

Updated Study Report

**Population Stabilization Policies and Programs in
Egypt
2014**

Prepared By

Dr. Osama Refaat

**Supervisor of Master Degree, International Institute,
Arab Academy for Science & Technology
International Master Trainer, Johns Hopkins University
PPD International Consultant, UNFPA
Ex. Technical Adviser, Assistant Minister, MOHP**

Cairo/Egypt

2014

INDEX

CONTENTS

1- Introduction and Background	3
A- Geography of Egypt	3
B- Population Size and Structure	5
2- The Situation of Egypt Population in Three Different Eras	6
2.1- History Profile on Population Evolution in Egypt	7
2.2- Dimensional Population Problems of Egypt	8
A- Population Growth Rate	8
- Population Projection of Egypt	12
- Rate of Natural Increase	14
B- Unbalanced Distribution	15
C- Population Traits (Characteristics)	16
C.1- Population Characteristics - Age Structure	16
C.2- Health Characteristics	21
- Fertility	21
- Mortalities	24
- Life Expectancy	32
C.3- Educational Characteristics – Illiteracy	33
C.4- Social Characteristics	36
C.5- Economic Characteristics	39
3- Population and Family Planning Profile	40
Family Planning Contraceptive Method Use	41
4- Progresses toward Population Stabilization	46
Statement on Population Stabilization	47
Policies, Strategies, Objectives	48
5- Priorities for Future Policies and Strategies	49
6- Conclusion	56
7- Definitions of Certain Abbreviations	56
8- References	57

1- INTRODUCTION AND BACKGROUND

Egypt has a consciousness of the overpopulation risks with its dimensions and the demographic problem since the 1960s. From this respect Egypt has faced major challenges to stabilize its population policies and programs particularly after its last revolutions in January and June 2014. The policy leaders of the government of Egypt have assured that the continuous annual increase in population growth rate will create and formalize an obstacle towards achieving the economic growth and development sustainability. Egypt is still facing three dimensional population problems, "First: The increase of population growth rate, Second: The unbalanced distribution of population over the land and Third: The decrease in population traits". Therefore, the government of Egypt has considered the population development is one of its national priorities.

Certain population figures changed during the last three years (2011-2014) due to the instability of the political circumstances in Egypt. However, the Government of Egypt exerted a lot of efforts and achieved successes in improving the population figures over the past decades. Nowadays the new president with the new government has put updated and modified strategies to fast improving and developing the Egyptian situations. **This report will cover** the updated knowledge of population events and policies throughout the last 4 years since 2009.

Unfortunately, despite that family planning and reproductive health programs in Egypt have played an important role in lowering the population growth rate from 2.8% in 1986 to 1.6% in 2008, The Central Agency for Public Mobilization and Statistics, CAPMAS in Egypt registered the increase of the population growth rate to 2.6% in 2012 and 2.5% in 2013 which means that the population daily increase reached 5604 persons in 2013. While, the total fertility rate which showed the decreasing from 5.3 in 1980 to 3 in 2008 (EDHS, 2008), now it reached 3.5 in 2014. The crude birth rate which decreased from 39/1000 in 1986 to 26.6/1000 in 2007 reached 31.9/1000 in 2012 (CAPAS). While in the contrary, the maternal mortality rate decreased from 174/100000 in 1993 to 68/100000 in 2004, then reached 55/100000 in 2008, then 50/100000 in 2012 and finally it increased to 52/100000 in 2013. Egypt has still a long journey to overturn the population trend and achieve stabilization.

A- Geography of Egypt

Egypt is located in the northeast corner of the African continent. It is bordered by Libya to the west, Sudan to the South, the Red Sea to the east and the Mediterranean Sea to the north. The big bulk of Egypt till the left branch of red sea (including Suez Canal) is located in Africa continent, while the area between the two branches of the red sea which is north, middle and south Sinai is located in Asia continent. The Arab Republic of Egypt is divided into four main geographical divisions. The first division is The Nile Valley and Delta. Its area is around (40 Thousands K.M²). The second division is The Western Desrt, which is (680 Thousands K.M²). The third division is The Eastern Desrt, which is (220 Thousands K.M²). The fourth division is Sinai Peninsula which has an area about (60 Thousands K.M²) Egypt has the largest, most densely settled population among the Arab countries. The total area of the country covers approximately one million square kilometers. However, much of the land is desert, and six percent only of Egypt's area inhabited.

B- Population Size and Structure

The latest population census in Egypt was carried out in November 2006 and announced in 2008. According to the results, Egypt has a de facto population of 72.2 million. This number excludes the roughly 3.9 million Egyptians who are living abroad. According to the 2012 census, official figures released by the Central Agency for Public Mobilization and Statistics indicate that Egypt's population has reached 92 million living on just 5.3% of the country's area. This statistic shows a growth of 18% since the last census conducted in 2006, when population amounted to 76.5 million.

What is unexpected that The Egyptian population growth rate at home increased from 85 million in August of 2013 to an expected 86 million 2014, which means one million in six months.

The recent estimation announced by CAPMAS in a year 2014 stated that the Egyptian population estimate both at home and abroad is to reach around 94 million. The detailed figures showed that the population inside the country hit 87 million **and** outside the country hit 7 million.

It was noticed that the population pyramids of Egypt in sequential times has still showing broad base. This means that Egypt is suffering from unbalanced age structure (About 55% of the peoples are below 25 years old, while about 34% of the peoples are below 15 years old" these figures would clarify that the work power represents 21.8 million only from the peoples which may cause a stress burden on Egypt Governorate to achieve the economical development and welfare. However, Egyptians had made civilization and built the pyramids with a population of only two million. Our population at the early 20th Century was 10 million, twofold increased to 20 million by mid-century and threefold at the end of the century hitting 64 million in 2000.

Picture (3)



Picture (4)



By the beginning of 2008, it is estimated that population had increased by around one and half million to reach 74.3 million (CAPMAS 2008). Today Egypt ranks sixteenth on the list of the most populous countries worldwide. Our population is approaching 94 million, while the population growth rate is 2.5% in 2013 against 2.6% in 2012.

2- THE SITUATION OF EGYPT POPULATION IN THREE SEQUENTIAL EPOCHS

“What was Egypt in the Past”.

This part of the report describes the past events of family planning and population and covers the progress made to date. It clarifies also the policies which had been carried out by policy makers and stakeholders during the ancient times relative to the situation of Egypt now and the future vision and strategic plan.

Picture (5)



2.1- History Profile on Population Evolution in Egypt

The ancient Egyptians among the firsts who think in family planning and population.

The Egyptian papyrus of the 19th Pharaonic Family, indicate that family planning practices started 2000 years before Christ (BC). These papyrus mentioned multiple descriptions for contraception as local methods.

Population problem in Egypt started since **1930s**.

In 1935, A discussion about family planning was carried out in the Egyptian Medical Association Committee.

In 1937, The Mofti who was the head of Islamic religion declared that family planning was legal and not prohibited.

In 1939, a non governmental organization called Maady Child Association was established to provide antenatal care and family planning services.

In 1947, the first family planning center was established.

- At that time they were using sponge, salts and grape leaves as contraceptive methods.
- Then vaginal rings (diaphragm), male condoms and family planning booklets, were provided by Pathfinder Association

In 1952, the association for population studies was established to cover the demographic researches.

In 1953, the national population committee established.

In 1960's consciousness of demographic problem arose, where directions to develop the Supreme Council for Family Planning had been given, considered and taken into action. At that time Egypt had a population of 26 million people.

In 1962, the announcement of the first official governmental support for family planning indicating the real birth of the population policy in Egypt.

From this respect the ministry of health introduced the family planning national plan of action in three phases:

1. To provide different cafeteria of family planning methods.
2. To develop well equipped clinics for family planning services.
3. To support the costs of family planning methods.

1965, The Government of Egypt decided to consider that the population problem was a national one which a key constraint to development.

1973-1982, The Government of Egypt (GOE) announced its national population policy for ten years.

In 1984, The first national conference for family planning was held in Cairo to set the goals and objectives of the national population council which was established in 1985 to put the recommendations of the solution of population explosion into action.

1992-1997, Government of Egypt put its five years strategic plan which adopted the fertility reduction goals:

- Long term target of reducing the population growth rate to 1.8% and total fertility rate (TFR) to 2.7% by the year 2007.
- Intermediate target of reducing population growth rate to 2.0% and total fertility rate to 3.5% by the 1997.

5 years achievements and taken actions during (1992-1997) to solve the population problem:

- Political commitment & support for family planning services & programs.
- National strategic plan for family planning.
- Developing & production of the national F.P. guidelines which were the basis of national quality assurance program.
- Establishment of national F.P. service delivery network.
- Developing the Regional Center for Training in F.P. & its national network of satellite training centers.
- Introduction of new contraceptive technologies to Egypt.
- Establishment of the national FP research program.
- Introduction to information, education & communication programs.
- Decentralization policy & strategy which lead to effective implementation of
- FP projects in the governorates of upper and Lower Egypt.
- Developing active private & NGO sectors in FP service delivery.
- Introduction to reproductive health & family planning diploma through faculty of Medicine, Ain Shams University.
- Establishment of national management information system which monitors the progress of family planning implementation in Egypt.

2.2- Dimensional Population Problems of Egypt

Egypt 2014

A- Population Growth Rate

Population census: Means the counting of all people, citizens and foreigners are alive at a certain date within certain geographical borders (state boarder). The count includes collecting data on their demographic and social characteristics. It has been known in Egypt since ancient times. The first census was carried out in 1882 and the total number of population at that time was 6.7 million. . While the 1897 count put the number at 9.7 million, in 1947 it multiplied to 19 million. In 1976, it stood at 36.6 million, double the 1947 figure. The 1996 census puts the number of population at 59.3 million. The 2006 census is the thirteenth to be held by the Central Agency for Mobilization and Statistics (CAPMAS). According to the 2006 census figures, the population (including those living abroad) is estimated to have reached 76.5 million at a growth rate of 37% over the 1996 figure.

Population in urban areas increased by 40.22 per cent and is now standing at 30,949,689; population in rural areas rose by 64.22 per cent and is put at 41,629,341. The government takes a census of the Egyptian population every ten years.

It was recorded at the CAPMAS report (2013) that Cairo is the biggest governorate as its population hit 9.2 million, followed by Giza with 7.5 million and Sharqiya with 6.4 million and the population is distributed on only 7.7 per cent of the total area of Egypt.

Total Population in Egypt 1995-2014

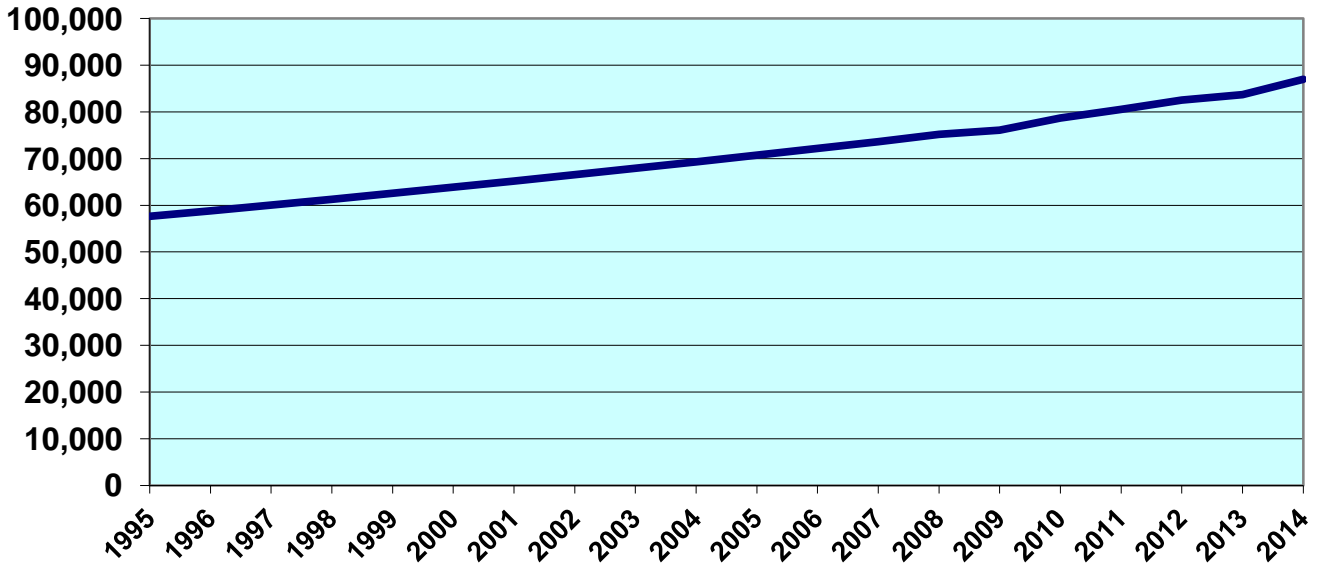
T.(1) Percentage Living in Urban and Rural Areas

Table (1) Shows the total population rate between 1995 and 2014, the size of Egypt's population and in the distribution of the population by urban-rural residence. The urban record shows (42,9 in 1995) and (35.3 in 2012) while the rural record shows (57.1 in 1995) and (47,1 in 2012). The table shows that the total Egypt's Population increased during this period by more than 51 percent. (57,642 in 1995 to 87,000 in 2014).

Years	Total Population (millions)	Place of Residence	
		Urban	Rural
1995	57,642	42,9	57,1
1996	58,835	42,6	57,4
1997	60,053	42,6	57,4
1998	61,296	42,6	57,4
1999	62,565	42,5	57,5
2000	63,860	42,5	57,5
2001	65,182	43,1	56,9
2002	66,531	42,9	57,1
2003	67,908	42,9	57,1
2004	69,313	42,8	57,2
2005	70,748	42,7	57,3
2006	72,212	42,5	57,5
2007	73,608	43,1	56,9
2008	75,225	43,0	57,0
2009	76,925	33,0	43,8
2010	78,685	33,8	44,8
2011	80,530	34,4	46,0
2012	82,550	35,3	47,1
2013	83,667	N/A	N/A
2014	87,000	N/a	N/a

These figures exclude Egyptians living abroad-----
- Source: CAPMAS

Ch (1) Total Population NOs/ Million (1995-2014)



**Ch (2) Percentage of Total Population Living in Urban and Rural Areas
(1995-2012)**

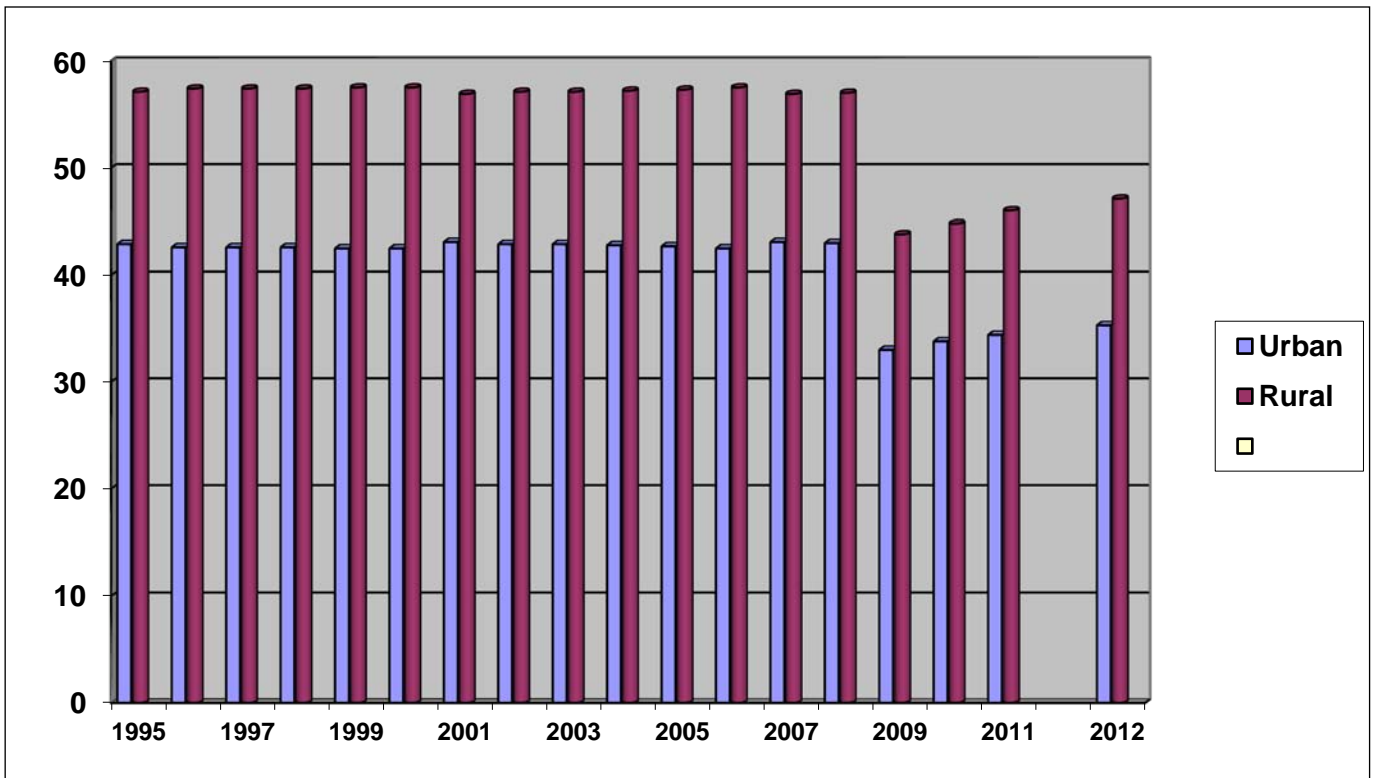


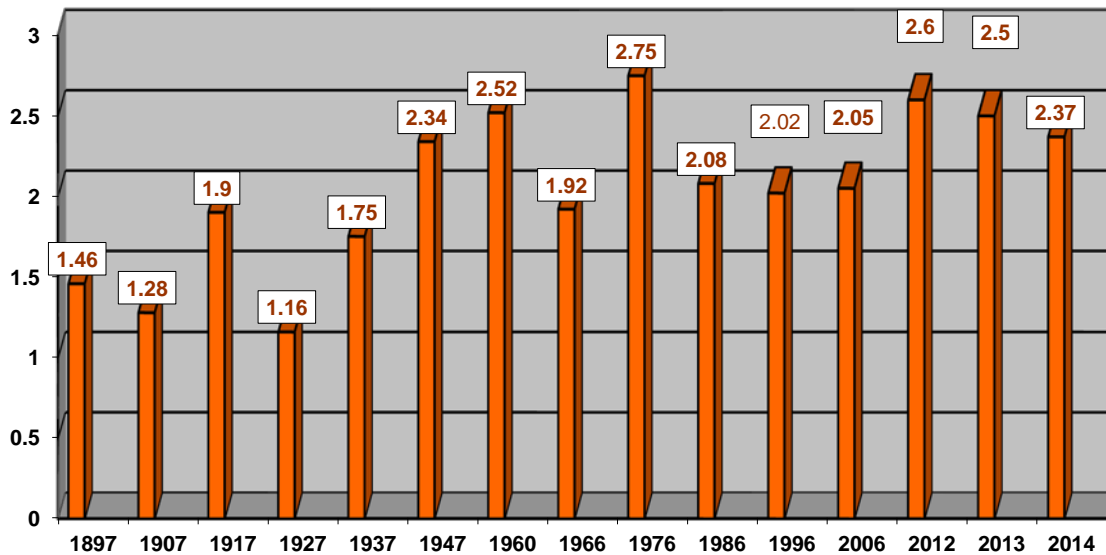
Chart (2) shows the percentage numbers of the living population in the urban and rural areas of the governorates of Egypt. It is noticed that the numbers of the living people in rural areas are more condensed than the urban ones during the periods (1995-2012). CAPMAS - 2013

The figures of Egypt's population growth rate reached in May 1, 2008 (74,8 million without those living abroad and 78.7 million including those living abroad). According to final results of that year's census as announced by the Central Agency for Public Mobilization and Statistics (CAPMAS 2006-2008-2009). The males numbers recorded were 37.2 million from the total population (up 22.6 percent from the 30.4 million in 1996), while 35.6 million are females which is (22.9 percent more from their 1996 count estimated at 29 million).

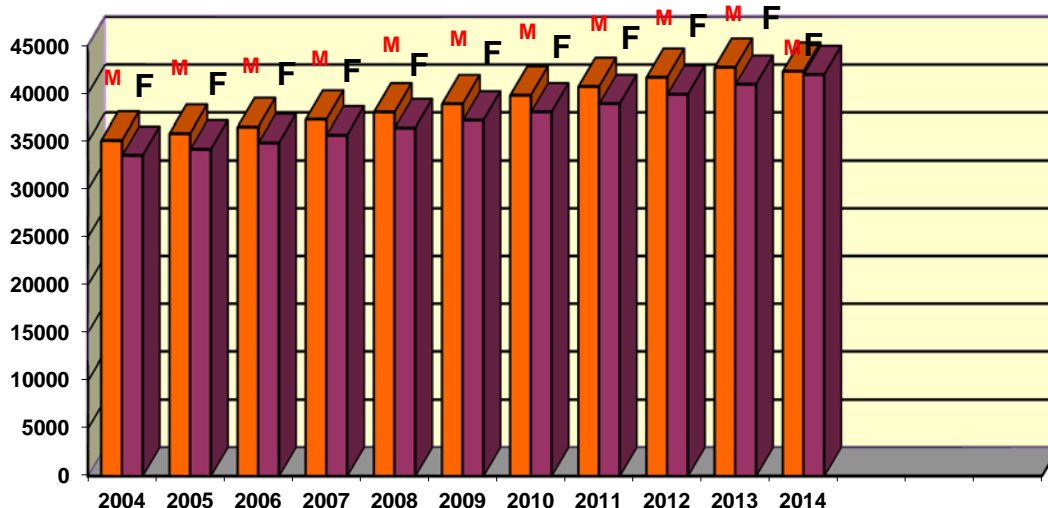
The following chart (3) shows population growth rates in percentage during the period 1897-2014. In a statement, CAPMAS noted that the population daily increase reached 5604 persons and that the growth rate reached 2.5 per cent in 2013 against 2.6 per cent in 2012. While the expected increase in 2014 will be 1,582,149 persons with an average 2.37%. The expected figures during 2014 clarifies that an average 5447 child is born in Egypt per day, it means a baby is born per 16 second. A person dies every 81 second. It turns into 1 066 deaths daily in Egypt.

**The Population Growth Rate (%)
From 1897-2014
(CAPMAS-2014)**

Ch. (3)



Ch (4) Population Estimates By Sex (2004-2014)



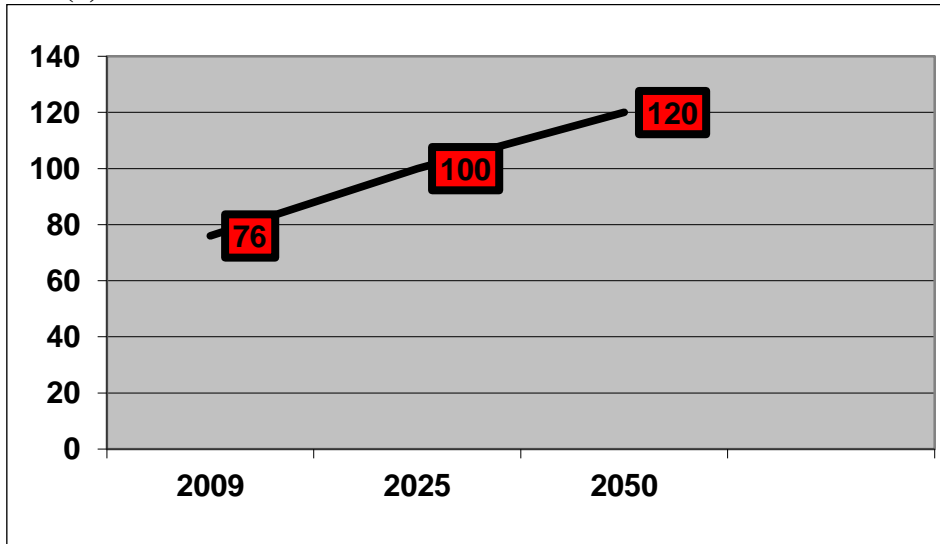
The population estimates for males and females (CAPAM- 2013)-(Egypt population clock, 2014).

