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# Domestic Resource Flows

## Report of a case study in Egypt

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The views expressed in this report are those of the mission and not necessarily those of the United Nations Population Fund.



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# Preface

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In the Programme of Action, adopted at the International Conference on Population and Development (ICPD) in Cairo on 5-13 Sept 1994, countries have committed themselves to attain specific goals in the field of population and sustainable development. Measuring financial resources, which countries commit to population activities is an important way to monitor the progress of the implementation of the Programme of Action of the ICPD.

UNFPA is collaborating with the Netherlands Interdisciplinary Demographic Institute (NIDI) to develop and maintain an updated system for the collection, analysis and dissemination of information on both international and domestic financial resource flows for population activities.

The classification of population activities in this study closely reflects the principles of the ICPD. For operational reasons, it was decided to restrict data collection to the “ICPD costed package” mentioned in paragraph 13.14 of the Programme of Action. This means four categories of population activities:

- family planning services;
- reproductive health services;
- STD and HIV/AIDS programmes;
- basic research, data and population and development policy analysis.

In paragraph 13.15 of the same document, it is estimated that, in developing countries and countries with economies in transition, the implementation of programmes in the area of reproductive health, including those related to family planning, maternal health and the prevention of sexually transmitted diseases, as well as other basic actions for collecting and analyzing population data will cost \$ 17.0 billion in 2000, and increase to \$ 21.7 billion in 2015. Two thirds should be paid by the recipient countries, one third will be paid by the international donor community.

The case study in Egypt was conducted from 29/11/1997 to 17/12/1997 , and forms part of the UNFPA-NIDI project which measures global financial resource flows for population activities. For this purpose, questionnaires have been mailed in 1997 to public and private donor organizations in developed countries, and to government departments and national NGOs in developing countries. Collecting all this information from a broad range of

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respondents requires in-depth attention to issues of definitions, classifications, response rates and time lines. To better understand and resolve these problems, seven case studies will take place during 1997 and 1998. The case studies will complement our knowledge about financial flows for population activities which were obtained through the mail enquiry. The first study took place in Indonesia in August 1997 and coincided with the domestic data collection period there (for 1996 data). The case study in Egypt took place after regular data collection had already been completed.

Data for this report were gathered in December 1997 by a two persons: Ms. M. Exterkate from the UNFPA/NIDI Resource Flows Team, and Ms. Ouahiba Sakani, from the Cairo Demographic Centre. Valuable help was provided by Mr. Abdul Muniem Abu-Nuwar, UNFPA representative, and Ms. Sahir Abdul Hadi, UNFPA deputy representative.

Due to the complexity of international and national resource flows in population assistance, and the relative short duration of the study, it is possible that this report contains significant omissions or errors. The author will welcome any comments or corrections.

Marja Exterkate,  
December 1997

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# 1. Demography of Egypt

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The Arab Republic of Egypt lies on the northeastern corner of the African continent. The country is classified as a 'middle income economy', even though the GNP per capita has increased from US\$ 660 in 1988 to US\$ 790 in 1995.

In January 1996, the population of Egypt was estimated to be 60.2 million. Although the total area of Egypt is roughly one million square kilometers, the population is distributed unevenly over the country: almost the entire population lives on 5.5 per cent of the land, which includes the Delta region in the North (Lower Egypt) and the Nile River Valley (Upper Egypt). Despite the government's efforts of land reclamation and raising new settlements, only a tiny portion of the population lives in the remaining New Valley area, Red Sea and Sinai regions (UNFPA, 1996, p. 9). This combination makes that the inhabited areas in Egypt are very densely populated: for the country as a whole the population density in the inhabited area comes to roughly 1090 persons per square kilometer, but this can vary from 33,000 persons per square kilometer in Cairo to 23 persons per square kilometer in Suez.

Table 1 gives some demographic indicators. Prior to the second World War, fertility levels were high, decreasing gradually after the war (UNFPA, 1997, p. 14). The Crude Birth Rate (CBR) declined from a level of almost 43 births per 1000 population to an estimated 34.5 in 1972, after which it began to rise. At the end of the eighties, the CBR began declining again to a level of 27.6 in 1996. The trend in the total fertility rate also has been downward, with a decline accelerating until 1990. Fertility levels fell from around 5.3 births per women during the years 1979-1980 to 3.6 births for the period 1993-1995 (UNFPA, 1997, p. 14). The pace has slowed considerably during the first half of the nineties. An increase in the age of marriage, and increased use of contraception have contributed to this decline of fertility.

Before the second World War, mortality levels were also high, but began declining after the war (UNFPA, 1997, p. 15). Much of this reduction was owed to a sharp decline in the number of deaths in early childhood: infant mortality levels fell from 200 deaths per 1000 births in the 1940s to 150 per 1000 deaths in the early 1970s and subsequently to 56 in the beginning of the nineties.

*Table 1. Basic demographic indicators.*

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	1960	1976	1986	1996
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Population (million)	26.1	36.6	48.2	60.2
Annual growth rate	2.3	1.9	2.8	2.1
Percent urban	38	44	44	43
Crude Birth Rate	42.9	35.7*	38.6	27.6
Crude Death Rate	16.9	10*	9.2	6.2
Total Fertility Rate	7.2	5.5***	5.1***	3.4***
Infant Mortality Rate ***		150	112	56
Maternal Mortality Ratio			320	
Life Expectancy at birth male	51.6	52.7	60.5	62.9**
female	53.8	57.7	63.5	66.4**

\* 1980

\*\* 1991

\*\*\* These figures relate to the periods 1970-75; 1980-85, and 1990-95 respectively

Sources: CAPMAS, Statistical Yearbook, 1990-1995 (July 1996), and Statistical Yearbook 1991-1996 (July 1997);  
 For Infant Mortality rates: World Development Indicators, CD Rom, World Bank, Feb 1997;  
 For Maternal mortality rates Source: NPC, Formulation of Population Strategies, 1997-2007.

The country's past high fertility resulted in the rapid growth of the population: from 36.6 million people in 1976 to 60.2 million in 1996, an increase of 64 per cent.

Today, Egypt's demographic situation is marked by declining fertility and mortality, and the continued urbanization of the population (UNFPA, 1994, p. 8).

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## 2. Methodological issues

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From 29/11/97 to 17/12/97 interviews were held with representatives from ministries, international donors (bilateral, multilateral, private), and national and international NGOs in Cairo. A total of 11 field offices of international donors (bilateral, multilateral, NGOs) were visited, five government departments, and five national NGOs.

With a few exceptions, the cooperation of all respondents was very positive. In the months preceding the case study, questionnaires were sent to four government departments and four NGOs. All government departments which received a questionnaire provided information and three out of four NGOs filled in the questionnaires. All data was processed before conducting the case study.

The specific objectives of the case studies are:

- to fine-tune and refine data collection procedures for estimating financial resource flows for population activities. These procedures can be used in a later stage in the global mail enquiry;
- to provide more information on how resource flows are directed towards population activities within the countries covered by the case studies and how the ICPD Programme of Action is implemented;
- as benchmarks for studying the quality of data gathered through the mail enquiry;
- to investigate the roles of NGOs and the private sector in the field of population activities;
- to study possible methods for sustainability used within the country: e.g. cost recovery in public programmes;
- to gather more information on financial sources in relation to the implementation of the Programme of Action of the ICPD: are there any changes in priority at the government or at the donors' level; has the ICPD Plan of Action influenced the population policy and programmes within the country? And how?
- to study co-ordination between and among government departments, NGOs and donors.

To optimize the quality of the information, the team followed as much as possible a standard strategy:

- questionnaires were controlled and internal and external quality checks were done;
- during the interview with representatives from the organization, inconsistencies and uncertainties in the data were clarified;
- if necessary information was corrected or adapted, in some cases a second visit was made to the organization;
- written documentation about activities and the financial situation of the organization were collected as much as possible;
- in-depth oral information was gathered about various activities of the organization such as historical overview of funding, implementation of the ICPD Programme of Action, future plans and activities, future financial outlook, et cetera.

During the case studies it became clear that some aspects of the data collection pose some problems. Some of the most important are:

- the questionnaires were either for NGOs or for government departments. This created a problem for organizations which are semi-autonomous. Neither questionnaire was directly applicable to them;
- after the ICPD conference, the general concept of 'population activities' changed: projects which were used to be classified as health projects, are now seen as population projects. This was a problem for some of the international donors, and government departments, which had a separate population and health sector. Issues like 'reproductive health' fall in between;
- within the RF-project the population categories as defined in paragraph 13.14 the ICPD 'Programme of Action' (United Nations, ICPD94, vol.1, p. 70) are used. An important problem is formed by the fact that the four population activity groups which are used to categorize financial flows are not completely mutually exclusive. Especially the lines between reproductive health, family planning and sometimes HIV/AIDS prevention activities are not always obvious;
- another problem is more of a political nature and was encountered by the RF-team in its measurement of global financial flows. Many agencies, governmental and non-governmental, bring 'reproductive health' into their agenda whether or not it is in context. Sometimes the word 'population' in its broader sense is simply replaced with 'reproductive health';

- indirect national expenditures on staff, housing, utilities and so forth are often ignored, as well as other indirect financial mechanisms like e.g. television and radio broadcasting time for messages on population and family planning;
- The complexity of the funding of government health and family planning services, make it difficult to estimate exact expenditure figures; Data on private sector sales are very hard to get. Estimates for this were mainly derived from DHS surveys.



## 3. Official Population Policy and Programmes

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### 3.1 | Family Planning

Efforts within the Egyptian government to organize a national population policy started in 1939 with the creation of the Ministry of Social Affairs in order to study the population question and the social consequences thereof (Robinson, *et al.*, 1995, p. 26). At the end of 1953 the National Commission for Population Affairs was established. In these years, the government did not reach a broad based consensus on population policy, and gradually, the population policy initiative languished. In 1960, the National Commission for Population Affairs was transferred into an NGO, the Egyptian Family Planning Studies Association, which changed its name in 1962 into the Egyptian Family Planning Association, and affiliated with the IPPF. In 1964, the Ministry of Health (MOH) took the first step into the field of family planning with the creation of a population research and family planning division in the Research Section of the MOH (Robinson, *et al.*, 1995, p. 27).

