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POPULATION

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USAID/EGYPT: POPULATION STRATEGY

Table of Contents

	Page
I. SECTOR OVERVIEW	1
A. Sector Constraints	3
1. Policy	3
2. Medical Restrictions	4
3. Constraints on Private Sector Provision of Services	4
4. Ministry Obstacles to Cost Recovery	5
5. Technological Constraints	5
6. Institutional Constraints	5
II. SECTOR STRATEGY	6
A. Strategic Objective: Increased Level and Effective Use of Modern Contraceptive Methods	6
B. Programs	7
1. Increased Family Planning Service Volume and Improved Service Quality	7
2. Improved Information for Policy Makers	8
3. Improved Management Capacity in Implementing Agencies	9

Population Strategy

I. Sector Overview

Egypt is hard-pressed to expand services and employment opportunities fast enough to keep pace with its rapid population growth. The population, now at 56 million people, has more than doubled in the past 30 years.

Recent statistics on the levels of birth and death rates suggest that the rate of population increase may have slowed markedly during the latter part of the 1980s, decreasing from a high of 3.03 percent in 1985 to an estimated 2.47 percent in 1990. This reduction is a result of substantial decline in the crude birth rate, from a level of nearly 40 births per thousand population in 1985 to 32 per thousand in 1990. Even though the current rate of population growth is less than it was in 1960, it is still very rapid. If Egypt's fertility rate were to remain at current levels, Egypt would be 92 million people by 2013 and 171 million by 2038. This kind of growth would place great strains on Egypt's economy and health care and education systems.

The problems of rapid population growth are compounded by the lack of natural resources, especially limited availability of arable land. In 1990, there were almost 1200 persons occupying each square kilometer of inhabited area. Although the majority of Egyptians (56 percent) live in rural areas, Egypt is becoming progressively more urbanized. Urban growth is placing further pressure upon the country's scarce agricultural land and contributing to a myriad of social problems including housing shortages and unemployment.

Population growth is affected by fertility, mortality and migration. According to the 1988 Egyptian Demographic and Health Survey, mortality levels were fairly high in Egypt until after World War II. At that point both the crude death rate and the infant mortality rate began to decline. The crude death rate decreased by half between the 1940s and the 1960s from 30 to 15 deaths per thousand population. By the late 1970s the rate had declined further from 15 to 10 deaths per thousand.

The crude birth rate also declined after the Second World War, but at a slower pace than mortality. The crude birth rate averaged just under 50 births per thousand during the 1940s and declined a mere 10 percent to 45 births per thousand in the 1960s. By the late 1970s the crude birth rate had fallen only slightly to 40 per thousand.

Recent data reveal the same trends. Between 1980 and 1988, the crude death rate fell from 10 to 8.1 per thousand: a decline of 19 percent. Conversely, during the same period the crude birth rate remained constant at around 37.5 per thousand. In sum, mortality in Egypt has declined substantially while commensurate reductions in the birth rate have lagged, resulting in a high rate of population growth.

Migration is a less important, yet not insignificant determinant of population growth. According to the 1987 Egyptian Migration Survey, the number of Egyptian emigrant workers was 1,210,000 in 1985. Including the accompanying dependents of emigrant workers, a total of 3,425,000 Egyptians emigrated between 1973-1985. While this out migration contributes to economic welfare of families and helps the employment picture slightly, it does not significantly influence the population growth.

Clearly, the key to controlling the high rate of population growth in Egypt is reducing the total fertility rate: the average number of children a woman bears by age 49 at current fertility levels. The factors which influence fertility rates include: maternal education, employment of women, urban versus rural residence, age of marriage, duration of breastfeeding and use of contraceptives.

Fertility rates are negatively correlated with educational level: the higher the woman's educational level, the lower her fertility. For the five-year period between 1983-88, the highest total fertility rate (5.7 births) was among women with no education. The fertility rate was 5.1 for women who completed some primary school; 3.8 for women who completed primary school and 3.2 for women who completed secondary school. Women who are employed outside the home for cash have an average of 3.2 births while women who do not work have an average of 4.9 births.

Moreover, urban women are leading the fertility transition. Women residing in the urban governorates have the lowest fertility rates while women in rural Upper Egypt have the highest fertility rates.

The total fertility rate is also inversely correlated with age of marriage. That is, the later the age of marriage the less exposure to possible pregnancy. Fortunately, there has been a steady decline over time in early marriage (before 16 years of age). One-third of women age 40-49 married before 16, but only one-seventh of women age 20-24 married before the legal age.

Finally, the duration of breastfeeding can contribute to fertility declines. Women in Egypt breastfeed their children for an average of 17 months, providing approximately nine months of insusceptibility to pregnancy. Unfortunately, urban educated women tend not to breastfeed their infants as long and are, therefore, unsusceptible for a shorter period. If rural women follow suit, this could exacerbate their already high fertility.

