EGYPT'S POPULATION POLICIES AND FAMILY PLANNING

PROGRAM: A CRITICAL EXAMINATION

A Thesis

by

ALINE B. CARR

Submitted to the Office of Graduate Studies of Texas A&M University in partial fulfillment of the requirements for the degree of

MASTER OF ARTS

August 1996

Major Subject: Anthropology
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ABSTRACT


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Egypt's national family planning program, in existence since 1965, has been fairly successful in increasing the use of family planning methods and lowering the population growth rate in Egypt. However, the fact that as few as 10 percent of women in rural Egypt are using a birth control method calls into question the "success" of Egypt's population program as a national endeavor and reveals a distinct disparity between contraceptive prevalence in rural areas as opposed to urban areas. This thesis will characterize and evaluate Egypt's national family planning program on the basis of demographic, ethnographic, and interview data in order to: discern the historical development of Egypt's population policy and its implementation, determine why the program has not reached its goals in rural Egypt, and discuss the sustainability and policy implications of the program. Contrary to other evaluations of family planning in Egypt, this examination will use a holistic, systemic method of evaluation which will consider a wide number of sociocultural, environmental, economic, political, and health related factors that influence population growth in Egypt. By conducting the evaluation in this manner, I will reveal that although the Egyptian government may have a well-intentioned population policy, it has been poorly implemented and improperly evaluated. It has emphasized population control and the sale of contraceptives while ignoring cultural beliefs and practices, the importance of the family and community in Egypt, social and political conflicts, environmental problems, and the socioeconomic and health care needs of Egyptians.
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INTRODUCTION

Although the effects of overpopulation on a global scale have been fiercely debated in scientific, political, and religious circles for decades, a large amount of demographic and scientific data indicates the world is facing an international dilemma imposed by a rapidly growing human population for which basic needs are becoming increasingly difficult to provide. World population, now estimated at 5.76 billion, is expected to reach the 10 billion mark by the year 2050 (USBC 1995). The expansion of family planning services has therefore become a priority target of national and international development programs both as ends in themselves and to promote other development goals (Sadik 1991:6).

The most rapid population growth is occurring in Islamic countries, especially the Arab countries of the Middle East and North Africa (PRB 1994; Weeks 1988:13). Characterized by higher-than-average fertility rates, often over six children per woman, Middle Eastern and North African countries are facing water shortages, increasing poverty, socioeconomic inequities, increased consumption and waste, growing environmental and health problems, and increasing foreign debt (Obermeyer 1993:34-35). Egypt especially has been deeply affected by population growth. The population of Egypt has grown rapidly over the past fifty years, increasing from 19 million in 1947 (Kelley et al. 1982:35) to 58 million in 1994 (PRB 1994). As a result, Egypt has become one of the most densely populated nations on earth with a population size that has outpaced the country’s efforts to improve socioeconomic programs and utilize its dwindling natural resources in a productive yet environmentally conscious way. One of the first Arab countries to implement a government-supported family planning program, Egypt implemented its first national program in 1965. This program fully supported the use of modern contraceptives to lower birth rates.

Statistically speaking Egypt has experienced a good deal of success in lowering birth rates since the formal initiation. Egyptian women are now having an average of 3.9 children (PRB 1994) compared to 5.5 in 1970 (Keyfitz and Flieger 1990:128), and the number of women using modern contraceptive methods has risen

The journal model used for this thesis is American Antiquity.
from 10 percent in 1969 (Kader 1987:177) to 45 percent in 1994 (PRB 1994). In light of this success, Egypt has joined ten other developing nations in a program called "Partners in Population and Development: A South-South Initiative" (Crossette 1994:1). Along with Bangladesh, Colombia, Indonesia, Kenya, Mexico, Morocco, Thailand, Tunisia, and Zimbabwe, Egypt will challenge the notion that birth control is merely a Western idea that is incompatible with traditional cultures and will share family planning program skills and experience with other developing countries (Crossette 1994:1).

In the rural areas of Egypt, however, where 55 percent of the population currently reside (PRB 1994), as few as one woman in ten are using family planning services (Stephens 1992:45). This calls into question the "success" of Egypt's family planning policy as a national endeavor and reveals a distinct disparity between contraceptive prevalence in rural areas as opposed to urban areas. Some researchers have suggested that although Egypt's population growth rate has dropped, the population policy needs to promote maternal and child health and economic opportunities for women before Egypt will begin to experience a true demographic decline (e.g., Courbage 1994; Faust et al. 1991; Gupte 1981; MacKenzie 1985; Stycos et al. 1988; UNFPA 1992). Instead of focusing on health and development activities, Egypt's population policy and family program have been driven by population target goals that emphasize fertility control through increased access and usage of contraceptives.

Although non-governmental organizations (NGOs) and private voluntary organizations (PVOs) sponsor some family planning programs in Egypt, the largest and most prevalent is the government program. The program is a centralized program administered by the Ministry of Health, and for the most part, implemented, administrated, and evaluated by Ministry of Health employees through the government's public health care system. The Ministry of Health has promoted family planning as a cure for Egypt's economic woes and has seriously promoted specific contraceptive technologies chosen by the government on the basis of their reliability.

The program has only sporadically been combined with socioeconomic development programs and has yet to be associated with environmental education and resource management programs. When it has been extolled as an important requirement for the betterment of women's health and the health of their children, the program has only been promoted as such under the guise of persuading more
women to use contraceptives. Essentially, however, family planning has not been installed as part of women’s health care, nor has it improved the quality of health care available. While government funding for rural health care have continuously been cut, Egypt has continued to ardently promote family planning as the key to good family health. This has resulted in an inadequately managed program, heavily influenced by changing national and global political agendas and economic conditions, and a direct reflection of Egypt’s rigidly stratified sociopolitical system.

Although the promotion of contraceptives has received modest to good results in urban Egypt, especially among the more westernized middle and upper classes for whom fertility holds some economic implications, the subservient power status of the underprivileged classes within the nation state of Egypt “precludes independent planning of their lives in their own best interest” (Morsy 1981:161). The health care needs of rural Egyptians has generally been accorded low priority (Morsy 1981:161). Thus, it appears to some that the government is more interested in the unborn rather than caring about the health of the living.

As a national policy, family planning in Egypt has been treated, both by Egypt and its foreign aid donors, as a necessary requirement for development to occur and to gain approval for development funds. The global and national level concern with population levels, however, has not been articulated in a way that makes sense or draws great concern at the local level. The family planning program has instead been based on a “technocratic model” of development whereby the spread of technology to the masses will result in development or “modernization” (Cernea 1991:7). These models guide state-induced interventions and are linear in planning, neglect the social dimensions of development and fail to “put people first” (Cernea 1991:7). Family planning, if viewed in this way, has merely become another isolated sector of an already overly sectorized, state-induced scheme in which the various segments of the program (i.e., planning, implementation, evaluation) are separate from one another and devoid of historical, cultural, socioeconomic, and political context.

This thesis will characterize and evaluate Egypt’s national family planning program on the basis of ethnographic, survey, and interview data in order to: (1) discern the historical development of Egypt’s population policy and its implementation, (2) determine why the program has not reached its goals in rural Egypt, and (3) discuss the sustainability and policy implications of the program.
Contrary to other evaluations of family planning in Egypt, this evaluation will take into account social, environmental, economic, political, and health related factors which both affect population growth and are in turn influenced by it. By conducting this evaluation in this way, I intend to reveal that although the Egyptian government may have a well-intentioned population policy, it has been poorly implemented and improperly evaluated. It has emphasized the quantity of contraceptives sold while failing to address the cultural beliefs and practices of Egyptians along with their socioeconomic and health care needs. Family planning, however, can have an enormous impact on the future development of Egypt if it can be tailored to the needs of the beneficiaries rather than to the needs of Egypt's centralized administration.
SETTING

Geography and People of Egypt

Geography and Population

Located in the northeastern corner of Africa, Egypt (Figure 1) has for centuries functioned as a major thoroughfare connecting the Middle East, Sub-Saharan Africa, and Europe, and despite centuries of colonial rule by Arabs, Ottoman Turks, and British, the Egyptians have managed to maintain their own identity and international influence. Today there are nearly 60 million Egyptians (PRB 1994) who constitute nearly one half of the world's Arabic-speaking peoples and a large portion of the world's Muslim population (Harris 1988:2). Cairo, the largest city in Egypt and all of Africa, has a population of approximately 14 million (Linden 1994:1).

Most of Egypt's approximately one million square kilometers consist of arid desert, broken only by a few oases and the Nile River Valley and Delta. The Delta region north of Cairo (also called Lower Egypt) and the Nile Valley south of Cairo (Upper Egypt) comprise a mere 4 percent of Egypt's total land mass, a land area slightly larger than the state of Maryland (Caputo 1985:580) and Egypt's primary source of arable land. This small region is home to approximately 96 percent of Egypt's population, making it one of the most densely populated areas on earth (PRB 1994; Caputo 1985:580).

A little over half, 55 percent, of the population (PRB 1994) reside in rural areas, but the vast disparities between urban and rural socioeconomic conditions has led to an increase in rural to urban migration. Many rural areas are characterized by poor social services and poor sanitary and living conditions. This combined with land loss due to mechanized farming, land redistribution, industrialization, overcrowding, pollution, and desertification has contributed to the migration of landless farmers to the cities. As a result, Egypt's cities are faced with an expanding number of impoverished city dwellers and growing problems of homelessness and unemployment.

