

# ADOLESCENT AND YOUTH REPRODUCTIVE HEALTH IN EGYPT

Status, Issues, Policies, and Programs

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## ABBREVIATIONS

AIDS	Acquired immune deficiency syndrome
ARH	Adolescent reproductive health
ASFR	Age-specific fertility rate
CEDPA	Centre for Development and Population Activities
CSI	Clinical Services Improvement
DHS	Demographic and Health Survey
EFPA	Egypt Family Planning Association
FGC	Female genital cutting
FP	Family planning
HIV	Human immuno-deficiency virus
ICPD	International Conference on Population and Development
ILO	International Labor Organization
IPPF	International Planned Parenthood Federation
JHU/CCP	Johns Hopkins University Center for Communications Programs
MOH	Ministry of Health and Population
NGO	Nongovernmental organization
RTI	Research Triangle Institute
SHIS	School Health Insurance System
STI	Sexually transmitted infection
TFR	Total fertility rate
UN	United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

# 1 INTRODUCTION

This assessment of adolescent reproductive health (ARH) in Egypt is part of a series of assessments in 13 countries in Asia and the Near East.<sup>1</sup> The purpose of the assessments is to highlight the reproductive health status of adolescents in each country, within the context of the lives of adolescent boys and girls. The report begins with social context and gender socialization that set girls and boys on separate lifetime paths in terms of life expectations, educational attainment, job prospects, labor force participation, reproduction, and duties in the household. The report also outlines laws and policies that pertain to ARH and discusses information and service delivery programs that provide reproductive health information and services to adolescents. The report identifies operational barriers to ARH and ends with recommendations for action to improve ARH in Egypt.

The Egyptian government, led by President Hosni Mubarak, is paying more attention to the needs of Egypt's youth to try to ensure a more healthy transition into adulthood. Nearly one in four (22%) Egyptians is an adolescent (ages 10–19) and young adults as a whole (ages 10–24) make up about one-third of the population—just over 20 million persons.<sup>2</sup> Egypt's adolescent population (ages 15–24) will grow from 13.8 million in 2000 to an estimated 16.5 million in 2020 (Figure 1). Educational attainment has increased for both girls and boys in the last decade, but girls are disproportionately represented in the “no education” category and fewer girls than boys are found at every level of educational attainment (Figure 2). Young men make up most of the adolescent labor force, yet young women face much higher rates of unemployment (Figure 3). Marriage is socially important and proving fertility is paramount for couples when they first marry. In 2000, young women ages 15–24 contributed nearly 800,000 births to Egypt's total fertility and that number will continue to rise (Figure 4).

Yet, state entities do not have clear or consistent definitions of adolescents, and adolescents have been largely neglected by policies and programs. Many women marry while still in their teens and enter into marriage with only vague information on reproductive health. Reproductive health information and services are considered the domain of the married. Women are for the most part, not seen for family planning services until they have had their first child. Still, as contraceptive prevalence has risen for all married women (from 47.1 percent in 1992 to 56.1 percent in 2000) and for married adolescents, unmet need for family planning has declined among adolescents and young women and is currently about 10 percent (Figure 5).<sup>3</sup>

Several promising initiatives are underway to reach adolescents with reproductive health information and services. The potential for the success of these initiatives is heightened by the high-level political support that currently exists in Egypt. However, several challenges remain. The reproductive health needs of youth would be addressed best as part of a broader package aimed at the healthy development of youth through a multisectoral approach including health, education, and labor. Within this multisectoral approach, the sexual and reproductive health of young adults is a critical dimension of individuals' transition into adulthood and overall well-being. Young people need more information on reproductive health and access to services before they have their first child. Finally, more information is needed on the reproductive and sexual behaviors of youth. This research will provide a strong underpinning for future ARH programs.

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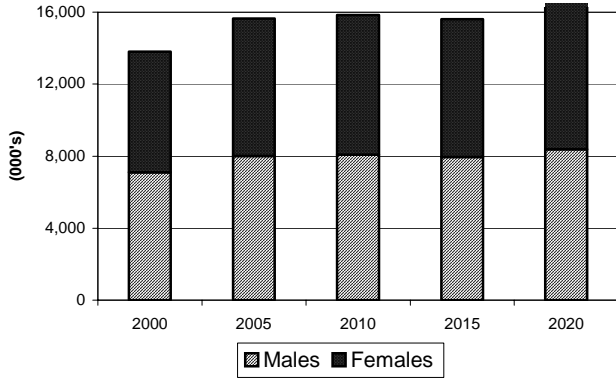
<sup>1</sup> The countries included in the analysis are Bangladesh, Cambodia, Egypt, India, Indonesia, Jordan, Morocco, Nepal, Philippines, Sri Lanka, Pakistan, Vietnam, and Yemen.