What was Previously Expected for Population Projection 2009-2025-2050

The international demographers were expecting our population to reach to about 100 million people in 2025. They further expected our population to reach about 120 million people in 2050. (Talk of Egypt's Ex. President). The following chart (5) shows the previously expected population projection till 2025 and 2050.

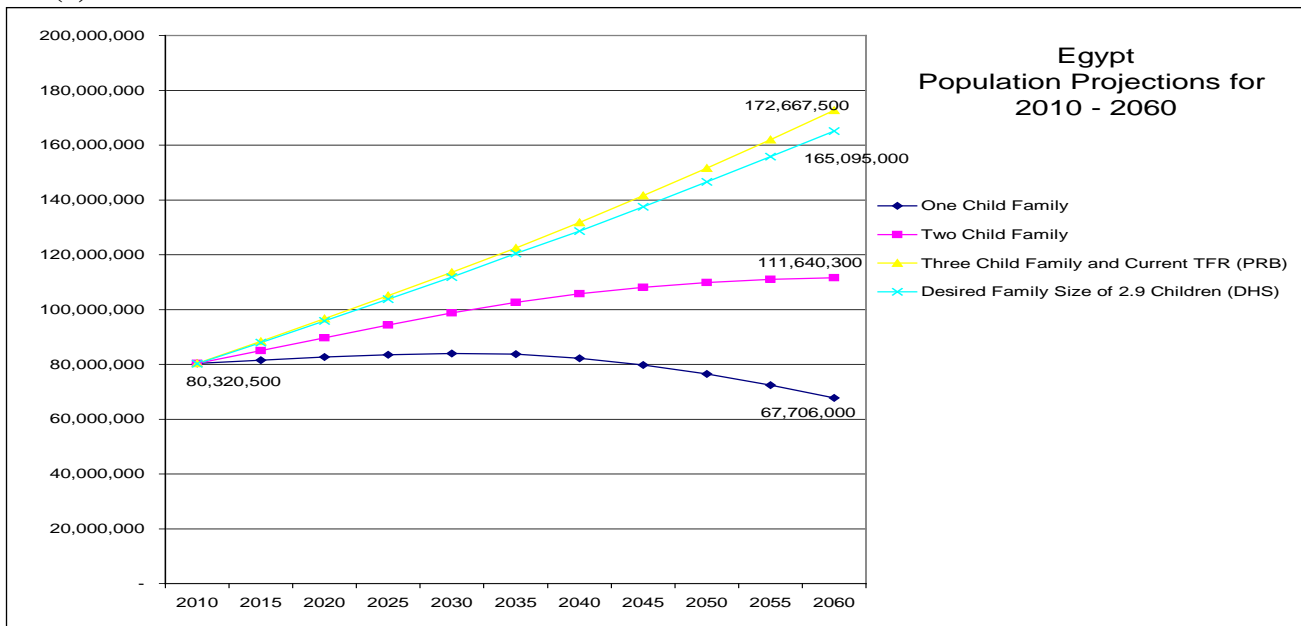
Previously Expected Population Projection 2009-2025- 2050

Ch.(5)



Previously Expected Population Projections of Egypt 2010-2060

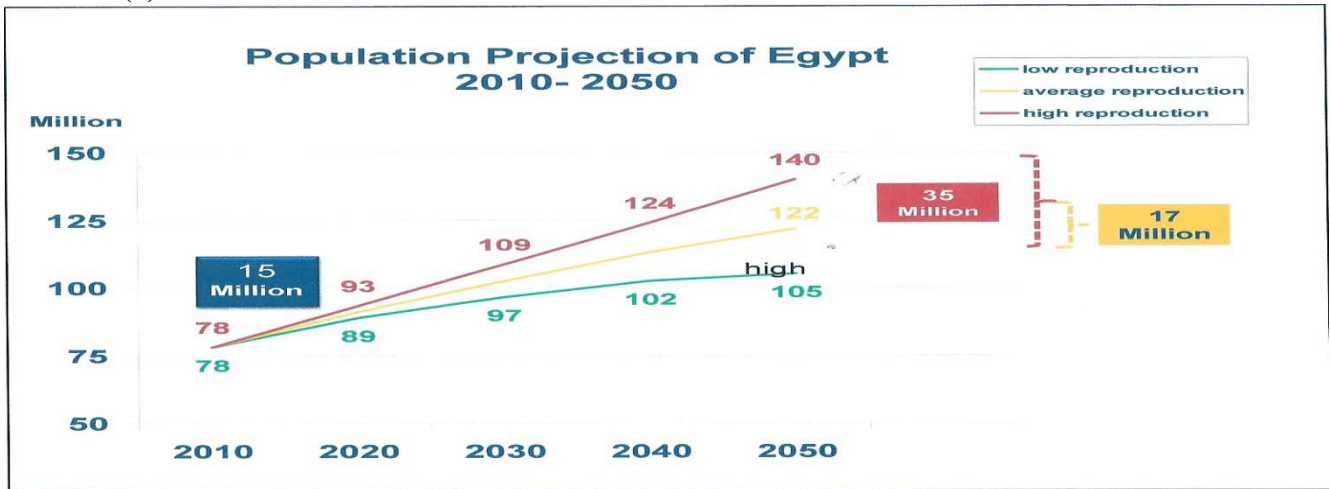
Ch (6)



Currently Expected Population Projection (UN. 2012)

Three scenarios (2010 – 2050 - 2090 – 2100)

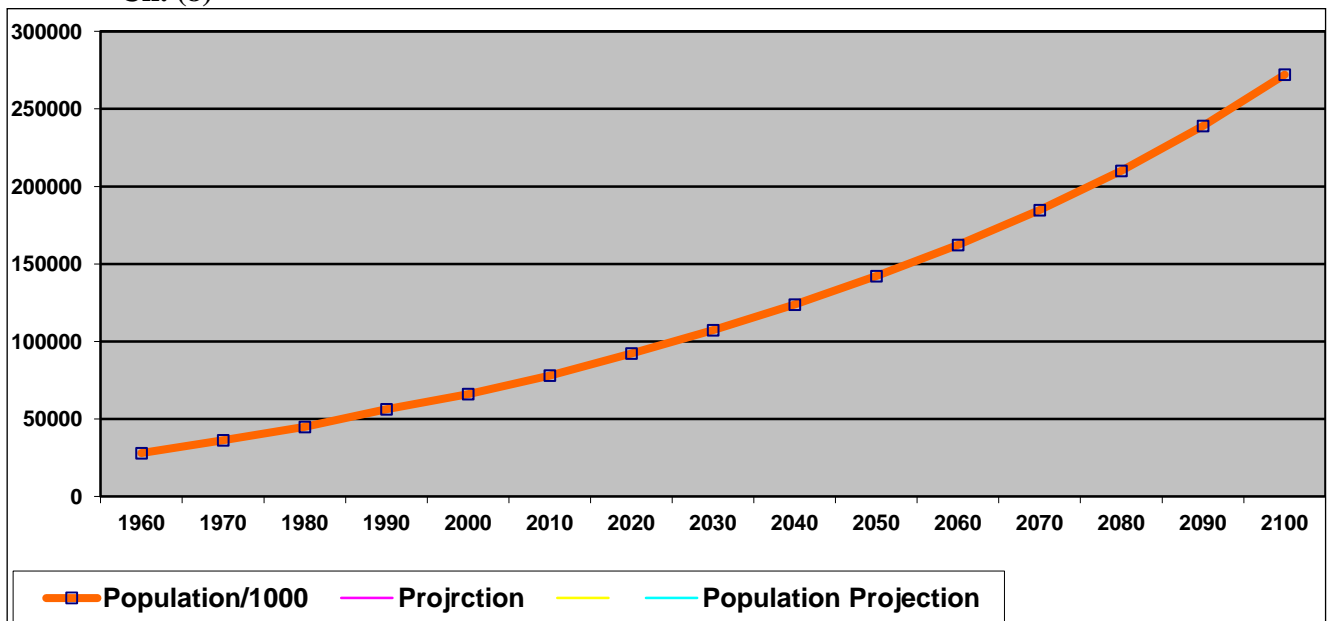
Ch (7)



The United Nations proposed three expected scenarios for Egypt reproduction. (Resource 2012). The previous chart shares to continuous increase in reproduction (2010-2050). The three scenarios are: #1) The red line which is representing high production shows that the population will be 140 million in 2050, So if Egypt would adopt the scenario of high production average the population might reach 214 million in 2100. #2) The yellow line which represents the average (medium) reproduction shows that the population will be 122 million in 2050, but if Egypt adopts the medium average scenario the population will be 136 million in 2090. #3) The blue line which represents the low average of reproduction shares that the population will be 105 million in 2050, while if Egypt adopts the scenario of low population average (two children for each family) the estimation will be 105 million in 2054. The difference between the medium scenario and the low scenario will be 17 million in 2050. while the difference between the low scenario and the high scenario will be 35 million in 2050.

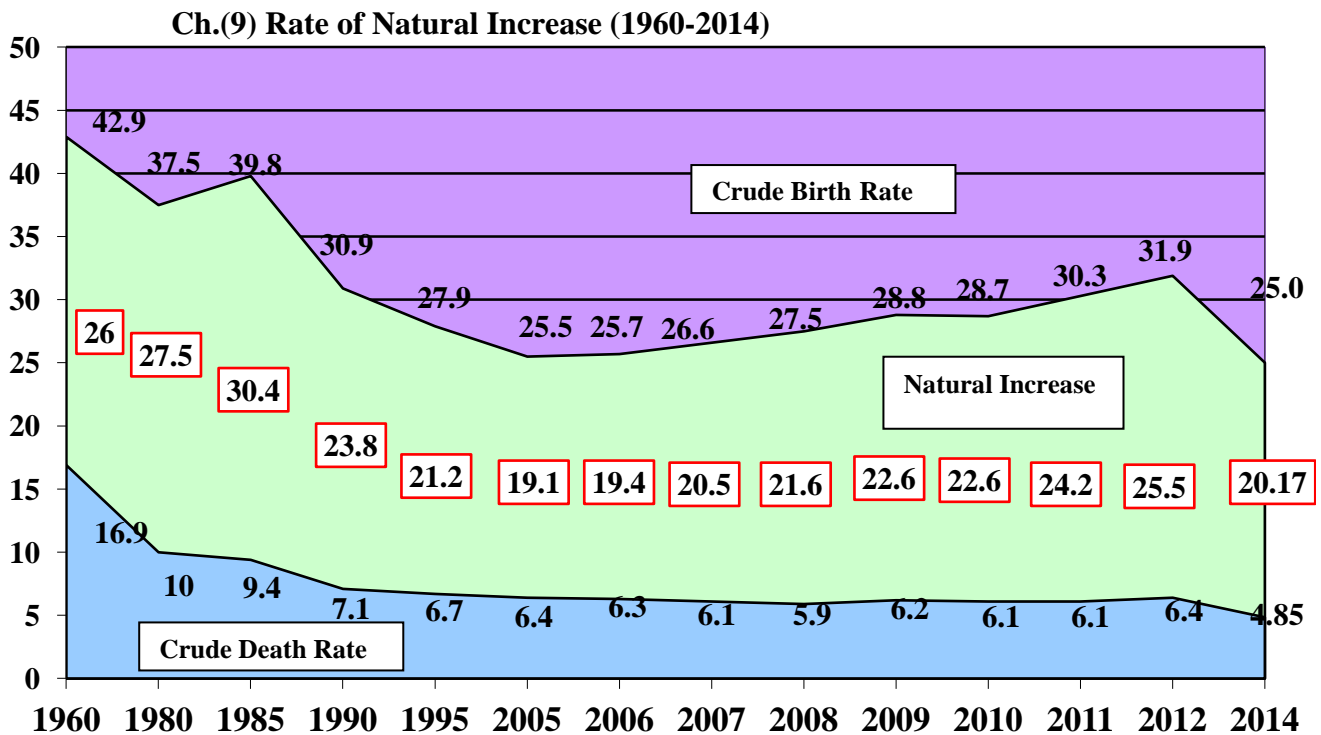
Population Projection of Egypt 1960 - 2100 (World Population Review 2014)

Ch. (8)



Rate of Natural Increase

This natural increase rate represents the difference between the level of births and deaths in a population during years 1960 - 2014. It indicates the fast population growth and the account of these two natural events. The following chart (9) shows that the rate of natural increase has been declining in Egypt since 1990 and the started to increase again from 2007 to 2012. Egypt population will increase by 1,582,149 persons (1.90%) in 2014. It is expected that 1 988 180 children will be born and about 389 079 persons will die.



Most of the decline in the rate of natural increase has been the result of changes in fertility behavior. The crude birth rate (CBR) dropped from a level 42.9 per thousand populations in 1960 to 26.6 per thousand by 2007. The previous figure shows the decline leveled off in the mid-1990, with the CBR fluctuating around a level of 27 births per thousand until the end of the decade. At that point CBR resumed declining although slowly reaching a level of 25.7 in 2006 and then rising slightly to 26.6 in 2007 and continue increasing till it reached 31.9 in 2012. The crude death rate at a comparably low level in 1990 also declined further in the period although the pace of decline was slow and erratic with the level of 5.9 in 2008 and then started to increase to 6.2 in 2009 and continue increasing till it reached 6.4 in 2012. In 2014 the crude birth rate is 25.02, death rate 4.85 and natural increase is 20.17. (Population reference Bureau, 2014). This figures mean that in 2014 the number of births is 1,464,621 million and the number of deaths 286622 persons. (World population clock, 26 September, 2014 - Hour: 20:47:30)

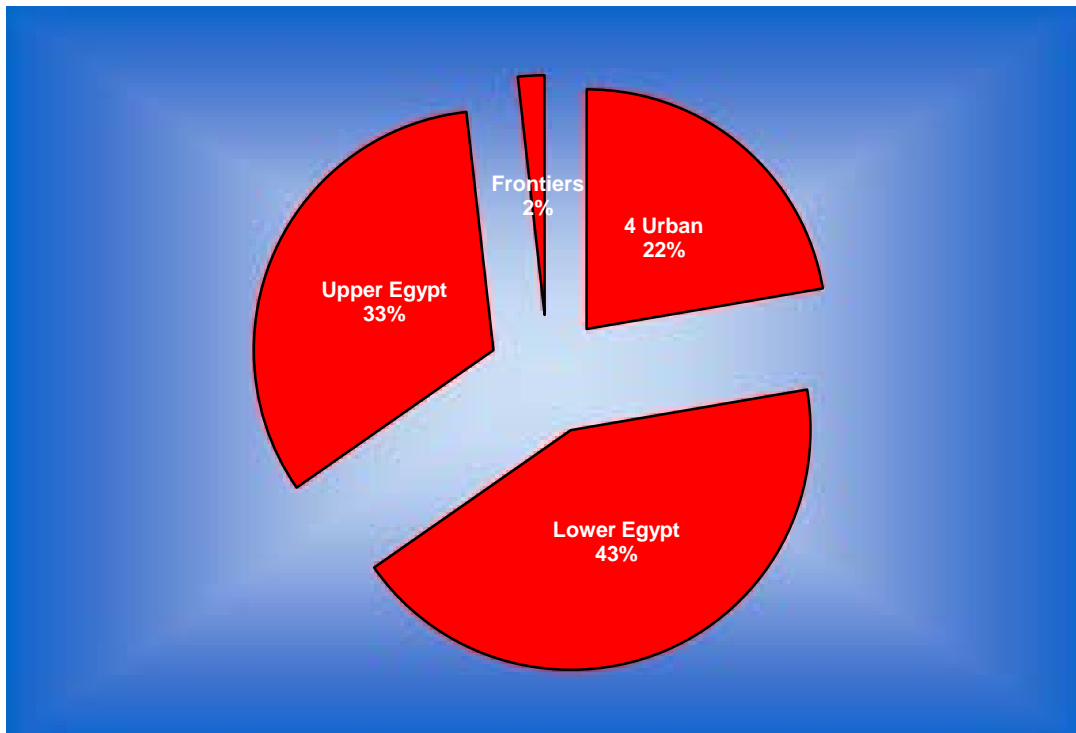
B- Unbalanced Distribution

The unbalanced distribution of Egypt's population over the land is the second dimension of the population problem. Population is condensed in only 6% of the total area of Egypt which is one million square kilometers.

The following pie chart (10) shows the percentage demographic distribution of the population in different governorates. Governorates of upper Egypt represents 33%, governorates of Lower Egypt represents 43%, the four urban governorates represents 22% and the frontiers represents 2%.

**The Demographic Distribution of the Population
In Egypt's Governorates
(CAPMAS- 2013)**

Ch.(10)



C- Population Traits (Characteristics)

The followings are the declining of the population traits which is the third dimension of Egypt's population problems.

C-1 Population Characteristics

- The young-age structure of the population.

C-2 Health Characteristics

- Fertility.
- Mortalities: Neonatal, infant, child and maternal.
- Life expectancy.

C-3 Educational Characteristics

- High illiteracy and declining educational level.

C-4 Social Characteristics

- Decrease of woman's participation in labor force.
- Unemployment rate.
- Marital Status.

C-5 Economic Characteristics

- Population and Resources

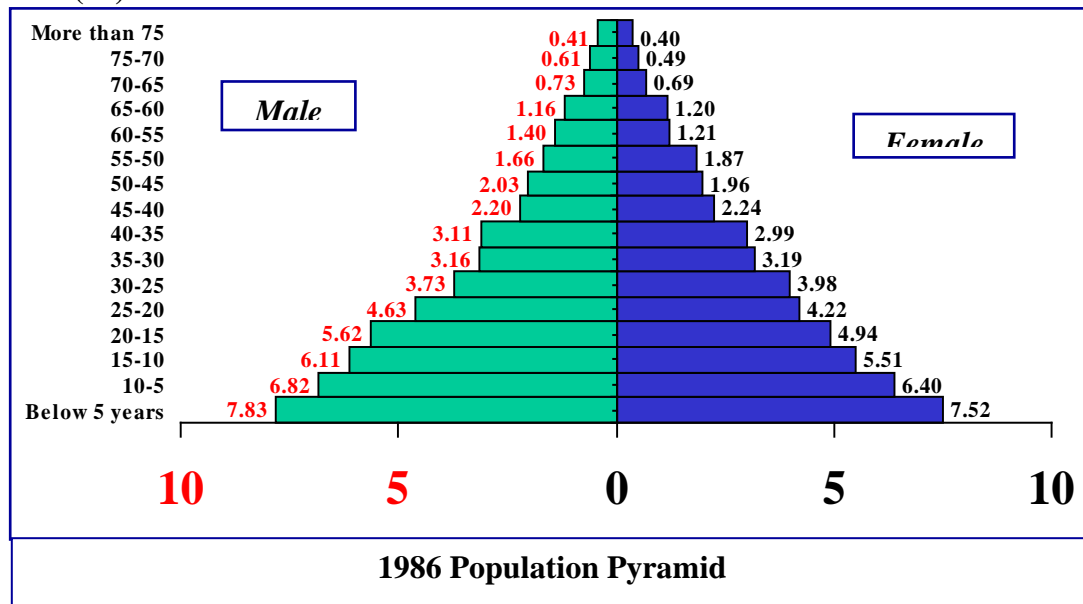
C-1 Population Characteristics

Age Structure

The age structure of the de facto household population reflects the effects of past demographic trends in Egypt, particularly high fertility. The following charts showing the differences between population pyramids during different periods (1986, 1996, 2000, 2004 and 2008).

This difference is an outcome of lower fertility over the past several decades in urban and rural areas.

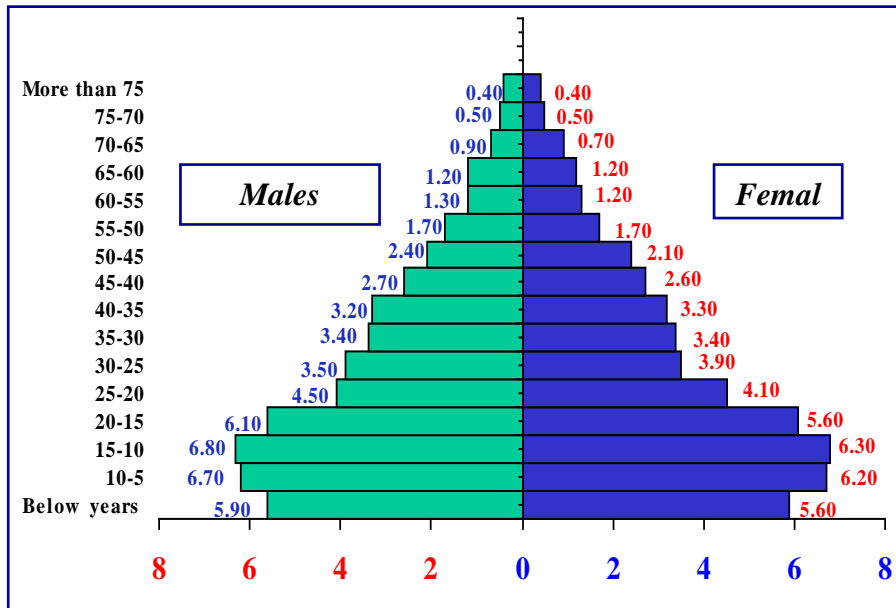
Ch. (11)



The population pyramid of year 1986, showed a broad base of age structure (5 years and below) which resembled 15.2% from the total population, while the age structure below 25 years resembled 51.7% of the total population. The numbers of the population census at that time indicated that 50% of Egypt's population is suffering from illiteracy. The participation of women in work power between the ages of 12-64 years was estimated by about 18% only in 1986. The unemployment rate was 10.7% of the total population work power.

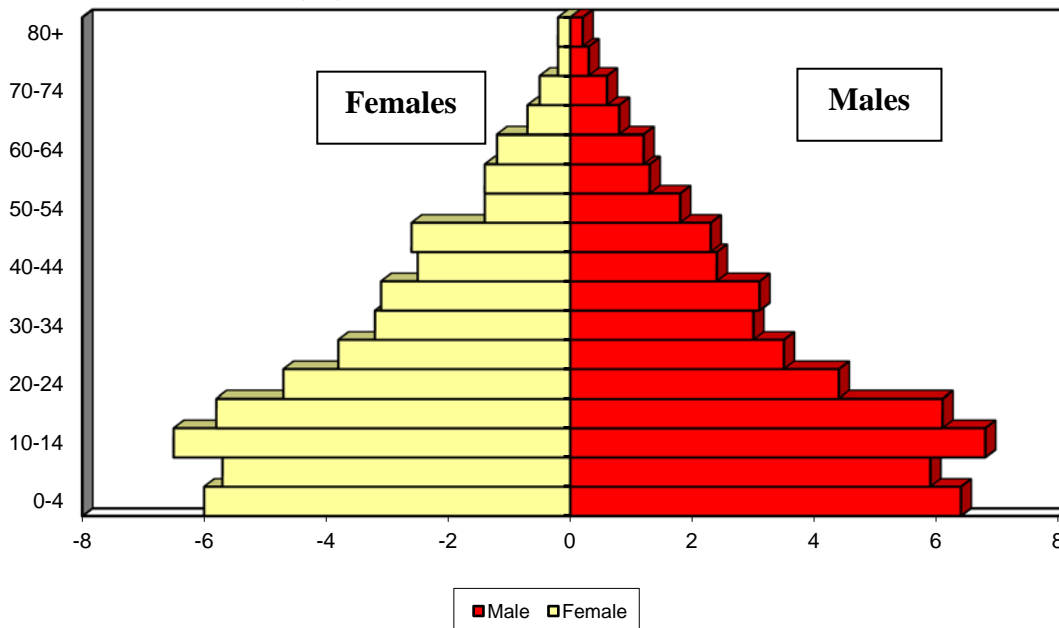
Ch. (12)

1996 Population Pyramid



The population pyramid of year 1996 showed a disturbed figure of age structure. The indicators showed an increase in the ratio of child percentage between 5-10 years. It was noticed that there was a little improve in decreasing the percentage of illiteracy from 50% in year 1986 to 39% during year 1996. The participation of women in work power between the ages of 12-64 years increased to 22% in 1997 and settled to 21.6% in year.2002. The unemployment rate was about 8.9% of the population work power. However, the figures of unemployment rate started to increase to record 9% in year 2000 and 9.9% in year 2003.