The cultural distinctions between rural and urban Egypt are also significant. The adoption of western customs, commodities, and dress has occurred to a great extent among the middle and upper urban classes, while traditional Egyptian and
Figure 1. Africa and the Arab Republic of Egypt
Muslim practices have remained more prominent in poor urban working class neighborhoods and rural towns. In general, however, Egyptian society overall remains a patriarchal, group-oriented society characterized by strong family and community ties and strong traditional and religious values. Traditional culture is geared to the welfare of the group, the family in particular, and the fulfillment of one’s designated social role is emphasized rather than the development of individual talent or the satisfaction of personal goals and desires (Harris 1988:2). Because of the emphasis on the family unit, everyone is expected to marry and become parents, and traditional gender roles are strictly adhered to among many families. Great importance is placed upon men’s responsibilities to be the decision-makers, providers, and protectors of their families, and political power and the ownership of economic resources has for the most part resided in the hands of men. Sons remain a symbol of family strength, a status symbol for their parents, and are responsible for continuing the family lineage, preserving family wealth and property, the providing family labor, and caring for their aging parents.

Women, on the other hand, have historically been valued as childbearers, homemakers, and caregivers. In the most conservative of families, they may be forbidden from appearing before strangers unveiled and may need their father’s or husband’s permission to leave the house. Gender roles, however, vary greatly from community to community and family to family. Primary education (grades 1 through 8) is now compulsory for both genders and has led to an increase in the number of women attaining higher levels of education. Literacy levels remain low, however, with only 63 percent of adult men and 34 percent of women being literate (World Resources Institute 1992:254). The number of women employed outside the home, both in urban and rural areas and in formal and informal work sectors, has steadily grown as well. Fewer numbers of children though, living in poor urban areas or rural areas, are able to go to school or only attend for several years. Because the educational system in Egypt has been unable to keep up with the number of children being added each year, it is plagued by overcrowding, neglect, and under-motivated and under-paid teachers. Many parents cannot afford to pay for school supplies, clothing, or transportation needed to send their children to school much less pay for the special tutoring needed to ensure that a pupil is able to pass the state exams. If
money is lacking, often daughters will be kept at home in order to pay for a son's education.

Religion

Approximately 90 percent of Egyptians are Sunni Muslims descended from a mixture of Hamites, the indigenous pre-Islamic population, and Arab conquerors (Compton's 1994). Islam, along with the Arabic language, was brought to Egypt after Mohammed's death in 632 A.D. by Arab invaders from western Asia. About 10 percent of Egyptians are Christians belonging to the Coptic Orthodox Church which traces its traditions back to the first century Biblical gospel writer Saint Mark (Cofsky 1993:46). The Copts are primarily descendants of the Hamites of the Nile Valley, and the Hamitic language still survives in some Coptic churches.

Islam is the official religion of Egypt, and Egypt's political and legal system is based upon a combination of Islamic laws and secular laws. Religious power in Egypt is distributed among five organizations: (1) the Sheikh of al-Azhar University (the university of Islamic learning), (2) the Mufti who determine whether national legislation is consistent with the Sharia (Islamic law), (3) the Ministry of Religious Endowments, a source of revenue and authority for government-owned mosques; (4) the Muslim Brotherhood, the oldest fundamentalist political organization; and (5) the Sufi sects, often inspired by a saint and exercise both social and political influence at the local level (MERI 1985:18). Every aspect of life, including the political, economic, legal, and social rules of society is defined down to the smallest detail by the sacred book of Islam, the Koran (Dean 1957:49). For this reason, traditionalist Muslims claim that religion and politics are inseparable in a truly Muslim society (Watt 1988:92). As in so many regions of the Islamic world, this has resulted in an ongoing struggle between secular government leaders and Islamic extremists who believe the true Islamic and Egyptian way of life can only be preserved and improved through the imposition of a strict Islamic code.
The Economy

Many of Egypt's current problems stem from centuries of colonialism followed by developments which took place under President Nasser during the 1950s and 1960s (Abdallah and Brown 1988:32). When the Free Officers, led by Lt. Col. Gamal Abdel Nasser, forced the abdication of King Farouq in 1952, nearly two millennia of foreign rule ended, and Egypt was proclaimed an independent republic (Fluehr-Lobban 1990:29). President Nasser embraced socialism and turned to the Soviet Union for military and economic aid. By the mid-1960s, the government had assumed control of the financial, communications, and utilities infrastructures, as well as a large part of the manufacturing and construction industries, foreign trade, and the transportation systems (Harris 1988:5). The public sector became the largest employer, and government price controls on products seriously constrained profitability (Abdallah and Brown 1988:37). This over-centralized, top-heavy structure is superimposed on a centuries-old bureaucratic tradition, combining delay and corruption (Abdallah and Brown 1988:37).

When Sadat assumed the presidency in 1970, he turned away from socialism and introduced *infitalah*, an "open door" policy, supported by one billion dollars per year in economic assistance from the United States. Although this assistance was meant to aid in the democratization and privatization of Egypt, a process which continues today (The Middle East 1992:29), change has been slow. Egypt has one of the largest public sectors in the developing world with government, public sector enterprises, and the armed forces employing 36 percent of the workforce (Compton's 1994). The inefficient public sector is so large that turning Egypt into a market-based economy will take many years and will cause more unemployment (The Middle East 1992:29). Government overregulation has prevented technological modernization and foreign investment, and the bureaucracy is resistant to change, low-paid, and the lack of coordination between individual ministries impedes procedures and policymaking (Abdallah and Brown 1988:37).

Agriculture comprises the second largest sector of the economy, employing 34 percent of the workforce (Compton's 1994), most of whom are rural peasants (*fellahin*). Although the Aswan High Dam now enables Egyptians to grow three crops
per year rather than only one, soil salinization, pollution, and urbanization below the
dam has actually decreased production. The International Monetary Fund (IMF) has
also insisted that Egypt shift its agricultural production from staple foods to export
crops, such as cotton and sugarcane, in order to produce more hard currency to pay
off its foreign debts (Mitchell 1991:20). As a result, Egypt can no longer provide
sufficient food supplies for its growing population and has been forced to rely heavily
upon extensive amounts of food imports, primarily wheat and meat (Compton's
1994). Food accounts for about one quarter of Egypt's total imports, although much
of the grain imported into Egypt is used for animal feed to support the growing
demand for meat by the wealthy (Mitchell 1991:20).

The loss of arable land has resulted in a reduction in export revenues and
agricultural production. The cropped area almost doubled between 1882 and 1980,
but due to population growth, the per capita cropped area declined 50 percent to a
meager 0.27 feddans (1 feddan=1.038 acres) per person in 1980 (Sadik 1991:281).
Huge land reclamation projects, such as the Aswan Dam, can only accommodate 4
to 5 million additional people, a number Egypt can produce in 4 or 5 years (Sadik
1991:281). Thus rapid population growth tends to nullify the land or job-creation
benefits of huge development projects, ones which can hardly be duplicated every
five years (Sadik 1991:281).

Most of Egypt's foreign revenues are drawn from tourism along with
petroleum sales, Suez Canal tolls, and remittances from Egyptian workers abroad.
The increase in imports along with huge drops in oil prices, high inflation, high
unemployment, subsidies and price freezes to sustain the living standards of the
poor have all contributed to worsening economic problems. Many resources are now
beyond the means of the poor despite the fact that Egypt receives the largest amount
of U.S. foreign aid with the sole exception of Israel. This high level of funding,
provided to promote democratization and the establishment of a free market
economy, has provided millions of Egyptians with new sewage systems, power
stations, telephone networks, and other infrastructure projects.

The aid, however, has come at the price of dependence on imports of
American food, machinery, and technology (Mitchell 1991:32). This dependency
development scheme has escalated Egypt's foreign debt to over $41 billion (Reuters
1994). In addition, few projects have benefitted poor rural Egyptians. This is partly due to the fact that although the U.S. has loaned money to Egypt for development to support democratization and privatization, the majority of U.S. funding has been in the form of military aid rather than economic development aid. For the fiscal year 1994-95, Egypt received $815 million from the U.S. Agency for International Development (USAID) for development and $1.3 billion from the U.S. government for military aid (Knight-Ridder 1994).

Although a large portion of Egypt's debt to the U.S. was forgiven for Egypt's support in the Gulf War, Egypt has had little recourse but to negotiate with the International Monetary Fund (IMF), continue borrowing money from foreign donors, and borrow internally in an attempt to pay off its debts. Egypt's internal debt is so high that $40 billion have been borrowed from social security and pension funds, and a number of Egyptian institutions are now failing to pay social security installments on time (Reuters 1994). The situation is likely to be made worse by reforms, such as cutting food subsidies, endorsed by the IMF to ensure that Egypt will be able to pay off its debts.

The Political System

The Constitution of 1971 defines Egypt as an Arab Republic with a democratic/socialist system, headed by a President elected by popular referendum. The nation's capital, located in Cairo, oversees 26 territorial administrative units called governorates. President Mohammed Hosni Mubarak as been in office since 1981 and was elected to a third six-year term in 1993. The National Democratic Party (NDP), of which President Mubarak is leader, is the dominant party and controls 100 percent of the seats on the Advisory Council and over 70 percent of the seats in the People's Assembly (Compton's 1994). The formation of political parties must be approved by the government, but Islamic groups are illegal although the largest Islamic party, the Muslim Brotherhood, is tolerated by the government.

President Mubarak of Egypt has attempted to secularize and democratize the country, but as the economy has worsened and Western influences have continued to erode traditional values, Islamic groups have increased pressure on the
government to follow Islamic law. It is the government that is held responsible for providing a socioeconomic environment necessary for standards of living in both urban and rural areas to rise (Sadik 1991:281). President Mubarak has nonetheless only allowed very limited democratic institutions to develop and is becoming more and more unpopular with the general public (Economist 1993:7811). During the 1993 presidential election, more than 18 million voters were eligible to go to the polls to mark "yes" or "no" on the ballot next to the sole candidate's name, Mubarak. Few marked "no" because voters must use their national identity card to obtain ballots (Napoli 1993:55). Mubarak has also limited the formation of political parties, has refused to allow Islamic fundamentalists to participate in political discussion or the political process, has criminalized some types of political dissent, has expanded police powers, and has arrested or detained thousands of Egyptians for questioning (Economist 1993:7811).

