "policy neutral." We are therefore recommending a unified strategy here, rather than differentiating between "optimal" and "policy constrained" as we have done in the other sectors. We would review this recommendation in case there is a significant slackening in the promised policy directions or in overall program vigor.

## II. Overall Goal

The overall goal of all of USAID's projects in the health, population and nutrition sector is to bring about improved health status and quality of life for the Egyptian populace at large. This goal is to be achieved by reductions in morbidity and mortality and through reductions in birth rates.

## III. Historical Worsening of Quality of Life

The population of Egypt has risen from 10 million in 1897 to 19 million in 1947, 31 million in 1967 and to 46 million in 1983. With a habitable area of only about 15,000 square miles out of a total area of 411,000 square miles, Egypt presently has a density rate in its habitable area of over 3,000 persons per square mile. Population pressure on agricultural land is similarly severe. Even allowing for double cropping, Egypt's cultivated land has remained stagnant at about eleven million acres during the last two decades: progress on land reclamation and the extension of irrigation facilities has been entirely offset by the expansion of cities. The rise in the people to land ratio to the present four per cultivated acre has resulted in a substantial and ever growing food deficit despite very high crop yields. Population densities in Egypt are among the highest in the world and additional serious effects on the quality of life result from extreme urban crowding and the deficiencies in providing the needed additional housing, school, health, water and sewage, and transportation facilities.

Population pressure on the land and on available infrastructure facilities has continued to intensify at alarming rates since population growth rates have not yet slowed down (except perhaps in the last year or two). The natural increase rate was 2.6 or 2.7 percent during the early and mid-1960's, fell to 2.2% or even lower during the 1968-73 period, but then crept steadily higher to 2.9% by 1980. The significant cause of the continuing high natural increase rates has been a steady fall in the crude death rate from 17 per thousand in 1960 to about 11 per thousand in 1980, owing to improved health services. The overall decline in fertility was not as substantial: from 43 per thousand to about 40 (a temporary descent to 35 per thousand during 1970-72 took place starting in 1967, but this resulted from political/military insecurity and from economic hardships, while a major factor for the subsequent recovery was rapidly improving economic conditions).

There has indeed been some decline in the fertility rate in Cairo, Alexandria and some other urban areas as a result of family planning activities and a general rise in the age at marriage, but the effect of these trends has been entirely offset by the fertility increases in rural areas, especially in Upper Egypt. Without substantial progress soon in lowering the overall birth rate, the quality of life will continue to get worse as the

dependence on foreign food expands dangerously and as infrastructural improvements fail to keep up with the escalating demands of a rapidly increasing population. Early progress is necessary in order that the cumulative effects can begin to take hold on overall population size by the end of the century. With gradual movement to a 3-child family average by 2,000, Egypt's population would expand to 60 million then, compared to 70 million with no reduction in fertility.

#### IV. GOE Population Program

The government of Egypt established a National Committee for Population Problems in 1953 to undertake studies in demography and population. By 1955, the Committee had established 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. The committee, renamed the Egyptian Family Planning Association, has acquired non-governmental status, although governmental financing continued through the Ministry of Social Affairs. This Association continued the coordination of private, voluntary efforts.

The Supreme Council for Family Planning was established in 1965, 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 (now called the Population and Family Planning Board) was established with programs launched through Ministry of Health facilities. Specific family planning services appeared to be de-emphasized during the 1973-80 period upon adoption in 1973 by the Council of "the socio-economic approach to fertility reduction." The other factors affecting fertility appeared to be given greater priority including: raising the standard of living; education; employment of women; mechanization of agriculture; industrialization; reduction of infant mortality; and social security. The Council did, however, establish the specific goal of increasing the number of users of family planning services from 540,000 in 1972 to 2.5 million in 1982. The 1980 Egyptian Fertility Survey indicated a contraceptive prevalence of 24%, implying 1.7 million contraceptive users, while this percentage may have risen to 30% in 1982. There was thus a short-fall of some 400,000 users. The Population and Family Planning Board issued a comprehensive strategy statement in December 1980 calling for a reduction in the fertility rate to 20 per thousand by the year 2,000 through 1) upgrading family planning services integrated into relevant health and social activities