Following these initial efforts, official population activities in Egypt passed through different phases. During the first phase (1965-1975), the adoption of the first population policy concentrated on the provision of concentrated family planning services. The underlying assumption was that if couples had adequate information and family planning supplies, they would adopt family planning, and fertility would decline (Moreland, 1995, p. 3). In 1965, a Supreme Council for Family Planning was established to serve as the top policy making body in population and family planning (Robinson, *et al.*, 1995, p. 27). An executive Family Planning Board was created as the operating agency for the Council (*ibid.*). The actual delivery of services had to be done by the Ministry of Health, which had the staff and facilities, and the Ministry of Social Affairs for the supervision of NGOs (*ibid.*). Family planning was not a priority, and was always discussed in official development plans as one of four lines of action to deal with the population problem. The other three being resettlement in new communities, reorganization of existing villages, and increased skills and productivity of the labor force (Robinson, *et al.*, 1995, p. 31). In 1973, a separate department of family planning was established within the MOH. During the second phase (1975-1985), policy shifted to emphasize the importance of

socio-economic development as a key factor in reducing fertility (Moreland, 1995, p. 3). In effect, the country adopted the slogan ‘development is the best contraceptive’. The Supreme Council for Family Planning was renamed into The Supreme Council for Population and Family Planning while the Family Planning Board was renamed into Population and Family Planning Board (Robinson, *et al.*, 1995, p. 32). In 1975, the policy was articulated further to recognize the simultaneous importance of three inter-related dimensions of Egypt’s population problem: a high rate of population growth, population characteristics (relatively low level of socioeconomic development in rural areas) and an unbalanced population distribution (Robinson, *et al.*, 1995, p. 31). During 1976, the MOH made family planning an integral part of its programme at all clinics and hospitals, and was later given responsibility for all family planning service delivery (Robinson, *et al.*, 1995, p. 34).

In 1977, the Population and Family Planning Board launched a ‘Population and Development Project’ in rural areas, with the objective to upgrade overall population characteristics (e.g. education, health) as well as the socioeconomic environment (Moreland, 1995, p. 3). Besides the service delivery through the Ministry of Health and the Ministry of Social Affairs, the Ministry of the Local Government was added as being responsible for the community-based activities. Within this second population policy (issued in 1980), more emphasis was placed on face-to-face communication and community-based activities to promote family planning (EDHS-95, p. 4). During this time only moderate support was provided to family planning; it was felt that the problem of rapid population growth could be solved by faster economic growth and resettlement programmes (Moreland, 1995, p. 3).

Until 1985, population policy has shifted between an emphasis on development (“development is the best contraceptive”) and an emphasis on the need for direct family planning interventions to decrease the rate of population growth. Since 1985 (the third phase), policy seems to have swung in the direction of more direct interventions to reduce the rate of population growth (UNFPA, 1997, p. 23). The creation of the National Population Council in 1985 which initially had the President as its Chairman (and later the Prime-Minister), is indicative of this trend

(UNFPA, 1994, p. 12). The National Population Council (NPC) took over the Supreme Council for Population and Family Planning, the Population and Family Planning Board was replaced by the National Family Planning Project, which is one of the four major projects established under the NPC (Moreland, 1995, p. 4). The NPC is composed of five Ministers: i.e. those of Education, Information, Health, Planning, International Cooperation, and Social Affairs.

NPCs role is to coordinate the population activities of all sectors (government departments, NGOs, private sector) in Egypt, mainly in the areas of family planning, child welfare, women's status, and literacy. Implementation of policies and programmes in these areas continued to be the responsibility of the relevant ministries (EDHS-95, p. 4). The NPC is coordinating a more decentralized approach to services that emphasizes governorate-level initiatives for tackling the population problem (Moreland, 1995, p. 4). Although the National Population Council is supposed to be the main coordinating body for population activities, the vertical programmes function almost independently (UNFPA, 1994, p. 13). The third national population policy was formulated and adopted in 1986 by the NPC, and contained specific population targets which are being revised from time to time. During 1991/92, the Technical Secretariat of the NPC organized a series of working groups and symposia, which resulted in a revision of the National Population Policies and Strategies covering the period 1997-2007 (Robinson, *et al.*, 1995, p. 41). This new strategy aimed to increase the contraceptive prevalence rate from 47.6 per cent in 1991 to 55 per cent in 1997, 59 per cent in 2002 and to 65 per cent in 2007 (see also table 2). This increase in prevalence was expected to reduce the birth rate from 32 in 1991 to 25 in 2007 (*ibid.*).

In 1993, the government took a further step to enhance its commitment by appointing a State Minister for Population and Family Welfare, who was at the same time occupying the post of NPC Secretary-General (UNFPA, 1997, p. 23).

*Table 2. Egypt's Medium-Term Population Goals*

	1997	2002	2007
Rate of natural increase	2	1.9	1.8
TFR	3.5	3.1	2.7
CBR	27	26	25
CPR (%)	55	59	65

Source: NPC, Formulation of Population Strategies, 1997-2007.

Recently, based on the recommendations of the International Conference on Population and Development (ICPD), another attempt was made by the NPC to revise the 1986 national population policy to take into account the Programme of Action recommendations (UNFPA, 1997, p. 24). E.g. greater emphasis on providing reproductive health services and supporting non-governmental organizations in the development of local communities (EDHS-95, p. 4). The policy identifies three main ways of achieving its objectives: further expanding and upgrading family planning services with special reference to rural areas; improving health services particularly for infants and mothers, and using IEC to change negative concepts and misinformation related to family planning (Robinson, *et al.*, 1995, p. 41).

Prior to the ICPD conference in 1994, the State Minister for Population and Family Welfare was changed into State Minister for Population and Family Planning. A separate Ministry of Population and Family Planning was established and assigned the responsibility for overseeing the family planning service delivery of both the MOH and the NGOs as well as assuming a supervisory role for the activities of the Cairo Demographic Centre (UNFPA, 1997, p. 25).

In January 1996, the Ministry of Population and Family Planning was merged with the Ministry of Health to form a new Ministry of Health and Population (MOHP). In July 1996, the MOHP disseminated an updated and comprehensive strategy framework for Reproductive Health and Family Planning activities which incorporates all the major elements of the ICPD programme of action (UNFPA, 1997, p. 24). The MOHP is now working to operationalize the country's population policy in conjunction with the relevant ministries and all other sectors nationwide (including NGOs and the private sector) involved with issues of population, women's reproductive health and family planning (*ibid.*). Apart from the vast network of public health facilities, the MOHP aims at strengthening and energizing various NGOs working in the health and population field (UNFPA, 1997, p. 28).

Within the MOHP, there are now three sectors: population and family planning; curative; preventive. The women's health package, which integrates mother and child care, reproductive health and family planning at the primary level falls under the population and family planning sector. However, the vertical structure of the different sectors make it very hard to integrate reproductive health concepts in other activities outside the population and family planning sector. There is for example no connection with STD and HIV/AIDS control which falls under the preventive sector.

### **Quality of Care**

The contraceptive prevalence rate (CPR) has increased from 24 per cent in 1980 to 48 per cent in 1995 (EDHS-95). The increase was steady during the eighties, but since 1991, the CPR has stayed at a plateau of around 48 per cent. At the same time, regional differences vary from a low 24 per cent in rural Upper Egypt to 59 per cent in urban Lower Egypt (EDHS-95). Another feature is that the family planning programme almost exclusively relies on two methods, the IUD and the pill: 72 per cent of current users have an IUD, 20 per cent use oral pills (NPC statistics). Surprisingly, it was the other way around in 1980: At that time 16 per cent had an IUD, and 69 per cent used pills (EDHS-95).

In Egypt, there are about 3,500 clinics offering family planning services, but the quality of services is sometimes not up to standard. An USAID initiative through the Systems Development Project within the MOHP, started 1,5 years ago with the aim to improve the quality of the family planning clinics. The 'Quality Improvement Programme' uses a set of 100 indicators to measure quality performance. Each service delivery point is rated on a scale of 0 to 100 per cent. Those clinics scoring 100 per cent for two successive quarters are labeled as 'Gold Star' clinics. About 800 clinics now have a gold star.

### **3.2 | Harmful Traditional Practices**

According to the EDHS-95, 97 per cent of ever-married women in Egypt are affected by Female Genital Mutilation (FGM). Officially, the Government of Egypt has been opposed to FGM since the 1950s, but due to political concerns no wide scale action had been promoted to eradicate this practice (UNFPA, 1997, p. 22). A common belief among policy makers is that harmful traditional practices will disappear by themselves with the improvement of education and socioeconomic conditions (ibid.). Since the ICPD, the issue of FGM has emerged on the public agenda in Egypt. A task force on FGM, which groups volunteers from various backgrounds, including NGOs and university and health professionals, was established in 1994, and has been developing strategies to eradicate FGM. A workshop was organized in Cairo in November 1996 on the subject. Egypt is now perceived to have a leadership role in the region on this delicate issue (UNFPA, 1997, p. 22). The task force works under the aegis of the National NGO Committee for Population and Development and meets once a month.

In July 1996, the Minister of Health and Population issued a decree forbidding FGM to be performed in hospitals and public and private clinics (Nadia Ramsis Farah, *et al.*, 1997, p. 17). In June 1997, the decree was

overturned by a mid-level administrative court (*ibid*). In striking down the decree, the judge of the case indicated that his ruling did not deal with the practice or its justification, if any, under Islam. Rather, the ruling focussed on the legality of the ban, which he said placed undue restrictions on doctors. It is still prohibited for FGM to be performed in MOHP facilities and non-medical personnel, such as midwives and barbers are still not authorized to do the procedure. The ruling will be appealed by the State's Lawsuit Authority. Overturning the ban has not stopped the efforts of NGO groups and the government to eradicate FGM (Nadia Ramsis Farah, *et al.*, 1997, p. 17). In December 1997, a position paper of the FGM task force was launched, in which they expressed its unconditional denunciation.