Because Egypt's attempts at socialism and democracy have been unsuccessful in providing a stable socioeconomic environment, Egypt's Islamists believe a stricter Islamic government with a legal code based on Islamic law, a less pro-Western foreign policy, and a greater identification with Islam as a political ideology is the only way to solve Egypt's problems (Murphy 1992). Moderates, like the Muslim Brotherhood, hope to bring this about through persuasion and the use of electoral politics to implement their agenda. In addition, the Muslim Brotherhood and other Islamic groups are gaining public support through the provision of social services which compete with government-provided services. Islamic banks which offer human services and investments based on Islamic organizational principles are already becoming popular alternatives to government facilities (Murphy 1992). Islamic groups are also providing funds for needy college students, and they have opened health clinics that are more efficient and less expensive than government or private health care. On the other hand, militant Islamic groups like Gamaa Islamiyya, the Islamic Group, argue that change to an Islamic state can only be won by a violent revolution (Murphy 1992). They are putting political pressure on the Egyptian government by conducting terrorism within Egypt against government employees, Coptic Christians, and foreign tourists.
Population Trends in Egypt

The documented demographic history of Egypt spans 53 centuries with census data available from as early as 3340 B.C. (Kelley et al. 1982:34). Censuses were taken by the pharaohs of ancient Egypt for war or taxation purposes, and although the accuracy of these records is unknown, the population of ancient Egypt may have been two or three million (Gupte 1981:13). Russell (1966:69-82) estimates that between 30 B.C. and the 5th century A.D., the number of Egyptians may have multiplied to a high of 4 million, but this number steadily declined beginning with the Arab conquest of the seventh century A.D. and continuing through the Middle Ages (Musallam 1983:110) (Figure 2). From the second half of the fourteenth century to the beginning of the fifteenth century, the population was greatly depleted and much of the country abandoned due to a number of reasons including the Black Death and its later recurrences, the occupation of Egypt by the oppressive Mameluk regimes, warfare with the Bedouins, and agricultural and economic degradation (Musallam 1983:110-113).

Figure 2. Population Growth in Egypt. (Kelley et al. 1982:34; Keyfitz and Flieger 1990:128; Russell 1966:69)
A major change of direction took place for Egypt when Napoleon occupied Egypt in 1798 with the aim of disrupting the British trade link with India (Butt 1988:36). Although Napoleon was eventually forced out, it was not before Egypt was exposed to the modern world of western Europe after the stagnation and isolation of the Ottoman period. The first census from modern times, undertaken by a French expedition to Egypt in 1800, estimated Egypt's population to be around 2.5 million (Gupte 1981:13; Kelley et al. 1982:34), but a later census taken during the mid-1800s revealed the population had begun to increase and had grown to 4.5 million (Kelley et al. 1982:34). The building of the Suez Canal during the mid-nineteenth century further opened up Egypt to the global arena, increasing trade and economy.

Beginning in 1882, the Egyptian government itself began to take regular censuses at approximate 10 year intervals, and according to these early records, the population took its first big leap around the late 1800s and early 1900s. The population more than doubled itself, jumping from 6.8 to 15.9 million between 1882 and 1937 (Kelley et al. 1982:34). The Egyptian population took its biggest leap, however, following World War II, doubling in less than 30 years between 1950 and 1980. This increase is often misinterpreted resulting from an increase in fertility rates. In actuality, it was more a consequence of a dramatic decrease in mortality rates and an increase in life expectancy due to the implementation of modern medicine and improved living conditions. The infant mortality rate alone decreased by half between 1950 and 1980 (Table 1), and the crude death rate decreased from 24 per 1,000 people to 8 (Keyfitz and Flieger 1990:128). Although the total fertility rate did rise during the 1950s and 60s, the TFR and the crude birth rate have been falling slowly since the 1970s.

During the 1980s, Egypt's population increased from 41.5 million to 54 million in 1990 (Keyfitz and Flieger 1990:128), and as of 1994 is estimated to be close to 58.9 million (PRB 1994). Over one million people are being added each year (Keyfitz and Flieger 1990:128; Stephens 1992:45). In 1991, Egypt's population rose by 1.3 million, an increase of one baby about every 24 seconds (Stephens 1992:45), and the annual percentage of natural increase has increased to 2.3 in 1994 (PRB 1994). The mortality rates, however, have continued to drop, and life expectancy has risen to 60 years for men and 63 for women (PRB 1994). Also, the total fertility rate for
Egyptian women has dropped to 3.9, and it is estimated that 45 percent of married women are using modern contraceptive methods (PRB 1994).

Table 1. Observed and Projected Mortality and Fertility Rates in Egypt.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Pop. (mills)</th>
<th>Crude Death Rate</th>
<th>Infant Mortality Rate</th>
<th>Life Expectancy (yrs)</th>
<th>Crude Birth Rate</th>
<th>Total Fertility Rate</th>
<th>Natural Increase (%/yr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1950</td>
<td>20.3</td>
<td>24</td>
<td>200</td>
<td>42</td>
<td>50</td>
<td>6.6</td>
<td>3.2</td>
</tr>
<tr>
<td>1960</td>
<td>25.9</td>
<td>20</td>
<td>175</td>
<td>47</td>
<td>45</td>
<td>7.1</td>
<td>3.4</td>
</tr>
<tr>
<td>1970</td>
<td>33.0</td>
<td>16</td>
<td>150</td>
<td>52</td>
<td>38</td>
<td>5.5</td>
<td>2.7</td>
</tr>
<tr>
<td>1980</td>
<td>41.5</td>
<td>12</td>
<td>100</td>
<td>58</td>
<td>40</td>
<td>5.3</td>
<td>2.6</td>
</tr>
<tr>
<td>1990</td>
<td>54.1</td>
<td>8</td>
<td>71</td>
<td>63</td>
<td>31</td>
<td>4.2</td>
<td>2.1</td>
</tr>
<tr>
<td>2000</td>
<td>66.7</td>
<td>6</td>
<td>46</td>
<td>68</td>
<td>23</td>
<td>3.0</td>
<td>1.5</td>
</tr>
<tr>
<td>2010</td>
<td>78.5</td>
<td>6</td>
<td>32</td>
<td>71</td>
<td>21</td>
<td>2.3</td>
<td>1.1</td>
</tr>
<tr>
<td>2020</td>
<td>89.0</td>
<td>6</td>
<td>23</td>
<td>73</td>
<td>17</td>
<td>2.1</td>
<td>1.0</td>
</tr>
</tbody>
</table>

Note: Data from Keyfitz and Flieger (1990:128).

Although population growth rates in Egypt still exceed the average growth rates for the world as a whole, they have dropped considerably (Table 2). The young age of Egypt's population, however, 40 percent of whom are under the age of 15 (PRB 1994) insures rapid population growth for many years even if the fertility rate is reduced to 2 children per woman this year. Thus, President Hosni Mubarak has said that population is Egypt's "problem of problems" (Mahran 1984:13-15). Two-thirds of rural Egyptians live in the Delta (Kelley et al. 1982:68) while the remainder live in Upper Egypt where the soil is less fertile. Settlement is often so dense along the Nile that it is often difficult to determine where rural ends and urban begins (Fluehr-Lobban 1990:20). Many towns with populations in the hundreds of thousands resemble small cities, while Egypt's urban centers are so crowded with rural migrants.
that some areas take on village-like characteristics (Fluehr-Lobban 1990:21).

Rural-to-urban migration has been increasing rapidly since the 1940s when a
census in 1947 recorded that 66 percent of the population was rural (Kelley et al.
1982:71). Fertility rates also vary considerably between rural and urban areas.
According to Khayat (1994:35), the TFR for rural women was 4.9 in 1992 as
compared to 2.9 for urban women. The fertility rates are highest in the rural areas of
Upper Egypt, followed by the rural areas of Lower Egypt. The total fertility rates in
Cairo and Alexandria averaged 5.9 in 1960 but dropped by two children by 1975
(Stycos et al. 1988:20). Infant mortality rates are also higher in rural areas. In 1987,
57,059 rural infants died as opposed to 36,985 infant deaths in the cities (United

Table 2. Population Growth in World Regions and
Some Middle Eastern Countries.

<table>
<thead>
<tr>
<th>Region</th>
<th>Natural Increase (%/year)</th>
<th>Total Fertility Rate</th>
<th>Population Doubling Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>World</td>
<td>1.6</td>
<td>3.2</td>
<td>43</td>
</tr>
<tr>
<td>More developed countries</td>
<td>0.3</td>
<td>1.7</td>
<td>264</td>
</tr>
<tr>
<td>Less developed countries</td>
<td>1.9</td>
<td>3.6</td>
<td>36</td>
</tr>
<tr>
<td>Algeria</td>
<td>2.5</td>
<td>4.2</td>
<td>28</td>
</tr>
<tr>
<td>Egypt</td>
<td>2.3</td>
<td>3.9</td>
<td>31</td>
</tr>
<tr>
<td>Iraq</td>
<td>3.7</td>
<td>7.0</td>
<td>19</td>
</tr>
<tr>
<td>Jordan</td>
<td>3.3</td>
<td>5.9</td>
<td>21</td>
</tr>
<tr>
<td>Saudi Arabia</td>
<td>3.2</td>
<td>5.5</td>
<td>22</td>
</tr>
<tr>
<td>Syria</td>
<td>3.7</td>
<td>6.9</td>
<td>19</td>
</tr>
<tr>
<td>Tunisia</td>
<td>1.9</td>
<td>3.3</td>
<td>36</td>
</tr>
</tbody>
</table>

*Note: Data from PRB (1994).*
Of the 45 percent of Egyptians that now live in urban areas (Population Reference Bureau 1992), most live in Cairo and Alexandria, where the square footage of living space and quality of accommodation continue to deteriorate and unemployment proliferates (Harris 1988:3). It is estimated that Cairo is inhabited by 15 million people and with the addition of 1,000 babies born every day and the influx of thousands of rural migrants, the population is expected to increase to 20 million by the year 2000 (BBC 1993). Oweiss (1990:5) estimated the population density of Cairo to be 42,000 people per square mile, and according to the BBC (1993), every person has only 5 square inches of green space. The rural migrants moving to Cairo in hopes of finding jobs have instead found themselves homeless, unemployed, and forced to live in the streets. Three million squatters live in the City of the Dead (Cairo's cemetery), and a half million are roof dwellers (BBC 1993).