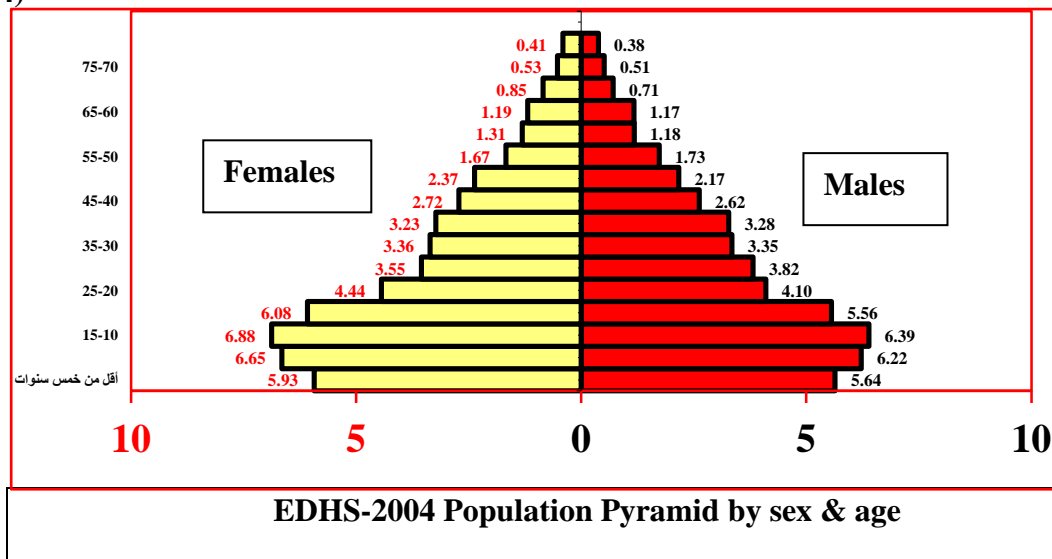
Ch. (13)



Population Pyramid by sex & age Egypt 2000

There was a clear declining of population traits during year 2000. The population pyramid showed a wide base representing the young-age structure of the population between 10-14 years and below. There were also high illiteracy, declining educational level, decrease of woman’s participation in labor force and increase of unemployment rate to 9%.

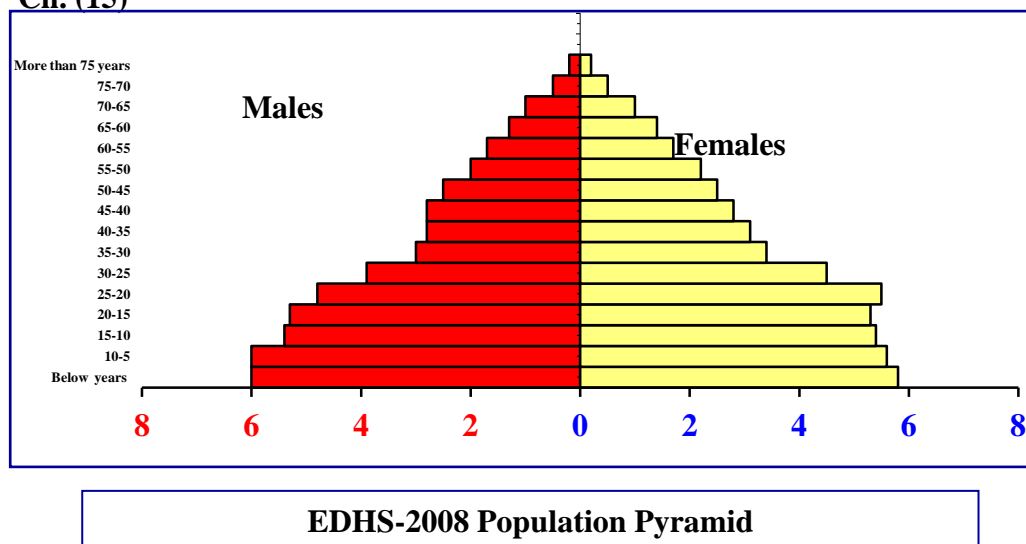
Ch. (14)



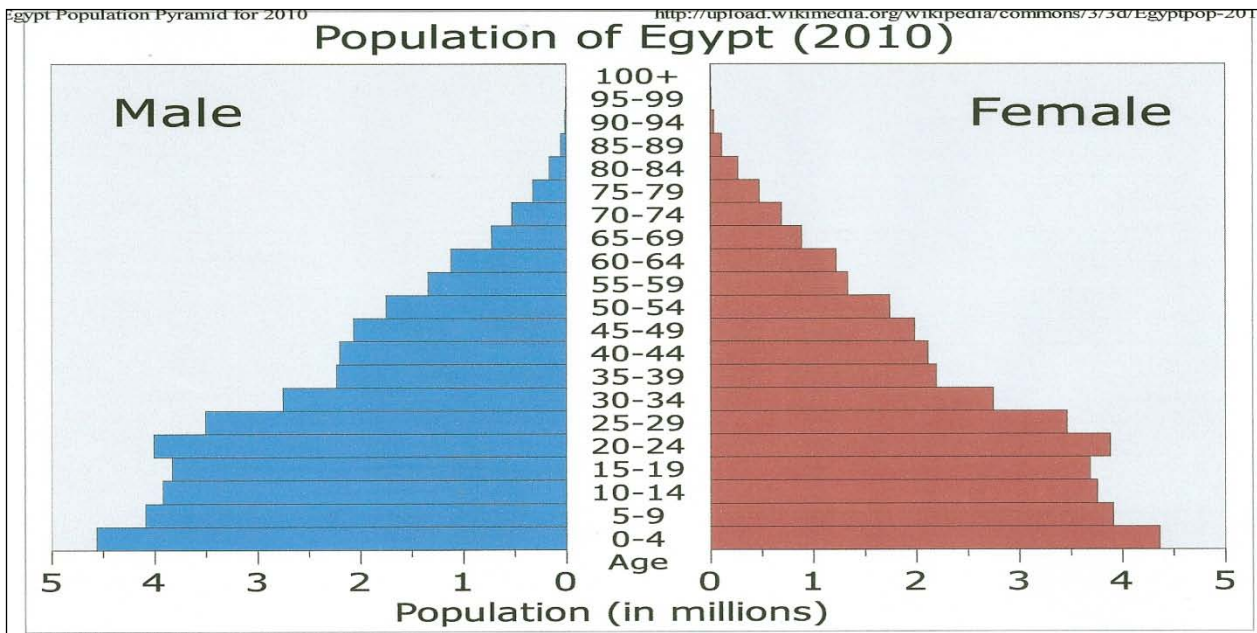
The 2004 Pyramid base shows an obvious shrinkage. The comparison between the population pyramid 1986 and the population pyramid 2004 shows the followings:

- Declining the age structure below 5 years to 11.5% in 2004 relative to 15% in the pyramid 1986.
- The population percentage for the age below 15 years in pyramid 2004 shows 37% relative to 40% in population pyramid 1986.
- The wide population base of pyramid 1986 (below 5 years) became the population target of family planning program in 2004 (16 years difference).
- There was an obvious increase in the percentage of females in the reproductive age to be 26% during the 2004 relative to 23% during the year 1986

Ch. (15)



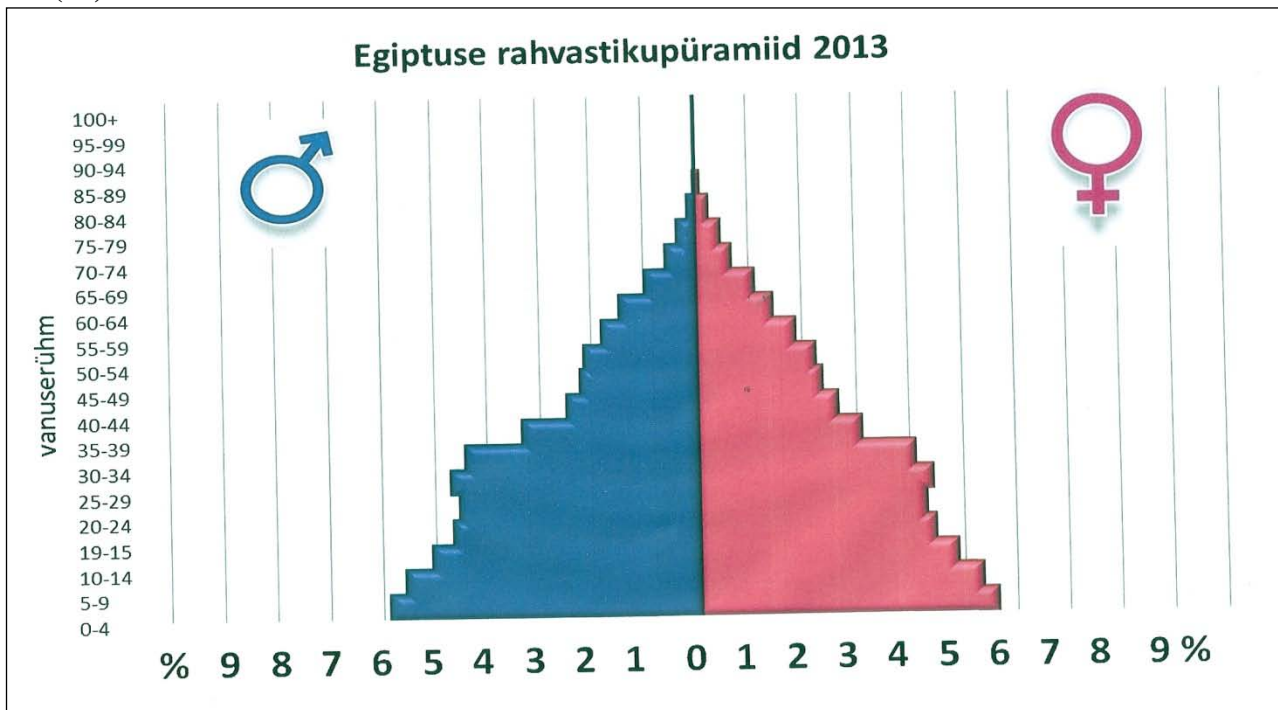
The population pyramid 2008 was constructed using the sex and age distribution of the household population. The age structure of the de facto household population reflects the effects of past demographic trends in Egypt, particularly high fertility. The majority of the household population pyramid is broadly – based with the young and soon to be married representing 55 percent was less than 25 years old. The proportion under age 15 was greater in the rural population (37 percent) than in the urban population (30 percent). Despite that there is a clear shrinkage of the pyramid base relative to the previous pyramids, still has a wide base. This pattern is typical of countries that have experienced relatively high fertility in the recent past.



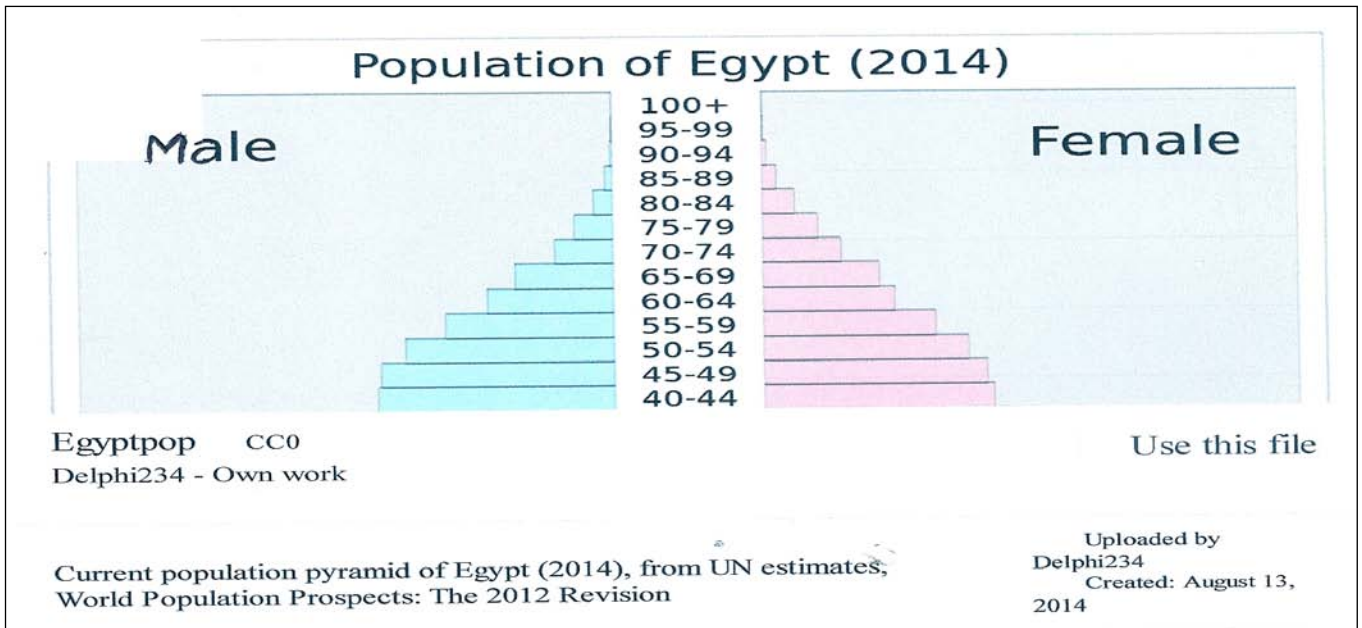
Ch. (16)

The previous chart (16) shows the femal and male estimate by million in 2010. The pyramid shows also the very wide base which means a lot of number in the age of 0-20 years old that formulate a burden on the government..

Ch.(17)



The previous chart (17) shows the 2013 population pyramid which clarifies that it still has a wide base representing the age (0-4 & 5-15 years). The big problem that the numbers of alives within the wide base will be in the reproductive age after 5-15 years. Meanwhile, another big problem due the big reproductive numbers of people wthin the middle of the pyramid at the age (19-40 years). It was also noticed that the numbers of males to some extent very near to the numbers of the females.

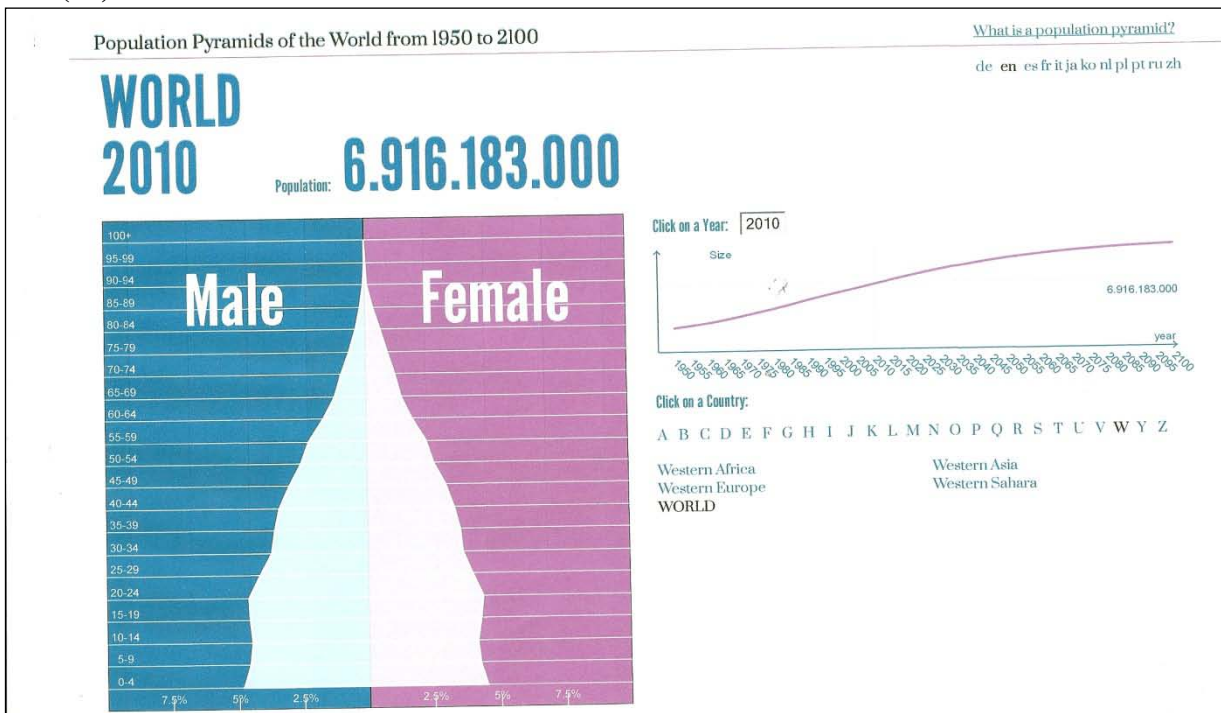


Ch. (18)

The current year 2014, the population pyramid of Egypt is still showing a widen in the middle (40-49 years) and then started to be narrow (55-100 years). The expected male number in 2014 is 42,310,678 million (50.2%), while the female number is 41,956,443 million (49.8%).(WPC-2014)

The World Population Pyramids (1950 – 2100)

Ch. (19)



The previous chart (19) shows the figures of the world population pyramids from 1950 to 2100. The Right curve shares that the world population figures will continue increasing till year 2100. While the left pyramid shows narrowing in the middle (Age 25-44 years) with wide base (04- 24 years) and a little narrow base (10-14 years) and finally very narrow top (60-100 years).

C-2 Health Characteristics

Fertility

The total fertility rate is a usual measure for examining the overall level of fertility. It is interpreted as the number of children a woman would have by the end of her childbearing years.

The level of current fertility is one of the most important topics in this report because of its direct relevance to population policies and programs. This part shows different levels and trends in current and cumulative fertility in Egypt. The following table (2) and chart (20) presents the current total fertility rate for age group 15-49 years old in rural and urban areas of the governorates of Egypt during year 2008. It shows also that there is clear declining in total fertility rates of areas in Lower Egypt and frontiers governorates rather than Upper Egypt in particularly the rural areas rather than the urban ones.(EDHS-2008-2014)

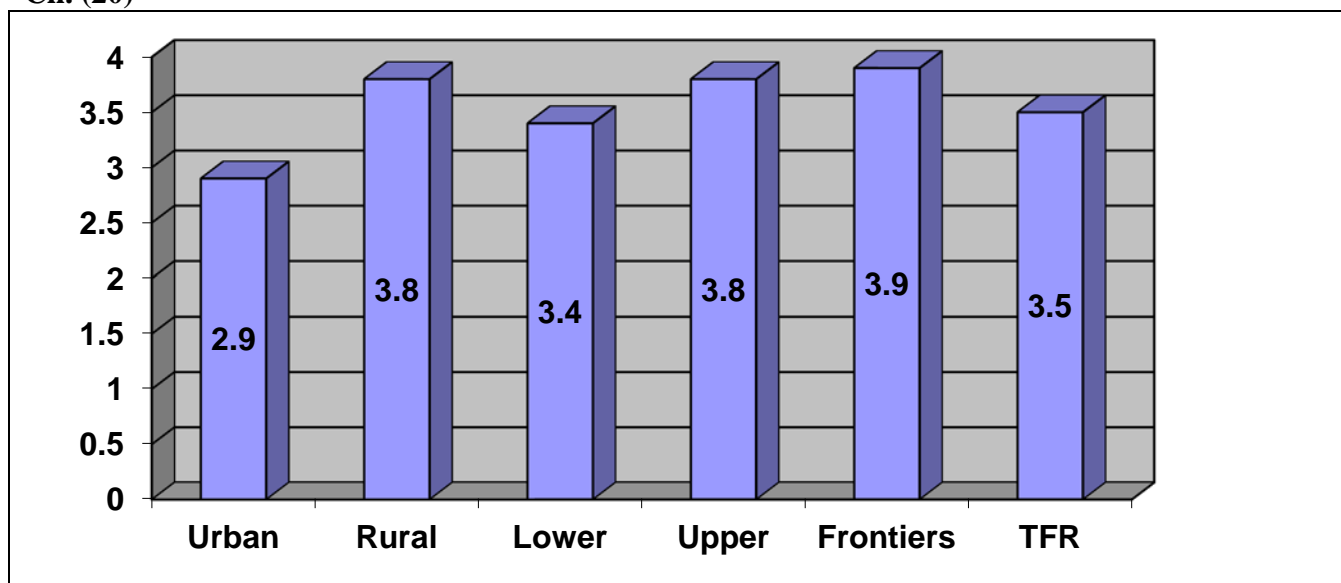
Current Fertility Rates by Residence (2104)

T. (2)

Age Group	Urban	Rural	Urban GOV.	Lower Egypt			Upper Egypt			Frontier GOV.	TOTAL
				Total	Urban	Rural	Total	Urban	Rural		
TFR 15-49	2.9	3.8	2.5	3.4	3.0	3.6	3.8	3.2	4.1	3.9	3.5

Total Fertility Rate by Place of Residence (2014)

Ch. (20)



Age Specific Fertility Rate in Selected Years 1980 – 2008- 2014

The age structure has a very important impact on TFR changes in Egypt. The following table (3) shows the different female age groups (Per 1000 women in reproductive age) from 1980 to 2014. The table shows that the higher numbers between age groups during years from 1980-2014 is always the age group 25-29 years old then followed by the numbers of age groups 20-24 years old which are reflecting the direct cause of broad base of the population pyramids. All the ages below 25 years will be the fertile women after 10-15 years which affects annual TFR.

However, there is a clear decline in TFR from 5.3 during 1980 to 3.0 during 2008 with exceptional fluctuation during years (1998 & 2000) where it started to rise to be 3.4, while it reached 3.5 in 2014.

The results also in the following table (3) and curve (chart 21) indicate that all age groups have shared in TFR decline. However, the decline has been more rapid among older women than younger women. Age specific fertility rates among women age 30 and over, fell by around 50% or more between 1980 Egyptian Fertility Society (EFS) and 2008 EDHS. However, the total fertility rate increased to reach 3.5 in 2014.