### 3.3 | STD, HIV/AIDS

Routine surveillance for STDs and HIV/AIDS is not existing, so the prevalence of STDs and HIV/AIDS is unknown. It is however estimated that Egypt has a very low prevalence of STDs and HIV/AIDS. The first diagnosis of AIDS inside Egypt was made in 1986, and since then 615 Egyptian nationals have been officially registered with HIV/AIDS, of whom 152 persons had actually developed AIDS, and 463 were HIV+. Another 360 foreigners were registered as well, of whom 10 had developed AIDS. In 1986, the National AIDS Committee (NAC) was established in the preventive sector in the MOHP. The NAC estimates that between 5,000 and 7,000 persons are HIV infected in Egypt (UNFPA, 1996, p. 61).

In 1988, a Short Term Plan for prevention and control for one year was formulated together with WHO (UNFPA, 1996, p. 61). The plan focussed on laboratory testing, sero-surveys, training and health education (*ibid.*). In 1991, a Medium Term Plan for 1991-1993 was prepared, also in conjunction with WHO. This programme consists of the following components:

- surveillance: small surveys were conducted in at-risk populations, e.g. prisoners, patients with blood transfusions, tuberculosis patients, STD infected persons;
- health education: brochures, conferences, TV/radio programmes, letter advertising at-risk profession (physicians, nurses). In 1996, an AIDS 'hot line' was created, funded by the Ford Foundation;
- counseling: home visits to patients and their relatives, in addition to TV programmes.

### 3.4 | The role of mass-media

In Egypt, mass media plays a major role in spreading family planning messages to the public. According to the EDHS-1995, 81 per cent of the EDHS respondents watch television daily, and 64 per cent listen to radio daily (EDHS, 1995, p. 28). Furthermore, 71 per cent of ever-married women said they first heard about family planning from the television (ibid., p. 55).

A national IEC project was launched through the newly created Family Planning IEC centre in the Ministry of Information/State Information Service in 1979, as part of an agreement between USAID, MOH, and MOI/SIS. This centre planned and executed a campaign to raise public awareness about the population issue and to build favorable attitudes about family planning. It made use of television and radio as well as print media. All these initiatives were primarily funded by USAID (Robinson, *et al.*, 1995, p. 34).

Since its establishment, the approach has gone through four stages (SIS, 1992, p. 25). In the early eighties the mass media campaign focussed on awareness messages concerning the population problem in Egypt, with the slogan 'Look around you'. Since the mid eighties the messages emphasized specific family planning advice and information, initially using the motto 'Small family equals better life'. It carried messages regarding child's and mother's health as well as consequences of having a smaller family size. The campaign's major objective was to create comprehension, while urging people to adopt family planning methods. At the end of eighties, more specific messages about contraceptive use were aired on the television. Awareness of the population problem became very high. The family planning concept became an important issue on the public agenda. The media achievements of the last decade have been widely felt throughout the country. Although many of the message themes are widely recalled, there are several gaps that still need to be bridged in order to further increase the prevalence rate. Since the beginning of the nineties, the campaign focuses on 'Closing the Gap', including themes like e.g. the Gold Star, or HIV/AIDS prevention.

In order to achieve this goal, the IEC Centre is using a combination of face-to-face contacts, group discussions, and mass media. It collaborates and coordinates its efforts with, and provides technical assistance in IEC to other organizations (government and NGO) working in the field of family planning. There are currently about 65 IEC centres in Egypt. They use cartoons, tv, radio, cinema, newspapers, annual symposia, face to face contacts, et cetera., and work through:

- specific messages through 150 radio programmes, 36 tv programmes and newspapers;
- drama series on tv and radio;
- special campaigns.

The production costs and activities in the 65 centres are paid by USAID. The MOI/SIS is extremely committed to the national population and development goals and has ensured that a significant proportion of broadcast time has been devoted to population-related issues (UNFPA, 1997, p. 29). The Government of Egypt pays for this broadcasting time on tv and radio.

## 4. Financial Flows

Quite some studies on the costs of Egypt's Family Planning programme have already been undertaken at the request of the National Population Council or USAID Cairo.<sup>1</sup> In Egypt, the national family planning programme is supported by private and public funding. Public funding consists of contributions from the Government of Egypt, and the international donor community. Table 3 gives an overview of the total costs of family planning projects which are funded by donors and Government of Egypt contributions, by source of funding. Total costs rose from 44.7 million Egyptian pounds (roughly US\$ 10.7 million) in 1988/89 to 79.4 million in 1991/92; fell to 66.6 million in 1993/94, and started increasing again to 95.6 million (around US\$ 28.2 million) in 1994/95.

*Table 3. Total costs, and sources of funding of Egypt's Family Planning Projects, 1988/89 to 1994/95*

	Private funding		Public funding		Total costs (in million of Egyptian pounds)
	Sales revenues, client payments	Sponsoring agencies	Donor agencies	GOE contribution	
	%	%	%	%	
1988/89	8.2	0.5	44.5	46.7	44.7
1989/90	10.7	0.8	51.7	36.9	60.4
1990/91	9.8	2.1	54.3	33.8	72.3
1991/92	11.6	1.7	49.4	37.3	79.4
1992/93	13.8	2.8	49.0	34.4	72.2
1993/94	12.8	2.6	40.5	44.2	66.6
1994/95	7.7	1.3	36.0	55.1	95.6

Sources: Five year trend study report on the trends of the costs of the FP programme in Egypt: the costs of FP activities which received funding from the public sector. Reports

<sup>1</sup> Among these are:  
 R. Scott Moreland: Investing in Egypt's Future: Costs and Benefits of Family Planning in Egypt, June 1996.  
 Warren, C. Robinson and Fatma H. El-Zanaty: The Impact of Policy and Program on Fertility in Egypt: The Egyptian Family Planning Success Story, July 1995.  
 Petrich and Associates: Five year trend study report on the trends of the costs of the family planning program in Egypt: the costs of family planning activities which received funding from the public sector, July 1, 1988 -June 30, 1989 until July 1-June 30, 1993, January 1995.

on the costs of the FP programme in Egypt: the cost of FP activities which received funding from the public sector, July 1, 1993 - June 30, 1994; July 1, 1994 - June 30, 1995.

Table 3 also shows that in 1994/95, the Egyptian government contributes about 55 per cent of the total costs. These contributions include indirect GOE contributions, like television and radio broadcasting time and the press space provided by the Ministry of Information to the State Information Service for family planning messages (see also the report of Petrich and Associates, 1995, p. 22). Unofficial statements say that approximately 10 per cent to 20 per cent of the government contributions are actual financial contributions. The international donor community provides 36 per cent of the total costs, and the remaining nine per cent is covered through fees paid by users, and some sponsoring agencies. These are e.g. agencies that sponsor or carry out family planning activities, like the Coptic and English church or some private organizations.

For 1988/89 to 1991/92, information was available about the distribution of these costs over separate budget lines, according to the Egyptian budgetary divisions (Moreland, 1996, p. 134):

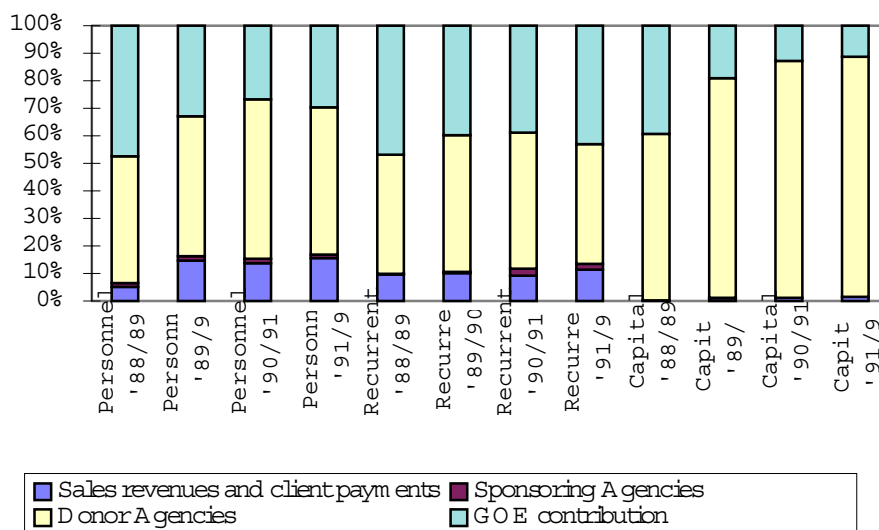
- personnel costs: salaries and incentives;
- other recurrent costs, e.g. operations and maintenance of health care facilities; central offices and vehicles; in-country training; research and evaluation; expendable office and medical supplies; television and radio air time; press space; donor supplied contraceptives; raw materials used in the local production of oral contraceptives;
- capital costs: costs relating to e.g. medical equipment; computers; data processing and audiovisual equipment; office furniture; vehicles; renovations; buildings.

Annex II (“Costs of Family Planning Activities in Egypt, 1988/89 to 1991/92 by budgetary line”) shows that approximately 70 per cent of the costs concern ‘other recurrent costs’.

Personnel and other recurrent costs are fairly evenly distributed between donors and GOE, whereas capital costs are for more than 80 per cent paid by the international donor community (see also figure 1).

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Figure 1. Sources of funding of several budgetary lines, 1988/89 - 1991/92



Source: R. Scott Moreland: Investing in Egypt's Future: Costs and Benefits of Family Planning in Egypt, June 1996.