It has been said that Cairo is undergoing an "environmental fallout" (BBC TV 1993). Lead pollution has reached one of the most critical levels in the world, and noise pollution in the city is 10 times higher than recommended by international regulations, causing close to two thirds of city's residents to use sleeping pills in order to sleep (Oweiss 1990:39). Building codes which restrict the construction of new buildings and industry on the extremely limited "green land" are not respected or enforced, and attempts to resettle people into new desert cities have failed miserably. The Population Reference Bureau (1994) estimates that Egypt's overall population will reach 97.9 by 2025, and 68 percent of those Egyptians will be residing in urban areas (Keyfitz and Flieger 1990:128). Much of this has led the government to view population as a burden (BBC TV 1993), and there is concern for the encroachment of slums into middle and upper class areas.

Egypt appears to be moving through the stage of the demographic transition in which the population growth rate approaches a peak, and it is expected that in time the next stage will be reached where the birth rate and rate of increase will both decline (Kelley et al. 1982:35). This may be some time in coming, however. The high rate of population growth has been seen by the Egyptian government, as well as by international aid agencies, as Egypt's main hindrance to economic development (Wahba 1988:15), although Egypt's population is less a cause than a consequence of Egypt's development problems.
DEMographic THEORY AND POPULATION POLICYMAKING

Demographic Theories of Fertility: A Brief Overview

Introduction

In order to understand the basis and evolution of Egypt's population policy and the organization of Egypt's family planning program, one must understand the theoretical and methodological underpinnings of their development. In this section, I will briefly discuss the most important demographic theories which have influenced population research and policymaking in Egypt since the 1940s. This will be followed by a section discussing the historical evolution of Egypt's population policy and family planning program and how it has been influenced by western-based demographic theory and policymaking methods. In addition, this will show the need for more holistic anthropological research, both in demographic research and policy science, in order to influence the planning and implementation of family planning programs, other types of development programs, and the policymaking process.

The evaluation of the causes and consequences of population growth has embodied a long history of convoluted and often conflictive theories and hypotheses stemming from a variety of disciplines including ecology, economics, biology, demography, and anthropology. The battle lines have primarily been drawn between the economists, who generally believe man and technology will prevail, and the ecologists who predict global environmental catastrophe in the wake of overpopulation. As the war between economists and environmentalists continues, however, social demographic theory today has become relatively weak to nonexistent (Greenhalgh 1994; Holden 1984; McNicoll 1980). This has led demographers, such as John Caldwell (1993; Caldwell and Caldwell 1987) to show a growing interest in anthropological approaches to population research.

Since the mid-1940s, the field of demography developed five major theories or sets of theories to explain variations in fertility. These included demographic transition theory, several “post-classic” transition theories, and a smaller class of
institutional and contemporary approaches to reproductive change (Greenhalgh 1994:5).

*Classic Demographic Transition Theory*

Classic demographic transition theory, formulated by Notestein (1945), was a unilinear evolutionary theory which proposed that population growth progressed through three stages beginning with high fertility and ending with a stable or zero population growth. The first phase consisted of high fertility and high mortality resulting in slow population growth. This was followed by a transitional phase of falling mortality resulting in rapid population growth. The final phase consisted of low mortality and decreasing fertility, eventually leading to population stabilization. This fertility transition was instigated by urbanization and industrialization which led to an improved economy, a higher standard of living, weakened family life, and the need for a large number of children.

Classic transition theory was a version of modernization theory, the paradigm of third world development that dominated sociocultural and scientific research between World War II and the late 1960s (Greenhalgh 1994:5; Weeks 1989:74). The modernization school, which embraced many disciplines, created universal theories rooted in nineteenth-century evolutionary theory that focused on social and economic forces of change to the exclusion of political and cultural ones (Greenhalgh 1994:5). In universalistic, Eurocentric fashion, classic transition theory maintained that all cultures would eventually proceed through the same lengthy, evolutionary, irreversible fertility change.

Classic transition theory does not specify the causal relationships which exist between mortality and fertility rates and the development process, but the basic concept that fertility will eventually decline worldwide is still accepted today (Findlay and Findlay 1987:33). Although it has been shown that fertility decline does not diffuse automatically from the developed to the less developed countries, the very failure of this part of classic transition theory has promoted more research into the causal mechanisms of fertility decline (Findlay and Findlay 1987:33).
Post-Classic Fertility Transition Theories

Classic demographic transition theory was subsequently tested during the 1960s and 1970s. Beginning in 1963, the European Fertility Project was launched to test transition theory using historical data from 700 provincial units throughout Europe. The results revealed there was no overall consistent relationship between fertility decline and industrialization (Knodel and van de Walle 1979). The study did, however, discover that fertility decline in Europe varied according to social, economic, and demographic conditions. Fertility in some non-industrial provinces was found to be low while infant mortality rates were high. Thus, economic development was found to be a cause of fertility decline in some places but not universally. The data instead suggests that one of the more common similarities in those areas that had undergone fertility declines was the rapid spread of secularization (Weeks 1989:76). Secularization, especially when accompanied by mass education, can occur independently of industrialization and often spreads quickly, being diffused through social networks (Weeks 1989:76).

An alternative theory, although supportive of classic demographic transition, was the theory of demographic change and response put forward by Davis in 1963. Davis (1963) suggested that demographic change is stimulated by mortality decline. In order to sustain its standard of living, a society undergoing mortality decline would respond by controlling its population growth through birth control, rural to urban migration, and emigration.

Another alternative to classic transition theory emphasized microlevel changes in family organization and the status of women (Greenhalgh 1994:7). The wealth-flows theory of the 1970s tied fertility decline to a reversal in the net intergenerational flow of goods and services from the older to the younger generation (Caldwell 1976, 1982). Modernization eventually tears extended families into nuclear units. For nuclear families, parents spend more of their income on children who become an economic burden rather than economic advantage.

During the 1980s, the role of women and women's status began to play an increasingly important part in fertility theories. Mason (1986, 1987) proposed a set of hypotheses connecting the status of women and fertility. She hypothesized that
women's education and their position in the household affected their economic autonomy and social status. Women with more independence and status did not have as great a demand for children as an economic asset or status symbol.

The economists, between the 1960s and 1980s, were primarily formulating microeconomic theories of fertility. These included consumer-choice models which hypothesized that families made an economic choice between children and other goods (Becker 1960) and broader theories which added social and biological constraints to the economic process of decision-making (Leibenstein 1975; Easterlin 1978). Richard Easterlin's theory of relative income postulates that fertility decisions are made according to individual perceptions of future income and employment. Fertility fluctuates according to economic fluctuations, rising if jobs are plentiful and decreasing in economic downturns.

A more recent theory combines institutional theory in economics with other fields to explain population change. McNicoll (1994) argues that the pattern of reproductive change is shaped by a society's institutions, such as community structures, family systems, and sex roles, as they change through time and individual behavior adapts.

Contemporary Fertility Transition Theories

Demography today is dominated by narrow sociological and microeconomic theories, focusing on individual couples, families, and personal networks but ignoring the interface between micro and macro-level institutions (Greenhalgh 1994:9). This includes the diffusion approach discussed earlier whereby fertility decline is reduced to the technological issue of the spread of contraceptives through diffusion. This approach emphasizes communication about contraception and suggests that changes in the acceptability of contraceptives, rather than economics, leads to a drop in fertility (Cleland 1985; Cleland and Wilson 1987). The approach is reductionistic and treats culture as a variable (separate from social, political, and economic organization) rather than as a constant. It also assumes that women everywhere have nothing better to chat about than contraception (Greenhalgh 1994:9).
During the 1960s and 1970s, dependency and world-systems theories challenged modernization theory, arguing that Western involvement in the Third World produced underdevelopment rather than development. Blaut (1993) argues that the academic work of history, geography, and other fields has been based on an implicit assumption in the historical superiority of Europe. Despite these views, there is a lingering influence of Eurocentric modernization theory (Greenhalgh 1994:10). Population programs evolve to become more “modern.” Women’s status improves with westernization/modernization and thereby fertility decreases.

*Anthropological Approaches to Demographic Theory*

Transition theories have been insufficient in their explanations of population growth. They have often focused on singular causes for population change, they are oriented toward either micro or macro-level institutions, they have treated culture as a variable separate from other institutions (i.e., economy, politics), and they have assumed linearity and universality. However, this narrow view of population guarantees failure by ignoring the complexity of human society and the interrelationships between sociocultural factors and political and economic institutions at all levels. Changes in population growth can only be attributed to multiple causes.