2) institution of community based socio-economic programs of development conducive to family planning practices and 3) strengthening educational and information programs to promote changes in fertility behaviour toward the small family norm and widespread contraceptive practice. The key element is the expansion of family planning services, especially into rural areas, through their integration into on-going health and social programs. The private sector was increasingly relied upon in the urban areas and the public sector in rural areas with greatly expanded mass media population information. For the GOE to achieve its target of a 50% reduction in the fertility rate by the year 2,000, there must be an increase in contraceptive use from the current 25% or so to 60% or more, and the new norm for completed family size must decline from the current 5.5 children per married couple to three.

Family planning services are available through 5,000 private pharmacies, 500 private clinics of the Egyptian Family Planning Association supervised by the Ministry of Social Affairs and through the Ministry of Health (MOH) facilities: in urban areas (120 hospitals and 490 clinics or centers) and rural areas (49 hospitals and 2,450 units or centers). The health network is designed so that there is a facility within 3 kilometers of every village with a population over 3,000. The health system is thus in a good position from the point of view of infrastructure in promoting a vigorous expansion of family planning activities.

#### V. USAID Population Sector Strategy

As early as 1971, the United States had provided family assistance to Egypt through support of international organizations and contractors in their operations research tests and contraceptive research studies. Under an "umbrella" Family Planning project agreed to in September 1977, the United States has extended through the end of 1982 assistance totalling \$67.6 million. The objective has been a strengthened family planning delivery system to increasing numbers of Egyptians through greater supplies of contraceptives, reorganization of the MOH'S family planning services, training of professionals and testing the expansion of an integrated delivery system for health, family planning and other social services. Specific activities have included the renovation of 385 rural health units and centers, establishment of field training centers for 240 doctors annually as well as for MOH staff and other professionals; carrying out a multi-media information, education and communication campaign; and engaging in a social marketing program for promotion and distribution of contraceptives through pharmacies and private physicians in Cairo, Alexandria and the Delta areas.

In January 1983, a new USAID project was initiated for the period 1983-86 with the continuing objective of increasing family planning practice (USAID grant \$102.6 million; total costs \$166.1 million.) The new or strengthened activities under this project include 1) expansion of the coverage of the privately operated Family of the Future project to the smaller urban areas; 2) greater involvement of the private sector in the State Information Service's mass media population information campaign; 3) assisting the MOH in launching a rural based family planning campaign, initially focussing on the 12 governorates with already active programs. The MOH will promote family planning within the context of overall programs for improving health and well-being especially the rural maternal and child care activities; 4) improvement of the quality of population statistics for evaluation and planning purposes; and 5) fertility research both through Egyptian organizations and international agencies operating in Egypt. This project is likely to be continued through FY 1989.

VI. Constraints to Effective Fertility Control: Other Necessary Remedial Actions

USAID actions in assisting the GOE to bring about more effective fertility control should not be limited to USAID programs under the direct control of the USAID offices of Population and Health. While the propagation of family planning devices and information have a direct bearing on fertility behavior, there are numerous other governmental programs or economic, social or cultural factors which have at least indirect or long-term influence on fertility behavior. All of these programs or factors are detailed in Table I, together with the recommended priorities attached to USAID involvement. Direct family planning services and their advertisement are naturally assigned the highest priority. Top-level GOE political support is also assigned a very high priority and a renewed Presidential statement on November 6, 1983 and the National Population Conference of March 1984 are promising to stimulate more vigorous GOE family planning efforts. The other actions listed in the table which are assigned a priority of 5 or above need to be addressed across the USAID Mission or by specific offices, e.g., Education, to ensure that fertility control in Egypt becomes truly effective over the long-term.