<sup>2</sup> 1996 Egyptian Census, cited in Ibrahim et al., 1999; Khalifa and El Zahra, 2001.

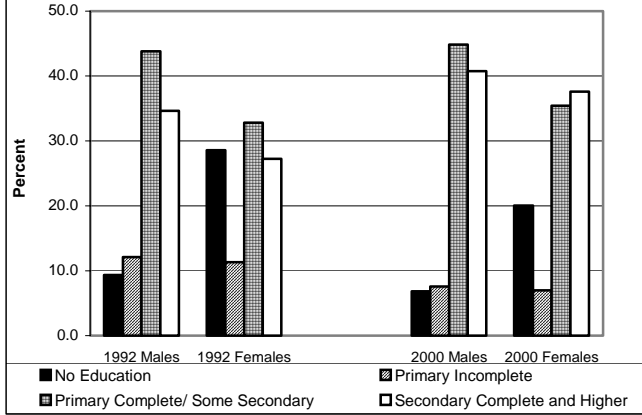
<sup>3</sup> El-Zanaty and Way, 2001.

ARH indicators in Egypt

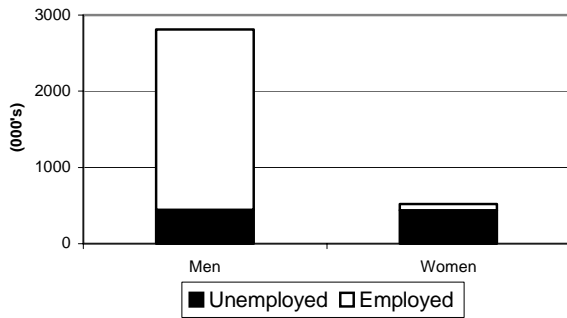
**Figure 1. Total Adolescent Population (Ages 15-24)**



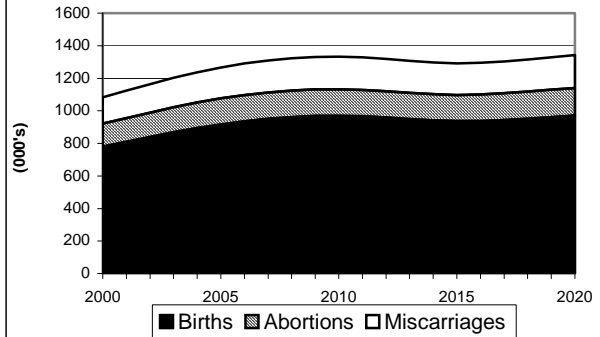
**Figure 2. Years of Education Completed (Ages 15-24)**



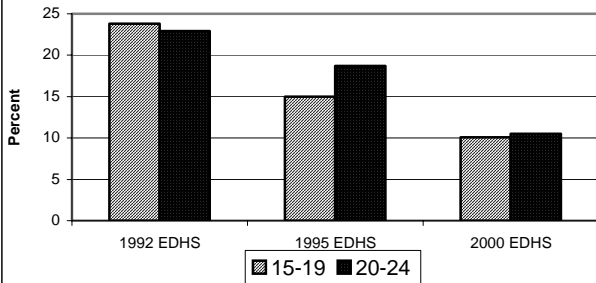
**Figure 3. Employment by Sex (Ages 15-24)**



**Figure 4. Annual Pregnancies and Outcomes (Ages 15-24)**



**Figure 5. Total Unmet Need for FP (Ages 15-24)**



Note: See Appendix 1 for the data for Figures 1 through 5

## 2 SOCIAL CONTEXT OF ARH

It is important to consider specific aspects of the social environment when talking about ARH. Among these elements are: gender socialization, education, employment, and marriage.

### Gender socialization

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Adolescence is a crucial period of the life cycle for socialization to gender roles. In Egypt, strong gender differentiation occurs in adolescence. “Girls have much less free time than boys, are much less mobile, are much less likely to participate in paid work, and have heavier domestic responsibilities regardless of whether or not they are in school.”<sup>4</sup> The movements of adolescent girls are restricted and their participation in public activities is severely limited. A large number of young women (35%) are both out of school and not involved in paid work so they tend to spend their adolescence in private spaces.<sup>5</sup> Young women’s marriageability is an important consideration. Women strive to be “marriageable” and to fulfill the conventional vision of womanhood. Women’s decision-making powers are limited. For a high proportion of married women (38%), decisions about their own health care are made by their husbands alone; another 23 percent of women make these decisions jointly with their husbands, and only 36.4 percent make these decisions themselves.<sup>6</sup>