Greenhalgh (1994:12) suggests that the aim of fertility research should be “whole demographies” that contextualize reproductive behavior not only in the social and economic terms of conventional demographic theory, but in political and cultural terms as well. An emerging approach to demographic inquiry, the culture and political economy of reproduction, is a multidisciplinary approach that utilizes the conceptual and methodological tools of cultural anthropology. This approach directs attention to the embeddedness of community institutions shaping fertility in structures and processes operating at regional, national, and global levels, and to the historical roots of those macro-micro linkages (Greenhalgh 1994:13). Research which ignores these factors, whether based on provincial-level historical European databases or large fertility surveys such as the World Fertility Survey, will not yield satisfactory explanations of demographic behavior (Kertzer 1994:51). The political economy
approach, however, combines social structure and individual agency by using both quantitative and qualitative methods. The aim is not to decide which sector (i.e., culture, political, economic, fertility, mortality, migration) is more important but rather to understand how reproductive institutions and behaviors have evolved and how they relate to one another (Greenhalgh 1994:13).

Demographic Research and Policymaking in Egypt

Demographic Transition in the Islamic World

Applying demographic transition theories to the Islamic World has revealed that population growth in that part of the world has not gone through the traditional transitional phases. Instead, Islamic demographic patterns are thought to be exceptional because they have not declined with development according to the western model (Obermeyer 1992:33). Arab demographic researchers, however, have primarily followed in the demographic theoretical tradition of searching for one or a few causes behind population change at certain levels of society, leading them to a non-holistic perspective.

According to Courbage (1994), although urbanization, economic growth, and education has led to reduced fertility rates among the higher social classes, when generalized throughout the population these factors have had little effect on population. This has been often attributed to Islam and the low status of women (Clarke 1985; Obermeyer 1992; Omran and Roudi 1993; Weeks 1988). Obermeyer (1992:53) suggests that the persistence of tensions between Islam and the West and the fundamentalist reinterpretation of the religious tradition concerning the status of women will continue to support rapid population growth in Islamic countries. Better health care and declining mortality can be achieved without altering the status of women, and family planning policy will have little effect without changes occurring in gender relations and family definitions. Caldwell (1986) also attributes the high fertility rate in the Arab World to advanced health care systems which have lowered mortality rates. Courbage (1994) insists that greater female participation in the labor force has had the greatest effect on fertility reduction in the Arab countries of North
Africa. This is because through employment, women gain a new self identity as producers rather than merely reproducers. In addition to female employment, state subsidies, and foreign migration have also decreased population growth (Courbage 1994).

*Demographic Research in Egypt*

Much of the research into demographic behavior in Egypt has consisted of regional and national surveys conducted under the auspices of the National Population Council and the Central Agency for Public Mobilization and Statistics (CAPMAS). These have included but are not limited to: the Household Distribution of Contraceptives in Rural Egypt conducted in 1977 (Gadalla, et al. 1980); the Egyptian Fertility Survey (EFS) of 1980, conducted by CAPMAS as part of the World Fertility Survey (WFS) program (CAPMAS et al. 1983); the 1980 Egyptian National Baseline Survey of Family Life and Family Planning; the 1982 Egypt Follow-up Survey on Family Life and Family Formation; the Rural Fertility Survey (RFS) of 1980, and the Egyptian Contraceptive Prevalence Surveys (ECPS) of 1980 (Khalifa et al. 1982) and 1984 (Sayed et al. 1985). All of the surveys collected information on fertility levels and attitudes, family size preference, contraceptive knowledge and practice, availability and accessibility of family planning services, and basic socioeconomic background of women (i.e. age, economic status, etc.). The EFS and RFS included more detailed information about households, and information on male attitudes and behaviors and couple communication. More recent surveys include the 1988 Egypt Demographic and Health Survey (EDHS) which surveyed 9000 Egyptian women (Sayed et al., 1989) and the 1991 Egypt Male Survey (EMS) conducted by the Cairo Demographic Center (Sayed et al. 1992).

These surveys have led to a miriad of smaller surveys and detailed studies based primarily on quantitative survey data. Some deal explicitly with contraceptive prevalence (e.g. Aly and Shields 1991; Entwisle et al. 1988, 1989; Stycos et al. 1982). Others have compared various population variables to education: mass education and Islamic revival and population (Faust et al. 1991); and education, income, and desired fertility (Cochrane et al. 1990). A lesser number of studies have
dealt with the mortality and health of women and children: (Casterline et al. 1992; Kane et al. 1992; Lane and Meleis 1991; Nawar 1995; Tekce 1990).

Qualitative research in Egypt, however, has been somewhat neglected although studies which include in-depth interviewing of family planning clients and providers are being conducted (e.g. Guimie et al. 1995; SPAAC 1994). Also neglected has been qualitative information regarding reproductive health and health perceptions in Egypt. Some work has been conducted by Inhorn (1994) on infertility; Hamamsy (1975) and Sukkary (1981) on traditional midwives; Assaad on female circumcision (1980); El-Katsha et al. (1989) on women, water, and sanitation in rural Egypt; and Lane and Meleis (1991) and Morsy (1978, 1980, 1981, 1993) on health and illness perceptions.

**Policymaking**

The quantitative research, as with the popular transition theories, has been obsessed with finding particular causes or variables which produce and maintain the high population growth rate in Egypt. In a microlevel approach, it reveals only bits and pieces of the larger complex population dynamics occurring in Egypt rather than approaching population as a process which affects and is affected by all of the institutions making up Egyptian society. Demographic research in Egypt has pointed to important factors which support high fertility in Egypt, such as the dependent status of women and economic inequities. In response to this, Egypt's population policy includes a variety of goals including population resettlement, development, the creation of employment for women, and family planning. The policy, however, has been based on the diffusion approach and has primarily emphasized the distribution of contraceptives (Cleland 1985).

As mentioned earlier in this section, according to this theoretical perspective, fertility decline will result through increasing the use of contraceptives. It emphasizes that this is best accomplished through communication about contraception and suggests that attitudes toward the acceptability of contraceptives should be changed, rather than economic conditions, in order to cause fertility to decline. It assumes that the demand for contraceptives already exists and that the problem lies in the supply
of contraceptives. This perspective has had a direct bearing on the population policy process in Egypt.

Demography emerged as a field of public policy with the adoption of the World Population Plan of Action (WPPA) in 1974 (Sadik 1991:3). Policymaking in the field of population relies on several discrete but interrelated activities including: population data collection and analysis, research, dissemination, policy formulation, policy planning, policy implementation and evaluation (Sadik 1991:3). Many agencies, including the United Nations Population Fund (UNFPA) and the U.S. Agency for International Development (USAID) use this scheme, or a variant of this framework, for the design of their population assistance activities (Sadik 1991:3) (Figure 3). This framework has also been transferred to developing countries like Egypt.

This model is not based on participatory development. It shows a lack of concern for the needs of the beneficiaries as determined by the beneficiaries themselves and a reliance on quantitative data and narrow causal issues. Neither are clients or beneficiaries involved in the policy planning, implementation, or evaluation of programs. This type of policy process relies on an objective process of problem identification. In this type of problem identification, more common in authoritarian political systems, an effort is made to employ scientific measures of the effects of events on people while there is little or no reliance on how the people interpret effects of events (Jones 1984:41). This is clearly the way population policy has been utilized in Egypt where the clients of family planning have not been involved in the policy process. As will be shown in the second half of this thesis, Egypt's population policy is a direct result of demographic research which has “underestimated the socio-cultural structures of real societies” (Cernea 1995:15).

Egypt's family planning program, preoccupied with the diffusion of contraceptives, can be said to be based on a “technocratic model,” an approach that deals with the technological variables of development disembodied from their Egypt's contextual social fabric (Cernea 1995:15-16). Essentially, both the problems found in the policy making process and the implementation of Egypt’s family planning program are problems of technology transfer. A Western process and technology
Figure 3. Steps in Population Policymaking (Sadik 1991:4-6; USAID 1985)

Definitions of Steps in Policymaking Process

**Data Collection**: data from censuses, surveys, vital registration.

**Research**: information on causes and consequences of fertility, mortality, migration, population growth, structure, composition, and distribution, as well as the operational and methodological aspects of integrating population variables into development planning and the impact of development policies and programs on demographic variables.

**Dissemination**: process by which research data is made available to population policy planners.

**Policy Planning and Formulation**: the formulation and design of policies which reflect research and the goals and priorities of an agency or country.

**Policy Implementation**: the translation of policies into programs.

**Policy Evaluation**: the continuous assessment, monitoring, and evaluation of programs and policies.

**Policy Analysis**: continuing activity drawing on research, policy planning, implementation, and evaluation to help identify issues that are insufficiently understood or overlooked in policy development and to determine the types of data needed to improve the knowledge base.

(Sadik 1991:5)
developed in the West have been transferred, more or less intact, to a society which differs greatly in terms of institutions, cultural attitude, and social organization from Western industrialized society. As discussed earlier in the section, *Anthropological Approaches to Demographic Theory*, what is needed are "whole demographies" and demographic research based on a multidisciplinary, multi-level approach, such as Greenhalgh's (1994) *Culture and Political Economy Approach to Reproduction*. 
EGYPT'S POPULATION POLICIES AND PROGRAMS

The early Egyptian censuses, beginning in 1882, prompted initial concern from health care workers for Egypt's rapid population growth and its future consequences. As early as the 1930s, the Egyptian Medical Society expressed concern about population problems and the repercussions of repeated pregnancies on women's health. As a result, the Grand Mufti of Egypt issued a fatwa, or legal opinion, in 1939 which permitted family planning. This fatwa stated in effect that the use of contraceptive methods under certain conditions does not conflict with the laws of Islam (Gadalla 1978:30). Following this issuance, the Ministry of Social Affairs was organized in 1939 to study Egypt's population, and the first Egyptian family planning clinic was opened in 1945 (Gadalla 1978:30). It was soon closed, however, due to a lack of interest and participants.