USAID has made a significant contribution over the years to reduce fertility by increasing girls' access to primary education through school construction, creating jobs for women through small and microenterprise activities and, more recently, by promoting breastfeeding. The Basic Education I project provides access to a primary education to 500,000 girls each year. Likewise, the small and microenterprise project has made loans valued at LE 1.4 million to 800 women entrepreneurs. A survey of 717 repeat borrowers in Alexandria revealed a 16 percent increase in permanent female employment and a 35 percent increase in

temporary female employment in the first year of the project, these 717 borrowers had created over 200 jobs for women. Finally, the Child Survival Project, in concert with UNICEF, established a national policy on breastfeeding and has begun to promote prolonged breastfeeding as a child spacing method.

Although these determinants are important, the use of contraceptives is a key determinant of fertility and the one which USAID is most able to directly influence. Since 1975, USAID has been the principal donor assisting the Government of Egypt in population and family planning, primarily through two previous projects and the current Population/Family Planning II Project. UNFPA is the most important provider of grant assistance after AID. The Dutch, German, Japanese and recently the European Community, also provide limited assistance.

Family planning activities in Egypt have achieved notable success. The total fertility rate fell from an average of 5.2 births per woman in 1980 to 4.4 births per woman in 1988. These fertility declines are in part attributable to an increase in the contraceptive prevalence rate (CPR) from 24% to 38% of married women of reproductive age. This absolute increase in the CPR of 14% represents a relative increase of 60% over the eight year period. Preliminary results of the CAPMAS Maternal and Child Health Survey indicate CPR increased to 47.6% by the end of 1990, a doubling of the rate of contraceptive use in 10 years.

Despite these impressive achievements, significant challenges remain. The policy, technological and institutional factors which constrain further increases in the CPR and, hence declines in fertility are identified and discussed below.

A. Sector Constraints

1. Policy

Since the early 1960s, the Government of Egypt (GOE) has formally identified rapid population growth as a key constraint to development. It was not until the 1980s, however, that strong and consistent leadership and a comprehensive public sector program for delivering family planning services emerged.

As part of Egypt's Five Year Development Plan for 1992-1997, the National Population Council (NPC) drafted a National Population Policy in 1990. The policy declares, "The population problem is considered the first problem that hinders the development efforts in Egypt with its present population of 54 million and increasing by more than a million every eight months... This population increase will affect the population density, will encroach on the present agricultural land and burden the State efforts for the provision of subsistence, housing, education, services, employment opportunities and a decent life for citizens."

The draft Population Policy and recently issued 1992-2007 National Population Strategy recommend that the GOE address the problem of national population growth through a multi-pronged strategy that calls for increased contraceptive use as well as improvements in maternal and child health, the status of women, literacy, and population distribution. President Mubarak and influential religious leaders such as the Grand Mufti and the Pope of the Coptic Church frequently call attention to the importance of family planning. While there is acute awareness of the impact of rapid population growth at the highest levels within the GOE, a critical gap exists between high level policy statements and allocations of government budgetary and operational support.

A number of factors constrain the ability of the GOE to support its national family planning program. The Egyptian economy is suffering severely and experiencing tremendous strains on both private and public resources. While current reforms are addressing some of the central policy constraints hampering economic growth, it is unlikely that the GOE will be in a position to support its national family planning program at the necessary level in the near future. Substantial donor contributions are warranted and needed during this time.

In addition to broader concerns of inadequate resource allocation to population activities, there are several specific policies which constrain the expansion of family planning services and, hence, increased utilization. These include:

2. Medical Restrictions

The professional dominance, particularly by physicians, which characterizes the Egyptian health sector limits the access of women to family planning. This occurs for both logistical and cultural reasons. First, current policy limits clinical family planning service delivery to physicians. In fact, injectable contraceptives, which in many developing countries are provided by paramedics, are restricted to obstetricians/gynecologists in Egypt. For modesty reasons, women are often reluctant to see a male physician and undergo a physical examination in order to obtain contraceptives. Women frequently circumvent this restriction by going directly to a pharmacy to obtain non-clinical methods, but pharmacists have not yet been adequately trained to be frontline family planning providers.

3. Constraints on Private Sector Provision of Services

According to the 1988 Egyptian DHS, the private commercial sector delivered approximately 70 percent of all family planning services in Egypt. However, this finding masks the fact that all but a minute portion of contraceptives in the private sector are provided by donors or by GOE parastatals. These contraceptives are sold at low subsidized prices, which has resulted in private providers benefiting from the subsidy and charging for services what their clientele market will bear. By thus subsidizing the private sector, the commercial pharmaceutical and medical device providers have been unable to compete in the Egyptian marketplace. To remedy this situation, USAID has already phased out of supplying the private sector through the public sector distributor and will phase out of providing

contraceptives to the Family of the Future (FOF) Contraceptive Social Marketing project in 1993. USAID is helping FOF to identify commercial suppliers and to procure contraceptives from them.