### Education

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Egypt’s President Hosni Mubarak declared education a national priority in the 1990s, calling the 1990s the National Decade for the Eradication of Illiteracy. Furthermore, the constitution guarantees the right of all citizens to free education at all levels and makes basic education compulsory for all children starting at age six. However, fewer than one-half of all parents abide by this law, instead enrolling their children in school when the children are seven or eight years of age. Access to education has increased significantly over the last 10 to 15 years, and the proportion of adolescents who have never attended school has fallen in great part because of increased enrollment by girls, especially residents in Upper Egypt, and adolescents from poor households. These groups, along with those in rural Lower Egypt, have also registered lower drop-out rates. Still, there is a large gender gap in adolescents’ education. For example, there are only 82 girls for every 100 boys in secondary school. This difference is more acute among adolescents from poor households, with the ratio of girls to boys in secondary school falls to 69.<sup>7</sup>

***Curtailed education:*** Contrary to popular belief, a nationally representative survey found that early marriage is not one of the main reasons cited by youth for dropping out of school.<sup>8</sup> However, lesser educational attainment is strongly associated with early pregnancy. The proportion of women ages 15–19 who are pregnant or have given birth decreases from 17 percent among those with less than a primary education to 7 percent among those with at least a secondary education.<sup>9</sup>

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<sup>4</sup> Mensch et al., 2000.

<sup>5</sup> Ibrahim et al., 1999.

<sup>6</sup> El-Zanaty and Way, 2001.

<sup>7</sup> Shafey, 1998; Ibrahim et al., 1999.

<sup>8</sup> Ibrahim et al., 1999.

<sup>9</sup> El-Zanaty and Way, 2001.

## Employment

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The legal age for employment is 15. However, in a recent study, one-half of the male and one-sixth of the female adolescents reported working,<sup>10</sup> and many of those are younger than age 15. Although 15–19 year-old boys are obliged to serve in the military, 59 percent of boys in this age group work and only 6 percent are neither working nor in school, compared with 34 percent of older adolescents girls who neither work nor attend school. The large percentage of young women neither working nor in school suggests an underutilization of their time. Most of the young people who work said they were doing so because their family needed the money.

## Marriage

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Various issues need to be addressed when talking about the effect of marriage on ARH in Egypt. These are: age at marriage, social pressure, *Orfi*, and consanguineous marriage.

**Age at marriage:** The legal age at marriage for women is 16 years and for men it is 18, but a significant number of young women (28%) marry before the legal age, especially in rural areas.<sup>11,12</sup> Girls are more likely than boys to marry as adolescents (e.g., 12% of adolescent girls and 0.87% of adolescent boys are married).<sup>13</sup> The median age at marriage in Egypt is among the lowest in the Near East. Conversely, the fact that age at marriage is increasing poses a new challenge, particularly among young men, who tend to marry later and be more sexually active before marriage compared with girls or young women. With the median age at marriage increasing, young persons are more likely to become sexually active outside of marriage (and thus with more, shorter-term partners).<sup>14</sup> Therefore, the risks of sexually transmitted infections (STIs) and unplanned pregnancy and abortion are higher.

**Social pressure:** Once married, couples are under social pressure to begin childbearing immediately. There is a great emphasis placed on couples to prove their fertility.

**Orfi:** *Orfi*, a practice in which young Egyptian couples obtain a clandestine marriage certificate without announcing to their families their intentions to marry, appears to be a growing practice. In Islamic societies, a marriage becomes official through its blessing by the couple's families and its public announcement from the families. *Orfi*, therefore, is at best a weak substitute for formal marriage. Young couples use *Orfi* as a way to sanction their sexual relationships. However, since the families have not blessed these unions, and because pregnancy to unmarried women is unacceptable in Egypt, pregnancies resulting from *Orfi* unions are presumably unplanned and unwanted. Since many young couples enter into these relationships without the benefit of reproductive health services and information, their risk of unwanted pregnancy is high.

**Consanguineous marriage:** Approximately 57 percent of married adolescent women are married to a relative.<sup>15</sup> More than one-third of all married women report being married to a relative.<sup>16</sup>

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<sup>10</sup> Ibrahim et al., 1999.

<sup>11</sup> Ibrahim et al., 1999.

<sup>12</sup> El-Hamamsy, 1994.

<sup>13</sup> Adolescents are defined as those ages 10–19 years. POLICY Project, 2000; Ibrahim et al., 1999.

<sup>14</sup> Among married women, the median age of marriage has increased from 18 years among 45–49 year-olds to almost 21 among 25–29 year-olds. El-Zanaty and Way, 2001.

<sup>15</sup> El-Zanaty and Way, 2001.

<sup>16</sup> El-Zanaty and Way, 2001.



# 3 ARH ISSUES

Other issues that effect ARH, such as early, high-risk pregnancy, unwanted pregnancy and abortion, and STIs and HIV/AIDS, need to be considered as well.