## 4.1 | Role of the International Donor Community

### 4.1.1. Historical Overview

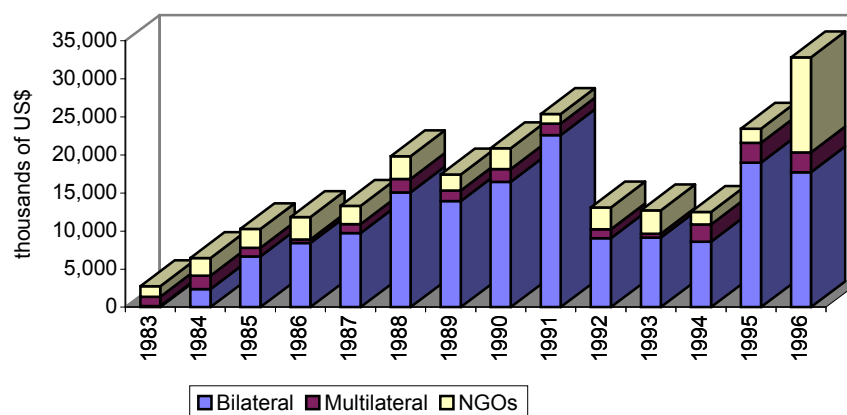
Financial assistance to Egypt has been very high in general: in 1995, a total net ODA per capita of US\$ 35 was disbursed. This was almost five per cent of Egypt's 1994 GNP (Human Development Report, 1997, p. 190).

Since the inception of the Egyptian National Family Planning Programme in 1965, the international donor community has been an important contributor (financial as well as technical assistance).

In the 1960s, assistance came mainly from non-governmental organizations (e.g. IPPF, Population Council, Ford Foundation), and was research focussed. Multi-and bilateral agencies started activities in late 60s, early 70s. Figure 2 gives an overview of international assistance for population activities in Egypt by channel of distribution, since the beginning of the 80s.

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Figure 2. International assistance for population activities in Egypt by channel of distribution, 1983-1996



Source: GPAR reports

Expenditures increased from almost US\$ 3 million in 1983 to US\$ 25 million in 1991. The years 1992 to 1994 stagnated at a level of US\$ 13 million annually, and since 1995, the budget increased again. Bilateral flows count roughly for 70 to 80 per cent of the international aid, followed by NGOs and lastly by multilateral organizations. In 1996, the NGO component is relatively high, as this includes some of the USAID's projects which are executed by international NGOs, e.g. Pathfinder International, the Futures Group, or Family Health International. The international community spent roughly US\$ 33 million in 1996, of which 60 per cent goes to family planning services (see figure 3).

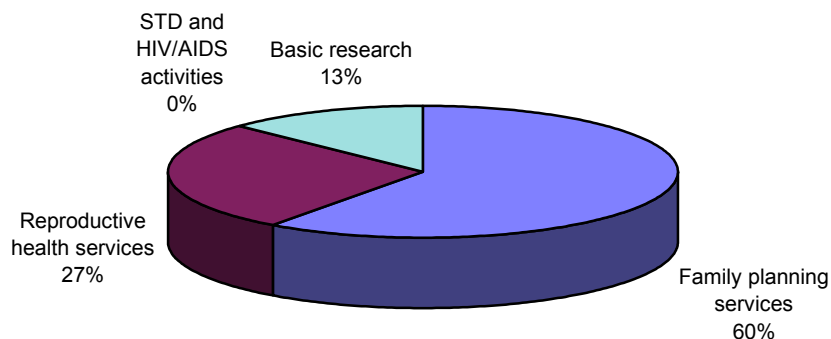
#### 4.1.2 Main International Donors in the Field of Population and Development

International donors have created a donor coordinating mechanism called the Donor Assistance Group (DAG), which meets monthly to discuss common interests and to share information related to their individual development assistance efforts (SCF/USA, 1995, p. 3). The DAG has organized sub-groups focussing on several issues like Environment, Women in Development, Human Resources Development, Population, and Water.

The donor sub-group on Population was formed in 1992, has 21 members, and meets four times a year to discuss population issues (SCF/USA, 1995, p. 3).

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Figure 3. Final expenditures of the international donor community in 1996, by category



Source: GPAR reports

The main donors in Egypt for population activities as defined in this casestudy are UNFPA, USAID, and The Netherlands.

### A. Donor countries

#### USAID

USAID financial assistance to Egypt goes back to 1971, but until 1977, this assistance was always channeled through other US based or other international agencies, like AVSC, Pathfinder, Population Council, or IPPF (Robinson, 1995, p. 46). The first bilateral agreement was signed in 1977. Since 1978, USAID has been the largest donor to Egypt's family planning programme, providing about 75 per cent of all donor assistance (SCF/USA, 1995, p. 9). On humanitarian development, roughly US\$ 815 million a year is spent, of which on average US\$ 15 million goes annually to population related projects. All current USAID flows in Egypt are bilateral, sometimes executed through US based agencies. USAID's population programme has focussed on the development of population policies, the expansion and improving family planning services, supply of contraceptives, IEC, and improving the institutional capacity of key organizations involved in family planning (SCF/USA, 1995, p. 9).

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In 1978, USAID started with a 'Population and Family Planning Programme I', which lasted ten years, and had a budget of US\$ 65,05 million. The aim of the project was to strengthen family planning services and increase the availability and variety of contraceptive devices nationwide.

1983 saw the start of the Population and Family Planning II programme, which was implemented for 12 years, with a budget of US\$ 113 million. It was a continuation of activities started under 'Population and Family Planning Programme I'. New private and public sector initiatives were added, like the Clinical Services Improvement Subproject in the private sector, and the Systems Development Project in the MOH and the Institutional Development Project at the National Population Council.

Activities under the umbrella of 'Population and Family Planning III' started in April 1994, and were implemented until June 1997. The programme has been extended until July 1998. The major goals of this project, which has been budgeted for US\$ 62 million, are in line with Egypt's national population goals, namely to reduce the population growth to two per cent by 1997 and to 1.8 per cent by 2007; and to reduce the Total Fertility Rate to 3.5 by 1997 and 2.7 by 2007.

The 'Population and Family Planning III Program consists of seven subprojects, implemented through three government departments, and an eighth subproject implemented by Pathfinder International. Technical assistance for the 'Population and Family Planning III Programme' is undertaken by Pathfinder International through a consortium with other U.S. organizations, known as the Population Project Consortium. Pathfinder coordinates this, and provides assistance in the implementation of various subprojects. The other U.S. organizations are:

Johns Hopkins University/  
Centre for Communication

Programmes:	in the area of IEC and marketing
The Futures Group:	in the area of policy and research
Family Health International:	in the area of biomedical research and quality control
E. Petrich and Associates:	in the area of MIS, supervision

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Approximately US\$ 54 million is allocated for eight sub projects, which are:

Implemented through the National Population Council (NPC):

1. Institutional Development Project (IDP):  
to continue the development of the capability of the NPC to plan, coordinate and report on family planning activities at the national and the local level (US\$ 9.8 million);
2. Regional Centre for Training in Family Planning and Reproductive Health (RCT) (at Ain Shams University)  
to continue providing high-quality clinical family planning training and support to physicians, nurses and trainers in both the public and private sectors (US\$ 3.9 million);
3. Clinical Services Improvement Sub-project (CSI)  
a sub-project of the Egyptian Family Planning Association, with support for its RH/FP services and assistance to complete the transition to self-sufficiency (US\$ 3.8 million);

Implemented through the Ministry of Health and Population:

4. Systems Development Project (SDP)  
to improve the management system for family planning service delivery through training courses and workshops and will support improvements in the quality of family planning services (US\$ 15.5 million);
5. Teaching Hospital Organization/Family Planning Services (THO/FPS)  
to provide practical experience in the provision of injectables and Norplant in addition to the more usual contraceptive technology experience with pills and IUDs, including post-partum IUD insertion (US\$ 1.7 million);

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6. Contraceptive Commodity Sub-project (CCP)  
to provide IUDs, condoms, Norplant and injectables for distribution to the public sector and selected non-profit NGOs providing family planning services (US\$ 7.5 million);

Implemented through the Ministry of Information:

7. State Information Service/IEC Centre (SIS/IEC)  
to continue support for mass-media (US\$ 6.7 million);

Implemented by Pathfinder International:

8. Special Initiatives for the Private Commercial Sector to improve the quality of care provided by private-sector pharmacists and physicians, including family planning continuing education and efforts to strengthen and expand the linkages between these groups (US\$ 4.2 million).

The GOE contributes around 25 per cent of the total project cost for this Population and Family Planning III project, of which 10 per cent is in cash and the remainder in-kind, including salaries and benefits, travel and other costs for participant training, and air time on television and radio.

Figure 4 gives an overview of USAID's annual expenditures during POP/FP I, POP/FP II, and POP/FP III.

USAID will continue with a 'Population and Family Planning IV' project, which is likely to start in July 1998: the proposed budget is US\$ 90 million for four years, which increases the annual budget to roughly 22 million. With this increase, a greater effort can be made to overcome the plateau of CPR, which has been on a level of 48 per cent since 1991. More emphasis of the Population IV project will be on social marketing and training of young managers.

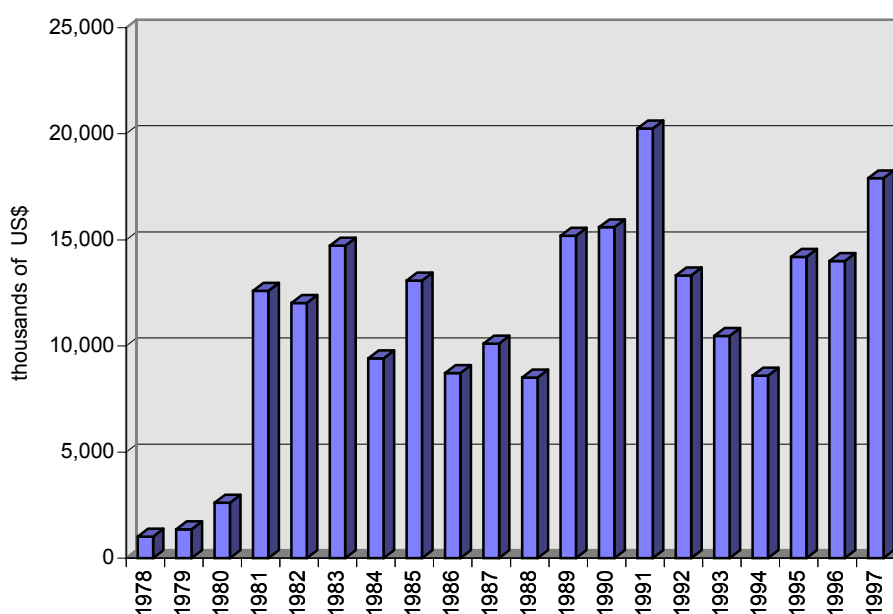
The Egyptian Pharmaceutical Training Company receives contraceptives from USAID, and subsequently sells it to the public and NGO sector. With the exception of some locally manufactured pills, all contraceptives are provided by USAID. This contraceptive supply costs USAID US\$ 4 million annually. Additional supplies have been made available in the past by UNFPA, and by JICA.