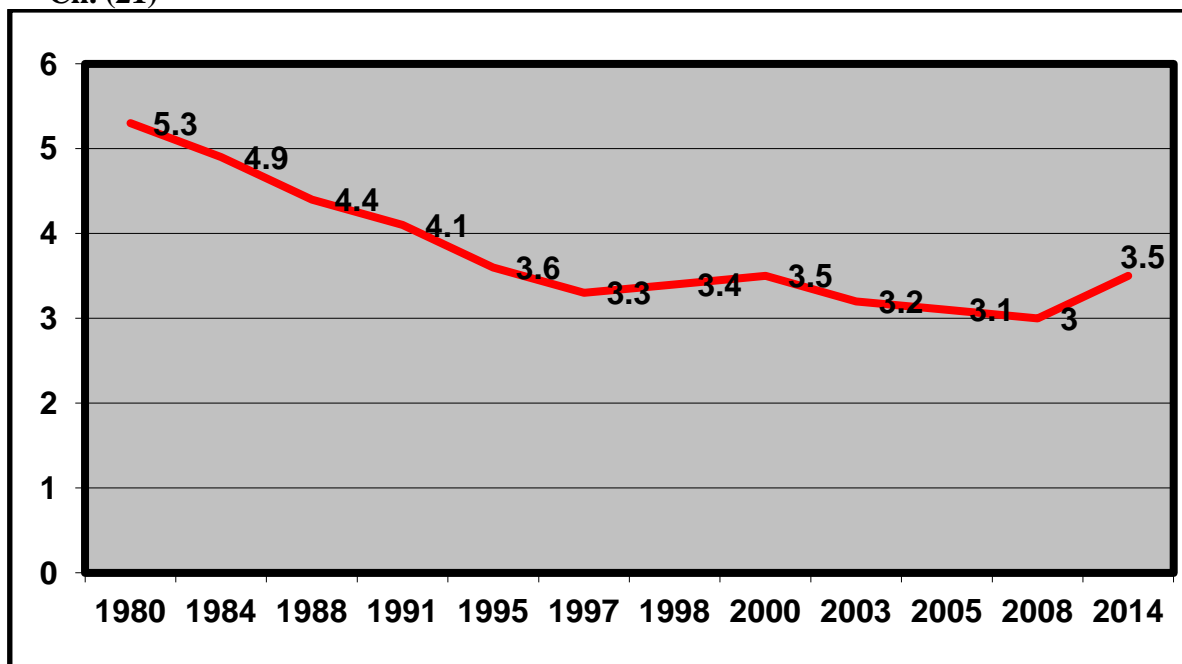
Age Specific Fertility Rate in Selected Years 1980 – 2008- 2014
(Per 1000 women in reproductive age)

T. (3)

Age Groups	1980	1984	1988	1991	1995	1997	1998	2000	2003	2005	2008	2014
15-19	78	73	72	73	61	32	64	51	47	48	50	56
20-24	256	205	220	207	200	186	192	196	185	175	169	213
25-29	280	265	243	235	210	189	194	208	190	194	185	201
30-34	239	223	182	158	140	135	135	147	128	125	122	133
35-39	139	151	118	97	81	65	73	75	62	63	59	69
40-44	53	42	41	41	27	13	22	24	19	19	17	17
45-49	12	13	6	14	7	5	1	4	6	2	2	4
TFR	5.3	4.9	4.4	4.1	3.6	3.3	3.4	3.5	3.2	3.1	3.0	3.5

The Curve of Total Fertility Rate
1980 - 2014

Ch. (21)



Mortalities

- Neonatal Mortality
 - Infant Mortality
 - Child (Under 5 years) Mortality
 - Maternal Mortality
-

This part presents the information of neonatal, infant and under 5 years old child mortality. The figures describe the current level of mortality in Egypt. The following table (4) clarifies the different levels of mortality for the periods 0-4, 5-9 and 10-14 years. It was noticed that the maternal and child national program of Egypt has succeeded to decline the mortality rates of the neonatal, infant and child (under 5 years) over the last 21 years before 2014. The under five mortality for the period 0-4 years was 28.3 deaths per 1000 births in 2008, while the rate decreased to 28 in 2014. The infant mortality rate was 24.5 deaths per 1000 births in 2008, while the rate decreased to 22 in 2014, and the neonatal mortality rate was 16.3 deaths per 1000 births in 2008 while the rate decreased to 14 in 2014.

Early Childhood Mortality Rates 2008- 2014

T.(4)

Neonatal, Infant and Under Five Years Child						
	Neonatal Mortality		Infant Mortality		Under 5-years Mortality	
Years	2008	2014	2008	2014	2008	2014
0-4	16.3	14	24.5	22	28.3	28
5-9	18.6	19	32.7	30	38.5	34
10-14	21.4	19	40.6	33	54.0	39

The following table (5) shows the neonatal, infant and under 5 years mortality rates from various selected surveys during 1965-2014. It was noticed that the results suggest that early childhood mortality levels have declined steadily over the past 21 years. Infant mortality decreased by more than 40%, from a level of 41 deaths per 1000 births during the period 10-14 years before the survey (1994-1998) to a level of twenty five deaths per 1000 in the five year period preceding the EDHS (2004-2008) and then it continued in decreasing till 33 in 2014 . Under five, mortality declined from 54 deaths per 1000 births during the period (10-14) years before the survey to 28 deaths in the 5 year period before the survey and it almost reached 39 in 2014.

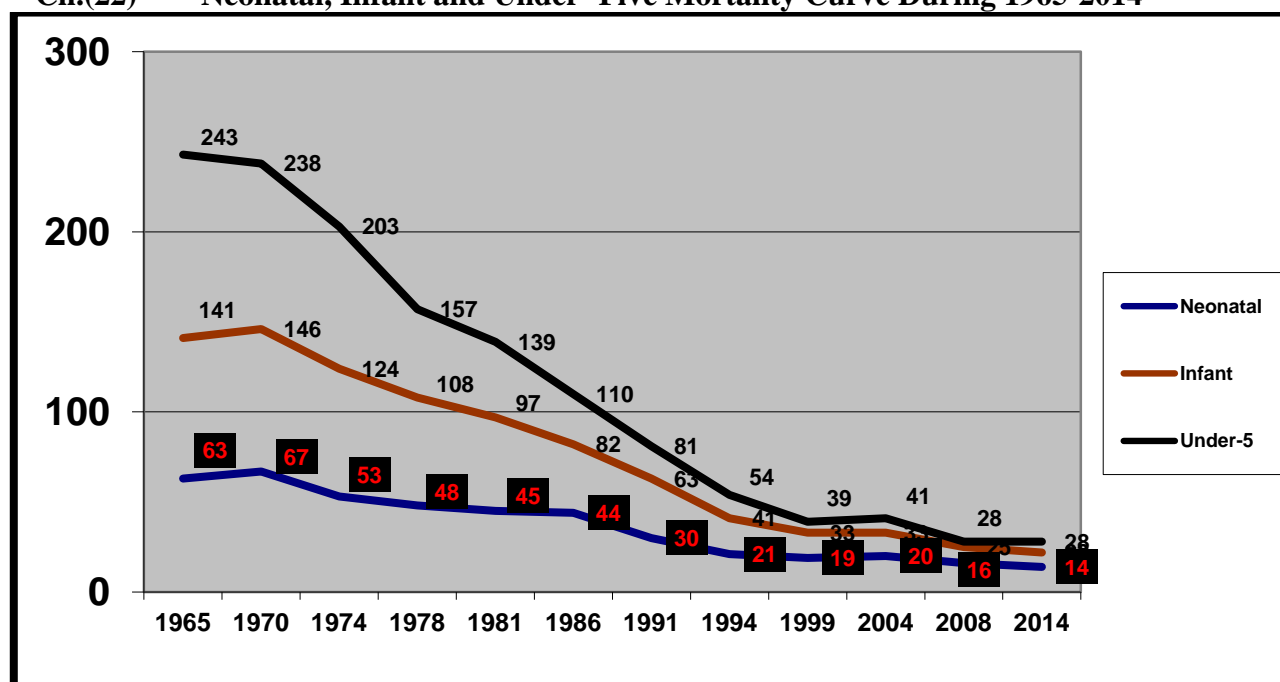
The estimated mortality presented in the following chart (22) confirms that early childhood mortality has fallen significantly in Egypt during the past three decades. An Egyptian child was almost six times as likely to die before the fifth birthday in the mid-1960s as in the early 2000s. The overall rates decreased mortality is increasingly concentrated in the earliest months of life. In the mid-1960s, around 40% of deaths occurred after the child's first birthday, by the time of the 2008 EDHS, only 14% of all deaths under age five took place after the first 12 months of life.

Neonatal, Infant, Under-Five Mortality from Various Selected Surveys During 1965-2014 in Egypt

T.(5)

Preference period	Survey	Neonatal mortality	Infant mortality	Under-five mortality
2008-2014	SIS- 14	14	22	28
2004-2008	EDHS- 08	16	25	28
1999-2003	EDHS- 08	19	33	39
1994-1998	EDHS- 08	21	41	54
1991-1995	EDHS-95	30	63	81
1986-1990	EDHS-95	44	82	110
1981-1985	EDHS-95	45	97	139
1978-1982	EDHS-92	48	108	157
1974-1978	EDHS-88	53	124	203
1970-1974	EFS-80	67	146	238
1965-1969	EFS-80	63	141	243

Ch.(22) Neonatal, Infant and Under- Five Mortality Curve During 1965-2014



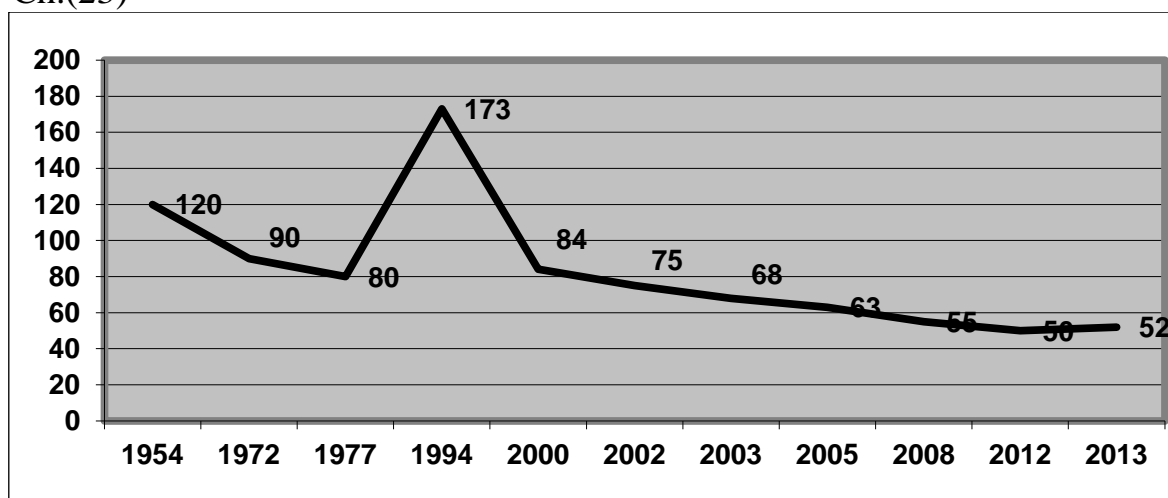
The previous curve shows a clear declining in under-five year mortality rate from 243/1000 in 1965 to 28/1000 in (2008 and 2014), the infant mortality rate decreased from 141/1000 in 1965 to 25/1000 in 2008 and then it reached 22 in 2014, while the neonatal mortality rate decreased from 63/1000 in 1965 to 16/1000 in 2008 and then it reached 14 in 2014.

• Maternal Mortality

The maternal mortality rate in Egypt has changed many times over the past five decades. The data collected of maternal deaths per live births in 1954 indicated that the maternal mortality rate was 120/100,000. In 1972 the figures decreased to 90/100,000 and continued decreasing to 80/100,000 in 1977. Then in 1994, the Egyptian National Maternal Mortality Study (ENMMS 1992/93) summarized the data collected and reported an overall maternal mortality ratio (MMR) of 174/100,000. The Egypt National Maternal Mortality Study 2000 (ENMMS 2000) revealed a dramatic drop of 52% in maternal deaths to an MMR of 84/100,000. The figure continued in declining to be 75/100,000 in 2002. Due to the huge efforts of Egypt Governorate and policy makers, MMR declined in year 2003 to 68/100,000, then 63/100,000 in 2005 and reached to 55/100,000 in 2008, then it continued in decreasing to be 50 in 2012 and it increased again to reach 52 in 2013.

The Maternal Mortality Rate Curve of Egypt During 1954-2013

Ch.(23)



T. (6) The following table shows the rating of Egypt between PPD member countries

**MILLENNIUM DEVELOPMENT GOAL
ACHIEVEMENT STATUS IN THE MEMBER COUNTRIES**

PPD Members	FP (Any method of Contraceptive Prevalence)	Maternal Mortality ration	Infant/Child Mortality Total per 1000 live births	HIV/AIDS Prevalence rate (%) (15-49) M/F	Population (Growth Rate)	Life Expectancy M/F	Ageing (Population 60 years and above)	Absolute Poverty (Pop. living below national poverty line)	Education % Illiterate (>15 years) M/F	Gender (Empowerment Measure, Rank)
Bangladesh	58	380	54	-	2.09%	62.8 / 64.6	5.2	33.7	50 / 69	69.0
Benin	19	850	101	1.7 / 2.1	2.73%	54.0 / 55.6	4.0	33.0	54 / 77	n/a
China	84	56	33	0.2 / 0.1	0.59%	70.3 / 73.9	10.8	4.6	5 / 14	n/a
Colombia	77	130	24	1.0 / 0.5	1.46%	69.8 / 75.8	7.5	64.0	6 / 5	46.0
Egypt	60	84	33	0.1 / <0.1	1.75%	68.2 / 72.7	7.0	16.7	33 / 56	68.0
Gambia	10	540	72	1.0 / 1.3	2.84%	55.2 / 58.0	6.0	n/a	-	n/a
India	48	540	64	1.2 / 0.6	1.38%	62.4 / 65.7	8.0	28.6	27 / 52	n/a
Indonesia	60	230	38	0.2 / <0.1	1.41%	65.8 / 69.5	8.3	27.1	8 / 17	n/a
Jordan	56	41	21	-	2.49%	70.4 / 73.5	5.1	11.7	5 / 15	n/a
Kenya	39	1000	65	4.6 / 8.9	2.57%	49.5 / 47.8	4.3	52.0	22 / 30	n/a
Mali	8	1200	130	1.6 / 2.2	2.63%	47.8 / 49.1	3.7	n/a	73 / 88	n/a
Morocco	50	220	35	-	1.55%	68.1 / 72.5	6.6	19.0	37 / 62	n/a
Mexico	68	83	19	0.3 / 0.2	1.16%	73.1 / 78.0	7.7	n/a	8 / 11	42.0
Nigeria	13	800	111	4.6 / 6.2	2.38%	43.6 / 43.9	4.9	34.1	26 / 41	n/a
Pakistan	28	500	75	0.2 / <0.1	2.09%	63.6 / 64.0	5.8	32.6	38 / 65	58.0
Senegal	11	690	80	0.7 / 0.9	2.34%	55.1 / 57.6	4.1	n/a	49 / 71	n/a
Thailand	72	44	18	2.0 / 1.1	0.68%	67.3 / 74.3	9.4	n/a	5 / 10	55.0
Tunisia	63	120	21	<0.1 / <0.1	0.99%	71.6 / 75.8	8.5	7.6	17 / 35	n/a
Uganda	23	880	79	3.7 / 4.9	3.37%	48.8 / 50.0	3.8	44.0	21 / 41	n/a
Yemen	21	570	64	-	3.46%	60.2 / 62.9	3.6	41.8	31 / 72	70.0
Zimbabwe	54	1100	61	21.0 / 28.4	0.62%	37.9 / 36.6	5.4	34.9	6 / 14	n/a

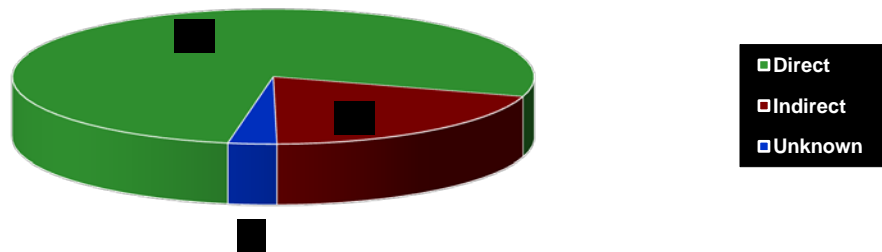
Source : UNFPA

As in many other countries, the risk of maternal death was higher in mothers aged more than 40 years and in women who had already had five or more children. Most maternal deaths occurred during delivery and the 24 hours after delivery (49%), or during the six weeks after delivery (27%). Women who died were more likely to have delivered in a health facility and less likely to have delivered at home than women who died in childbirth in Egypt in general; and 62% of maternal deaths took place in health facilities, 29% at home, and 9% during transportation. The majority of women who died sought medical help when they experienced problems (93%).

Primary Medical Causes of Maternal Death

Medical causes of death were classified into two categories, direct causes and indirect causes. Based on the single main cause of death determined by local advisory groups, direct obstetric causes were responsible for 77% of maternal deaths and indirect causes for 20% of maternal deaths. It was not possible to determine a cause of death for 3%. Ch.(24)

Classification of Maternal Deaths
Ch.(24)



Direct causes

Hemorrhage before and after delivery was the leading direct cause of maternal death (43%), with most hemorrhage deaths due to postpartum hemorrhage. The records showed that there were 32 maternal deaths from hemorrhage per 100,000 live births.

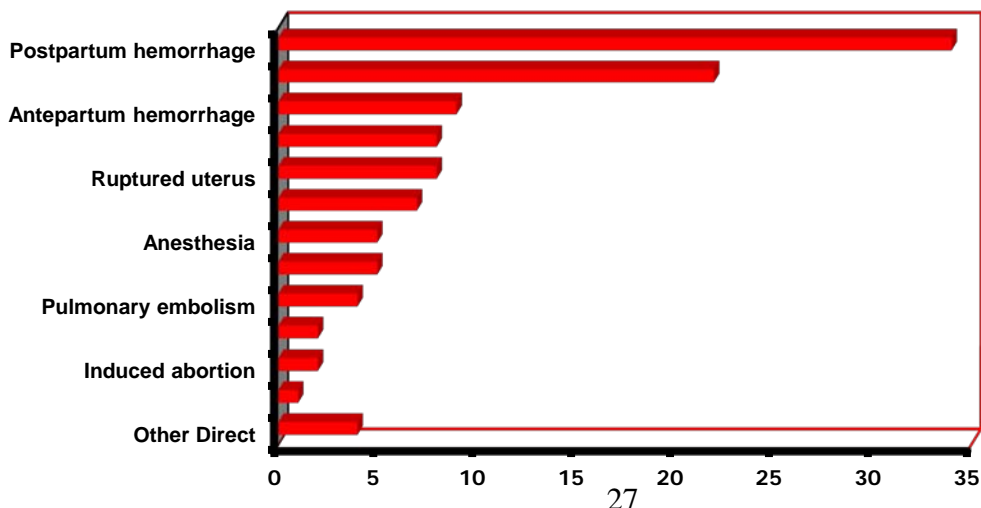
The figure of other important direct obstetric causes of maternal death was hypertensive diseases of pregnancy (22%) which almost means that the MMR for hypertensive diseases was 18/100,000.

The MMR due to sepsis (8%) which means 7 maternal deaths per 100,000.

The Records for ruptured uterus was (8%) which presented 7 maternal deaths per 100,000, cesarean section (7%) which means 6 maternal deaths per 100,000. The obstructed labor recorded (5%) which represented 4 maternal deaths per 100,000, anesthesia (5%) and unsafe abortion (2%).

A disproportionate number of postpartum hemorrhage and cesarean section deaths occurred in private facilities, possibly due to lack of blood, poor back-up, or delays in transferring patients to the hospital. The MMR due to lack of transportation was 4/100,000 in 2000, compared to 7/100,000 in 1992-9

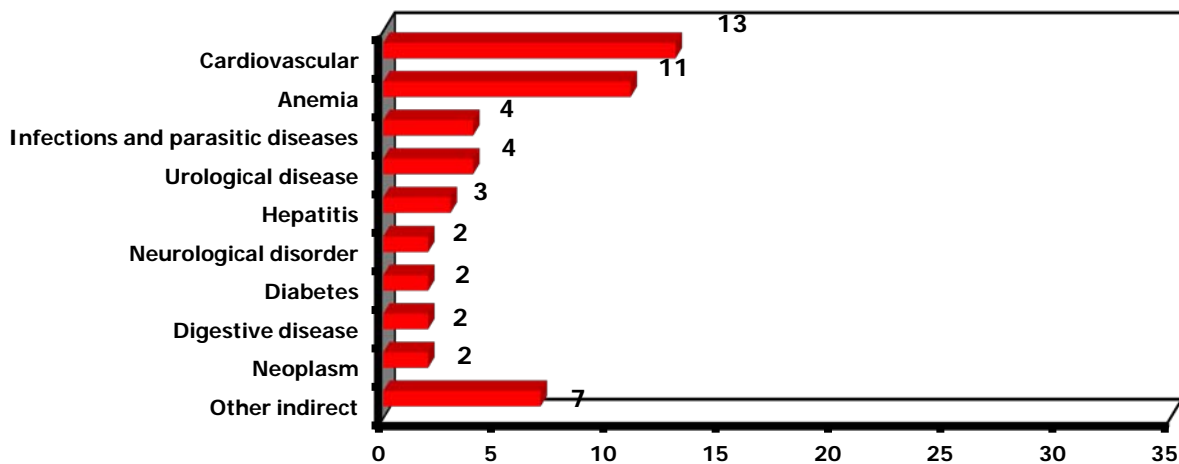
Ch.(25) Direct Causes of Maternal mortality



Indirect Causes

Cardiac disease was the leading indirect cause of maternal death (13%) which recorded 11 maternal deaths per 100,000 and the most common cardiac problem was rheumatic heart fever. Anemia was the second most important indirect cause of maternal death (11%) which presented 9 maternal deaths per 100,000. The other factors that can affect MMR are shown in the following chart like infections, urological diseases, hepatitis, diabetes and neurological disorders. etc.

Ch.(26) Indirect Causes of maternal Deaths



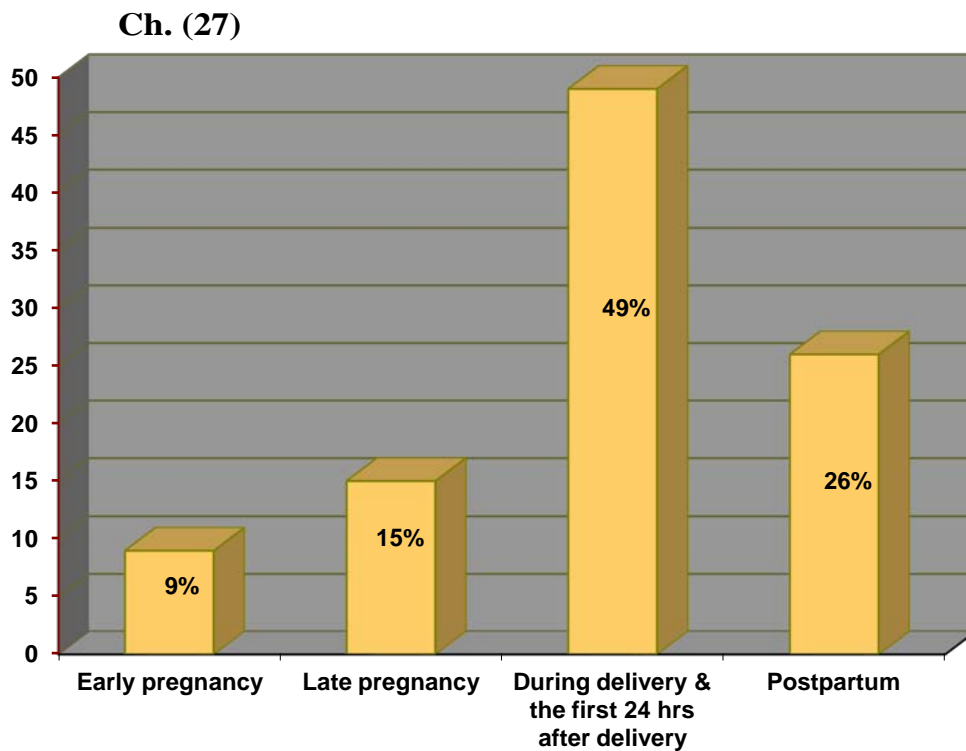
The Egyptian national maternal mortality (ENMMS 2000) also found that mortality in infants of women who die from maternal causes has declined. In 50% of cases of maternal death in 2000, the fetus or infant also died, whereas the figure for 1992-1993 was 57%. When maternal death occurred during delivery or postpartum, 34% of infants died at birth or soon after, compared to 43% in 1992-1993, suggesting that there may have been improvements in the care of newborns.

Timing of Maternal Death in Percentage during Pregnancy and Postpartum Periods

The Egyptian national maternal mortality (ENMMS 2000) noticed that there are different percentage figures of death time relative to pregnancy and postpartum periods. Ch.(27)

- 9% of pregnant women died during the early pregnancy period (before 6 months).
- 15% died in the late pregnancy period (6-9 months).
- 49% died during labor or 24 hours immediately after delivery.
- 26% died during puerperal sepsis period (11% in the first week after delivery, 7% in the second week and 8% in the third week).