## **Early, high-risk pregnancy**

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The median age at first birth ranges from 20 years among older, rural women to 23.9 years among younger, urban women. By the age of 19, one-fifth of married women have already begun childbearing.<sup>17</sup>

## **Unwanted pregnancy and abortion**

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Although there are no data on illegal abortions, some in the health sector have the impression that there is a large number of illegal abortions taking place. It is surmised that these are largely due to clandestine marriages (*Orfi*) among young couples along with the shame and social problems in not following religious custom.<sup>18</sup>

## **STIs and HIV/AIDS**

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Although data on STIs are lacking, persons working with youth allege that these are a real problem.

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<sup>17</sup> El-Zanaty and Way, 2001.

<sup>18</sup> Shalaby, 2001; UNFPA/MOHP, 2001.

# 4

## LEGAL AND POLICY ISSUES RELATED TO ARH

Legal and policy issues related to ARH include legal barriers, existing ARH policies, and ARH policy initiatives.

### Legal barriers

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Although the Child Law of 1996 entitles working women to maternity leave and breaks during work for breastfeeding, there are no provisions for first-time or adolescent mothers who are not working.<sup>19</sup>

Another legal barrier is that state entities do not have clear or consistent definitions of adolescents. Generally, therefore, policies and programs have largely neglected adolescents.

### Existing ARH policies

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A 1998 review of Egyptian policy with regard to adolescents found, on the one hand, that there are important policies affecting adolescents and that 11 ministries, a specialized committee for youth within the People's Assembly, and two specialized councils are responsible for addressing the needs of adolescents. On the other hand, state entities do not have clear or consistent definitions of adolescents, and it is generally felt that policies and programs have largely neglected adolescents. Yet 10–19 year-olds comprise nearly one-fourth (22%) of Egypt's population, whereas young adults (ages 10–24) make up about one-third—just over 20 million persons.<sup>20</sup> Relevant policies that affect young adults, directly or indirectly, are described below.

**Population policy:** Egypt's population policy explicitly addresses young adults only through provisions for health care for girls prior to marriage and premarital exams and counseling. The prevalent attitude in the country is that the best way to protect children and young adults from engaging in unacceptable behaviors, such as premarital sex, is to maintain their ignorance of such practices. What limited reproductive and sexual health education young people have received has been the responsibility of families.<sup>21</sup>

**School health:** Preventive health care, including check-ups, vaccinations, and curative and rehabilitation services, are provided through the School Health Insurance System (SHIS) as a result of a 1992 law mandating health services for students. In addition, Ministry of Health and Population (MOHP) services and university clinics and hospitals are available to people of all ages. These services do not systematically include reproductive health care, however. There is no scheme comparable to the SHIS for out-of-school youth, although as of 1998, several ministries were discussing ways to provide health insurance to these young people.<sup>22</sup>

**Female genital cutting/female genital mutilation:** Female genital cutting (FGC)—a “deeply-rooted tradition” in Egypt and other countries of the Nile valley and Africa—is typically performed on girls ages 9–13 years and has recently been banned by law. Nevertheless, while its practice is decreasing, it is still widespread; 97.4 to 99.1 percent of married girls and women ages 15–24 reporting being cut. (While in

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<sup>19</sup> Shafey, 1998.

<sup>20</sup> 1996 Egyptian Census, cited in Ibrahim et al. 1999; Khalifa and El-Zahra, 2001.

<sup>21</sup> Shafey, 1998.

<sup>22</sup> Ibrahim et al., 1999; Shafey, 1998; UNFPA/MOHP, 2001.

1995 almost 94 percent of married women aged 15–19 years reported that they intended to have their daughters cut, this had dropped to 80.5 percent in 2000.<sup>23</sup>

**Marriage:** State policy accords great importance to marriage and motherhood. The legal age at marriage is 16 years for girls and 18 for boys. Both ages are considered too low for marriage by many, yet there is still a significant number of underage marriages.

**Motherhood and childhood:** Egypt’s Constitution provides for the protection of mothers, children, and youth and guarantees the right of women to medical, physical, psychological, and social health care. In 1988, a presidential decree established the National Council for Childhood and Motherhood. In addition, an entire chapter of the current Five-Year Plan (1997/1998 to 2001/2002) is devoted to motherhood and childhood.<sup>24</sup> The aforementioned Child Law of 1996 entitles working women to maternity leave and to breaks during work for breastfeeding, but it does not have any specific provisions for first-time or adolescent mothers.<sup>25</sup>

**Abortion:** According to Al-Bindari (2001), the Child Law of 1996 also provides for “protecting women against unsafe abortion,” although he does not elaborate on this point. While abortion is illegal under Islamic law, he asserts that Islam does permit abortion to save the life of the mother. It is reported that in the public sector, health centers do treat abortion complications and providers don’t ask women the reason for the complications. In the private sector, abortion is available to some degree, albeit clandestinely.<sup>26</sup>

### **ARH policy initiatives**

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An examination of ARH policy initiatives includes consideration of ARH strategies and new political support to focus attention on adolescents.