4. Ministry Obstacles to Cost Recovery

The control over pricing of contraceptives (along with other pharmaceutical and medical devices) by the Ministry of Health (MOH) constrains supply and diversification in the private commercial sector.

5. Technological Constraints

The primary technological constraints to increasing the contraceptive prevalence rate (CPR) are lack of access to more longer term clinical methods, such as injectables and NORPLANT, and lack of local manufacturing capability for IUDs.

The fact that Egypt manufactures only oral contraceptives under license from Schering, coupled with a lack of foreign exchange, limits the availability of contraceptives in Egypt. To overcome this constraint, USAID has helped Egypt by financing the import of IUDs and condoms under the Population and Family Planning Projects I and II, and will continue to do so for the public sector under POP/FP III. Meanwhile, in conjunction with UNFPA, USAID is exploring the economic feasibility of local production of IUDs. The local production of condoms has proven to be too expensive and quality control too demanding to be locally produced.

NORPLANT, a new implant contraceptive effective for five years, has not yet been registered in Egypt, nor has an introduction strategy been finalized. Unless these steps are completed, USAID cannot donate this new advanced contraceptive to provide a greater choice in the Egyptian family planning program. As this method is implanted into the upper arm, it was found to be preferred by many conservative woman who do not want an IUD for modesty reasons.

6. Institutional Constraints

The private/commercial sector in Egypt is the largest provider of family planning services. From a structural viewpoint, this characteristic implies a special challenge in planning assistance to the sector. The national program depends heavily on the private sector to be a partner in service delivery. However, by its very nature as a non-public mechanism, the private/commercial sector is not amenable to the same controls and accountability as are public or not-for-profit sectors.

While the public sector provides less family planning services than the private commercial sector, it exerts considerable control over family planning service delivery through its policies and regulations. For example, the Private Voluntary Organizations (PVOs) are

ability of the public sector to provide quality family planning services is constrained by its employment and salary practices among other managerial constraints. In addition, MOH control over pricing of contraceptives, pharmaceutical, and medical devices constrains supply and diversification in the private commercial sector. Finally, the National Population Council has weakly performed its mandate to formulate and operationalize a national population policy.

II. Sector Strategy

It is difficult to disentangle the web of relationships between population growth, quality of life and economic development. Nevertheless, the negative effects of high population growth are evident in many aspects of Egyptian life: population distribution, food supply, education, employment, sanitation and health.

In the short term, increases in contraceptive use contribute to improvements in the health of women and children, as well as lessen the pressure on the country's educational and health care systems. In the long term, increases in contraceptive use contribute to slowing the rate of population growth which allows the economy to expand in real terms, thereby improving the population's welfare. In the Egyptian setting, family planning is a sound and necessary investment.

The Mission has been convinced since 1975 that increasing access to family planning will improve the quality of life for Egyptians individually and collectively. Initial efforts in the population/family planning sector were policy-based. These efforts were followed by supporting targets of opportunity for family planning service delivery. After winning acceptance of the family planning approach (versus waiting for development to take care of the population problem), USAID redesigned and focused its efforts on family planning. As a result of these initiatives, the service delivery component rapidly expanded in the late 1980s.

USAID remains committed to supporting family planning activities based on the conviction that these activities will enhance human resource productivity and the quality of life of Egyptians which, in turn, will facilitate achieving the goal of enhancing Egypt's role as a model of stability, democracy, free markets and prosperity in the region.

The strategic objective for the population sector is increased level and effective use of modern contraceptive methods.

The Office of Population will measure progress toward achieving this strategic objective through periodic surveys of the contraceptive prevalence and use effectiveness rates. Assuming the 1992 Demographic and Health survey validates the baseline figures, the Mission expects to assist the Government of Egypt (GOE) to increase contraceptive prevalence from 48.5 percent in 1992 to 53 percent in 1997 and to increase use effectiveness from 81 percent in 1992 to 91 percent in 1997. In order for the GOE to achieve these

targets, couples must have access to information and services which will enable them to select an effective method, use it correctly and continue use.

By improving the effectiveness of contraceptive use, the GOE could reach its 1997 total fertility target of 3.5 with an even lower contraceptive prevalence rate. If the GOE achieves both use effectiveness and prevalence targets, fertility could drop even more.

Three program outcomes correspond to this strategic objective:

Program Outcome 4.1: increased family planning service volume and improved service quality.

The measure of family planning service volume will be couple years of protection. The proxy indicator for service quality is the number of physicians, specialists, pharmacists and service providers trained.