Table 1  
DETERMINANTS OF FERTILITY AMENABLE TO CHANGE

Determinant Category	Importance/ Weight of Determinants (10=High;1=low)	Degree of Government Influence	Degree of Donor Influence	Number Years Before Affects Fertility	Political/ Adminis- trative Feasibility	Population/ Family Plan Program Priority
<b>A. Governmental</b>						
1. Adopt Comprehensive Population Policy Top-level Political Support	8	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	6
4. Raise/enforce marriage age	4	8	2	3 years	4	4
5. Enforce compulsory school enrollment	6	8	2	7-10 years	5	5
6. Reduce food, education subsidies (so that parents absorb greater share of total costs of having children)	4	9	4	2 years	4	6
7. Restrict public housing eligibility	3	9	1	5 years	3	3
8. Limit guaranteed employment	5	9	1	5+ years	3	3
9. Enforce child labor laws	6	7	1	3-5 years	5	6
10. Reduce subsidies for child raising	3	9	1	6 years	5	2
11. Incentive/disincentives for individuals, communities, governorates	6-7	9-10	5-6	3-4 years	7	7

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

## VII. GOE Health Policy

The integral parts of the GOE health policy include family planning, the establishment of readily accessible medical facilities, and the supply of inexpensive medications. As indicated at the end of section IV, the GOE attainments in the establishment of numerous hospitals and clinics and their accessibility to the vast majority of the Egyptian population are impressive. Also impressive is the number of available physicians. The Egyptian population per physician ratio is about 1,000, placing Egypt easily in the top 10 percent among low and middle income countries with respect to this health indicator. Middle-level health workers such as nurses have been in short supply in public facilities due less to the lack of training facilities (with over 5,000 nurses graduating per year) than to losses to private facilities or to other occupations. There also have been insufficient skills in critical clinical and management areas and an essentially curative focus at the expense of prevention activities.

The educational system actually has trained too many physicians either for the maintenance of adequate quality or for the health services to sustain. The rapid expansion in enrollments in the medical schools with close to 5,500 physicians now graduating each year has caused deficiencies in skills among many physicians, while the GOE policy of absorbing too many physicians in public health services has placed a severe strain on the MOH's recurrent budget. The effect of the endemic budgetary squeeze has been inadequate maintenance of buildings and equipment and insufficient supplies.

A major shift in the GOE's health policy since 1982 is the intention to increase gradually the coverage of the Government Health Insurance Organization (GHIO). The organization is presently maintained near solvency by legally required payroll contributions and co-payments by patients for services and drugs. While such expansion is intended to relieve the financial pressures on the MOH through the increasing transfer of patients to the GHIO, the latter eventually will require large operating subsidies with the transfer of less well-heeled patients whose fees and contributions will increasingly fall short of the cost of the medical treatment. A major deficiency in the GHIO is its failure to promote preventive activities and to offer family planning services. Some urban patients are treated in University hospitals operated by the Ministry of Education outside the MOH system. A large and increasing proportion of urban medical treatment, particularly among the well-to-do, takes place through private channels. The most indigent persons, particularly in the rural areas or the urban perimeters, often rely on traditional medicine or pharmacists and otherwise can only afford the MOH system. Yet the MOH's budget has not been expanding rapidly enough to keep

up maintenance or to purchase adequate supplies. Thus, medical service delivery to the poor will continue to suffer. This insufficiency may arise both because health delivery is viewed as a consumption activity and hence accorded less priority in central budget allocations than the "productive sectors" and because of the continuing burden of too many comparatively high salaried physicians. The current GOE programs of increased privatization and expansion in the operations of the GHIO may relieve the financial pressures on the MOH but will not eliminate them entirely.

For several years, the GOE has been attempting to shift from a highly centralized administration to one decentralized to the level of Egypt's 26 governorates. Governorate level personnel are being given increased responsibility for administration of the MOH services in their areas.

Malnutrition has been largely avoided in Egypt by the GOE policy of subsidies to make adequate foodstuffs affordable for almost all the people. In recent years, the nutritional status of many otherwise relatively poor families also has been raised by remittances from family members employed overseas. The malnutrition that does exist is mostly the result of inadequate iron in the diet, poor weaning practices, and intestinal disease.