**ARH strategy:** A significant new breakthrough is the recent (March 2001) development of a foundation document for a national adolescent strategy prepared by the MOHP, UNFPA-funded Reproductive Health Including Information, Education, and Communication Project (RH/IEC). The 78-page document, titled “National Adolescent Strategy: Towards Improving the Outcome of Adolescence,” presents an assessment of the health, well-being, and status of adolescents; offers recommendations for addressing the needs of adolescents; and provides examples of ways to do this. While the RH/IEC Project may consider its document to be the national strategy, the UNFPA confirms that it is, in fact, a background document for a national strategy that has yet to be developed. Once that strategy is developed, the MOHP envisions that implementation will require the mobilization of no less than nine ministries.<sup>27</sup>

**New political support to focus attention on adolescents:** Egypt’s First Lady, Mrs. Suzanne Mubarak, has publicly stated that Egypt needs to focus on its youth. More specifically, she underscored the need to eliminate gender discrimination and girls’ illiteracy and improve girls’ education and health care. The MOHP reports that she based her statements at least in part on the national adolescent strategy document. Indeed, Mrs. Mubarak also expressed support for increasing the age at marriage for girls to 18 years, providing specific reproductive health services for young women, implementing the new law that bans FGC, and increasing the role of nongovernmental organizations (NGOs) in addressing the needs of girls

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<sup>23</sup> Ibrahim et al., 1999; El-Zanaty and Way, 2001.

<sup>24</sup> There are conflicting accounts of when the national council was established, and of the exact translation of its name from Arabic. Shafey, 1998; Al-Bindari, 2001.

<sup>25</sup> Shafey, 1998.

<sup>26</sup> Shalaby, 2001.

<sup>27</sup> Shalaby, 2001; Hamed, 2001; Abou-Taleb, 2001; MOHP, 2001a.

and young women. Her call to specifically target Egypt's youth heralds a new sensibility and appears to pave the way for institutions to address the needs of youth.

# 5 ARH PROGRAMS

ARH programming is occurring on a number of levels: public sector, community, and nongovernmental.

## The public sector

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Unmarried youth do not receive reproductive health services from the public sector. Nevertheless, in terms of programs, there are some model interventions in place and promising initiatives in the works, at least in part as a consequence of Egypt's notable involvement in the 1994 International Conference on Population and Development (ICPD) in Cairo. The ICPD was a catalyst for action on reproductive health in Egypt. Government institutions mobilized around the conference and NGOs also became intensely active. The level of activity has remained high since then, and UN agencies, International Planned Parenthood Federation (IPPF), and other donors have been playing a supportive role. "The strategy for reaching Egypt's population objectives has been broadened to support the expanded availability of reproductive health services and community development efforts of NGOs. The new strategy also stresses female education and calls for increased employment opportunities for women to reduce the gender gap."<sup>28</sup>

**National youth campaign:** A noteworthy effort is a national media campaign run by the State Information Service of the Ministry of Information in collaboration with the MOHP. The campaign promotes reproductive health services for young women through public "Gold Star" clinics that meet a series of quality of service criteria. The intervention involves a series of five television spots; outreach meetings at local information centers for young people with medical, religious and community leaders; dissemination of brochures; and street dramas. Collaborating on this is the USAID-funded Population IV Project, in particular the Johns Hopkins University Center for Communication Programs (JHU/CCP). "If I Stop Dreaming," another mass media activity, is a television program that touches on ARH issues. There are also two TV channels serving low-literacy populations that broadcast relevant health messages.<sup>29</sup>

**Telephone hotlines:** Early in 2001, the MOHP, with support from UNFPA, launched a hotline for young persons to provide medical information on reproductive health issues. It receives about 20 calls per eight-hour shift. In addition, the National AIDS Control Program has managed a hotline for four years. It does not specifically target youth, although there are young callers among the approximately 10,000 callers each year.<sup>30</sup>

**Peer education:** The National AIDS Control Program reports that it has been targeting youth with HIV/AIDS information and messages to encourage voluntary counseling and testing through two types of initiatives. One, started in 1996, uses the peer education approach in five industrial cities to reach youth and adults working in factories. The other, started in 1990, involves awareness-building through seminars, peer education, and dissemination of materials among students in secondary and preparatory schools and universities. The reach and outcome of these interventions has not been methodically evaluated, however.<sup>31</sup>

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<sup>28</sup> El-Zanaty and Way, 2001.