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### Netherlands

Since 1986, the Netherlands have spent 14.3 million Dutch guilders (roughly US\$ 8.5 million) on population activities in Egypt, mainly concentrated in integrated rural development projects (see table 4). The Netherlands is supporting one of the most integrated population projects in Egypt, 'the Fayoum Rural Health and Family Planning Project: an

*Figure 4. USAID's expenditures for Population and Family Planning activities in Egypt, 1978-1997*



Sources: Population/Family Planning II, final report on project activities, and verbal information at USAID Cairo.

evolving model of Integrated Development'. The first phase from 1992 to 1996, and now is going through its second stage, which will last five years (SCF, 1995, p. 18). Financial allocations for the second phase are approximately US\$ 8.3 million. The project, which started long before the ICPD Programme of Action, corresponds directly to the recommendations of that Programme.

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*Table 4. Netherlands' main project expenditures 1986-1996  
(in Dutch guilders)*

	1986-1990	1991-1996	Total
Fayoum Rural Health and Family Planning	350,000	5,500,000	5,850,000
Damyetta Rural Health and family Planning	5,200,000	2,300,000	7,500,000
Population and Family Planning		437,000	437,000
UNFPA Support to NGOs/ICPD	500,000		500,000
Total	6,050,000	8,237,000	14,287,000

Some of the project's unique characteristics are:

- participatory mechanism for decision making;
- The project is decentralized, directly connected to the Governor of Fayoum;
- The needs of women is seen in a holistic manner;
- Development activities are implemented by villagers for villagers.

In 1996, the Netherlands supported seven projects, with total expenditures in 1996 amounting to 2,689,000 Dutch guilders (approximately US\$ 1.6 million).

### **European Union**

The EU has two major bilateral projects.

The first service delivery family planning project started with activities in January 1992, with the construction of 20 family planning clinics in Qena Governorate (a five year project plus four years extension, and was budgeted for 1,5 million ECU), through MOHP. The purchase of equipment and recruitment of staff is currently underway. In 1996, 780,000 ECU (US\$ 975,000) was disbursed into this project.

In March 1997, a project to support an integrated series of family planning activities in Upper Egypt has started through the MOHP. This 'Support to Population programme in Upper Egypt' project will be implemented over a period of five years, and is budgeted for 10 million ECU. It has moved away from the traditional service oriented approach, and now promotes family planning as an integral part of health and welfare of the family.

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Together with the UNFPA, Netherlands, and Ford Foundation, the EU commits 395,021 ECU (US\$ 490,000) for the period 1995-1999 to support the National NGO Committee on Population and Development with regard to salaries, training, and workshops. Through the NGO Co-financing budget, the EU provides support for one or two years for some smaller NGO projects, through European NGOs.

### **JICA**

Japan has supported population projects in Egypt since 1983, although population is not a priority area. In general, the Japanese focus on specific issues and tackle them through direct targeting, rather than following a more integrated approach (SCF, Dec 1995, p. 17). Direct funding has included a family planning project at Naga-Hamadi from 1989 to 1994, implemented through the National Population Council. This project focussed on service delivery and contraceptive supplies. Currently, they only provide neosampoon (vaginal foaming tablets) to the clinics of the MOHP. It is a four year project (1994-1997). The total amount for Neosampoon provision is US\$ 754,000 for this four year period.

## **B. UN Organizations**

### **UNFPA**

UNFPA began in Egypt with the first population programme of 1971-1975, and is now in its fifth programme cycle (1992-1996). The bulk of UNFPA's past assistance was devoted to strengthening the National Population Council (NPC) and CAPMAS (Central Agency for Public Mobilization and Statistics) (UNFPA, 1994, p. 35). Because USAID provided almost all modern contraceptives, UNFPA played only a minor role in contraceptive supplies, mainly by providing injectables and some spermicides. The first programme (US\$ 5.8 million) focussed on the delivery of family planning services through health centres (UNFPA, 1996, p. 15). The second country programme (1977-1981) totaled US\$ 10 million, of which US\$ 4 million was directed toward demand creation and the strengthening of family planning services as well as assistance in the local production of oral contraceptives and biomedical and operational research (UNFPA, 1996, p. 15). The third (1981-1985; US\$ 15 million) and fourth (1986-1991; US\$ 13.3 million) country programmes concentrated on the expansion of MCH/FP activities aimed at improving services through the country's Population and Development Project (UNFPA, 1996, p. 15). The fourth programme also included feasibility studies of the local production of contraceptives to permit a wider mix of contraceptive methods, including IUDs. The fifth programme cycle (1992-1997; US\$ 20 million) covers four

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main areas, namely maternal and child health, IEC, data collection and analysis, and population policy formulation. Currently, the sixth program (1998-2002) is being developed.

As can be seen in table 5, 45 per cent of UNFPA regular resources of the fifth country programme are committed to Maternal and Child Health and Family Planning, and 20 per cent to Population Policy Formulation.

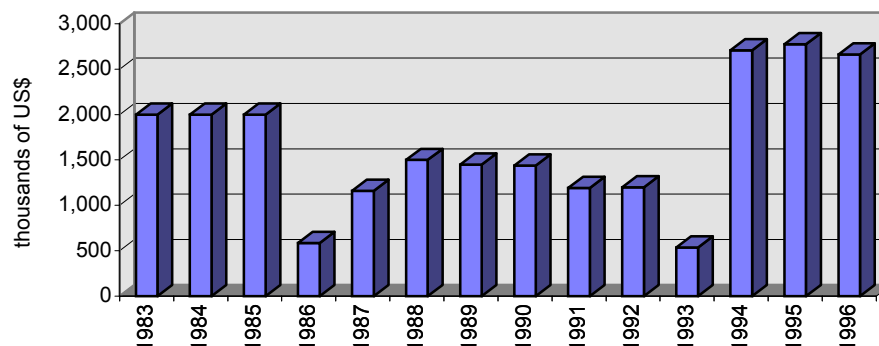
Of the allocated resources of US\$ 20 million for the fifth programme cycle (1992-1997), nearly US\$ 10 million was spent at the end of 1996. An overview of actual expenditures during 1983 and 1996 can be seen in figure 5. The relatively low expenditures during 1993 can be explained by two facts. Firstly, although the project formulation for the 5<sup>th</sup> Country programme continued, this was seriously hampered by the fact that both the government and the UNFPA Cairo office were very busy with the preparations for ICPD. Secondly, by then most fourth country programme projects had been completed (UNFPA, July 1995, p. 52).

*Table 5. UNFPA Fifth Country Programme, Programming Situation per category (in US\$)*

	UNFPA Sources	Regular	Other Sources, incl. Multi/Bi	Total
Maternal and Child Health and Family Planning		4,500,000	7,500,000	12,000,000
Information, Education and Communication		950,000	1,000,000	1,950,000
Data Collection and Analysis		1,500,000	500,000	2,000,000
Population Policy Formulation		2,000,000	500,000	2,500,000
Special Programmes		300,000	500,000	800,000
Programme Reserve		750,000		750,000
TOTAL		10,000,000	10,000,000	20,000,000

Source: Country Brief for Mid-term Review Fifth UNFPA Country Programme Egypt, July 1995.

Figure 5. UNFPA's expenditures for population activities, 1983-1996



Sources: Robinson, *et al*, 1995, p. 44, and UNFPA Cairo

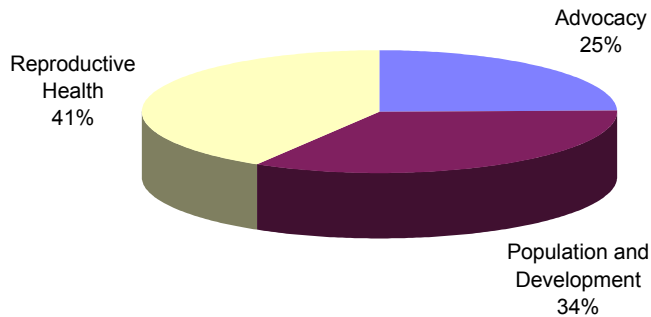
In June 1995, the UNFPA and UNDP endorsed new programme and policy directions for UNFPA in the light of the ICPD recommendations. UNFPA proposed to concentrate its core funding in three programme areas:

- Reproductive Health, including Family Planning and Sexual Health;
- Population and Development Strategies;
- Advocacy.

When expenditures for ongoing projects are categorized according to these categories, we can see in figure 6 that during the fifth programme cycle, 41 per cent was spent on Reproductive Health, including Family Planning and Sexual Health, 34 per cent for Population and Development Strategies, and 25 per cent for Advocacy. Reproductive Health projects focus on strengthening the mix of family planning services, funding of service delivery projects conducted by national NGOs (e.g. CEOSS), and training for nurses. Under Population and Development projects are demographic research support to the Cairo Demographic Centre; strengthening management capabilities of the NPC; establishing governorate level demographic profiles and providing support to NGOs towards implementation of the ICPD programme of action. Advocacy projects are concentrated on school target groups, agricultural extension workers, youth, and religious groups (UNFPA, 1997, p. 62).

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Figure 6. UNFPA's expenditures during 1992-1996 by programme area



Source: UNFPA Cairo

### UNICEF

UNICEF has worked in Egypt since 1954, and is currently in its 1995-2000 programme cycle. (SCF/USA, 1995, p. 24). The allocated budget for the Reproductive Health component (safe motherhood, nutrition, HIV/AIDS, PHC) within this 1995-2000 programme cycle is approximately US\$ 4.8 million, of which US\$ 900,000 for a Safe Motherhood project and US\$ 400,000 for a STD, HIV/AIDS control programme.