Timing of Maternal Death in Percentage



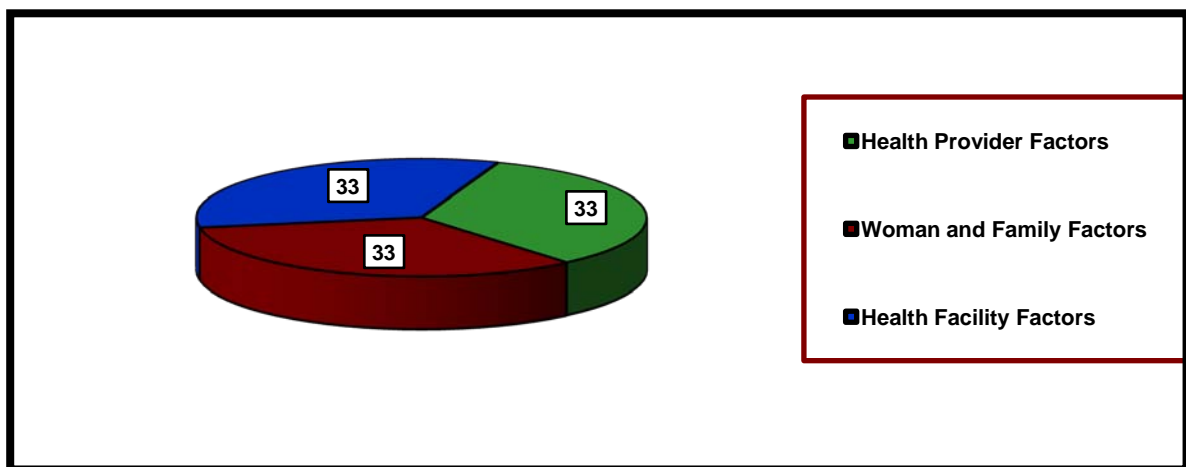
Main Avoidable Factors Contributing to Maternal Death

Avoidable factors contributing to maternal death were classified into three categories: health provider factors, health facility factors, and woman and family factors.

Further, the information of Egyptian emergency obstetric care protocols (CEOC) showed that the two main avoidable factors of death were substandard care on the part of health care providers (59%) and delays in seeking care on the part of the woman and her family (42%). (Note: A woman's death may have been caused by more than one factor). Although the proportion of births attended by a skilled health provider has increased significantly since 1992-93, substandard care by health providers-in particular obstetricians and general practitioners-remains the most important avoidable factor, contributing to 54% of maternal deaths. Substandard care in the private sector is of particular concern, since deliveries in the private sector (26%) have overtaken deliveries in the public sector (22%).

Main Avoidable Factors

Ch.(28)



In 2000 one or more avoidable factors contributed to 81% of maternal deaths (93% in 1992)

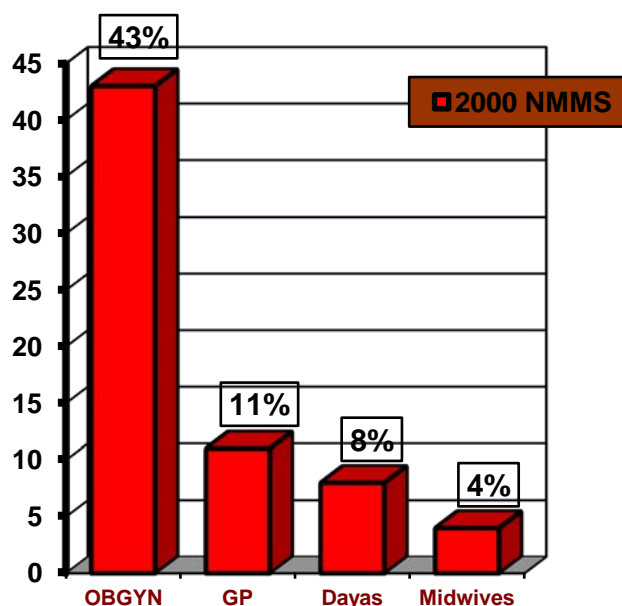
Maternal Deaths Attributable to Substandard Care by Providers

Ch.(29)

Health Provider Factors

Due to low quality service delivery

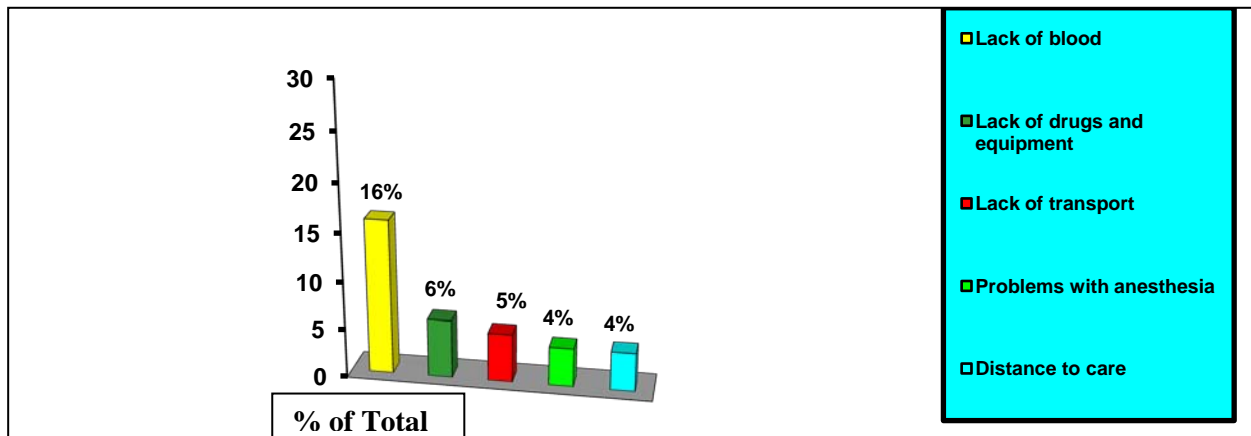
- General practitioners presents 11%
- OB/GYN represents 43%
- Dayas represent 8%
- Midwives and delivery assistants 4%



Health Facility Factors

- Shortage of blood packages contributed by 16% in maternal deaths.
- Shortage of essential drugs contributed by 6% in maternal death.
- Shortage of transportation and access to the hospital presents 5%.
- Problems with anesthesia present 4%.
- Distance to care presents 4%.

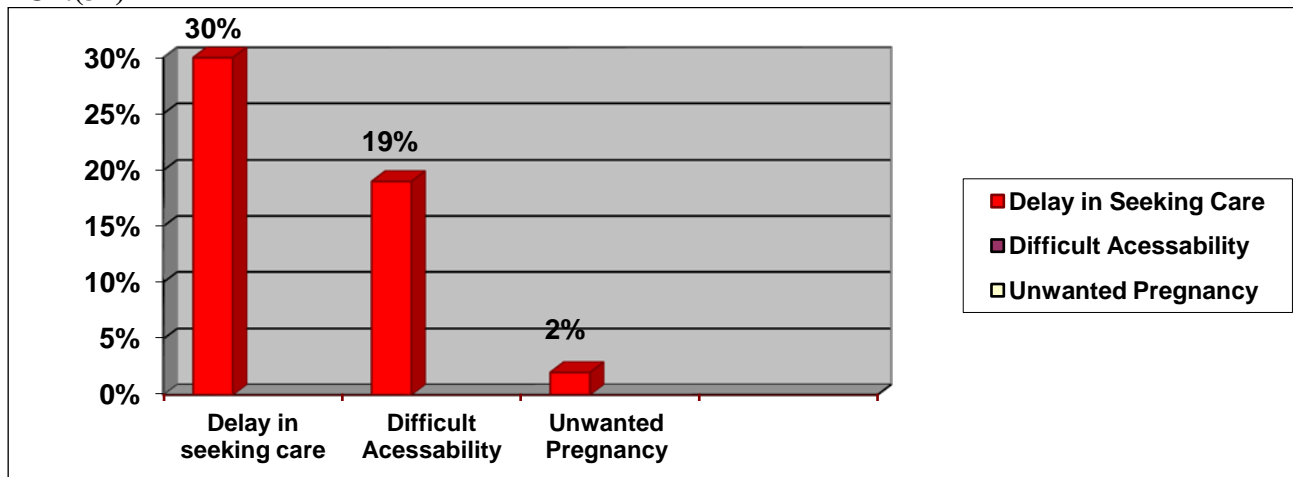
Ch.(30) Health Facility Factor



Women and Family Factors

- Delay in the detection of healthy problems contributed by 30% of maternal deaths.
- Difficulty in gaining easy services presented 19%.
- Unwanted pregnancy presented 2%

Ch.(31)



The previous mentioned figures of avoidable factors show disproportionately to maternal deaths, possibly due to delays in referral of women with obstetric complications and misuse of drugs used to speed up labor. In contrast, midwives and dayas made a positive contribution, with the exception of sepsis deaths, where the risk was higher for home deliveries attended by a daya.

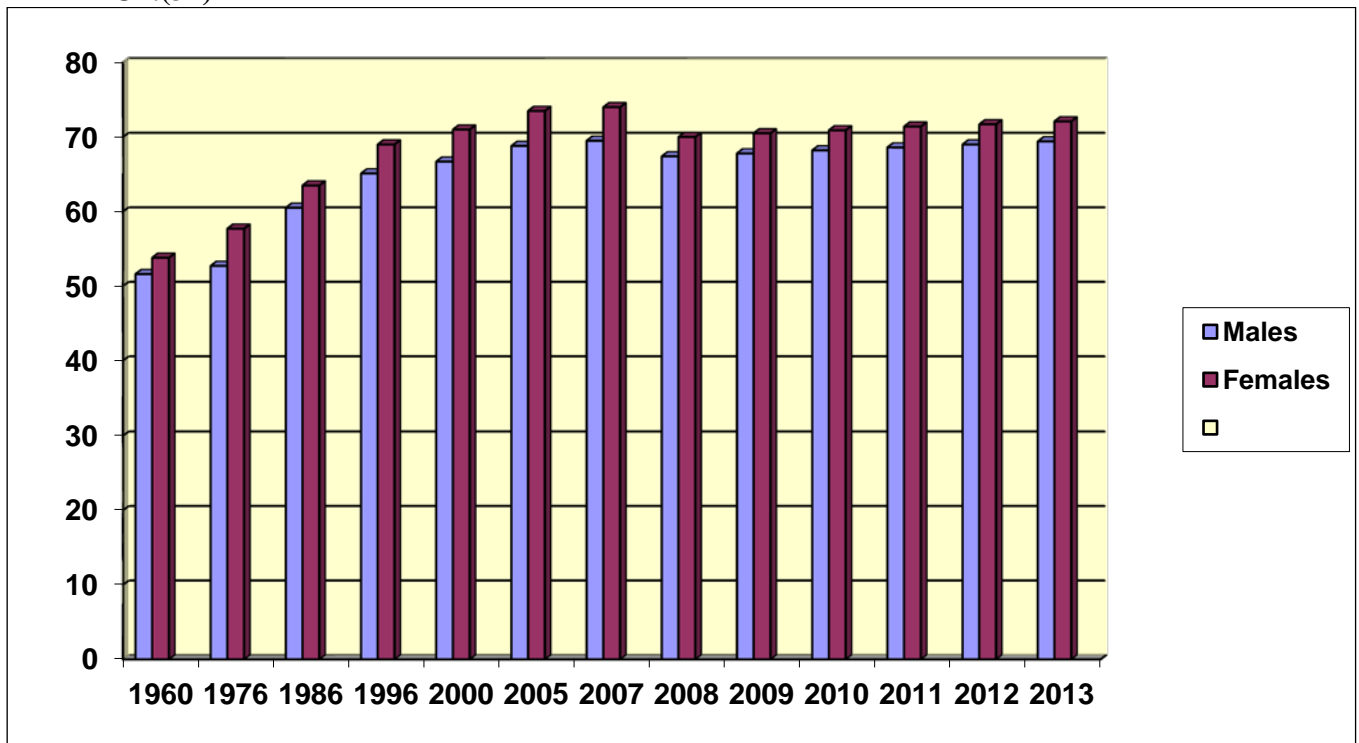
Shortage of blood was the most frequent avoidable health facility factor, contributing to 16% of maternal deaths and playing an especially important role in deaths from hemorrhage, ruptured uterus, and complications of cesarean section. Delay in seeking care, mainly because of failure to recognize danger signs during pregnancy or delivery, was the most frequent patient and family factor, contributing to 30% of maternal deaths. Delay was also associated with initially seeking care from general practitioners and private practitioners who were unable to manage obstetric emergencies or delayed referral to the hospital.

- **Life Expectancy**

The life expectancy was estimated in 1960 by 51.6 (Males) and 53.8 (Females) while in 1976 it increased to reach 52.7 (Males) and 57.7 (Females). In 1986 the life expectancy reached 60.5 (Males) and 63.5 (Females). During 1996 the figures continued in rising where it became 65.1 for (males) and 69 for (females), then in 2000 it was estimated as 66.7 (Males) and 71 (Females). In 2005 it reached 68.8 (males) and 73.5 for (females). In 2007 it increased to be 69.5 for (males) and 74.0 for (females). This means that life expectancy increased 20.2 years for females and 17.9 years for males between 1960-2007. The reason for this obvious increase was a result of providing high quality integrated health care services by Egypt governorate and preventing attacks of fatal disease (through applying standards of infection prevention control and high level of hygiene health services) for all citizens. These health services were in the form of family medicine which covers health care for all family members, primary health care which covers antenatal care, neonatal care, infant care and family planning services, health services through the hospitals of health insurance, the governmental hospitals, teaching hospitals and university hospitals. The umbrella of health insurance has played a very important role of saving life because the system is designed to cover the health care services for school students, university students, employees at governmental and private sectors and retired peoples as well. Most of the previous mentioned health care services were based on quality standards and accreditation. Ch.(32)

The Life Expectancy during 1960-2013

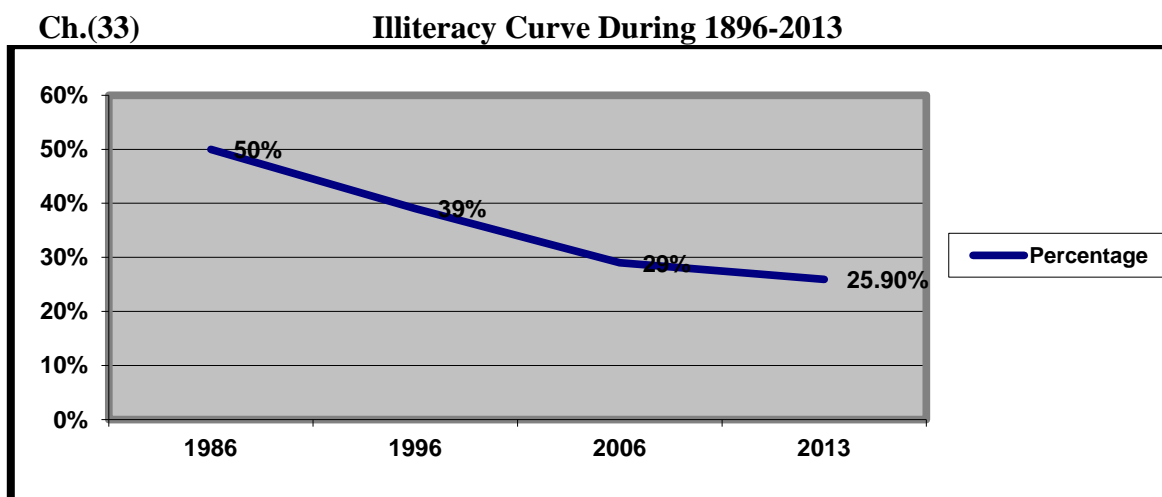
Ch.(32)



C-3 Educational Characteristics

A- Illiteracy

The estimated number of illiterates in 1986 presented 50%. In 1996 the figure decreased to 39% while it is estimated to have reached down to 29% of the entire population in 2006 and it continues in decreasing to reach 25.9% in 2013. A count has been taken for first time of the number of school drop-outs in the age group of 6 to 18 years old. The government of Egypt has put in its new strategy the eradication of illiteracy and enhancing the most recent education methods on all levels. The following chart (24) clarifies the declining of illiteracy curve between 1986-2013.



Illiteracy Eradicating -Picture (6)



The previous picture shows one of education classes for illiterate people at different ages. The government aimed at giving the illiterate student the basic educational skills that would enable him to contact various sources knowledge.

B- Education Levels and Attainment

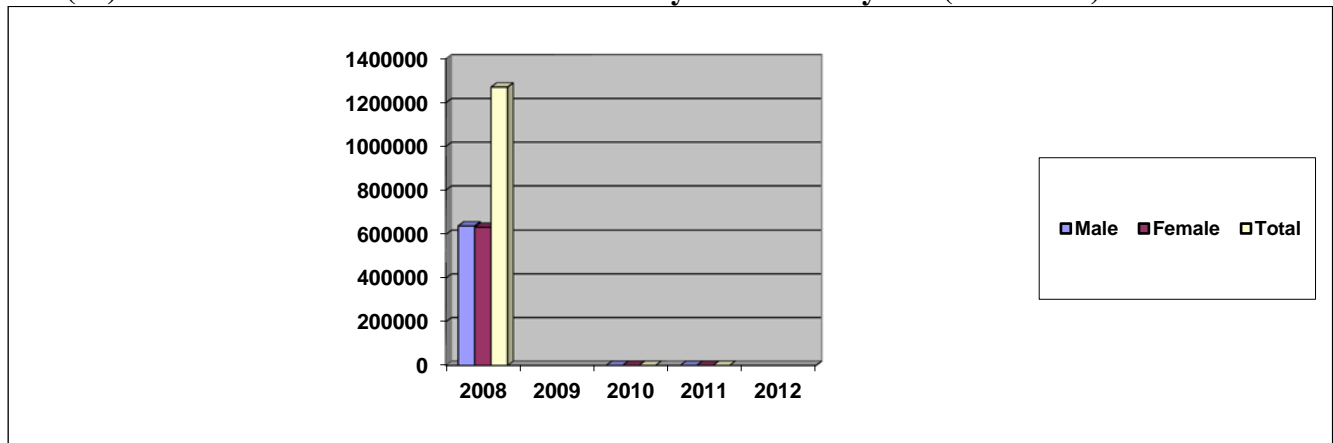
The following table (7) shows the background characteristics of different age groups for women relative to the levels of education from Primary to more than secondary levels. It shows also the percent of different age of women who are not educated. It was noticed that the level of education decreases with increasing age among respondents age 25 and over. It shows also that age 20- 29 had a higher level of education than in the 15-19 age group. This pattern was unexpected because the participation in schooling has been steadily rising among Egyptian women. The explanation lies in the fact that women who marry early typically leave school at a younger age than women who marry latter.

Educational Attainment- Percent of Women Age 15-49

T.(7) EDHS-2008

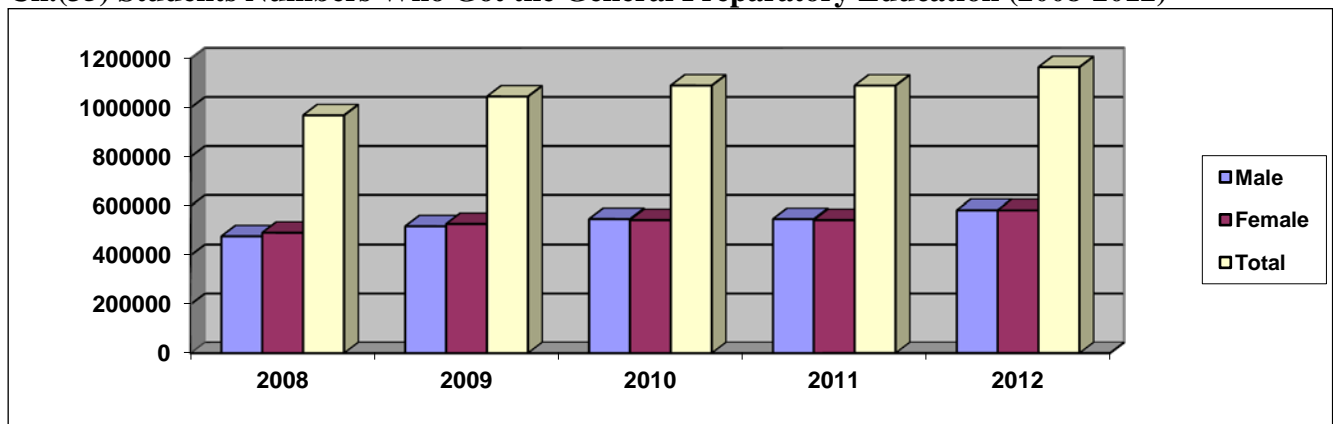
Background Characteristic	Highest Level of schooling attended or Completed						TOTAL
	No Education	Some Primary	Completed Primary	Some Secondary	Completed Secondary	More Than Secondary	
Age							
15-19	25.4	4.8	4.8	30.3	32.6	2.2	100
20-24	21.2	4.8	3.5	13.2	46.0	11.3	100
25-29	22.3	6.9	3.7	10.8	40.8	15.4	100
30-34	26.9	7.5	3.4	13.6	34.8	13.9	100
35-39	36.1	9.0	2.8	9.7	31.2	11.3	100
40-44	42.9	12.3	4.3	6.4	24.4	9.7	100
45-49	50.9	12.2	6.2	4.3	16.8	9.6	100

Ch. (34) Students Numbers Who Got the Primary Education by Sex (2008-2012)



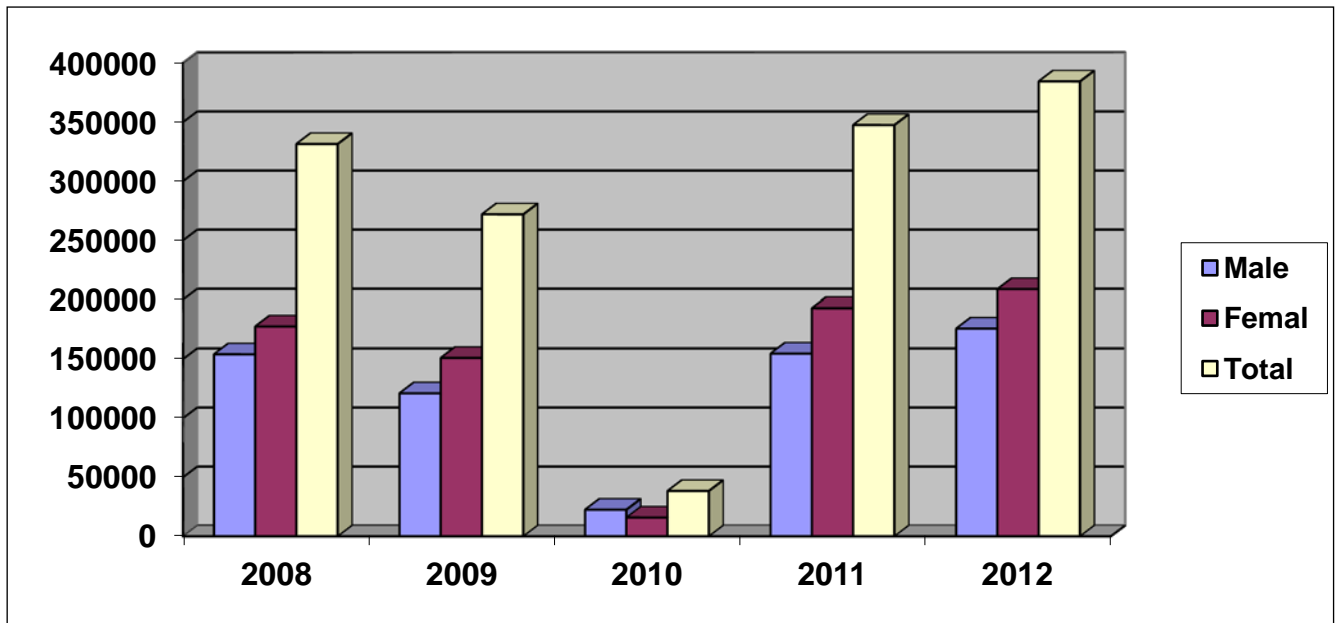
The previous chart clarifies that there is continuous increase in the numbers of both males and females in primary education during years 2008-2012 with some extent an equal numbers of males and females.