<sup>29</sup> Mackie, 2001; Shalaby, 2001; Hamed, 2001.

<sup>30</sup> Shalaby, 2001; Hamed, 2001; El-Sayed, 2001.

<sup>31</sup> El-Sayed, 2001.

**School-based health education:** Since the 1980s, the Ministry of Education has ensured that primary and secondary school curricula cover some information on physiology and family planning, and the science curriculum also now includes HIV/AIDS messages. Some of this information is given only to girls, and boys get minimal education on the topic. The vast majority of adolescents are familiar with family planning, and most can name at least one method. Two-thirds and three-fourths of 16–19 year-olds girls and boys, respectively, are familiar with HIV/AIDS. However, only 25 percent of youth with little to no education know about HIV/AIDS, and only 5 to 14 percent of youth report knowing about condoms. Only about 15 percent of unmarried (and 17% of married) 15–19 year-old girls can identify the timing of a woman’s fertile period. What young people do know they seem to have gathered from the media—not at school. Recently, the MOHP called for a new, coordinated effort among the relevant ministries to introduce a reproductive health course for adolescents in schools.<sup>32</sup>

In addition to the national adolescent program, the MOHP is currently completing a protocol for STI prevention and care that includes a section specifically reviewing adolescents’ vulnerability and identifying youth-centered actions to address their needs.<sup>33</sup> It also has developed a guide in Arabic for physicians explaining the physiological and psychological development of adolescents.<sup>34</sup>

### **Community-based interventions**

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A project that is proving highly successful in breaching the reproductive health information gap among youth is New Horizons, a “non-formal education program designed to demystify and communicate essential information in the areas of basic life skills and reproductive health” to girls and young women. New Horizons is community-based, designed to address the specific needs articulated by its target population, and demand-driven. The principal target group is illiterate girls and young women in villages. Most are aged 9–20 years, but New Horizons now involves young women and mothers as old as 25. It is also starting to target boys. So far, 16,000 girls have completed the thorough, 100-hour program. The project is active in all the governorates (provinces) of Upper Egypt and it is expanding into Lower Egypt. It is low-cost and proving to be sustainable, with local organizations taking the initiative to request training, participate in the educator training, and subsequently carry out the program. A project evaluation was underway in 2001 and was to be completed by the end of the year.<sup>35</sup>

### **The NGO sector**

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In Egypt, NGOs provide less than 3 percent of reproductive health services, while the public sector provides the majority. The government has 4,500 to 5,000 service delivery centers, compared with the Egypt Family Planning Association’s (EFPA’s) roughly 400. In fact, many consider the principal health care provider in Egypt to be the network of 17,000 pharmacies around the country.

The government heavily regulates NGOs. For example, the government appoints 50 percent of every NGO’s board of directors, and the EFPA is largely considered to be a public entity. Many feel that NGOs could be much more effective if they were given more leeway.<sup>36</sup>

Nevertheless, there is a nongovernmental project that is showing great promise for reaching a sizable number of youth with services. Clinical Services Improvement (CSI), a project of the EFPA jointly founded by the Egyptian government and USAID in 1988, is in the process of developing standardized

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<sup>32</sup> Shafey, 1998; Ibrahim et al., 1999.

<sup>33</sup> MOHP, 2000b.

<sup>34</sup> MOHP, 2000.

<sup>35</sup> Gamal, 2001; CEDPA and Notkin, 2000; CEDPA (factsheets) 2000.

<sup>36</sup> Ibrahim and Ibrahim, 1998; Edrees, 2001; Croll, 2001; Kamel, 2001; Mackie, 2001.

care and counseling services that will include youth-specific services, including “premarital” reproductive health care and counseling, through its network of nearly 90 centers in 19 of Egypt’s 27 governorates. The premarital services will also respond to what is understood to be a strong demand for “pre-sexual” care. Through its network, CSI has reached 24.6 million clients to date. In addition to the network, CSI is preparing television spots using socially acceptable language and ideas to promote the youth services. The USAID-funded Population IV Project, which is being implemented by Pathfinder International in collaboration with the Futures Group, the Johns Hopkins University Center for Communication Programs, and Family Health International, is working closely with CSI.<sup>37</sup>

**Operational research:** A team of NGOs and donors, including the Population Council and Save the Children, is launching a project in four villages in Minya to “positively influence the life trajectory of [out-of-school] young women, and that of future generations of girls” by increasing girls’ mobility, skills and knowledge; enhancing their sense of self-efficacy; promoting public and policy support for girls; and positively influencing existing norms concerning girls’ opportunities. The Population Council also plans to start a small-scale, operational research intervention among newlyweds and never-married adolescents in villages in Giza to increase their knowledge about a wide range of reproductive health matters, including marital relations, birth-spacing, breastfeeding, and so forth.