### WHO

The WHO programme focuses on the quality of life in rural and urban areas related to topics like health, sanitation, water, literacy, and income generation. Health is always used as entry point to other aspects of development. Between 1992 and 1997, WHO has committed US\$ 2.4 million for population programmes, of which 70 per cent for reproductive health, 28 per cent for population and development, and two per cent for advocacy. There are eight projects in the area of reproductive health, of which two are focussed on the prevention of STDs, including HIV/AIDS (US\$ 750,000 for the national programme for AIDS control).

## C. Development Banks

### World Bank

The World Bank is not so much involved in population activities in Egypt; most projects are education projects. The first major population project to be supported by the World Bank (an IDA credit of US\$ 17 million) is due to start later in 1997. The project will concentrate on stimulating demand for family planning and smaller family sizes in areas where fertility remains

high and contraceptive demand low, mainly in the rural areas of Upper Egypt. About 87 per cent of project funds would be provided to NGOs and local community organizations (UNFPA, 1997, p. 64).  
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Another project, which is still being developed is the Health Sector Reform project (IDA credit of US\$ 90 million). This should focus more on the PHC side. This will be implemented with many other donors: GOE, EU, Netherlands, USAID.

The World Bank also supports the Social Fund for Development directly (also IDA).

#### **D. International NGOs and Foundations**

##### **Ford Foundation:**

The Ford Foundation began its research activities in Egypt in 1954. During the 60s 70s, research focussed on demography in general, but gradually shifted towards child health and social science in the early eighties. The concept of reproductive health was introduced in the late 1980s.

Reproductive grants are concentrated in three main areas:

- grants to stimulate public debate in order to define priorities in reproductive health specific to Egypt, and to translate these into advocacy, programmes and services;
- grants to build the capacity of social science and interdisciplinary research addressing the conceptual basis of reproductive health;
- grants to address sensitive issues of reproductive health about which debate is often hampered by social constraints or taboos (e.g. FGM, STD, HIV/AIDS, sex education).

In Egypt, innovative research in reproductive health was already done before the ICPD, but the ICPD gave a big impetus. The Ford Foundation worked very actively with the then NGO steering committee (established at the end of 1993). Their work is a combination of research, policy making, and supporting grassroot organizations.

Before the ICPD, the Ford Foundation supported a small group researching female genital mutilation. The ICPD gave a boost to reproductive health issues and identified concerns that were specifically relevant to Egypt, such as female genital mutilation (SCF/USA, 1995, p. 26). The Ford Foundation saw the ICPD as a springboard upon which the issues of reproductive health could be launched into the mainstream of debate in Egypt. After the

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conference, the issue of FGM became much discussed, and interest grew dramatically. What was once a small group working independently to explore FGM has now grown into a task force with branches in five cities in the country (SCF/USA, 1995, p. 26).

AIDS and STDs was another issue that NGOs identified as an important aspect of reproductive health after the ICPD. The Ford Foundation had supported small activities related to AIDS and STDs prior to the conference. After the conference, the issue was picked up by many more interested parties and has gained importance (SCF/USA, 1995, p. 26). The AIDS hotline for instance started in September 1996, in the MOHP (a two year grant of US\$ 150,000).

The Ford Foundation annually spends around US\$ 800,000 on reproductive health in Egypt.

### **Population Council**

The Population Council in Egypt was established in 1978 as a regional office for the West Asia and North Africa region. Their budget is not country specific, as they work on regional networking. The Council's earliest activities were primarily directed toward strengthening research capacities in the region by way of encouraging interdisciplinary approaches to population studies. This led to the establishment of a regional research program in the field of population and development, MEAwards. MEAwards stands for Middle East Awards in Population and Social Sciences and sponsors individual researchers through e.g. fellowships, research awards, study groups and workshops. These MEAwards are co-funded with the Mellon Foundation, the Ford Foundation and Arab Fund for Social and Economic Development (Kuwait). During the late eighties a reproductive health research and consultation programme was added, especially in the field of maternal morbidity, e.g. healthy family planning. This project is co-funded with UNFPA, Rockefeller, the Netherlands, WHO and the Ford Foundation. During 1992, an operations research and technical assistance project was initiated. This program, which is USAID funded, supports applied research in family planning and reproductive health. With the preparations of the ICPD in 1993, activities related to family, gender and development, adolescence and youth, were launched. These activities are co-funded with UNICEF, IDRC, CIDA, the Netherlands, and UNFPA in the initial stage.

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The Council's annual budget for these population related activities is US\$ 1.96 million, of which roughly 60 per cent is spent in Egypt, and 40 per cent on regional activities.

**Pathfinder International**

Pathfinder International started in 1957 in Egypt with assisting the Egyptian Family Planning Association. Since the mid eighties they act mainly as an executing agency for USAID. In 1996, US\$ 6.7 million was spent by Pathfinder International for a subproject of the USAID, the Population and Family Planning III programme.

**Family Health International (FHI)**

FHI has been in Egypt for almost 20 years. Their main focus is on research, e.g breast-feeding, contraceptives, et cetera. About 85 per cent of the funds comes from USAID, the other 15 per cent from the Research Management Unit in the National Population Council. They work mainly through universities and research institutions. In 1996, approximately US\$ 150,000 was spent by FHI in Egypt.

## 4.2 | Role of the Government of Egypt

The Egyptian budget is sectoral in nature and allocations are functional, not project oriented. Budgets and financial allocations are prepared and disbursed by the central government to the governorate and local levels (Egypt National Report on Population, ICPD94, p. 44).

According to the 1996 questionnaires which we received from the MOHP and the NPC, these departments spent US\$ 86 million, of which 56 per cent for family planning services, 38 per cent for reproductive health services, one per cent for HIV/AIDS prevention activities, and another five per cent for basic research and policy analysis. It is expected though that this US\$ 86 million includes a certain amount which comes originally from the international community, and flows through the MOHP, and is therefore not a domestic flow. However within the period of the study it was not possible to disentangle this amount so as to ascertain the actual domestic financial flow.

**Ministry of Health and Population (MOHP)**

The MOHP is the most important actor in the field of population and family planning. Within the MOHP, there are three sectors: the population and family planning sector, the curative sector, and the preventive sector, all of

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which operate almost independently from each other. Women's health strategies fall under the population and family planning sector.

The Women's Health Package integrates mother and child care, reproductive health and family planning at the primary level with support and referral systems at the secondary level. But in practice, the referral system is weak, and programme implementation follows a vertical structure with no connection to STDs and HIV/AIDS (UNFPA, 1997, p. 40). The on going national population programme has not yet fully integrated the ICPD concept of reproductive health. The concept reproductive health is still limited to pre- and post-natal care and breast-feeding. Current reproductive health services are offered mainly by clinical service units. These activities are supported by a modest community-based programme and a weak commercial sector programme. The social marketing programme has ceased to exist (UNFPA, 1997, p. 41).

Most projects executed by the MOHP are externally funded from e.g. USAID, UNFPA and the EU. For these projects, the population and family planning sector received a total of L.E. 133 million (approximately US\$ 39 million) during 1996, of which L.E. 90 million originated from USAID, UNFPA, EU, and approximately L.E. 43 million came from the Social Fund for Development.

During the case study it was not possible to get exact figures of contributions of the population and family planning sector in 1996, but estimates were given at L.E. 317 million (US\$ 94 million), including L.E. 44 million (US\$ 13 million) for overhead and other recurrent costs.

The National AIDS Programme falls under the preventive sector. Approximately 50 per cent of the budget comes from the Government of Egypt, and the other 50 per cent from external sources. The Government of Egypt's contribution for the AIDS programme is difficult to determine, as there is no specific budget for the AIDS programme. However, the MOHP allocates US\$ 300,000 annually for blood safety. Concerning external donors, the 1988 Short Term Plan for prevention and control was funded by the WHO with US\$ 0.5 million for one year. During 1991 to 1995, the WHO committed US\$ 100,000 annually for the STD and HIV/AIDS control programme. For the years 1996 and 1997, US\$ 30,000 was disbursed by WHO; US\$ 150,000 by UNAIDS, and the Ford Foundation funded the AIDS Hotline with US\$ 150,000.

#### **National Population Council (NPC)**

The NPC is an autonomous organization responsible for co-ordinating population and family planning activities. Overall NPC allocations for the

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1987/88 - 1992/93 five year plan amounted to L.E. 7.2 million (US\$ 2.1 million) to cover the direct cost of its activities (Egypt National Report on Population, ICPD 94, p. 44). Additional resources have been obtained from donor agencies, especially UNFPA and USAID.

### **NPC projects:**

Also, most of the NPC projects are funded by international donors: UNFPA or USAID being the major ones. A major project funded by the GOE was executed from 1993 to 1995 and dealt with upgrading of existing health units and building of new ones and mobile clinics. The GOE allocated L.E. 9 million (US\$ 2.7 million) annually. After 1995, the project was transferred to the MOHP for its implementation. Starting in 1992, another project funded by the GOE dealt with upgrading of the NPC headquarter and building of new NPC branches in each governorate. The budget was L.E. 5 million (US\$ 1.5 million) annually.

Furthermore, emphasis was put on giving a boost to research on population issues (L.E. 5 million per year, of which 0.5 million from GOE and 4.5 million from international donors).

The future plans of the NPC are:

- revision of population policies in Egypt according to the ICPD programme of action. The allocated budget is US\$ 2 million for a two year period;
- extension of research activities on all population issues into new areas in Egypt, e.g. deprived regions (no budget yet);
- establishment of a centre of information on population activities for the Arab World (no budget yet);
- establishment of a national training centre for population activities: funding for the establishment and equipment should come from donors;
- new project for advocacy: funding for the establishment and equipment should come from donors.