Ch.(35) Students Numbers Who Got the General Preparatory Education (2008-2012)



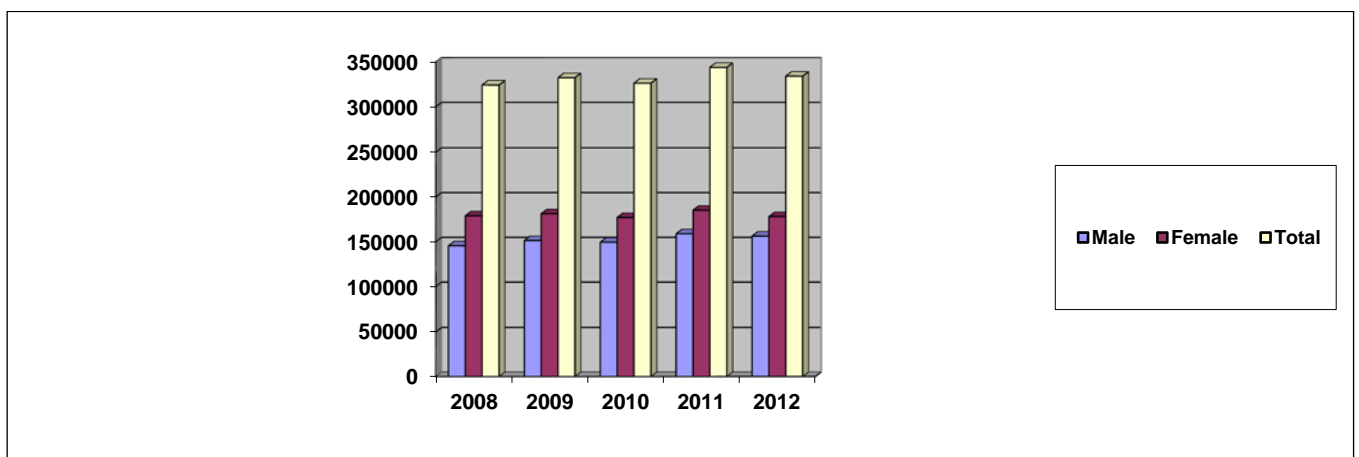
The preparatory education for males and females are near to each other during 2008-2012. (CAPMAS 2013)

Ch.(36) Male and Female Students Who Got the Secondary Education (2008-2012)



The previous chart (36) clarifies that the certified numbers from the males and females of the secondary education during 2008-2012 (CAPMAS 2013) are to some extent relevant to each other, However, there is a sudden declining in the student numbers of the secondary graduates during 2010. This phenomenon may be due to the disturbed political circumstances and educational recession in Egypt during this period. On the contrary, nowadays there is new strategy to promote and improve the educational plan and process based on the international standards.

Ch.(37) Development of Universities Graduates by Sex (2008-2012)



The previous chart shows the numbers of males and females from universities graduates during years 2008-2012. (CAPMAS 2013).

C-4 Social Characteristics

Labor Force

The participation of women aged 12-64 in work power presented 18% in 1984. This figure increased to reach 22% in 1997 and steadied at 21.6% in 2002. The labor force was estimated by 21.8 million in 2006 and was expected to be 29 million in 2021. This means that about 7.200 million will be added to labor force in 2021 which indicates that 478 thousand labor opportunities are annually requested. The CAPMAS-2010 announced that the labor force increased to be 25.2 million in the last estimated quarter of 2009 where 72.5% represents the participation of males from the total work power and 23% for females. The labor force continue in increasing in 2010, 2011 and 2012 as in the following table (T. 8- Ch.38)

Unemployment

The estimated figures of unemployment were 10.7% from total population work power in 1986. The figure decreased in 1997 to reach 8.3%. Then it increased to 8.93% in 2000 and 9.22% in 2001. It continued in rising to reach 11.0% in 2003. A little decrease is noticed in 2004 to be 10.32, and then it increased in 2005 to be 11.24%. The figure continued in declining to reach 8.7% in 2008. Finally the CAPMAS-2010 announced that the unemployment number is estimated 2.37 million where 22.85% represents the females and 5.27% represents the males in 2009. The CAPMAS also announced that the unemployment percentage rates increased to reach 9.4% in the last quarter of year 2009. The figures decreased from 2009 to 2010 and then started to increase during 2011 and 2012.

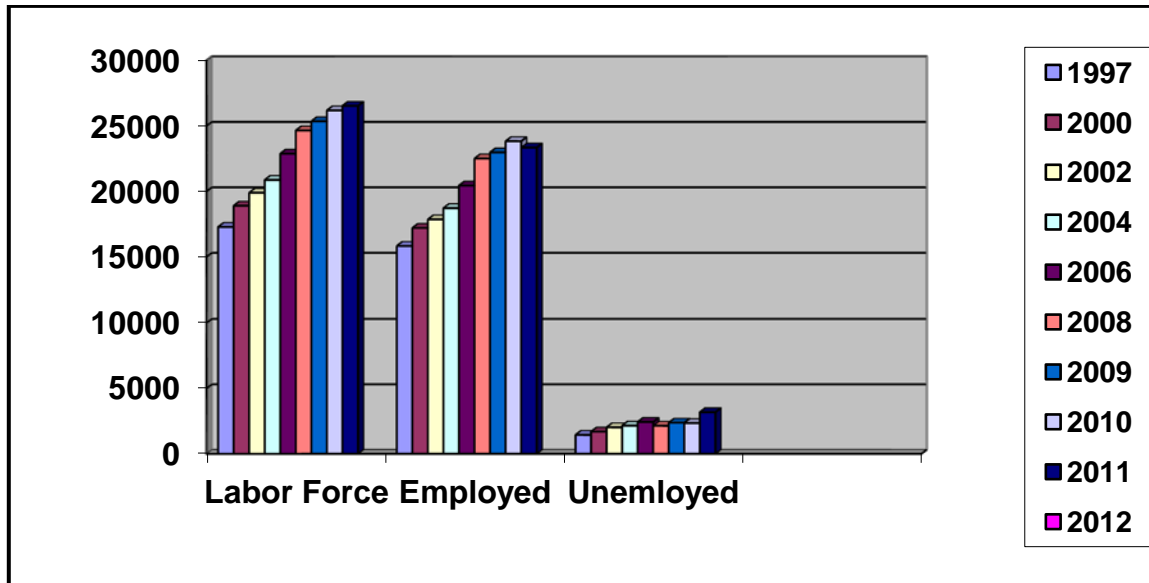
Annual Estimates of Labor Status and Unemployment Rate 1997- 2012

T.(8)

Years	Labor Force	Employed	Unemployed	Unemployment Rate %
1997	17277	15830	1446	8.37
1998	17631	16183	1448	8.21
1999	18230	16750	1480	8.12
2000	18901	17203	1693	8.93
2001	19340	17556	1783	9.22
2002	19887	17856	2021	10.17
2003	20360	18119	2241	11.01
2004	20872	18718	2154	10.32
2005	21792	19342	2450	11.24
2006	22878	20444	2434	10.64
2007	23859	21724	2135	8.95
2008	24651	22507	2144	8.70
2009	25353	22975	23780	9.40
2010	26180	23829	23510	9.0%
2011	26529	23345	31834	11.99%
2012	27020	23595	34248	12.7%

CAPMAS: 2009-2010- 2013

Ch.(38) Social Characteristic Curve of Labor Force, Employed and Unemployed Estimates



Egypt Unemployment Rate 1993-2014 | Data | Chart | Calendar | Forecast

Unemployment Rate in Egypt remained unchanged at 13.40 percent in the first quarter of 2014 from 13.40 percent in the fourth quarter of 2013. Unemployment Rate in Egypt averaged 10.55 Percent from 1993 until 2014, reaching an all time high of 13.40 Percent in the third quarter of 2013 and a record low of 8.10 Percent in the second quarter of 1999. Unemployment Rate in Egypt is reported by the CAPMAS, Egypt.

Ch. (39) Egypt Unemployment Rate (2012-2014)



In Egypt, the unemployment rate measures the number of people actively looking for a job as a percentage of the labor force. This page provides - Egypt Unemployment Rate - actual values, historical data, forecast, chart, statistics, economic calendar and news. Content for Egypt Unemployment Rate - was last refreshed on Wednesday, September 24, 2014.

The Marital Status

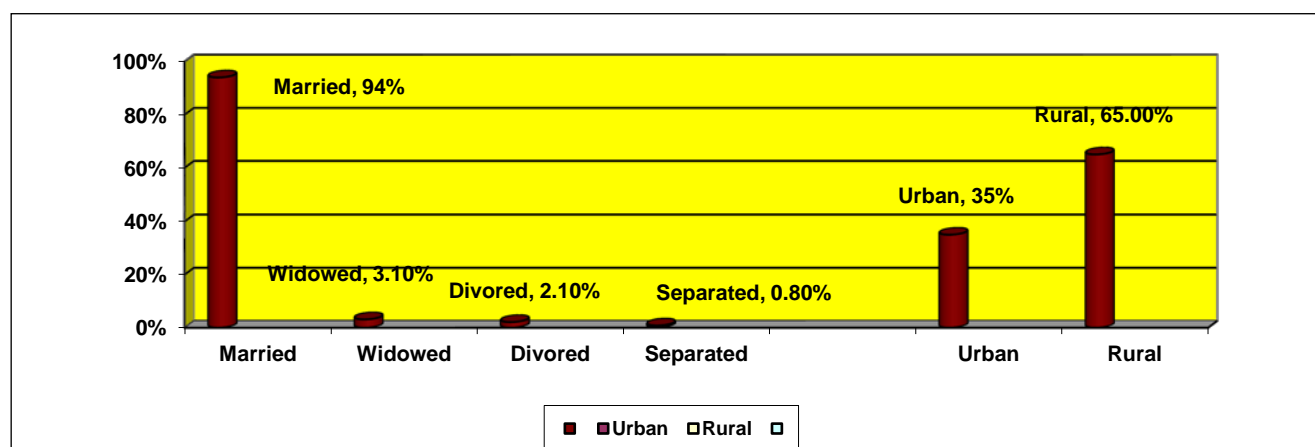
Marriage is one of the most important topics since it is a primary indicator of women's exposure to the risk of pregnancy. From the respect that the early age at first marriage in a population is usually associated with a longer period of exposure to the risk of pregnancy and thus higher fertility levels. The current marital status is totally estimated according to age 15-49 by 64.5% where the age groups 35-39 recorded 89.7% which is the highest figure while the age groups 15-19 recorded 13.1% which represents the lowest figure. The estimated records of women who never married were 30.7%. The most highest figure of never married women were 86.6% which represents the age groups between 15-19 relative to the lowest figure 1.9% which represents the age groups 45-49. The divorced cases were recorded by 1.5%, the separated 0.5% while the widowed cases were recorded 2.8%. EDHS-2008. In 2009 the marriage number was 759000 with a rate of 9.9, while the divorce number was 141000 with a rate of 1.8. This figures increased in 2010 to be 865000 marriages with a rate of 11.0 and 149000 divorces with a rate 1.9, in 2011 marriages were 898000 with 11.2 rate and 152000 divorces with 1.9 rate, in 2012 the number of marriages were 922000 with 11.2 rate and 155000 divorces with 1.9 rate. (CAPMAS 2013)

T. (9) Marital Status 2013-2014

Characteristic	Percent	Number
Marital status	%	NOs
Currently married	94.0	20,460
Widowed	3.1	669
Divorced	2.1	460
Separated	0.8	174
Age		
15-19	3.5	764
20-24	14.0	3,055
25-29	21.8	4,753
30-34	19.0	4,127
35-39	16.1	3,495
40-44	13.2	2,864
45-49	12.4	2,705
Urban-rural areas		
Urban	35.0	7,623
Rural	65.0	14,139

The table (9) shows that the currently married women represents 94%, the widowed women represents 3%, the divorced 2% while the separated 0.8%. The figures also clarifies the differentiation between the age group in % and the numbers. The figures in the table shares to the % and numbers distributed in Urban and Rural areas.

Ch. (40) Egypt Marital Status 2013-2014



C-5 Economic Characteristics

The government of Egypt has announced that the over population is a burden on economic growth and development. The current imbalance between population and resources is the largest imbalance; the largest challenge and topmost priority. As a result of this problem, the demand of importing the essential goods to compensate the community needs has increased, the size of agricultural lands decreased and the housing crises happened (in about 67% cases and more, you may find three persons are living in one bed room). There are also excess needs for hospitals, roads, traffics, transportation and all infrastructures. However, the government has introduced new agricultural lands for youth to cultivate them with consequent increase in the production of agricultural crops, but still the resources are not sufficient to cover the number of population which is an obstacle in front economic growth. Another big and great project is under construction right now which is digging a new branch for Suez Canal to enable the big ships to pass in two ways instead of one way now. The development of such international investment locations along side of the new canal will promote Egypt economical situation and introduce a lot of jobs for unemployment.

Picture (7) Suez Canal of Egypt



In August 2014, construction was launched to construct a second canal for half of the route of the canal, costing \$8.4 billion, to increase the canal's capacity. Funding was arranged by issuing interest bearing investment certificates exclusively to Egyptian entities and individuals and the target amount was collected over only six working days. The expansion is expected to double the capacity of the Suez Canal from 49 to 97 ships a day. Construction of the project is expected to take a year.

3- POPULATION AND FAMILY PLANNING PROFILE

Family planning (FP) is one of Egypt's national priorities. The population problem which covers population growth, demographic distribution and population characteristics stands one of the major challenges to be met if the effects of development are to be felt. The family planning policies and strategies in Egypt has passed through different phases since 1960s. Egypt's government announced the decree of the first official governmental support for family planning indicating the real birth of the population policy in 1962. Therefore, the ministry of health and population introduced the family planning national plan of action which aimed to provide different cafeteria of family planning methods, develop well equipped clinics for family planning services and support the costs of family planning methods. Then the national program of family planning started In 1980s. Its policies and strategies aimed to spread out family planning services with consequent increase the numbers of well renovated and equipped models of family planning clinics for about 50% (3900 clinics in 1981 to 6000 clinics in 2005).

There was also growth in the number of pharmacists by about 700% (3880 pharmacy in 1978 to 27000 outlets in 2004- CAPMAS). Those pharmacists participated in widening the scale of contraceptive methods provision and distribution. The expansion in clinical and pharmacy capacity was accompanied by an increase in the number of contraceptives distributed as measured by couple-years of protection (CYPs). The indicator that measures the approximate number of couples who are protected for one year by the use of all methods of contraception shared to increased CYPs from 1.1 million in 1980 to 6.5 million in 2004 which was an average increase of more than 600%.

In 1990s policies and strategies of the national program of Egypt have been modified, and updated to let the family planning services based on standard protocol and to be more accessible, more affordable and safe. In 1994 the Government of Egypt introduced the integrated health care system (family planning, reproductive health, maternal and child health) as new era of providing high quality service delivery in health care outlets (primary health care units, governmental hospitals, private sectors, teaching hospitals and university hospitals). The national family planning program and most of the family planning projects in Egypt were funded by United States Agency for International Development, USAID. In 1995 all the funded projects started the phase out of fund and put their implementation plans for sustainability. This fund sopped by the end of September, 2008.

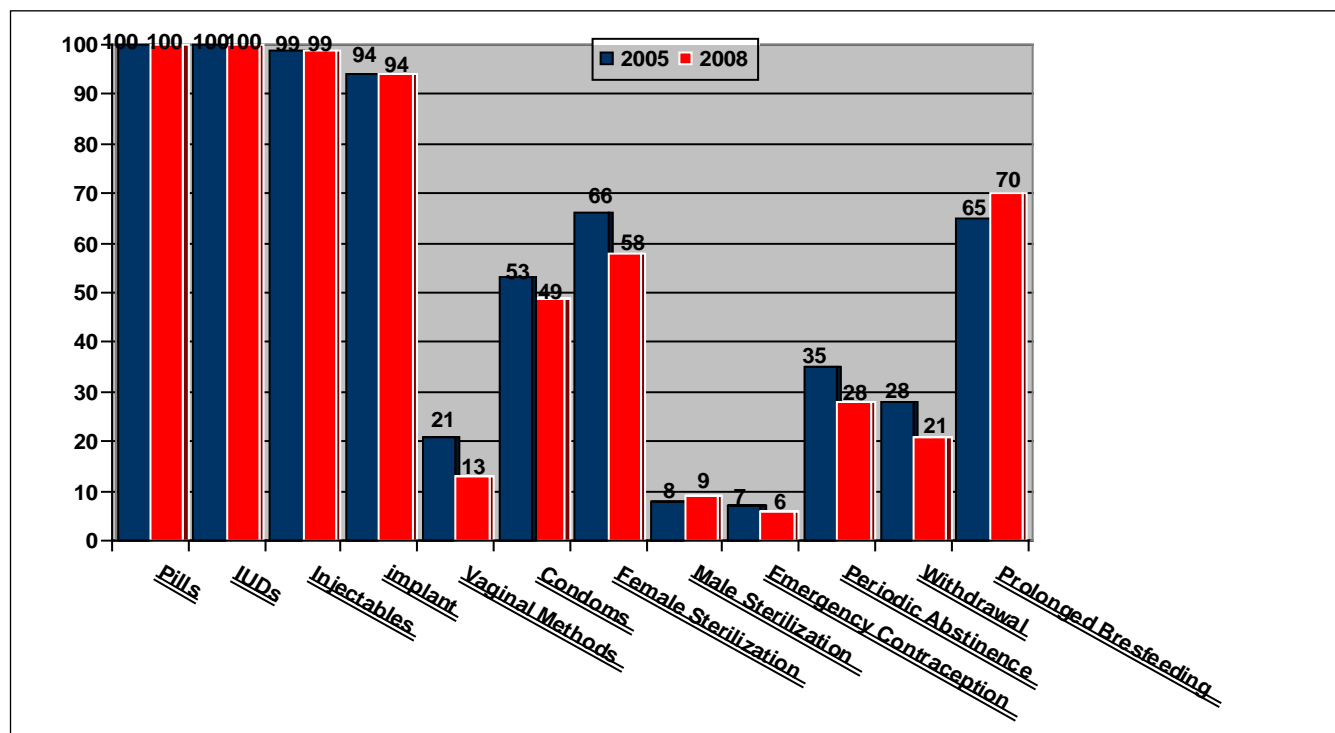
This part of the report covers the progress achieved to date in the family planning program of Egypt. Actually, the overall Egypt's demography has followed a classic transition from high fertility and mortality to lower fertility and mortality with consequent declining in total fertility rate in the last century. Declining the numbers of population annual increase by more than 12 million people. The proportional age distribution shows about 10 million young age group (15 years old and below). Declining in maternal deaths with 17,000 mothers' lives saved. The contraceptive prevalence rate has increased from 24.2% in 1980 to 60.3% in 2008 with consequent increase in the numbers of service delivery outlets. It is clear that the increase in family planning use have been a significant factor in this decline. This proves the great successful achievements of family planning program in Egypt in the last 28 years.(Population Stabilization Report 2010).

Knowledge of Family Planning

Awareness of family planning methods is crucial in decisions on weather to use a contraceptive method and which method to use. The results of EDHS-2008 show that the knowledge of family planning methods is universal among currently married women in Egypt. Nowadays in 2014 most of currently married women age 15-49 knew all types of contraceptive methods by 99.8%. In spite of such high figure of knowledge but still the usage just raised from 56% to only 59% in 2014.

Trends in Family Planning Knowledge Egypt 2005-2008

Ch.(41)



Family Planning Contraceptive Method Use

Trends in Ever Use of Family Planning (EDHS-2008)

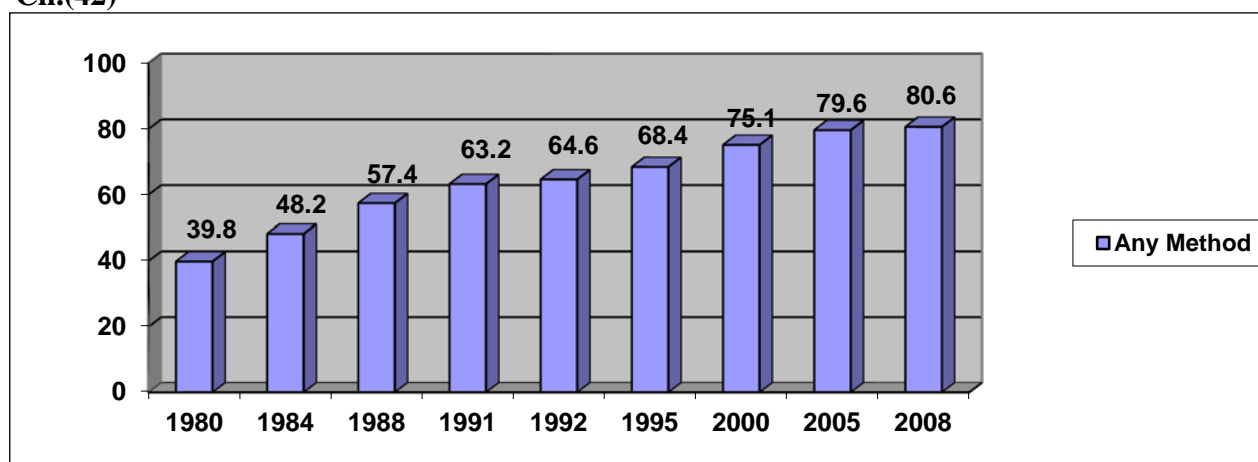
The ever use of contraceptive methods describe the overall family planning percentages use between (currently married women, previously married and became widowed or divorced; previously using women and recently stopped for any reason). The results indicate that 82% of married women had used a family planning method at some time. The highest level of ever use of any family planning method was 92% among currently married women between 35-39 age group, while the lowest level was found 31% among women age 15-19. The results also indicates that the level of ever use of any method increased from 40% in 1980 to 81% in 2008, with an average of 1.5% points per year. The following table (10) and chart (42) show the level of ever use of family planning among ever married women during 1980-2008.

T.(10)

Trends in ever use of family planning methods during 1980-2008 (Table)									
Years Surveys	1980 EFS	1984 ECPS	1988 EDHS	1991 EMCHS	1992 EDHS	1995 EDHS	2000 EDHS	2005 EDHS	2008 EDHS
Any Method	39.8	48.2	57.4	63.2	64.6	68.4	75.1	79.6	80.6

Trends in ever use of family Planning during 1980-2008 (Chart)

Ch.(42)



Trends in Current Use of Family Planning 2008-2014

The level and pattern of contraceptive methods use have changed during the last 34 years in Egypt. The average use doubled during the 11-year period between 1980-1991 (from 24% to 48%). The use rate continued to rise over the next 12 years although at a slower pace, where it reached a level of 60% in 2003 and there was an obvious little declining to (59.2%) till 2005, then it started the increasing to reach (60.3%) in 2008. However, in 2014 the expected figure is (59% as seen in chart 45).