**Programs beyond the health sector:** In addition to the health sector, there are institutions in other domains that have youth programs that can affect reproductive health outcomes. The National Council for Childhood and Motherhood, which is co-chaired by the First Lady and the Prime Minister, together with the Social Fund for Development plans to educate over 10,000 illiterate women (ages 16–45) and children (ages 8–18). The Ministry of Youth has a project costing about 11 million Egyptian pounds (roughly US\$3 million) to set up and run youth support centers in the governorates. One of the purposes of the youth centers is to decrease unemployment. In collaboration with the MOHP, the Youth Ministry is also working to raise awareness, particularly among youth in rural areas, of the problems of rapid demographic growth. The head of the Shoura Council, a national policymaking body, has recently advocated for preparing youth to participate in planning and implementation of national development programs. The National Women’s Council was established in 2000 with the objective of increasing the role of women in Egyptian society and decreasing education, employment, and other disparities between males and females.<sup>38</sup>

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<sup>37</sup> Edrees, 2001.

<sup>38</sup> Anonymous, various articles in *Al-Ahram*, 2000–2001; El-Zanaty and Way, 2001.

# 6

## OPERATIONAL BARRIERS TO ARH

### Inability to obtain services

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Doctors “routinely decline to prescribe any contraceptive method for young women (other than condoms or the rhythm method) until they have had a first birth.”<sup>39</sup>

### Limited information available to adolescents

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Adolescents’ lack of existing general knowledge and information about reproductive health, as well as a lack of agreement on and provision of adequate counseling and educational services appropriate for them, have stalled potential progress.

***Lack of existing knowledge:*** Young couples know little about sexuality and reproductive health when they marry, so they embark on their sexual and reproductive lives with little or no knowledge and limited skills for discussing or negotiating sexual and reproductive preferences and needs.

***Lack of availability of general information about reproductive health:*** To date, information and education on ARH specifically targeting Egypt’s young adults have been severely limited. This topic is been “covered only minimally in the school curriculum and the media, and often not addressed within families.”<sup>40</sup> Youth are starved for information on sexual and reproductive health and, in contrast to the perceived reticence of parents and society as a whole to talk about these issues, youth appear to be ready and eager to learn about all matters concerning their sexual and reproductive lives.<sup>41</sup>

***Limited counseling and service information for youth:*** Young adults severely lack sexual and reproductive health information. Physical maturation, reproduction, and sexuality are sensitive, even taboo, topics that are avoided within families, and youth demonstrate a tremendous gap in their knowledge of and interest in learning about these issues. While there is growing recognition of the need to educate young people and while there is growing momentum (though to varying degrees) behind efforts to provide sexual and reproductive health education, in many cases—as in the case of Egypt—it is yet to be decided what should be taught, and how.<sup>42</sup>

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<sup>39</sup> Shafey, 1998.

<sup>40</sup> Shafey, 1998.

<sup>41</sup> Edrees, 2001.

<sup>42</sup> Ibrahim et al., 1999; Edress, 2001; Tawil, 2001; El-Gibaly et al., 1999.



# 7 RECOMMENDATIONS

***Capitalize on the political support for reaching adolescents:*** The time is right to develop programs to meet adolescents' needs. Both the President and First Lady speak about the needs of young people to have a healthy transition to adulthood. Thus, political support for programs for adolescents is likely to continue.

***A holistic approach to adolescent health:*** It has been recommended that the reproductive health needs of youth be addressed as part of broader package aimed at the "healthy development of youth." Isolating the reproductive health needs of youth raises questions and ruffles sensibilities, and it can be perceived as a Western approach to addressing youth issues. Also, reproductive health is not necessarily a priority of youth; the more general concept of healthy development has more resonance among them. Additionally, reproductive health interventions for youth necessarily involve different social sectors, including education and labor.<sup>43</sup> However, the sexual and reproductive health of young adults is a critical dimension of individuals' transition to adulthood and overall well-being that has been sorely neglected.

***Provide information to adolescents:*** Although a number of activities address adolescents' needs for information on reproductive health, this remains a critical area for expanded interventions through a range of media, including in-school and out-of-school information programs, peer counseling, better counseling from providers, and mass media. Young women and men enter into marriage with insufficient information on sexuality, reproduction, and family planning. Many young women get pregnant immediately after marriage, with inadequate information on safe motherhood. Young couples practicing *Orfi* often begin their first sexual experience with little or no information.

***Improve premarital counseling:*** The common requirement for premarital examinations and counseling presents an excellent opportunity to provide useful information, referrals, and services to young couples.<sup>44</sup> Targeting couples that are engaged to be married or who have just been married is a socially acceptable intervention. In Egypt, there is a need to institutionalize premarital counseling for young couples. While premarital counseling and limited services may be offered, they are generally not standardized and are, instead, largely dictated by physicians' priorities, capabilities, and capacities to provide them.