#### VIII. USAID Health and Nutrition Strategy

##### A. Introduction:

The USAID views the health/nutrition sector as having a major contributory role in Egypt's economic development, particularly as it relates to decreasing fertility and mortality and increasing the productivity of the labor force. However, the health/nutrition sector must be supported by programs in other sectors, such as population, water and sanitation, education, housing and agriculture, in order to have the desired impact on the quality of life of the Egyptian population. The USAID has given priority to these other sectors to the extent that the health and nutrition programs now are operating in an environment conducive to success.

The health and nutrition programs over the next five years will support the GOE's health policy and will attempt to shift further the emphasis of the GOE program from one of a highly curative nature to one of public health orientation. In addition, emphasis will be placed on the role of the private sector in providing health care to the people of Egypt, thus lessening the GOE's financial burden in operating expensive curative care facilities.

##### B. Guiding Principles:

In 1982, a major assessment of Egypt's health sector was completed. This all-encompassing study recommended that the USAID:

1. Continue its current mix of projects that support the GOE's efforts to expand accessibility to primary health care and improved health services, particularly for women and for children under the age of 6; modernize and reorient health and medical training towards public health/community medicine; emphasize the importance of family

planning in overall economic development; use simple technology for reduction of child mortality (e.g. oral rehydration therapy); and emphasize other public health interventions using existing knowledge and technology or from results of biomedical research to rapidly make an impact on Egypt's priority health problems.

2. Assist the ARE in initiating a major program to provide water and sanitation services to the general population.

3. Further concentrate support on preventive health activities, including education, training, and nutrition.

4. Provide technical assistance to assist in the development of the private health sector.

The USAID has accepted these recommendations and has used them as the criteria for developing and refining the health sector strategy for the coming five years. (Water and Sanitation activities are discussed in Annex J).

#### C. The Program:

##### 1. Constraints to Program Development:

The principal historical failings in health programs have been a low share of the overall GOE budget, overemphasis on curative care and insufficient recovery of health costs from patients. Other constraints to the delivery of effective and efficient health care have included an excessive number of physicians being trained and an inefficient supply of nurses.

In developing the appropriate mix of ongoing (i.e. to expand or not) and proposed new projects for the next five years, emphasis has been placed on the recommendations of the health sector assessment, in order to develop a program that will have maximum impact in the short time frame of the strategy. By so doing, it is felt that there will be more of an impact than is presently possible on reducing fertility, morbidity and infant-child mortality.

##### 2. The Present Program:

The present program consists of four major projects, which contribute to the overall goal of improving health status by:

- o improving the delivery of urban and rural health and nutrition services.
- o increasing knowledge and utilization of oral rehydration therapy for diarrhea, particularly among infants and children.
- o implementing a medical education program that prepares physicians and health care workers for relevant, appropriate and effective community based health care services.

Ongoing activities consist of the Rural and Urban Health Delivery Systems Projects, the Suez Community Health Personnel Training Project, and the Control of Diarrheal Diseases Project. In addition, there are numerous small research activities funded under the Special Foreign Currency Program in cooperation with the U.S. Department of Health and Human Services; and a collaborative research program in nutrition funded by AID/W. Related projects include the basic village services project (K-605.2) implemented through USAID's decentralization office emphasizing potable water and drainage, and the nutrition and health programs managed by CARE and the CRS.

The MOH and pharmaceutical manufacturers are being assisted in a \$26 million program (0137) to expand the production, distribution and utilization of oral rehydration salts to control infant/child mortality from diarrhea related dehydration. This project supports the first national rehydration campaign which is scheduled to begin in 1985. The campaign will promote oral rehydration therapy (ORT) through the media, health facilities and pharmacies. In preparation for the campaign, oral rehydration salt production is being expanded in Egypt; MOH physicians and nurses are being trained in ORT; and media messages on ORT are being tested. ORT units are being established in hospitals and MOH clinics and research to improve the treatment of dehydration and diarrhea is being accelerated. Social research is also being carried out to determine acceptable approaches to mothers and the community for effective utilization and support of ORT. The national campaign is expected to reduce infant and child mortality due to diarrhea by 25%.