The following tables (11) show the changes that have occurred in the use of specific methods over the past several decades. The IUD use rose from 4% in 1980 to 36% in 2000, where it has remained essentially stable till 2008 and then started declining to reach (30.1%) in 2014 (chart 44). There was a significant increase in the use of the injectables after the method became available in 1990s, with the rate rising from less than 1% in 1992 to nearly (8%) in 2003 and it remained fluctuating around this figure till 2008, where it is expected to reach (8.5%) in 2014. According to EDHS-2008 the use rate did not increase between 2003-2008. However, the use of pills declined from a rate of 17% in 1980 to 9% in 1998, where it remained essentially stable until 2005. It started to increase again to reach modestly 12% during 2005-2008 and continued in increasing to be (16%) in 2014. (Chs.44 & 45)

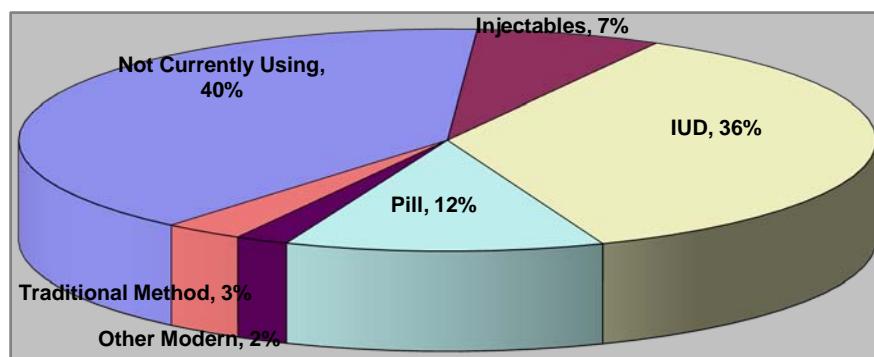
T.(11)

The Percentage Distribution of Currently Married Women 15-49 by FP Method Currently Used during 1980-2008

Method	1980 EFS	1984 ECPS	1988 EDHS	1991 EMCHS	1992 EDHS	1995 EDHS	1997 EIDHS	1998 EIDHS	2000 EIDHS	2003 EIDHS	2005 EDHS	2008 EDHS
All Methods	24.2	30.3	37.8	47.6	47.1	47.9	54.5	51.8	56.1	60.0	59.2	60.3
By Method												
Pill	16.6	16.5	15.3	15.9	12.9	10.4	10.2	8.7	9.5	9.3	9.9	11.9
IUD	4.1	8.4	15.7	24.2	27.9	30.0	34.6	34.3	35.5	36.7	36.6	36.1
Injectables	-	0.3	0.1	-	0.5	2.4	3.9	3.9	6.1	7.9	7.0	7.4
Implants	-	-	-	-	0.0	0.0	0.1	0.0	0.2	0.9	0.8	0.5
Diaphragm Foam	0.3	0.7	0.4	-	0.4	0.1	0.2	0.1	0.2	0.1	0.0	0.0
Condom	1.1	1.3	2.4	-	2.0	1.4	1.5	1.1	1.0	0.9	1.0	0.7
F. Sterilization	0.7	1.5	1.5	-	1.1	1.1	1.4	1.3	1.4	0.9	1.3	1.0
Abstinence	0.5	0.6	0.6	-	0.7	0.8	0.6	0.8	0.6	0.8	0.7	0.4
Withdrawal	0.4	0.3	0.5	-	0.7	0.5	0.4	0.3	0.2	0.4	0.3	0.2
Breast feeding	-	0.6	1.1	-	0.9	1.0	1.5	1.1	1.2	2.1	1.6	2.0

Current Use By Method – 2008

Ch.(43)



Trends in Family Planning Method Mix (1980-2008)

The following table (10) of method mix shows the dramatic shift from pill to IUD use which occurred during the past two decades. Almost 70% of current users relied on the pills in 1980 more than 4 times the percentage of users who relied on the IUDs. By 2008, about 60% of current users relied on the IUDs compared to 20% who employed the pills. It was noticed that there was also relatively rapid expansion of the use of injectables, where it shared to 12% of current users in 2008, compared with 5% in 1995 and only 1% in 1992.

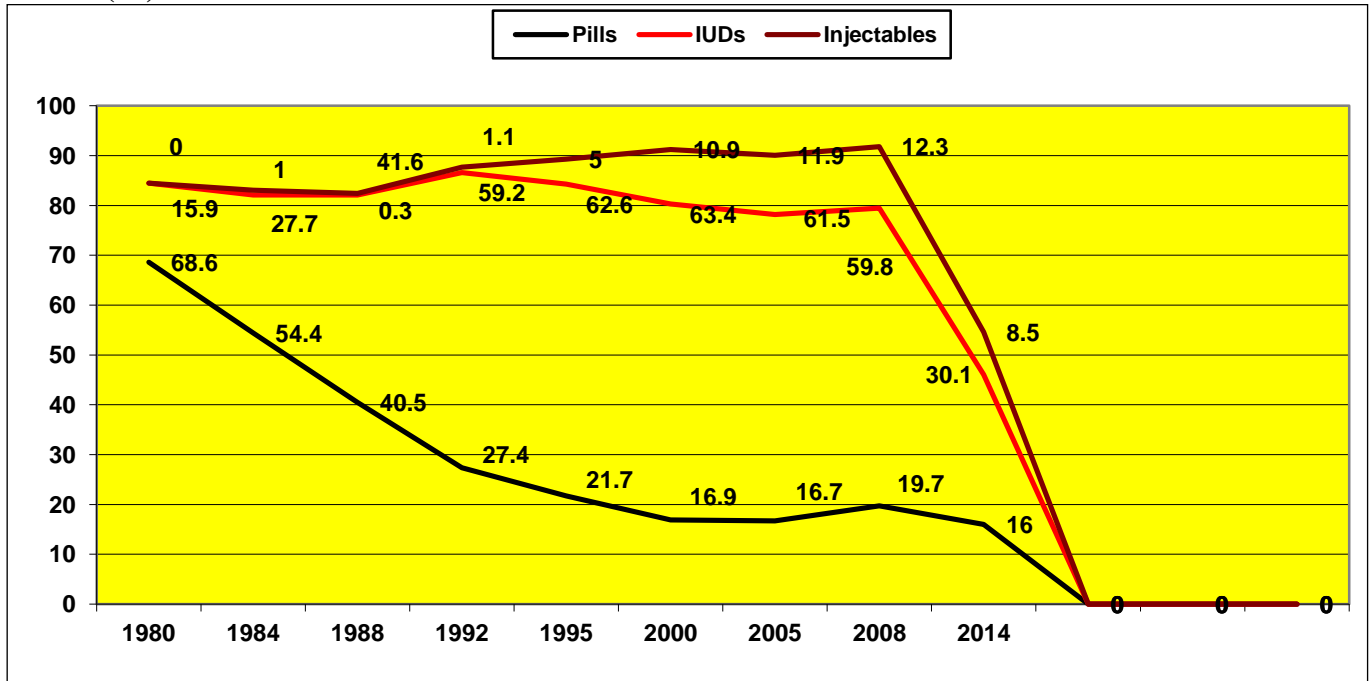
T.(12)

**Trends in Family Planning Method Mix
Percent Distribution of Currently Married Women 15-49 Who are using Any
Family Planning Method By Method Used in Egypt During 1980- 2008 – 2014**

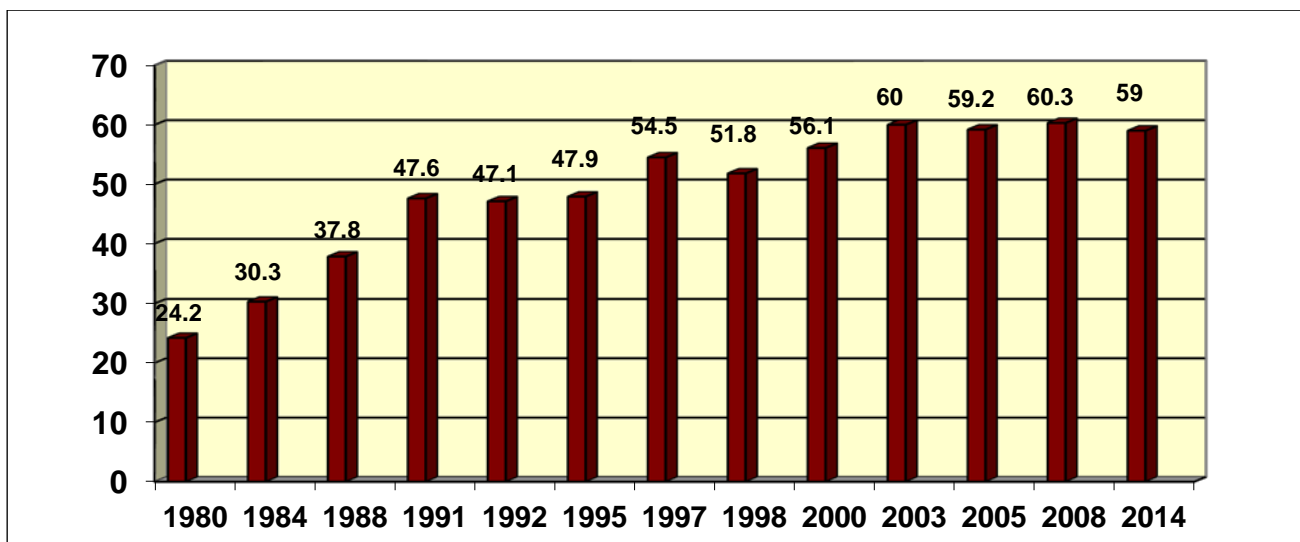
Method	1980 EFS	1984 ECPS	1988 EDHS	1992 EDHS	1995 EDHS	2000 EDHS	2005 EDHS	2008 EDHS	2014 EDHS
Pills	68.6	54.4	40.5	27.4	21.7	16.9	16.7	19.7	16
IUDs	15.9	27.7	41.6	59.2	62.6	63.4	61.5	59.8	30.1
Injectables	0.0	1.0	0.3	1.1	5.0	10.9	11.9	12.3	8.5

Trends in Family Planning Method Mix
Percentage Distribution of Currently Married women
Age Group 15-49 who are using any FP/Method by the Method Used
1980-2014

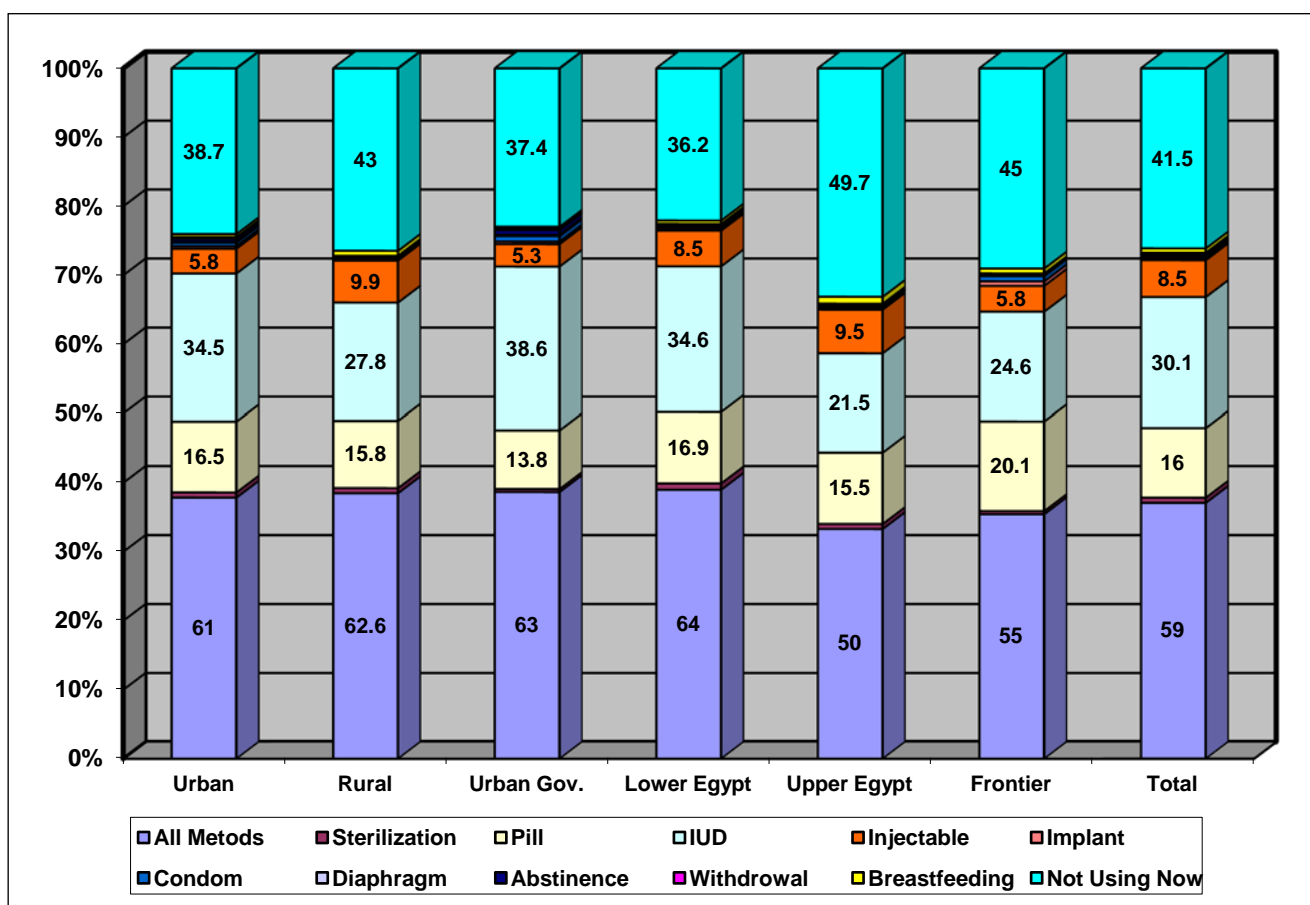
Ch.(44)



Ch.(45) Trends in Current Contraceptive Use in Egypt During 1980-2014



Ch. (46) Current Use of Contraceptive Methods in Urban and Rural Areas In Governorates of Egypt - 2014



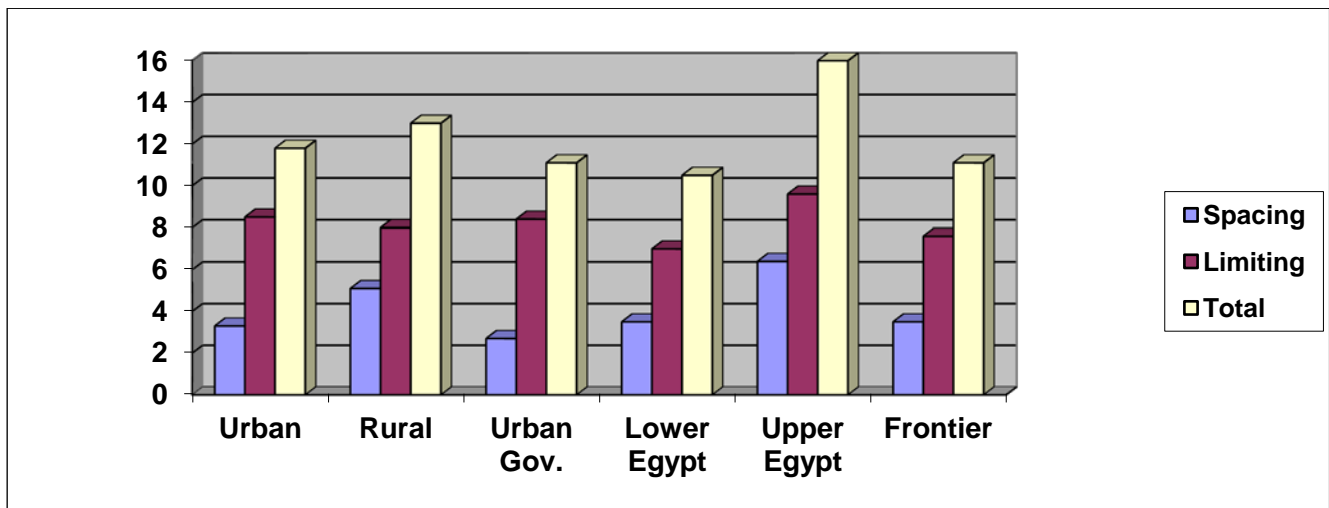
The previous chart clarifies the percent distribution of currently married women 15-49 by family planning method currently used according to urban-rural residence and place of residence, Egypt 2014

Unmet Need (2008-2014)

Unmet need was adopted a Millennium Development Goal (MDG) indicator in 2008. It is considered one of the major concerns of family planning programs that can enable the experts to define the size of the potential demand for contraception and to identify women who are the most in need of contraceptive services. At that time, it was recognized that the definition of unmet need had become increasingly complex over time and there was a need to adopt a definition for the indicator which could be consistently employed by countries in measuring unmet need. A new unmet need definition was adopted in 2012.

According to the revised definition, unmet need for family planning refers to fecund women who are not using contraception but who wish to postpone the next birth (spacing) or stop childbearing altogether (limiting). Specifically, women are considered to have unmet need for spacing if they are: At risk of becoming pregnant, not using contraception, and either do not want to become pregnant within the next two years, or are unsure if or when they want to become pregnant; Pregnant with a mistimed pregnancy; or postpartum amenorrhea for up to two years following a mistimed birth and not using contraception. Women are considered to have unmet need for limiting if they are: at risk of becoming pregnant, not using contraception, and want no (more) children; Pregnant with an unwanted pregnancy.

Ch.(47)The Unmet need for Family Planning - 2014



The above chart (47) clarifies the percentage of the women who are fecund and not using contraception but wish to postpone the next birth (spacing) or stop childbearing altogether (limiting). The unmet need was also identified as the sum of unmet need for spacing plus unmet need for limiting. While the total demand for family planning was identified as the sum of unmet need plus total contraceptive use.

4- PROGRESSES TWARD POPULATION STABILIZATION

The population stabilization process faced a lot of obstacles during the last three years since 2011 due to the unstable governmental systems and the difficult political circumstances. At that time there was multiple changes for the head of cabinet and ministers. Therefore, no one from the assigned government authorized persons gave any attention or caring towards the population development and stabilization. However, the former Egypt governments have considered the overpopulation problem as a national problem which was given top priority. The policy makers who plan to implement new strategies to reform the population policies and address the root causes of the overpopulation problem to seek sound solutions have faced multiple concrete challenges. In 2014 after the Egyptian revolution and electing the new president ElSiSi, the new cabinet with the president have put a modified and untraditional vision and strategies for the sake of the all Egyptians. They put a road map to help poor people and to improve the characteristics of the Egyptians. Therefore, gave an attention for the unbalanced distribution, so the planed to introduce three new governorates (Al Alameen, Middle of Sinai and Al Wahaat). The new government is very keen about maximizing the Egyptian human resources to decrease the unemployment rate and very keen to eradicate poverty and illiteracy. They put their plan to find solutions for problems that the Egyptians have suffered. The government has put all aim to facilitate the life services for the Egyptians like the access for health care quality, education standards, suitable housing and healthy environment. The ministry of health and population with the national population council and all the organizations who are working in family planning and reproductive health, maternal and child health started to review the health and population strategies to modify the action plans based on the new vision of Egypt. Actually, they will try to put untraditional solutions, new strategies, goals, objectives and new figures for population stabilization.

The Statement on Population Stabilization

The Statement on Population Stabilization was presented at the United Nations Population Conference in 1984, at the 40th anniversary of the United Nations in 1985, at the International Conference on Population and Development in 1993, and at the 50th anniversary of the United Nations in 1995. The following activities have been used to support the Statement:

A publicity campaign was conducted in each of the countries, including mailing the Statement to national leaders. A checklist was prepared for cabinet members, parliamentarians, the judiciary, the media, business leaders and donors on population stabilization policies.

National leaders in the largest signatory countries have been challenged to give recommendations on how they could fulfill the mandate of the Statement. The Statement has been used to prepare local population stabilization statements that have been signed by leading politicians, scientists, and professionals. In the largest signatory countries, population stabilization targets and timetables have been obtained. In each of the largest nations, population projections have been prepared based on total fertility rates of 1, 2, and 3 children, the current total fertility rate (TFR) and desired family sizes as measured by the latest knowledge-attitude-practice (KAP) survey.

The following considerations need to be reviewed before national plans of population stabilization can be formulated:

- What is the status of the existing family planning program? What additional program inputs would be needed to prevent unwanted pregnancies? What are the contraceptive training and supply needs?
- What modifications of national program reviews presented at the ICPD can provide the basis for formulating the policies and actions needed to achieve replacement size families? What percentage of the population has achieved replacement size families? What policies and actions are needed before couples have no more than two children?
- What are the legal issues that focus on improving the status of women, providing access to contraceptive services, increasing the age at marriage, etc?
- What are the legislative issues that need to be addressed? What is the potential of moving beyond family planning to prevent teenage pregnancies, increase the age at marriage, reinforce the spacing of births, and reach the one or two child goal? What actions need to be taken to improve the status of women, substitute for the workforce utility of children, and provide for security in old age?
- What level of education, especially for girls, and health services, is needed for replacement level fertility?
- What surveys of the public and national leaders could determine the actions needed to achieve replacement size families?
- Will there be opposition from religious or political leaders?

The eventual goal is to prepare national reports that prescribe the actions needed to achieve population stabilization in a given country. In India, these plans will be prepared for each state. Several states have already established population stabilization timetables and targets. The population stabilization reports will be presented to the heads of government, the cabinet, the legislators, governor-generals, the judiciary, the media, and key professional groups such as business, labor, medical, and education leaders.

As countries move towards population stabilization, the plans will be revised each year and distributed by mail. Thailand has a TFR (1.7) that would eventually result in population stabilization. In Brazil, without a formal population policy, the TFR of 2.4 is close to replacement. Mexico (TFR of 2.6), Bangladesh (TFR of 3.0), and Indonesia (TFR of 2.6) are all moving in a direction that could possibly achieve replacement level fertility within 15-20 years. In India, Andhra Pradesh, Tamil Nadu and Kerala have replacement level fertility. The Philippines (3.5) has a goal of reaching replacement level fertility by 2015-2020. Pakistan, with a TFR of 4.8, and Nigeria, with a TFR of 5.9, remain many years away from achieving population stabilization. With experience learned over the last 40 years, the reports will describe within and beyond family planning, the actions needed to prevent unwanted pregnancies, lower infant mortality, decrease adolescent pregnancy, increase age at marriage, the spacing of births and ultimately reinforce the two-child family. The reports will address the disparity

between the rights and opportunities of men and women within the cultural, economic, religious, health, education and economic settings. The reports will also address the pressures for high fertility, such as the desire for sons and the lack of opportunities for women outside the home. Beyond the broad development factors, the reports will explore the environmental problems, and sustainable development strategies.

Principles of the national population policy

So far The followings are the policies that have been addressed in Egypt:

- The family has the right to determine the most appropriate child numbers.
- The family has the right to get the correct information and materials that can enable it to carryout its decision within the legal channels, religious instructions and community culture.
- The Egyptian citizen has the right to immigrate internally and externally.
- The production capability of people should be upgraded and developed.
- Enhancing the decentralization system in the implementation of FP programs.
- Emphasizing the role of NGOs and private sectors in the management and implementation of FP programs.
- Enhance the equity and equality between genders.
- Achieve women empowerment and prevent harmful practices against women.

The national population strategies

The followings are the identified strategies of Egypt policy:

- Family planning and reproductive health strategy.
- Child health and child survival strategy.
- Literacy and education strategy.
- Improving women status strategy.
- Adolescent and youth strategy.
- Family support and protection strategy.
- Information, education and communication Strategy.
- Environment protection strategy.

Objectives of the national population policy

- Lower the population growth rate
- Achieve the balanced demographic distribution of the people.
- Progress the population traits and characteristics.
- Decline the demographic, social and economic gaps between the population groups and different geographic areas.

Still Egypt is Facing The Following challenges

- The population pyramid is broadly-based with the young-and-soon-to-be-married representing 40 per cent, which calls for double the amount of services presently made available.
- Birth rates are changing from one year to the other with death rates declining and family planning prevalence rates stabilizing between 48%-60% over the past three successive years.
- In-depth studies are required to lower birth rates and increase family planning prevalence rates to slow down population growth rates.
- Family planning methods, while available, are limited, falling short of fulfilling clients' needs.
- New modern methods should be made available.
- The private sector and NGOs have been instrumental in providing FP services and implementing population characteristic-improving programs.
- Despite that the media has played a leading role in the population and family planning area and the information published in newspapers and broadcast on radio and television, the family

planning prevalence rates have remained not satisfactory.

- A revision of the role of the media is called for so as to keep abreast of the social, cultural and behavioral changes in the community.
- Many obstacles have impeded a real partnership between all agencies working in the field.

In 2000, the government, attempting to face up to those challenges by revising the 1986 National Population Policy and introducing a fourth goal to bridge the demographic social and economic gap between population groups in the various regions. An unconventional strategy was also adopted with the purpose of slowing down birth rates and reducing fertility rates in order to raise the standards of living of the people in both the rural and urban communities with special emphasis on low-income groups.

The government has also introduced the National Population Strategy for the period 2002 to 2010.

The national population policy adopted with a clear vision and with an eye on introducing the latest in the world of scientific development, the policy aimed to:

- Promote family planning practices.
- Focus on women's health in their pre- and post reproductive years and help couples achieve their reproductive goals.
- Cooperate with the other agencies with the purpose of improving population characteristics.
- Promote the redistribution of Egypt's population.
- Provide health care to women at all ages.
- Provide services to remote and unattended areas.
- Provide modern family planning methods to service recipients.
- Provide high quality training to family planning service providers.
- Provide training for the private sector and NGOs in coordination with government agencies.
- Make family planning services available to all.
- Factor reproductive health and family planning into the state-provided health package.
- Ensure an international presence for Egypt at world forums to highlight the country's leading role.