***Work through the pharmacy network:*** The extensive networks of pharmacies provide a golden opportunity to reach a very large proportion of young adults with appropriate information, counseling, and methods of contraception and disease prevention. The typical barriers that young, unmarried persons encounter in the public sector are not present in pharmacies, and pharmacists could, and sometimes already do, serve as reliable, confidential, readily accessible basic information and service providers.

***Conduct research on sexual behaviors and special population groups:*** There is an urgent need to learn more about the reproductive and sexual behaviors of youth. Sexual behavior is a very difficult subject to broach, and the sexuality of youth, especially unmarried youth, is even more troublesome—so much so that even research on the subject is severely self-censored or stifled. Similarly, little is known about other subjects still considered too sensitive even to investigate: unwanted pregnancy, abortion, gender-based violence, commercial sex work, trafficking of girls and young women, and, more generally, patterns of

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<sup>43</sup> Ibrahim, 2001; Nawar, 2001; Yaish 2001.

<sup>44</sup>Nawar, 2001; Tyane, 2001; Bennour, 2001.

high-risk behavior, including those that increase the risk of HIV/AIDS. This research will provide a strong underpinning for future ARH programs.

## APPENDIX 1. Data for Figures 1 through 5

<b>1. Adolescent Population (15–24) (000's)</b>	<b>2000</b>	<b>2005</b>	<b>2010</b>	<b>2015</b>	<b>2020</b>
Males	7,107	8,014	8,088	7,960	8,380
Females	6,692	7,622	7,750	7,644	8,074
<b>2. Level of Education (%)</b>	<b>1992 Males</b>	<b>1992 Females</b>	<b>2000 Males</b>	<b>2000 Females</b>	
No Education	9.3	28.6	6.8	20.0	
Primary Incomplete	12.1	11.3	7.6	7.0	
Primary Complete/Some Secondary	43.8	32.8	44.8	35.4	
Secondary Complete and Higher	34.7	27.2	40.7	37.6	
<b>3. Employment (000's)</b>	<b>1998 Males</b>	<b>1998 Females</b>			
Employed	2,364	81			
Unemployed	444	441			
<b>4. Pregnancy Outcomes (000's)</b>	<b>2000</b>	<b>2005</b>	<b>2010</b>	<b>2015</b>	<b>2020</b>
Total Pregnancies	1,084	1,267	1,333	1,291	1,342
Births	781	917	970	937	971
Abortions	141	160	163	161	170
Miscarriages	163	190	200	194	201
<b>5. Unmet Need (%)</b>	<b>1992</b>	<b>1995</b>	<b>2000</b>		
Total Unmet Need (15–19)	23.8	15.0	10.1		
Total Unmet Need (20–24)	22.9	18.7	10.5		

### Assumptions and Sources:

Figure 1. Adolescent Population Projections were made by entering the base year population estimates from the UN medium population projection, *World Population Prospects, The 2000 Revision*, into the POLICY Project's SPECTRUM Model and projecting the population to 2020.

Figure 2. Level of education for 1992 was taken from the 1992 Egypt Demographic and Health Survey (DHS) report, and for 2000 was taken from the 2000 Egypt DHS report. The figures cited are a weighted average of household educational attainment statistics for 15–19 and 20–24 year-olds.

Figure 3. Employment statistics were taken from LABORSTA, the Labor Statistics Database operated by the International Labor Organization (ILO) Bureau of Statistics. Unemployment and labor force size (by age and sex) were taken from the ILO Yearbook of Labor Statistics. Labor force size is defined as the labor force economically active. The number of employed was estimated by subtracting the number unemployed from the labor force size.

Figure 4. Births, abortions, and miscarriages were calculated by multiplying the appropriate age-specific rates (i.e., TFR, abortion, and miscarriages) by the estimated number of adolescent females (single-age population estimates were calculated using the SPECTRUM Model). Total pregnancies were calculated by summing the total number of births, abortions, and miscarriages. Total fertility rate (TFR) and age-specific fertility rate (ASFR) for the base year were taken from the Egypt DHS 2000 report. TFR assumptions for future years were derived from the World Population Prospects data. Mortality and migration rates were derived from World Population Prospects data. The abortion rate was assumed to be 21 per 1,000 (Guttmacher Institute estimate). Since no age-specific rates were given for adolescents, the overall abortion rate for women was used. The miscarriage rate was assumed to be 15 percent (Guttmacher Institute estimate). Since no age-specific rates were given for adolescents, the overall miscarriage rate for women was used.

Figure 5. Levels of unmet need were taken from the 1992, 1995, and 2000 Egypt DHS reports.

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