Improvements in the delivery of urban health services have taken place through the Office of Health's Urban Health Delivery Systems Project (0065). This \$37 million project, implemented through MOH and Cairo University facilities in Cairo and Alexandria, is facilitating a major policy change. The resulting expanded and improved urban maternity and child health, family planning and nutrition services are promoting a greater MOH assumption of responsibility for public health and prevention as its central mission, away from the historical emphasis on curative care. These improved services have come about through retraining of 3,000 physicians, nurses, administrative personnel and other health care workers; and through the introduction of improved health care service interventions such as ORT, Growth Charting and Health Education. Broader research to assist in continuing this greater assumption of preventive care responsibilities will be promoted through the establishment of a new joint Cairo University/MOH Center for Social and Preventive Medicine.

Under the \$15 million Rural Health Delivery System Project (0015), some 1,500 physicians, nurses and sanitarians in four rural governorates have been trained and extensive field trials have been conducted to devise strategies to expand the outreach of the rural health services. The geographic scope of this program is doubling to 20 districts within these same governorates. The importance of the rural health services to the Egyptian population is indicated by sample surveys showing that 74% of the people in rural areas use the government's health services compared to 52% in the urban areas. The Control of Diarrheal Diseases project was initiated as a result of a special study sponsored under this project.

The \$12 million Suez Community Health Personnel training project (0136) has initiated an integrated medical education and health services program. The innovative character of the project is the training of physicians to provide community health services. Curriculum development by administrators, planning and implementation of health services, and the education of the physicians, including the establishment of additional training sites in areas of peak service activities, all go hand in hand.

3. 1985 - 1989:

With the possible exception of the Control of Diarrheal Disease Project, no major expansions or extensions of the existing projects are planned. Consideration is being given, however, to the expansion in FY 1985 of the Rural Health Delivery Systems Project to areas encompassing the Suez Community Health Training Project so that medical students there can benefit from training in health facilities upgraded to more modern standards in accordance with the findings of other health projects. Additionally, it is planned to extend the availability of technical assistance to the Suez Community Health Personnel Training Project through 1987, the year the first class graduates for this innovative medical school.

Dramatic reductions in infant mortality are possible through the use of simple oral rehydration therapy. An expansion of this activity is, therefore, under consideration. Additional funding (in FY 1987) will provide for a higher level of oral rehydration salt production and wider coverage to increase knowledge and utilization of ORS to reduce infant-child mortality.

New activities planned for the CDSS period are intended to support the on-going program, to expand the coverage of private health services and to expand the types of care available to the population. We are looking for high impact, short duration activities that will take into consideration lessons learned from past activities and, in combination with those activities, will contribute to decreases in fertility, mortality, and morbidity. Objectives thus, will be broadened (see paragraph C.2) to include:

- o Expanding the use of self-financing schemes in the delivery of health services.
- o Expanding the availability and utilization of basic childhood immunization services.
- o Expanding the availability of weaning foods and the knowledge of proper weaning food practices.
- o Expanding biomedical research into major diseases affecting Egyptians.

It is anticipated that pursuing these objectives will further the GOE's increasing focus on preventive services and shift free or subsidized curative services increasingly to a self-financing basis. Support for

the expansion of services to the Health Insurance Organization (a top priority to the MOH), the Curative Care Organization, the Medical Syndicate's Corporation for Investment and other group practice organizations are possible beginning in FY 1985. A program to address the wide spread problem of poor weaning food practices and its adverse impact on infant mortality is being planned. Iron fortification to combat anemia, as well as an expanded nutrition education activities, will support this program. Assistance also will be given to the GOE to allow them to develop the capability for manufacturing weaning food supplements in Egypt using locally available foods. This, together with better foods prepared by mothers in the home, will allow for the phase-out of Title II imports by approximately the end of FY 1988.

To meet the shortage of capable nurses, a new program for expanding the training of nurses is planned. This program is designed to double the number of nurses graduated each year to 7,000 and to provide for improved training materials emphasizing preventive care, maternal and child health, and family planning.

USAID support also is under consideration for the MOH's mass immunization programs as well as for expanded biomedical research directed towards such diseases as schistosomiasis, hepatitis, diarrhea and respiratory diseases. The results of this research should be applicable not only to Egypt's health situation but to those of other developing countries, as has already proved to be the case with the research on oral rehydration therapy.

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