The Egyptian government did not become officially involved in population growth issues until the 1950s, but since then, Egyptian government policy has approached the issue of population control in a variety of ways. Today, Egypt has the largest family planning program in the Middle East, one which has been almost entirely funded by the national government. Much of this funding has come in the form of external assistance used to equip Egypt's network of health centers and train personnel. In general, the population policy rests upon the Malthusian presupposition that Egypt's population has reached the bursting point. The four percent inhabitable land area is already too densely populated, and the country's resources cannot be stretched to accommodate more people (Wahba 1988:16).

In the following sub-sections, I will show how Egypt's population policy has evolved since its origination in 1965, and I will describe the way in which the policy has been implemented. As with most federal policies, Egypt's population policy has changed much over the past several decades according to changes in the political agenda. Each new approach, however, has emphasized that population control must be promoted solely through the use of formal positive sanctions, such as education, economic development, and family planning programs, without resorting to the use of coercion or punishment for families.
The Traditional Family Planning Approach

Policy

During the term of his presidency in the 1950s and 60s, President Gamal Abdel Nasser believed that Egypt's high population growth was the most serious obstacle to development of the country (Sadik 1991:289). In 1953, the National Population Commission was organized to study population issues, and a number of experimental Ministry of Health clinics were opened (Stykos et al. 1988:14). By 1962, President Gamal Abdel Nasser proposed a National Charter which specifically referred to the urgency for checking population growth (Gupte 1981:14). The government approached family planning with the philosophy that couples wanted to have fewer children and would do so if they were supplied with birth control information, contraceptives, and services (Gupte 1981:23). This gave the impression that the government viewed children as undesirable and burdensome.

Thus, the Supreme Council of Family Planning was established in 1965 followed by the instigation of family planning services in 1,991 health units in 1966 (Gupte 1981:17). Nasser also introduced a family planning "Week" in order to promote public awareness of Egypt's population problems and the country's goal of reducing the birth rate by one per 1,000 of the population each year. This policy, however, proved ineffective as the birth rate continued to climb, although it did provide a foundation for the delivery of health care services that is still in use (Gupte 1981:23).

Implementation

The First Family Planning Campaign

Under President Nasser's population reduction policy, family planning was viewed as the key mechanism to reduce population growth, and all married couples became eligible for family planning services. The family planning services available during the 1950s and early 1960s, however, were small-scale and lacking in coordination (Hassouna 1980:160). The Supreme Council of Family Planning was
created in 1965 to organize and implement a much larger family planning program. This organization was headed by the Prime Minister and consisted of the Ministers of Health, Higher Education, Cultural and National Guidance, Local Government, State for Cabinet Affairs, Religious Affairs, and Social Affairs, the President of the Central Agency for General Mobilization and Statistics, and the Chairman of the Executive Family Planning Board (Gadalla 1978:214). An advisory committee was then formed in each of the 26 governorates to advise the Supreme Council. These committees consisted of the governor and various heads of governorate departments. Regional bureaus were also set up to directly supervise the implementation of family planning services. The bureau personnel primarily consisted of Ministry of Health staff working on an overtime basis for a mere 30 percent of the salary of their original jobs.

In addition to the government program, several hundred private sector services were placed under the auspices of the General Family Planning Association. This organization was primarily run by women who had been active in voluntary groups that had been promoting family planning in most governorates long before the government became involved.

The strategy for implementing the national family planning program called for the rapid launch of a massive scale program with minimum expenditure, minimum establishment of new infrastructures, and maximum utilization of pre-existing health facilities and personnel (Gadalla 1978:214). In 1966, the program was launched by adding family planning clinics to the close to 2,000 pre-existing health units placed throughout Egypt. The birth control pill was introduced in these clinics and later followed by the intrauterine device (IUD). Condoms, creams, and diaphragms were introduced in 1970. The 1967 war with Israel, however, preoccupied government officials and stalled the family planning program. The Supreme Council rarely met, and clinics were under-budgeted, under-publicized, and under-staffed (Stycos et al. 1988:15). Annual funding for family planning services at each government health clinic averaged a mere $1,000 although each clinic served an average population of 15,000 people (Gadalla 1978:215). It was not until 1971 that international donors began to make contributions to Egypt's program.

The state's approach to family planning resulted in a program which was
clinic-based and supply-oriented. It was based on the so-called "cafeteria approach" which provided all types of contraceptives at low cost (IPPF 1978:41). Not all contraceptives were available, however. The pill was the main contraceptive offered followed by the IUD. The pill was more commonly promoted in rural areas while the IUD was limited to urban areas due to a lack of trained health personnel who could actually insert the devices. The pill was sold at 10 piasters (about 20 cents) per monthly cycle, and the IUD was inserted free of charge (Gadalla 1978:215). This meant that poor rural women had to pay for contraceptives, while urban women could have an IUD inserted free of charge. In deference to conservative religious and traditional views regarding the importance of reproduction, abortion was illegal, and sterilization was not promoted.

The doctors and staffs of the government health units were charged with adding family planning as an additional duty on top of their other daily responsibilities. With the help of other health care workers, physicians were expected to maintain medical records on all family planning clients, perform initial medical exams on new clients, supply patients with contraceptives and information about their usage and side effects, and conduct necessary follow-up examinations (Gadalla 1978:134). In addition to their regular duties, social workers from the social welfare centers of the Ministry of Social Affairs were given the responsibility of distributing information, educating the public about family planning, developing relations with village leaders and organizations, and recruiting volunteers to advocate family planning (Gadalla 1978:134).

As a result, family planning services in the government clinics were relegated to a few hours in the afternoons three days per week. The majority of physicians, especially in rural areas, were male and were working in rural clinics merely to satisfy the two year rural service required by the Ministry of Health of all medical students. The doctors were often uncommitted and unsympathetic to rural people and viewed their own clinical service as an ordeal to be endured until they could return to the city (Stylos et al. 1988:180).

Because motivation was so low and family planning was just one more problem for health care providers, the government began offering monetary incentives to health personnel in the form of proceeds from the sale of pills.
Renumerations were also offered by the Executive Family Planning Board for each IUD inserted. Physical examinations and follow-ups were rarely performed, and most women who wanted the service merely came to the clinic after hours when the nurse-midwife or clerk would sell them pills without an exam. Some women would send relatives or even children to buy pills for them (Gadalla 1978:134). When the monetary incentives for selling contraceptives were cut off, however, the clinic staffs lost interest (Stycos et al. 1988:180). Public response to the clinics dwindled rapidly, declining from an average of 19 new pill acceptors per month in 1966 to five per month in urban areas and only two per month in rural areas by 1973 (Stycos et al. 1988:15).

This led most observers and government officials in the early 1970s to believe that this first family planning campaign was a failure (Stycos et al. 1988:15). We can see that the campaign was indeed unsustainable for a number of reasons including inefficient services and supplies, lack of funding, lack of access, and lack of training and interest on the part of staff. This contributed to a reformulation of the population policy during the 1970s and an expansion in the family planning program.

The Development Approach

Policy

President Nasser’s successor, President Anwar el-Sadat continued Nasser’s efforts to reduce population growth, addressing the problem in keynote speeches and drawing up a national population policy for the decade from 1972 to 1982. The policy’s goal to reduce the birth rate from 44 per 1,000 in 1966 to 30 per 1,000 by 1976 was never realized (Hassouna 1980:160). Although the number of government clinics had increased to 2,900 located in 24 out of 26 governorates, and private clinics had increased to 446, the birth rate was only reduced to 39 per 1,000. Program participation was very low, especially in rural areas, where only an estimated 7.4 percent of reproductive age women used some form of family planning (Hassouna 1980:160). This, however, was coupled with a 30 to 50 percent
discontinuation rate (Hassouna 1980:160). As a result, the Egyptian government called for a new policy approach to the issue of population growth.

During the 1970s, family planning supporters began to advocate the idea that fertility levels would not decrease unless socioeconomic and behavioral systems conducive to lower fertility were present. "...irrespective of the policy intent, people will only adopt family planning if convinced of its benefits at the level of the individual and of the family" (IPPF 1978:36). Therefore, population programs should not be segregated from the development process. In response to these new trends, the Egyptian government agreed that development was the key to population control in Egypt rather than the mere delivery of family planning services (Stycos et al. 1988:15).

The new policy goals focused specifically on development efforts to change the socioeconomic system of Egypt to one conducive to low fertility (Gadalla & Rizk 1980:30; Gupte 1981:25). These policy goals included a wide array of community development programs including housing and sanitation projects, child health projects, agriculture projects, literacy and employment projects, and family planning. This was part of a larger global trend to move from sectoral development to holistic development.

*Implementation*

With the population policy now focused on development, the name of Egypt's Supreme Council for Family Planning was promptly changed to the Supreme Council for Population and Family Planning in 1973. Dr. Aziz Bindary was named as head of the Supreme Council, designated as the executive arm of the Supreme Council of Family Planning, and was given a staff of 500 and a budget of $5 million per year (Gupte 1981:15). The Supreme Council was given the responsibilities of conducting and evaluating population programs and coordinating the work of the various ministries involved (Gupte 1981:15).

Most of the Council's attention and resources were primarily devoted to a new national program called the Population and Development Project (PDP), created in an effort to combine community development projects with family planning projects.
Specific population target goals were set to achieve a crude birth rate of 23.6, a crude death rate of 13, and a population not to exceed 41 million by the year 1982 (Gadalla and Rizk 1980:60). It was planned that development projects would focus on reducing infant mortality rates, increasing child spacing, increasing literacy and women's employment opportunities, increasing industrialization and agricultural mechanization, encouraging people to move to urban centers other than Cairo and Alexandria, and increasing family planning communication and services (Gadalla & Rizk 1980:30). The Egyptian government also actively encouraged labor migration to foreign countries and resettlement in the new desert cities and newly reclaimed lands.