6- PRIORITIES FOR FUTURE POLICIES AND STRATEGIES

The followings still are the old strategies which are being revised and modified right now by professionals and experts.

“The prospective view of Egypt”

Egypt leaders have put a new vision and consequently new strategies that can be implemented within the nearest future. Actually, all the governmental organizations started to revise its situations to find untraditional solutions for accumulated problems from the past time. Therefore, they started to develop modified action plans that can go with the recent circumstances. The following part describing the old strategy which has been previously developed by the National Population Council to cover the period from 2007 to 2017. The strategic plan is being revised and updated by the experts right now. The old plan aimed to achieve the total fertility rate to 2.4 children per woman in 2012 and 2.1 children per woman by 2017, which will contribute to rationalize the levels of population growth and redouble the community's ability to deal with the expected population rates of increase. However, the figures for achieving stabilization will change in rate and year.

The old strategic plan of Egypt was deigned to be carried out through adopting four main axes; each of them includes a number of operational objectives and strategies which are as follows:

The first axis

Improve the quality of reproductive health (RH) services and ensure its availability within the frame of primary health care. The objective which will be implemented to achieve this axis ensures the accessibility of all those who need the RH/FP services and methods to high quality services in accordance to their preferences at the right time and with affordable prices. This requires that the contraceptive prevalence rate among married women in the reproductive age group reaches 68.5% in 2012 which means providing the service to about 10 million women. There will be four main strategies to achieve the previous objective, integration of RH/FP services within the frame of PHC programs at all levels, targeting vulnerable groups and geographic areas that have more need, enhancing the quality and effectiveness of RH/FP services and adopting an effective strategy to secure the provision of RH/FP services and methods.

The second axis

Change the attitudes to adopt the concept of the small family and meet the growing demands for RH/FP services. The objective of the second axis is to continue with the efforts to convince the Egyptian family to adopt –voluntarily- the concept of a two child family and to ensure that this objective will be achieved through avoiding unwanted pregnancies and seeking the use of reproductive health services. This means that the percentage of women wanting two children only reaches 75% as opposed to the current rate of 60%. This objective will go through three strategies, activating Advocacy and IEC Strategies/tools to promote the concept of Small Family and Women Health, promoting the role of the religious leaders and clarify the language of religious advocacy and targeting youth (male & female) to influence their reproductive behavior

The third axis

Strengthen the linkages between the population dimensions and comprehensive development frameworks. The objective of the third axis is to integrate the population dimension within sustainable development frameworks in order to maximize its effect on the success of the National Population and Family Planning Program. The main six strategies which will achieve the objective of the third axis are human development health by continuing promotion of mother and child care to increase life expectancy, increasing the enrollment rates in primary education especially for girls and support illiteracy eradication programs, economic dimensions and poverty by supporting women's social and economic development, supporting the participation of women and women's empowerment in the society, activating laws to integrate the population dimensions in the currently applied laws and conducting updates/revision to suit Egypt's national & international commitments and geographic distribution for local development and reshaping the population map.

The Fourth axis

To apply Monitoring and Evaluation System effectively to the National Strategy Proposed.

The objective of the fourth axis is the study and the evaluation of changes in the population indicators which show the state of reaching the national goal so that corrective measures can be taken when necessary.

The objective of the fourth axis will be implemented throughout four main strategies, improving coordination systems and mechanisms by collecting data related to population activities for all partners in this area, analysis and evaluation of data and indicators related to population issues and measuring progress, applying transparency and accessibility to information and indicators relevant to population status and designing evaluation systems and mechanisms.

Another proposed strategy was submitted by the policy project (Prof. Dr. Hussein Abdel Aziz) to ministry of health and population during the last 3 years through the project of “Policies to address fertility plateau in Egypt”, but the ministry of health and population did not completed .

The study conducted based on the collected population data and from the respect that half women, who drop out the use of contraception during the first year, attributed this to reasons related to quality of services. The stalling fertility level and the lack of evidences for further reductions is also combined with a clear stability in the stated ideal number of children per family around three, during last decades and was reported to be about 2.9 children according to the EDHS 2008. The data also indicated the early start of reproductive life (before 20 years of age) by a relatively high percentage of younger women reaching about 10%. Moreover, the three children norm is clear since 40% of women who have two children indicated their desire for a third one while data from the Observatory for Family Affaires (IDSC, 2009) showed that 40% of all recorded births are of order three or more. The current fertility levels and their trends are also associated with significant improvements in the overall health indicators (and the MDGs) that might lend support to the sustainability of the current norm, unless serious efforts are undertaken to change attitudes and culture. **These improvements include:**

- 1- Continuous declining infant mortality rate to be about 24.5 per 1000, for the period 2004-2008, and the same trend for child mortality rate to about 28.3 per 1000 during the five year preceding the 2008 EDHS survey,

- 2- Reduced maternal mortality ratio to around 55 per 100 thousands births in 2008,

- 3- Higher percentage of mothers receiving any type of antenatal care during pregnancy reaching 73.6% and those who received regular care reached 66.05 during the five -year preceding 2008,

- 4.Slightly more than 70% of births in the five year period before the 2008 survey occurred in a health facility,

- 5-In 2008, about three quarter of all delivered births during the above mentioned period were assisted by a doctor,

- 6-Increasing expectation of life at birth to reach 70.2 and 74.8 years, in 2009,

for males and females respectively. Overall, assessment of progress indicated that the specified goals for reproductive health as well as child survival are on the right track and some of the proxy indicators for fertility were also showing positive direction although only up to the early years of the millennium. This requires full understanding of both policy and organizational frameworks that are creating supportive environment for achieving national population goals. In turn, this would highlight possible policy, administrative and organizational challenges affecting the National Population and Family Planning Program and their implications for its performance and ability to achieve long term national population goals, irrespective of the prevailing stalling levels of fertility and population growth. Population Policies and Strategies High level population growth is the focus of official government intervention since the mid sixties, irrespective of the development in the specification of the population 3 situation, the strategies and approaches adopted as well as the changes in the roles and responsibilities of various stakeholders. **The reduction of fertility levels through expanding the utilization of contraceptives was at the centre of all interventions. This can be easily noted at various stages of the national population and family planning program.**

First Stage: Medical Approach:

Although no population policy document was issued at the beginning of government intervention, in the mid sixties, the national program adopted a fertility target aiming to reduce the CBR by about one per thousand annually and the formulated strategy centered on the following objectives:

- Reducing Natural increase from 2.54% in 1966 to about 2.1% by the end of 1970, resulting of a population size of about 33 million.
- Expanding coverage of service units to ensure fast increase of contraception utilization. Estimated number of users reached 400 thousand women in the first year and to increase to about 700 thousand and one million women in the following years to be able to reach the specified goal. According to this medical approach, increasing coverage is required to eventually respond to expected growing demand

for FP which would enable the program to reach the specified targets. Promotion of services was the first priority at this stage.

The outcomes, however, were affected by:

- MOH clinics were limited in coverage and providing FP services as an additional responsibility (overtime), under different supervision,
- Week availability of skilled human capacity in the area of FP and the limited number of trained physician and service providers.
- Lack of coordination among various stakeholders.
- Prevailing national political circumstances (the 1967 war) leading to changes

in priorities and resulting in a stand still position for the process. This continued up to the end of this decade. A Ministerial Committee established in 1969, to assess the FP program and to propose future directions, recommended enhancing the program to aim toward reducing the CBR by one per 1000 annually, establish additional FP clinics to provide highly subsidized contraceptives. At the same time, the role of IEC programs was emphasized through establishing the Nile Centers and establishing a working group at the Ministry of Planning (MOP) to integrate population dimensions into development planning.

The Second Stage:

Developmental Approach The revitalization of the program took place in the early seventies which was reflected in reshaping the institutional framework and considering FP among the main responsibilities of the MOH. The main approach, however, was modified to consider population growth among other aspects of the situation. The main aim remains to increased percentage of land utilization and accordingly improving population distribution within the context of the developed new map for Egypt. The establishment of new settlements, expanding toward desert land in governorates and large scale projects. In sum, assessment of progress during this period indicated that goals for fertility, contraceptives, mortality as well as maternal and child care were approaching achievement while those related to women, labor, youth , illiteracy, environment and population distribution require intensified efforts and resources for their achievements.

The Third Stage:

High political support, especially at the top level, effective coordination among various stakeholders within the context of an integrated population strategy while promoting decentralization at the implementation level, as well as a strong leadership for the program, high level institutional framework shown by a strong National Population Council, the establishment of the Ministry for Population and Family Planning and intensified IEC activities, were the main factors behind the progress achieved during these years. Holding the international conference on Population and Development in Cairo (1994) and its action plan emphasizing this comprehensive framework were also additional elements for strengthening population and FP activities in Egypt, and their expansion within the context of reproductive health approach.

The Fourth Stage:

Targeting/Health Orientation Approach in 1996 the recently established Ministry for population and family planning was abolished and the strong leadership role of NPC diminished while the overall responsibility for the national Population and FP program was transferred to the Ministry of Health and Population (MOHP), although the PM continue to chair NPC up to 2002. By the end of the millennium the MOHP embarked on a process to assess the validity of the latest population policy and its attached documents after around 15 years of implementation since 1986. The main purpose was to examine the various dimensions of the population problem, the specified goals and to assess the effectiveness of the adopted strategies for this period. The revision process was completed and a proposed policy document was drafted by April 2000. Its main contribution was adding another fourth dimension for the population problem concerned with the wide differentials between the prevailing demographic indicators for various regions and population groups. The document included 11 components covering all stakeholders concerned with

population situation. Operationalizing such policy directions a National population Strategy 2002-2017 was launched in November 2001, including for each of the 11 strategies the main objective, the specified sub-objectives as well as the responsibility for implementation. These strategies covered: Family planning and reproductive health; child health and survival; education and illiteracy; improving the status of women; adolescent and youth; support and family protection; IEC; Environment protection; Population redistribution; reducing demographic differentials and finally strengthen research and information.

8- The First Cycle 2002-2007

The comprehensive strategy 2002-2017 was implemented through a series of successive five year plans; the first covered the period 2002-2007 and elaborated various activities to be carried out within the framework of the different sub-strategies. Concerning FP and fertility indicators, the plan aim to reach the following goals by 2007:

- ♣ Increasing contraceptive to reach 63.1 % of women in reproductive age,
- ♣ Reducing unmet need to about 6 %.
- ♣ Increasing couple years of protection to about 9.8 million women,
- ♣ Reducing fertility level to about 2.9 children per women. Moreover, the plan included specific indicators for other components that are being generally covered within the overall strategy. The sub-strategies, however, were mainly elaborating the overall mandate of various contributing stakeholders, based on the assumption that long term effect would eventually lead to changing behavior and reduce fertility levels as needed, without focusing on the specified population aspects or indicating the path that would produce such impact. In addition, observations and comments about this five year plan can be high lighted in the following:

1. The main goal focuses on population growth. It aims to reduce fertility to reach replacement level (2.1 Child per family) by 2017 and accordingly reducing population growth to about 1.2% annually,
2. The absence of a comprehensive set of quantitative goals within the context of the 11 sub-strategies that would lead, if achieved, to realizing the national population goals. However, a subsequent document presented the specified quantitative goals for various areas and included a total of 80 indicators. Specific plans for monitoring progress, however, were not elaborated,
3. Specified national objectives for the long term strategy were mainly guided by the population and development action plan as well as the millennium development goals they were globally endorsed in 2000. This was clearly shown for child health (infant and child mortality), maternal mortality, coverage for primary education and reducing gender gaps as well as expanding access to reproductive health services,
4. Generic formulation of the stated objectives without specifying neither the selected mechanisms for implementation nor elaborating the relevant plan ,
5. Lack of any plans for monitoring progress as well as measuring the impact of the adopted strategies.

Irrespective of s

uch constraints, the performance of the first cycle of the long-term plan (2002-2007) showed positive results for several sub-strategies. The assessment indicated that progress was significantly noticed for the indicators of 13 contraceptives in order to voluntarily specify the desired number of children for the family (reducing fertility level) is being totally absent and the reference to FP is currently considered sensitive which might affect the country's achievement in that respect. Moreover, it can be noted that:

- ♣ The comprehensive nature of the population problem should be reflected in the formulation of this new vision to elaborate how this complex problem would be handled. An integrated population plan is the main responsibility of NPC, in collaboration with other stakeholders,
- ♣ The concept of human development is significantly important for various countries but their strategies are actually focusing on one aspect of the population situation (characteristics) without providing mechanisms about how this will affect other dimensions of the population problem,
- ♣ The expected outcomes of adopting such new vision is not anticipated to demonstrate how it will contribute to the handling of the population problem,

♣ Since 1975 the population policies & strategies and their subsequent documents, the population and development interlinks were considered the most likely acceptable approach to cope with the population situation. This almost covered all the pillars specified in the new vision although within the context of a comprehensive strategy. The main difference, however, is to push the growth dimension side way.

♣ Lack of monitoring and evaluation plans to assess progress in achieving what would be considered among specified national goals. Organizational Framework Efforts to have a governmental body responsible for handling the population situation can be traced back to the fifties when the Committee for Population Matters was established to assess the population situation and provide recommendation for the government. Such directions, however, were terminated and the committee was dissolved when the government decided to pull out completely from any involvement with the population situation. The first government organizational framework was established in 1965 as “the Supreme Council for Family Planning”. The Council was chaired by the Prime Minister and included as members all Ministers concerned with population. The technical Secretariat “Executive Board for Family Planning” was entrusted with managing the national family planning program with clear mandate aiming to reduce natural increase rate from 25.4 per thousand in 1966 to about 21 per thousand by 1970 resulting in a total population of about 33 millions by that date. The program was independently carried out although fully dependent on the Ministry of Health facilities and those of NGOs. The national program was later affected by the 1967 war and its subsequent circumstances that led to a complete stop of the activities up to 1969, when a Ministerial Committee was established to assess major activities and recommend future directions.

The Supreme Council and its Secretariat were reactivated after introducing some basic changes:

14 • Establishing an Executive Committee for the Supreme Council to be chaired by the Minister of Health,

- FP services were introduced within all Ministry of Health facilities that worked according to special time table in the afternoon,
- Allocating government financial resources (one million pound) for the Supreme Council activities,
- Establishing the Nile Center for Information within the context of the “General Agency for Information”,
- Creating a working group, within the Ministry of Planning” to integrate population dimension within development planning. The goal for the national program was to reduce the CBR by one per thousand annually to reach the level of 30 per thousand in 1978. During the period 1965-2011 the organizational framework for the population problem changed several times to reflect either changes in mandate, chairmanship and membership or administrative level within the hierarchy of the country. The High-level population council was reformulated 11 times as follows:

1) The supreme council for FP, 1965, chaired by the Prime Minister,

2) The Supreme council for family planning, 1972, chaired by the deputy prime minister,

3) The supreme council for family planning and population, 1974, chaired by the deputy prime minister,

4) The supreme council for family planning and population, 1977, chaired by the vice-president,

5) The national population Council, 1985, chaired by the President until endorsing the National Population Policy,

6) The national population council, 1986, chaired by the Prime Minister,

7) The national population council, 1996, chaired by the Prime Minister,

8) The national population council, 2002, chaired by the Minister for health and population,

9) The national population council, 2007, chaired by the Prime Minister,

10) The national population council, 2009, chaired by the Minister for family and population,

11) The national population council, 2011, chaired by the Minister for health and population. The main responsibilities for such high level council are to approve proposed policies, develop comprehensive integrated population plans, in collaboration with all stakeholders, coordination as well as monitoring and

evaluation. At certain time the 15 functions were expanded to have executing power for pilot experimental projects such as the population and development project, while at other points its role was narrowed to mainly research and data collection.

The Council has local branches in all governorates to support customized population activities at local level and ensure decentralization of population plan implementation. The performance of this high-council is affected by many factors that determine its role in connection with other stakeholders. Among these are the level of political support, the priority given the population situation, ability to mobilize resources as well as the leadership personality and background. At the same time, in two occasions a special Cabinet Minister was appointed to shoulder the responsibility of the population situation. The first, the Minister for population and family affairs was nominated during the period 1993-1996, during which the International Conference on Population and Development was held in Cairo in 1994 (ICPD). Besides, it contributed to creating supportive environment for the national program. The second occasion took place in 2009 where a Minister for Family and Population was appointed and assigned the responsibility for chairing the NPC. However, its role and responsibility was largely debated and the Prime Minister continued to chair the meetings of the Council with the presence of the Executive Committee. This long list of organizational structure clearly indicates the lack of stability, the absence of continuous political support and a clear vision about both the population problem and the institutional framework required for its successful handling and establishing effective working relationship with various stakeholders

- It also reflects the periodic seasonality that characterized the official political government position toward the population problem. Strategic planning, defining roles and responsibilities of all stakeholders, coordination between various programs to ensure their integration, the ability to assess the contribution of various programs in reaching national goals as well as periodic monitoring and evaluation should be spelled out within the mandate of such organs to ensure its effectiveness.

Challenges and Future Directions.

The previous discussion about the policies and the organizational framework pinpointed several challenges that clearly affect the country's ability to achieve its national population goals within the current political environment. Building consensus around the Population Problem The various dimensions of the population problem were almost stable since 1975 with the built in assumption that rationalizing population growth is the ultimate goal that will be affecting and at the same time affected by the development of the other population dimensions. This clearly requires adopting a comprehensive strategy, with clearly assigned roles and responsibilities. Moreover, it is important to note:

- Population policy should be one of the components of a comprehensive development policy and not a replacement. Both should be harmonized and their implications(outputs) need to be mutually taken into consideration.

16• The specified goals for the population policy should be mainly linked to various demographic processes although strategies for their implementation can be cross-cutting with other sectoral activities. This would again emphasize the importance of having full partnership among all stakeholders in the community.

- Population would continue to grow for a longer period but the main question is the size of such expected increase. Population Growth Fertility is the main factor determining the level of population growth since the role of permanent migration is ineffective. Accordingly, the focus of various population strategies was to work on changing culture and reproductive behavior to adopt small family size norm without having a clear definition of its size. The strategy 2002-2017, however, referred to the norm of two children per family through adopting the replacement level goal by 2017. This was also clearly spelled out in the latest population and FP strategy 2007-2012. Significant progress has been achieved during past years and the level of fertility declined from about 7 children per woman in the sixties to about 3 children around 200.

8. The pace of decline was slower in recent periods and reached a stalling level after 2003. The same trend was also noticeable for the level of contraceptive utilization since the prevalence fluctuated around 60 % of woman in reproductive ages in 2008 with no recent evidence

about any change of direction. The prevailing norm for the desired number of children around 3 is also supported by the fact that the ideal number of children for both ever-and currently married women was about 2.9 children in 2008 and is almost stable for the last 25 years. As noticed population projections are showing a large scale differences depending on the adopted base population (2006 census returns or those corrected using the results of the 2006 PES) as well as the highly risky estimates of Egyptians abroad fluctuating between 6 to 10 millions. However, for the sake of clarifying the point the UN/Population Division projection (the 2010 revision) is to be used. If fertility continues at its current level of 3 children, Egypt population would reach 89 million by 2015 and continue to grow to about 105 and 150 million by the years 2025 and 2050 respectively, providing UN projection according to different variants.

7- CONCLUSION

Egypt has a new look after its revolution. The new president and government are doing unbelievable effort to promote and improve the Egyptian people situation and to regain its distinction and glory on the level of worldwide. Nowadays, most of the policy leaders, policy makers and stakeholders are doing their utmost to maintain and sustain the achieved rates and have ambitious aspirations to enhance their achievements in all infrastructure, production and service sectors to stabilize the population status. This population increase challenges all efforts to provide more and better-quality services, create job opportunities and curb unemployment. It also undermines the pursuit of Egypt government for improved standard of living and even goes far beyond to pose a threat to Egypt's social stability and national security. Egypt is still considering its frequent success towards population stabilization polices and programs a long journey and not final destination.

8- DEFINITIONS OF CERTAIN ABBREVIATIONS

CAPMAS: Central Agency of Public Mobilization and Statistics.

EDHS: Egyptian Demographic Health Survey.

EIDHS: Egyptian Interim Demographic Health Survey.

EMCHS: Egyptian Maternal Child Health Survey, 1991.

ENMMS: Egyptian National Maternal Mortality Survey, 1992/1993.

EEOCP: Egyptian Emergency Obstetric Care Protocols, CEOC.

EFS: The Egyptian Fertility Survey.

FP: Family Planning.

MCH: Maternal and Child Health.

MOHP: Ministry of Health and Population.

NPC: National Population Council.

PHC. Primary Health care.

T. Table ()

TRF: Total Fertility Rate.

RH. Reproductive Health.

9- REFERENCES

Abdel-Azeem, F., S. Farid, and A.M, Khalifa. 1993. Egypt Maternal and Child Health Survey, Cairo, Egypt: CAPMAS- Egypt and Pan Arab Program for Child Development (Arab League).

Blackburn, R.D., J.A. Cunkelman, and V.M. Zlidar. 2000. Oral contraceptives-An update. Population Report, Series A. No,9. Baltimore, Maryland, USA: Johns Hopkins University School of Public Health, Population Information Program.

Central Agency of Public Mobilization and Statistics CAPMAS. Egypt 2006- 2009- 2010.

Chao, Dennis. April 2004. Family Planning in Egypt is a sound Financial Investment. Washington DC: POLICY Project.

Egyptian Demographic Health survey, EDHS. 1988-2008

Egyptian Maternal Child Health Survey, 1991.

Egyptian National Maternal Mortality Survey, 1992/1993.

Egyptian Emergency Obstetric Care Protocols, EEOC.

Female Genital Mutilation, Legalization, Social, Religious and History Issues, Prof. Dr. Mahmoud Karim, Professor of OB/GYN, and Head of Department, Ain Shams University. Edition-2009.

History of Family Planning and Circumcision since Ancient Times, Professor Dr. Mahmoud Karim, first edition, June 2009, I.S.B.N. 977-17-7023-3.

Karim M. and Ammar, R. (1965) "Female Circumcision and Sexual Desire", Ain Shams University.

Karim M. (1988) "Female Circumcision and Aids", Ain Shams University. Prof. Dr. Mahmoud Karim, Professor of OB/GYN, and Head of Department, Ain Shams University.

Hallouda, A.M., S.Z. Amin, and S. Farid, eds. 1983. The Egyptian Fertility Survey. 4 vols. Cairo, Egypt.

Ibrahim,S. 1995. State, women, and civil society: An evaluation of Egypt's population policy in family, gender and population in the Middle East: Policies in context, ed. CM. Obermeyer.Cairo, Egypt: American University Press.

International Food Policy Research Institute (IFPRC), 2001.
The Egyptian Food Subsidy System : Structure, Performance and Options for Reform.
Washington, DC.

Moreland, Scott, ed. 1996. Investing in Egypt's Future. Cairo: RAPID Project.

National Population Council 1981-2010

Policy Project in Egypt and The Future Group International in collaboration with Research Triangle Institute, and Center for Development and Population Activities (CEDPA) in 2006.

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

Robison, Warren C., and Fatma H. El Zanaty, 1995. The impact of Policy and Program on Fertility in Egypt: The Egyptian Family Planning Success Story. Washington, DC: OPTION II Project.

Robison, Warren C., and, Fatma H. El Zanaty, 2005. The Demographic revolution in Modern Egypt, Lanham, MD: Lexington Books.

United Nations Development Group (UNDG). 2003. Indicators for monitoring the Millennium Development Goals: Definitions, rationale, concepts and sources. New York: United Nation General Assembly.

The project of “Policies to address fertility plateau in Egypt” coordinated by the Social Research Center (SRC) of the American University in Cairo (AUC) and supported by the United Nations Population Fund (UNFPA), Cairo Office. (Prof. Dr. Hussein Abdel Aziz).

www.baseera.com.eg

13, Lebanon St. Mohandseen, Giza.

<http://worldpopulationreview.com/countries/egypt-population/>