USAID will undertake several simultaneous efforts to upgrade the quality of family planning services in the public, private voluntary and private commercial sectors. USAID will assist the MOH to upgrade the content and methodology of physician and nurse training courses, train service providers at the governorate level, institutionalize its counseling course and strengthen its outreach capabilities. Furthermore, the Mission will support the introduction and expansion of long term clinical methods such as NORPLANT, when registered in Egypt. The Mission will work with the Teaching Hospital Organization to expand hospital-based family planning services and utilize these facilities as training centers in advanced contraceptive methods. Finally, as an integral part of this overall public sector training effort, USAID will continue to support the Ain Shams University Regional Training Center which trains trainers and direct service providers for both the MOH and the teaching hospitals.

The Ministry of Social Affairs, through its network of registered Private Voluntary Organizations (PVOs), has been the major sponsor of family planning services in the non-government, not-for-profit sector. Although the community-based efforts of the PVOs play an important role in legitimating family planning in the eyes of the communities, their contribution to contraceptive prevalence in Egypt is quite low. Therefore, the Mission's strategy is to support only the large Clinical Services Improvement (CSI) Project of the Egyptian Family Planning Association (EFPA). Other sources of support will be sought to continue family planning activities in the PVOs.

According to the 1988 DHS, the private commercial sector provides approximately 70 percent of family planning services in Egypt. Mission strategy cannot overlook a service provider of this importance. Moreover, since this sector sustains its own activities by charging customers for goods and services, it requires only limited assistance in training and IEC. USAID will also target private sector pharmacists for training in family planning.

Improvement in service quality must go hand in hand with demand creation if the overall strategy is to succeed. That is, to increase family planning service volume, the GOE must first provide couples with accurate information regarding family planning. As the number of women of child bearing age increases, the State Information Service (SIS) will have to reach an increasing number of couples with family planning messages just to keep the contraceptive prevalence rate at its current level.

Studies show that three in five women of childbearing age want no more children. More than half of their husbands also desire no more children. The average ideal family size is 2.9 children - well below the current fertility rate. These data suggest that, given access to information on family planning and high quality services, couples would use contraception.

Hence, the importance of information, education and communication (IEC) cannot be underestimated. USAID has enjoyed a long, productive working relationship with the SIS. The success of previous IEC efforts and the potential returns to future investment justify greater emphasis in the future on upgrading the GOE's family planning outreach capability through mass media and interpersonal communications.

USAID will work with the SIS to develop a national communication strategy, intensify family planning television campaigns, strengthen governorate offices and re-energize information-education-communication activities. USAID will also strive to improve outreach programs in implementing agencies like the Ministry of Health.

Program Outcome 4.2: Improved information for policy makers.

The National Population Council (NPC) is the central government institution responsible for formulating and promulgating population policy and coordinating donor efforts in population and family planning. NPC's strategic importance lies with its potential to provide coordination at both the national and governorate levels. It is well situated to promote acceptability and to greatly increase local support, as well as play an important role in local resource allocation.

Hence, USAID will endeavor to develop the capability of the central technical secretariat, as well as governorate level offices, to plan, coordinate and report on family planning activities at the national and local levels. USAID will provide technical assistance to the NPC Research Management Unit to enable it to manage biomedical, programmatic and policy research.

By supporting policy research, seminars, and conferences, USAID will assist the NPC to influence policy makers about the importance of population and family planning programs to the economic development of Egypt. The NPC should address, in collaboration with other authoritative organizations, policy issues that affect the family planning program in Egypt, such as medical restrictions, private sector constraints, and ministry level obstacles to cost recovery.

Program Outcome 4.3: Improved management capacity in implementing agencies

Management has to do with the organization and direction of limited resources to achieve desired ends (goals, objectives, targets) and the assessment of progress or achievement towards those ends. Planning is a process of allocation of limited resources for desired or preferred objectives, and the defining (and redefining) of feasible targets given resource limitation. Supervision is the immediate oversight in the use of resources, particularly the costly and highly variable human resources.

These three activities--planning, management and supervision--are often combined under the general rubric of management. The need for management increases directly with the scarcity of resources.

As Egypt moves toward its goal of increasing contraceptive prevalence, the costs of the program necessarily increase. However, these costs can be minimized when resources are used effectively and efficiently. Thus, sound management is necessary to support these goals, not to mention the goal of decentralization.

Thus, USAID will assist four implementing agencies under the current Population/Family Planning II Project and its successor Project to improve their management capacity. Technical assistance and financial resources will be geared toward assisting the implementing agencies to refine MIS collection systems and information flow and to produce timely comprehensive annual plans. The NPC will be specifically assisted to produce and distribute a Strategic Plan for Population and Family Planning in Egypt based on service data, research and national policy. Ministry of Health (MOH) will receive specific assistance to produce, distribute and implement the Systems Development Project operations manual and to improve the MOH contraceptives tracking system.

The specific indicators and targets which are intended to measure progress toward outcomes will be contained in an auxiliary document.