The Population and Development Project (PDP)

The PDP, initially sponsored by the United Nations Fund for Population Activity and USAID, was introduced in 1977 to promote family planning within the context of community development (Entwisle et al. 1988:6). The PDP development projects were intended, through the distribution of loans, to encourage participation, provide concrete benefits, and raise village morale. By 1980, the PDP covered 2,871 villages, (Entwisle et al. 1988:6) and by 1982 over 1100 projects costing $2 million had been financed (Stykos et al. 1982:366). Projects were approved not only on the grounds of economic viability but also on their potential impact on attitudes and behavior toward family planning (Stykos et al. 1982:366). Of 584 projects carried out in 1983, 72 percent were aimed at improving services such as day care and youth centers, family planning, and roads and drainage. The remainder were largely devoted to stimulating small business projects in transportation, poultry raising, sewing, bee-keeping, and carpentry (Stykos et al. 1985:431).

Surveys from the early 1980s, however, reveal that although the PDP was having an effect on contraceptive knowledge and attitudes toward family size and family planning, actual contraceptive use rates and fertility rates had changed little, especially in Upper Egypt (Stykos et al. 1985:440). According to a 1982 survey, the number of organizations sponsoring development and family planning projects in each village in Egypt ranged from none to as many as four with the PDP being the most widely distributed (Entwisle et al. 1988:7). The number of social workers who
had been given the job of family planning education during the 1970s grew substantially by the early 1980s, but they were only present in a minority number of villages. The number of Ministry of Health clinics offering family planning services was also increased to 3,200 by 1983 (United Nations 1987b:196). All of the private and government family planning clinics were staffed by Ministry of Health employees with each clinic slated to have at least one physician, one nurse, and a midwife. Nevertheless, only about one-third of the personnel had actually been trained in the proper usage of contraceptives and the treatment of side effects (Entwisle et al. 1988:10), and only one quarter of the clinics were supplied with staff who could insert IUDs (Stycos et al. 1988:179). By this time, family planning supplies were not only available at public and private clinics but could also be obtained in hospitals, pharmacies, and from extension workers. Supplies were limited at both clinics and pharmacies, however, where often only one type of pill was available (Stycos et al. 1988:179).

Extension workers (known as raedats rifiats, Arabic for rural pioneers) were meant to be an important part of the PDP. They were local female volunteers recruited and trained during the 1970s (Entwisle et al. 1989:1026). Originally the PDP planned to provide one raedat per village to conduct home visits, promote contraceptive use, and assist in development projects (Stycos et al. 1982:366). According to the Rural Fertility Survey (RFS) of 1982, however, very few couples had actually been visited by a family planning worker. The 1982 RFS estimated there were only 2.5 raedats for every 10,000 individuals in Lower Egypt and only 1.7 in Upper Egypt (Stycos et al. 1988:87). As many as 80 percent of the husbands and 90 percent of the wives surveyed by the RFS(82) had never attended a family planning meeting nor been visited by a family planning worker, although 50 percent of the couples had heard about them (Stycos et al. 1988:78-79). According to Stycos et al. (1988:79), PDP officials argued that the raedats had been so effectively trained in integrating the family planning message with more social conversation with community development projects that their clients were entirely unaware that they had ever been "visited" by a family planning worker (Stycos et al. 1988:79). The same survey, however, also discovered that at least one-third of the respondents had never heard of any development projects either. Of the respondents who did
know about a project, the best known were family planning and tractor projects (Stycos et al. 1988:80).

Overall, the PDP did not have a major impact on population growth (Sadik 1991:290). It did not reach enough people, and exposure to community development projects was low (Stycos et al. 1988:117). As a result, the program slowly fizzled out during the mid-1980s.

**Other Projects Implemented Under the Development Policy**

Although the PDP was the primary focus of the Egyptian national family planning program during the late 1970s and early 80s, various other projects were initiated as well. In further attempts to integrate health care with community development, especially in rural areas, maternal and child health (MCH) clinics were expanded, along with clean water systems, programs to control parasitic and infectious diseases, and education and food programs (United Nations 1987b:196). As of 1976, 2,252 MCH centers were in operation in Egypt (Sukkary 1981:28). These centers offered various programs including female examinations before marriage and post-natal care for children up to age six. The staff usually consisted of two physicians who were often women, a nurse/midwife, two or three assistant nurse/midwives, a dentist, a pharmacist, a social worker, a nutrition specialist, and a lab technician (Sukkary 1981:28).

The Integrated Social Services Delivery Systems Project (ISSDSP), a small community-based program established in 1981 in the governorates of Menoufia and Beni-Suef, took a health-oriented approach to family planning. It originally dates back to 1977 when it was called the Menoufia Project. At that time, it was a household contraceptive distribution project which interviewed 21,000 women in 38 villages and offered free birth control pills to women who were married and at risk for pregnancy (Gadalla et al. 1980:106). Because of the program's success (a 45 percent increase in contraceptive prevalence), it was proposed that the project be expanded to include the distribution of IUDs, condoms, and vaginal foaming tablets (Gadalla et al. 1980:112). Also, in deference to the respondent’s questions regarding why only family planning services were being offered, the ISSDSP expanded to include a health and nutrition component. It emphasized the household distribution
of oral rehydration salts to alleviate infant and child mortality from diarrhea as well as improved referral of pregnant women for tetanus toxoid immunization to combat neonatal tetanus (Gadalla et al. 1980:112). Resources were also provided to aid in the creation of community action projects.

As for the more urbanized areas of Egypt, the private but government-subsidized organization called Family of the Future (FOF) set up a contraceptive marketing program in urban areas in 1980 and eventually began distributing half of Egypt's contraceptives. All of the pills, condoms, and IUDs sold by FOF were provided free of charge by the U.S. Agency for International Development (USAID) and resold to Egyptians at a small cost. For example, IUDs that sold in the U.S. for $140 were sold for less than $1 in Egypt (Stephens 1992:82).

In addition to the various clinic and distribution projects, the Egyptian government also utilized the mass media to communicate family planning messages to the general public. The Information, Education, and Communication Center (IEC) was established in 1979 to promote family planning through the media. Messages were aired on the radio and on television to promote the spacing of births by two years and the need to rely on physicians for family planning information rather than family and friends. The latter of the two suggestions had not been heeded as of 1982. The 1982 Rural Fertility Survey (RFS82) revealed that the most important initial sources of family planning information for the rural population was television and radio. Forty-six percent of the husbands and 39 percent of the wives interviewed had received information from these sources. Twenty-seven percent of the men and 35 percent of the wives had learned about family planning from friends. Only a small percentage had learned about birth control from professional sources such as family planning clinics (Stykos et al. 1988:77).

Despite internal and external efforts, the birth rate in Egypt during the late 1970s and early 1980s in fact increased to 40 live births per thousand people, a rate which had not been seen since the 1960s (MacKenzie 1985:21). Dr. Aziz Bindary, who had been in charge of the Supreme Council for Population and Family Planning from 1973 until 1984, was heavily criticized for having spent 11 years and $100 million promoting unsuccessful development programs while neglecting to promote the importance of family planning (MacKenzie 1985:21). Although the Egyptian
government had not ignored family planning entirely, large sums of money were spent on inefficient development projects, media ads, and scientific conferences with the assumption that fertility rates would decrease naturally as economic development increased. At the same time, no one was making pills or IUDs more available to the public (MacKenzie 1985:21) even though not only development but the use of birth control are necessary for fertility decline.

The fluctuating oil market had also resulted in the return of many Egyptian workers from the Gulf countries, exacerbating Egypt's population and economic problems. On top of this, the government's population resettlement schemes had also been unsuccessful. Reclaimed lands could not keep up with the population growth and the resulting demand, and many Egyptians found the new desert cities basically unappealing.

In summation, although the idea of integrating development with family planning, and the expansion of the family planning program into a variety of avenues, was an improvement over the first family planning program, it was inadequately planned and implemented. Development was promoted to the detriment of family planning services, and even then, many development projects were unsuccessful. Thus, with the onset of a new political administration in the early 1980s, the population policy was again targeted for change.

The New Family Planning Approach

Policy

Egypt's current President, Hosni Mubarak, has primarily followed the strategies of his predecessor, emphasizing socioeconomic development and the improvement of family planning services but with a greater emphasis on family planning services. He has often called upon Egyptians to take population problems seriously. In 1981, the national population policy was reformulated. The Supreme Council for Population and Family Planning redirected more of its efforts toward reducing the birth rate by raising contraceptive prevalence throughout the population. The approach to family planning, however, became more cautious in the face of
opposition from Muslim groups (Stykos et al. 1988:17). The First Five-Year Plan for the years 1982/83-1986/87 did not set any specific population goals (Stykos et al. 1988:17). It perceived the population problem could be solved by transforming the available manpower into a national benefit by making the work force more efficient through improving education and training programs and raising salaries to achieve a more equal income distribution (Wolfe 1987:38). Policies were established to encourage the private sector to create new jobs and to encourage employers to meet the real needs of their employees (Wolfe 1987:38).

As a result of previous mismanagement and failed strategies, the management of the national family planning program was also reorganized again into a more aggressive campaign. In 1985, the Supreme Council for Population and Family Planning was replaced by the National Population Council (NPC). The NPC's technical secretariat's responsibilities were to formulate policy and co-ordinate government agencies, the Central Agency for Public Mobilization and Statistics (CAPMAS) was given the responsibility of data collection and analysis, the Ministry of Information became responsible for awareness creation, and the Ministry of Planning was put in charge of integrating population into development planning (Sadik 1991:291). More specifically, the NPC emphasized family planning, health care for women and children, literacy, population education in schools, and the role of the media in population education. It aimed to implement programs to increase the age of marriage and provide employment for women, and a target was set to raise the contraceptive prevalence rate to 60 percent by the year 2000 (Sadik 1991:290).