### **Social Fund for Development**

The Social Fund for Development (SFD) was established in 1991, and was conceived as a safety net to address the social costs of the Economic Reform and Structural Adjustment Programme (ERSAP) in Egypt, which started in 1990. The SFD is a semi-autonomous agency that operates under the chairmanship of the Prime Minister. The SFD is financed by 18 donors, including the Government of Egypt, World Bank, European Union, Arab Fund for Economic and Social Development, Kuwait Fund for Arab

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Economic Development, Abu Dhabi Fund for Arab Economic Development, and the UNDP (Internet: <http://www.sfdegypt.org/>). As an integral part of ERSAP, the SFD was intended to assist, in the short term, the low income population groups most directly affected by the economic reform measures, and in the medium term, strengthen the government's institutional capacity to design and monitor poverty alleviation policies.

Although the fund was established in 1991, its activities actually started in 1993. The activities can be subdivided into five subprojects:

- public works programme: creation of employment by funding labour intensive projects through the local governments;
- community development programme: implemented through national NGOs. Within this programme, a population project has started recently which works at the family level, which is aimed at education, gender and income generation;
- enterprise development programme: through national NGOs: creation of jobs for the unemployed and other disadvantaged groups, through the development and support of new and existing businesses. Credit funds is delivered through banks;
- employment and retraining programme: in line with the government plan of privatization;
- institutional development programme: through NGOs and government. To strengthen the SFD's managerial efficiency and implementation capabilities.

Total resources committed by donors in phase I (1991-1996) are US\$ 746 million, of which 43 per cent loans, 57 per cent grants; for phase II (1997-2000) US\$ 700 million, of which 38 per cent loans, 62 per cent grants. Loans are IDA loans and are mostly directed towards income generating projects. 70 per cent of the financial resources was targeted to NGOs. The main donor for the second phase is the EU with 155 million ECU (approximately US\$ 194 million). These committed resources exclude salaries and overhead, which is around 2-3 per cent, and paid by UNDP. The total staff of the SFD is 150 people at present.

Although population as defined in this study, is not one of the main development issues the SFD is targeting at, the SFD does support a population project with a budget of US\$ 47 million. This project falls within the community development programme.

The population project is executed directly through grassroot NGOs in Upper Egypt (in villages), Alexandria (in slums), and North-Sinai (with nomads). The clinics they work in are NGO clinics, not government clinics.

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SDF provides training for the staff and invest in additional equipment. The projects may differ per village, depending on the needs (education, reproductive health, PHC, income generating). Loans are given through associations (e.g. the Egyptian Family Planning Association).

### 4.3 | Role of national NGOs

Concerns about the rapid population growth have been recognized since the 1930s. NGOs play an important role in the history of population and family planning in Egypt. In 1936, the Egyptian Medical Association discussed the problem and a group of university professors called for family planning. A few years later, in 1945, the Maadi Child Association, a private organization, was the first association to offer family planning services in Egypt (SIS, 1992, p. 4).

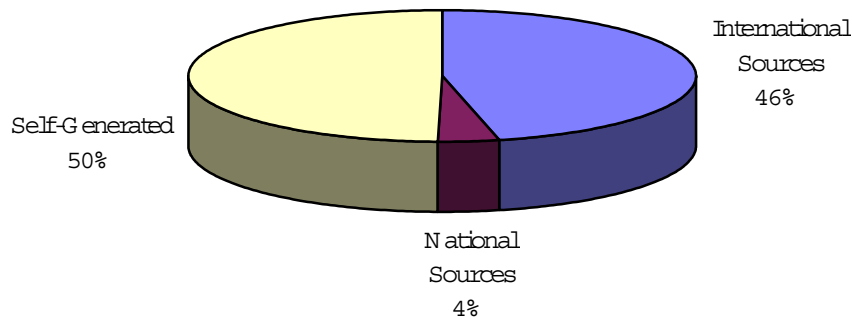
Egyptian NGOs played and continue to play a complementary role to that of the government with innovating and pioneering pilot projects. They also play a very important role in drawing attention to harmful practices like the eradication of FGM. Some 450 Egyptian grassroot NGOs are registered as active participants in the field of population and development.

All national organizations are required to register with the Ministry of Social Affairs under Law 32. On a day-to-day basis, the activities of NGOs involved in family planning are monitored by the MOHP. In the last few years, a lot of these NGOs have undergone a period of instability due to the changing of their affiliation with the Ministry of Social Affairs to the Ministry of Population, and again to the Ministry of Health and Population (CDC, p. 8/9). But within the last years, the political climate has changed in a manner which makes partnership between government and national NGOs and the private sector with respect to population and development issues possible (CDC, p. 8/9).

Most NGOs generate their own budget through international donors or they finance part of the costs by charging fees for supplies and services (figure 7).

*Figure 7. Sources of income of national NGOs in Egypt, 1996*

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Source: RF96 domestic database

From the three NGOs which replied to our questionnaires, we know that they spent almost US\$ 3 million in 1996. 64 per cent was spent on family planning services, 21 per cent for reproductive health services, six per cent for HIV/AIDS prevention activities, and another eight per cent for basic research and policy analysis.

#### **National NGO Commission for Population and Development (NCPD)**

In preparation of the ICPD, the NCPD was formed to organize the ICPD NGO forum and to provide support and assistance to the Egyptian NGOs in the field of Population and Development to further their participation in this event. Members of the NCPD started as volunteers. In 1996 they were officially established by ministerial decree. The main project (a five year project) of the NCPD is to 'support NGOs towards the implementation of the ICPD Programme of Action', and is funded by UNFPA, EU, the Netherlands and the Ford Foundation. Their main objective is to mobilize and strengthen NGOs to be able to implement the POA of Cairo, and to ensure the sustainability of these NGOs. The NCPD reaches this objective through organizing consultancies, workshops and training sessions, like assisting in how to write project proposals or improving managerial skills. After the training, the trainees hand in a project proposal. They are organized through two programme officers, and six task forces:

#### I. Reproductive Health:

1. Family Planning
2. FGM
3. Sexual Health

#### II. Population and Development:

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4. Population and Environment
5. Population and Migration
6. Population and Economic Development

The NCPD is not registered under Law 32, and are therefore completely independent. They maintain a database in which 600 grassroots NGOs working in the field of Population and Development are stored. During 1996, they spent US\$ 131,840 for their activities.

#### **Egyptian Family Planning Association (EFPA)**

In 1958 this NGO was initiated by the government, and established under the name 'Egyptian Family Planning Studies Association'. In 1962 the name was changed into the Egyptian Family Planning Association, and in 1965 it affiliated with IPPF. The EFPA is probably the most active national NGO in Egypt: they currently have 25 branches, in each Governorate one, except for South Sinai, and have about 460 clinics operating. In 1996, the EFPA had 12 projects, in four strategic areas. Table 6 shows that the total expenditures in 1996 for these projects came to L.E. 9.3 million (US\$ 2.8 million). In addition L.E. 900,000 (approximately US\$ 265,000) was spent on overhead.

The Clinical Services Improvement Sub-project (CSI) is a special activity of the Egyptian Family Planning Association. It started in 1988 as a joint effort between the Government of Egypt and USAID. The project provides high quality family planning and reproductive health services in a cost effective way through 90 health centres (covering 103 clinics). Their target population are middle income class people who are willing and able to pay.

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*Table 6. EFPA project expenditures in 1996.*

	Expenditures (in L.E.)	Percent distribution
1. Provision of unmet needs:		
* Development of family planning centres	332,647	
* Mobile clinics	15,960	
* Clinical services improvement (USAID funded)	5,665,638	
* Expanding family planning services (EU funded)	743,717	
Total	<b>6,757,962</b>	72.3%
2. Women's empowerment and man's responsibilities:		
* Mobilization of women leaders	127,852	
* Family development (SFD funded)	1,988,419	
* Man responsibility	75,659	
Total	<b>2,191,930</b>	23.4%
3. Awareness and youth activities:		
* From youth to youth in support of reproductive health	118,354	
* Advocating women's rights	72,256	
Total	<b>190,610</b>	2.0%
4. Organizational empowerment:		
* Training of volunteers and staff	83,015	
* Upgrading institutional and organizational structure	52,000	
* Strategy of resources development	73,120	
Total	<b>208,135</b>	2.2%
Grand total	9,348,637	100%
Overhead	918,616	

Source: RF96 questionnaire

Financial sources of the EFPA originate for around 50 per cent from external sources (mostly IPPF, and for the CSI project from USAID); 45 per cent to 50 per cent is self-generated income (revenues, interest), and approximately two per cent to five per cent are GOE contributions (including salaries for employees in the clinics).

### **Optical Evangelical Association for Social Services (CEOSS)**

CEOSS began as a literacy project in 1952, and later added programmes in home economics, agricultural services, health care, education, publishing and rehabilitation of the disabled. The organization is not a programme oriented organization, but very much community oriented.

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It is a private volunteer agency and currently work in three sectors through which they reach about 2 million people in 56 communities:

- development sector;
- policy sector;
- self reliance sector (nursing, carpentry, et cetera): 30 per cent of their income.

Within the development sector, they work through two strategies:

- ‘partnership development’: This strategy involves working directly with local communities through teams living and working with the target group on various programmes;
- ‘self-reliance development’: This strategy consists of working with development intermediaries such as community development associations, local community committees, mosques and churches.

They offer an integrated package existing of health (in 1973 the FP programme started), education, economics, agriculture and ecology, and communication.

CEOSS is not funded by the GOE. 70 per cent of their income comes from the international community, 30 per cent is self-generated. All people pay for the services, even the poor. Prices are dependent of income however. They spend annually about L.E. 10,000,000 for the whole integrated programme (US\$ 2.9 million).

### **Cairo Demographic Centre (CDC)**

The CDC is a training and research institute, established in 1963 under the joint sponsorship of the UN and the GOE. It is an interregional institution serving developing countries. In 1992, the GOE took over the full responsibility for the CDC. The Centre is a public institution financed by the GOE and external donors. Funding is used for training programmes, e.g.:

- strengthening training and research capabilities of CDC;
- global training programme in Population and Development.

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#### 4.4 | Role of private sector

The private sector plays a very important role in the delivery of family planning services in Egypt, although it has declined somewhat ‘largely as a result of the public sector IUD programme supported by international donors’ (Moreland, 1995, p. 4).

The contraceptive prevalence rate in Egypt is 48 per cent, and is very much dependent on two methods. When the total number of users by method is adjusted for the couple-years of protection (CYP), 72 per cent of family planning users are protected against pregnancies through an IUD in 1996, 20 per cent through oral pills, six per cent use injectables, 1.5 per cent condoms, and less than one per cent other modern methods (NPC statistics, 1996, p. 10). When looking at the source of supply of current users, 62 per cent gets contraception from the private sector (pharmacies, private clinics, and private doctors), 34 per cent from the public sector (MOHP units), and four per cent from NGOs, with the Egypt Family Planning Association dominating this latter small market. It should be noted however that the distinction between public and private medical practitioners is a difficult issue. Many government doctors work from nine in the morning to three in the afternoon and then accept patients in their private clinics (UNFPA, 1994, p. 14). Again, when these numbers are adjusted for the CYP, the contribution of the different sectors to the country’s CYP gives a different picture: 23 per cent is covered by the private sector, 69 per cent by public sources, and eight per cent by NGOs.

Although the private sector counts for 62 per cent of the supply of services, this picture changes when one looks at family planning services by method, as is shown in table 7: pills are bought primarily in the private sector, whereas the public sector is much more of importance for obtaining IUDs and injectables.

In 1996 private users spent about US\$ 3.12 million to obtain contraceptives from the public sector and US\$ 2.48 million from the private and NGO sector. These figures include fees-for-services. Estimated expenditures for family planning and reproductive health activities from the government and national NGOs in 1996 came to US\$ 83 million. Private users therefore account for only around seven per cent of the total expenditures for family planning and reproductive health activities.

*Table 7. Users of family planning methods by source of supply, 1996 (%)* // /

	Pills	IUDs	Injectables	Condoms	Other modern method
Private sector	90	5	11	51	5
Public sector	7	85	82	46	87
NGOs	3	10	7	3	8
Total	100	100	100	100	100

Source: NPC Statistics, 1996.

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## 5. Concluding remarks

Table 8 gives an overview of expenditures in 1996 for the population categories by the major actors.

When these figures are related to the 60.2 million population of Egypt, we see in table 9 that for 10,000 people US\$ 20 is spent on population activities, of which US\$ 12 goes to family planning activities.

Even though the GOE contributes roughly 70 per cent to the national family planning programme in 1996, the national family planning programme is still very donor dependent. The main reason for this is that the GOE contribution includes all kind of indirect contributions e.g. television and radio broadcasting time, press space provided. Unofficial statements say that approximately 10 per cent to 20 per cent of the government contributions are financial contributions. Furthermore it must be remembered that part of this GOE contribution is money which comes originally from an international donor and was channeled through the GOE. It was however within the time frame of the study not possible to disentangle this amount, and get the actual domestic financial flow.

*Table 8. Summary for 1996 expenditures by category*

	Total (US\$)	Family Planning %	Reproductive health %	STD. HIV/AIDS %	Basic research %
International donors	32,835,532	60	27	0	13
GOE	85,816,425	56	38	1	5
National NGOs	2,987,188	64	21	6	8
Total	121,639,145	57	35	1	7

*Table 9. Expenditures by category per 10,000 people, 1996 (\$)*

	Total	Family Planning	Reproductive health	STD. HIV/AIDS	Basic research
International sources	5.5	3.3	1.5	0	0.7
National sources	14.8	8.3	5.5	0.3	0.7
Total	20.2	11.5	6.9	0.3	1.4

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The international assistance will continue in the future. There are no signs of donors phasing out.

The main challenges for the future are to overcome the plateau of the contraceptive prevalence rate of 47 per cent, and to reduce regional disparities.

## **5.1 | ICPD and the Egyptian population programme**

The ICPD conference of 1994 had a clear impact on the population programme in Egypt:

- hosting the ICPD conference in 1994, has advanced the population agenda;
- different people were brought together (researchers, activists, legal people, medical persons), and increased the enthusiasm and motivation for certain fields, e.g. empowerment of women, youth and adolescents;
- sensitive issues were brought to the public agenda;
- the NGOs got a impetus;
- the implementation of the national population programme is in accordance with the ICPD's Programme of Action.

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## References

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- Abdel-Salam Hassan Abdel Hadi, (1996), A Follow-up mechanism for the implementation of ICPD Programme of Action in Egypt, EFPA, Dec.
- Cairo Demographic Centre, (1997), Development of monitoring and evaluation indicators: an implementation of ICPD/POA in the Egyptian context.
- El-Zanaty, Fatma, Enas, M. Hussein, Gihan, A. Shawky, Ann, A. Way, and Sunita Kishor, (1996), *Egypt Demographic and Health Survey, 1995*. Calverton, Maryland [USA]: National Population Council [Egypt] and Macro International Inc.
- SCF/USA, (1995), The International Conference on Population and Development (ICPD) plus one: an overview of the programme of action and donors in Egypt. Cairo, December.
- Moreland, R. Scott, (1995), *Investing in Egypt's future: the costs and benefits of family planning in Egypt*. Cairo: RAPID, Cairo.
- Nadia Ramsis Farah, Patricia Tibbetts, Julie Hanson Swanson, (1997), *Investing in the Egyptian Girl Child*. Cairo: USAID.
- National Population Council, (1996), Annual family planning statistics. Cairo: statistical compendium.
- SIS, (1992), The challenging task of family planning. State Information Service, IEC Centre, Cairo, Egypt.
- UNFPA, (1994), *Programme Review and Strategy Development Review (for country programme 1992-1997)*. Egypt.
- UNFPA, (1995), *Country Brief for Mid-term Review Fifth UNFPA Country Programme Egypt*. Egypt. July.
- UNFPA, (1997), *Programme Review and Strategy Development Review (for country programme 1998-2003)*. Egypt.
- UNFPA, (1996), *Contraceptive Requirements and Logistics Management Needs in Egypt*. Egypt: Technical report 34.
- Robinson, Warren C., Fatma, H. El-Zanaty, (1995), *The impact of policy and programme on fertility in Egypt: The Egyptian Family Planning Success Story*. Egypt.

## **Annex I: Persons contacted**

### **Multilateral Organizations**

Mr. Abdul Muniem Abu-Nuwar	UNFPA representative
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Mr. Mahmoud Gamal El Din	Senior program officer, World Bank
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### **Government of Egypt**

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Mr. Said Ouni	Ministry of Health and Population (MOHP), Preventive Sector
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Dr. Mahmoud Abd El Rahman	First Under Secretariate, Min. of Population and Family Planning, National Population Commission
Mr. Nabil Ramzy Gabriel	Director of financial and administrative division National Population Commission
Mr. Ehab Zaghoul	Manager population activities program, Social Fund for Development
Mr. Mohamed Samy Taha Sultan	Director IEC Centre, Ministry of Information: State Information Service
Ms. Afaf Rabie Zaghoul	Director press department, Ministry of Information: State Information Service
Ms. Dineke Korfker	Midwife/anthropologist; Consultant at the Population and Family Planning Sector, UNFPA/MOHP

### **Donor countries and organizations**

Mr. Jacob A. Rooimans	First Secretary Development, Netherlands Embassy
Mr. Mohamed Kamel	Projects coordinator, JICA
Ms. Ritsuko Sakamoto	Assistant resident representative, JICA
Ms. Rie Ogiwara	Consultant Ministry of Health and Population, JICA
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Executive Director, Egyptian Family Planning Association

**Annex II. Costs of Family Planning Activities in Egypt, 1988/89 to 1991/92 by budgetary line (in Egyptian pounds)**

	Total			Non-Public Sector				Public Sector			
				Sales revenues and client payments		Sponsoring Agencies		Donor Agencies		GOE Contribution	
<b>1988/89</b>	44,710,860	100%	3,679,611	100%	243,045	100%	19,914,857	100%	20,873,37	100%	
Personnel costs	10,320,175	23%	532,961	14%	143,840	59%	4,743,920	24%	4,899,453	23%	
Other recurrent costs	32,727,597	73%	3,142,733	85%	99,205	41%	14,166,105	71%	15,319,52	73%	
Capital costs	1,663,091	4%	3,917	0%	0	0%	1,004,832	5%	654,342	3%	
<b>1989/90</b>	60,400,378	100%	6,448,728	100%	456,475	100%	31,198,496	100%	22,296,69	100%	
Personnel costs	14,652,634	24%	2,153,845	33%	239,357	52%	7,436,235	24%	4,823,196	22%	
Other recurrent costs	42,277,343	70%	4,258,217	66%	213,540	47%	20,992,277	67%	16,813,37	75%	
Capital costs	3,470,404	6%	36,666	1%	3,578	1%	2,769,984	9%	660,176	3%	
<b>1990/91</b>	72,305,201	100%	7,059,848	100%	1,499,080	100%	39,282,950	100%	24,463,33	100%	
Personnel costs	18,309,792	25%	2,514,299	36%	299,894	20%	10,591,250	27%	4,904,348	20%	
Other recurrent costs	48,505,976	67%	4,483,767	64%	1,195,608	80%	23,967,439	61%	18,859,10	77%	
Capital costs	5,489,436	8%	61,781	1%	3,578	0%	4,724,262	12%	699,815	3%	
<b>1991/92</b>	79,369,639	100%	9,216,419	100%	1,368,559	100%	39,218,511	100%	29,566,10	100%	
Personnel costs	18,943,286	24%	2,960,083	32%	225,896	17%	10,144,194	26%	5,613,112	19%	
Other recurrent costs	54,063,222	68%	6,163,750	67%	1,135,871	83%	23,525,933	60%	23,237,66	79%	
Capital costs	6,363,134	8%	92,586	1%	6,792	0%	5,548,384	14%	715,372	2%	

Source: Scott Moreland: Costs and benefits of family planning in Egypt: investing in Egypt's future, June 1996.