The population policy expressed in the Second Five Year Plan for Socio-Economic Development (Wolfe 1987:186) sought to reduce the growth rate so that the rate of natural increase would drop from the 1986/87 level of 2.8 to 2.1 percent by 2001/02 (Table 3). This would be accomplished by lowering the general birth rate from the 1986/87 level of 37 per 1,000 to 31.5 in 2001/02 (Wolfe 1987:186).

Plans were also set to eradicate illiteracy through government and non-governmental literacy programs and the compulsory enrollment of all children in first year primary school. The NPC also proposed a novel idea whereby incentives would be given to high school and university graduates to teach literacy classes as a
national service before entering the work force. The plan also specified the need to reduce urban population and a goal was set to lower urban population to 41 percent by the year 2001 by removing Egyptians from Nile Valley Cities and resettling them in new desert cities (Wolfe 1987:186).

Table 3. Population Goals of Egypt's Second Five Year Plan for Socio-Economic Development

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate of Natural Increase (%)</th>
<th>Birth Rate (per 1,000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986/87</td>
<td>2.8</td>
<td>37.0</td>
</tr>
<tr>
<td>1991/92</td>
<td>2.6</td>
<td>34.7</td>
</tr>
<tr>
<td>2001/02</td>
<td>2.1</td>
<td>31.5</td>
</tr>
</tbody>
</table>

Note: Data from Wolfe (1987:186).

Implementation

The new NPC, formed in 1985, was headed by President Hosni Mubarak with Dr. Maher Mahran as its Secretary-General. With the support of Egyptian women, who called for better access to family planning services, and Muslim religious authorities, President Mubarak pledged to make birth control available to all Egyptians. Mahran began an aggressive national media campaign to promote the use of condoms which resulted in a fivefold increase in condom sales (MacKenzie 1985:21). In addition, Norplant was successfully tested in 2,000 Egyptian women, and plans were initiated to test it in 10,000 more (MacKenzie 1985:21). Mahran has also been very much in favor of sex education within the context of Islamic ideology in both schools and at home and the use of safe contraceptive methods which do not hinder sexual activity (Mahran 1989:22).

Cairo's Al-Ahzar University also issued a new declaration claiming that family planning was a good Muslim practice. Based upon the Koran's injunction that women should breastfeed for two years, they concluded that since breastfeeding is a
form of contraception, then the use of modern contraceptives is acceptable because it promotes good family health (MacKenzie 1987:21). They suggested that there should be a six year gap between children which could be achieved by breastfeeding for two years followed by four years of extra contraceptive control (MacKenzie 1985:21). This would not only protect the health of women but would also preserve their physical attractiveness for their husbands (MacKenzie 1985:21).

During the late 1980s and 1990s, international assistance organizations, mostly from the U.S., continued to support Egypt's population program either through direct funding to the national program or to smaller government-funded or private projects. Programs focused more attention on education and IEC programs, improved service delivery, and the procurement of more reliable demographic statistics. Projects included training programs in female sterilization for hospital personnel and promotion of a female voluntary surgical contraception program, population education programs for schools, biomedical research on the safety of contraceptives, local IUD production, the production of information videos and health books, and family life education combined with job training for women (UNFPA 1989:185-188). New contraceptive methods were also tested including the continuation of the government Norplant testing program, an FOF study on the acceptability of condoms, and a study of a progesterone releasing vaginal ring for use by lactating women (UNFPA 1989:189-191). Some support was also given for the training of village leaders and midwives in family planning. The International Planned Parenthood Foundation (IPPF) became involved in public education and the linking of family planning with women's development projects, such as income-generation and day-care services (UNFPA 1989:189). Christian organizations supported the Coptic Evangelical Organization for Social Services which offers family planning to Copts in its clinics as part of a wide range of integrated development services (UNFPA 1989:188).

The IEC's messages in the late 1980s and early 90s illustrated birth control methods including the IUD, oral contraceptives, and condoms (Stephens 1992:45). The IEC also set out to increase communication about family planning between husbands and wives and to persuade village and religious leaders about the need for family planning. This latter endeavor was supported by verses from the Koran that
encourage breastfeeding and birth spacing (Stephens 1992:45). Other official media campaigns for family planning ranged from the panicky to the patronizing and were thus largely unsuccessful (Wahba 1988:16).

The second campaign, also televised, but very much in evidence on posters in Cairo and Alexandria, is the *Unzur Hawlak* (One television campaign presents an animated film of two peasants, Hassanein and Muhammedein, speaking with a ham Upper Egyptian accent, one of whom defeats the other in a mock duel - the implication being that the victor has fewer children.... Look Around) campaign. In this effort, a poor urban family is shown surrounded by hosts of children who are all yelling at once while dragging their unfortunate parents into poverty (Wahba 1988:16).

The targets of these campaigns were largely poor rural Egyptians. Family planning messages can also be found in newspapers and other publications.

"Abu Kitir," whose name means "father of many," is the paternal character in a series of Egyptian cartoon messages encouraging family planning. His son, Wahid, complains about how there is no place for him in a home filled with six other children and an ever-pregnant mother. Another ad features a boy of about 10, covered in motor grease, working in a car repair shop and daydreaming. He envisions himself in new school clothes, skipping through a field with a backpack, enjoying the carefree childhood he is missing. The message is that planning a family protects children from a burdensome youth (Stephens 1992:45).

The fact that the birth rate has decreased and contraceptive prevalence has steadily risen in Egypt since the re-organization of the national program in the mid-80s seems to indicate that the family planning program is experiencing some success. By all indications, the population and development targets set by the 1988-1992 National Five-Year Plan for Economic and Social Development were achieved by the end of 1991 (UNFPA 1992:3). Today there are approximately 4,523 total family planning service delivery points supported by the public sector, NGOs, and PVOs (Guimie and Azziz 1995:1). Nevertheless, as of the early 1990s both private and public family planning service providers remain poorly coordinated, and even though there has been some success in certain regions, the quality of services and amount of supplies has not been uniform throughout the country (UNFPA 1992:3).

By the mid-1980s, all Egyptians lived within five kilometers of a free government health clinic, but many women were still unable to obtain family planning services (MacKenzie 1985:21). Although Egypt's health care system is impressive
on paper, many facilities are old, in a state of disrepair, and do not meet proper standards of cleanliness (Casterline et al. 1992:247). The poor working conditions for health care workers, along with low pay, still exist and have only increased their lack of motivation (Casterline et al. 1992:247). When the price of birth control pills was reduced from 15 piastres a cycle to five piastres, the physicians actually became poorer because part of their salary came from a percentage of those sales (MacKenzie 1985:21).

The government's overall strategy for the 1990s is to conduct more person-to-person programs (Stephens 1992:82). UNFPA-assisted projects will give priority to those governates where population growth is faster than the national average, especially in Upper Egypt (UNFPA 1992:3). Unreliable contraceptive supplies and the lack of trained personnel, however, are a serious concern. The country has a severe shortage of trained nurses, and the donation of free contraceptives from organizations such as USAID is unreliable (Stephens 1992:82). The Family of the Future (FOF) program, initiated in 1980 and reliant on free contraceptives from the U.S., closed in 1990 following cuts in U.S. foreign aid for family planning (Guimie and Azziz 1995:2).

The Current Contraceptive Prevalence Rate in Egypt

The use of family planning methods, especially the use of modern contraceptives, has been growing slowly in Egypt since the initiation of the first national family planning program. In January 1969, users of family planning services were estimated to be approximately 10 percent of married women between the ages of 15 and 44 (Kader 1987:117). The contraceptive prevalence rate increased to 26.5 percent by 1974, according to the National Fertility Survey (Sayed et al. 1985:151), 30 percent by 1984 (Sayed et al. 1985:151) 38 percent by 1989 (World Bank 1993:290) and is now estimated to be as high as 45 percent (PRB 1994).

The rate of contraceptive use, however, varies greatly between urban and rural areas and between Upper and Lower Egypt. The majority of Egyptian women using family planning methods live in urban areas where westernization has had more influence and a greater number of women are educated and employed in the
formal sector. Family planning methods are less prevalent among rural women in Lower Egypt and the least prevalent in Upper Egypt (Sayed et al. 1985:147) where a woman's status relies on her reproductive capabilities and a family's livelihood depends on the labor of its children. The ECPS of 1984 found that 68 percent of urban women had tried at least one contraceptive method compared to only 34 percent of rural women (Sayed et al. 1985:129). Of the 30 percent of women who were using family planning in 1984, 45 percent of these were living in urban areas while only 19 percent were from rural areas (Sayed et al. 1985:151). Also, the rate of contraceptive use in Lower Egypt was double that of Upper Egypt, and rural women in Lower Egypt were more than three times as likely as those in Upper Egypt to be using family planning (Sayed et al. 1985:150). Another survey, conducted in 1988 by the National Population Council, found that only one woman in 10 in rural Upper Egypt was practicing family planning (Stephens 1992:45).

The number of women who have tried birth control and are using some form of family planning also differs according to the number of children they have, their age, their socioeconomic situation, and their educational background. According to the ECPS of 1984 (Sayed et al. 1985:147), the contraceptive use rate rose along with age and number of children. It was also found that contraceptives were more prevalent among women who were literate, had at least some primary schooling, had non-agricultural jobs, and were married to men who had some education and were employed in non-agricultural careers. The highest percentage of women using birth control were urban, college-educated, working women (Sayed et al. 1985:158).

The most publicized and popular birth control methods currently used in Egypt are the IUD and the pill (Stephens 1992:45; WRI 1992:257). The IUD has become more common due to heavy government promotion and its ease of use when compared to oral contraceptives (Stephens 1992:45). In a 1988/89 survey (WRI 1992:257), 16 percent of married couples using a birth control method were using IUDs while 15 percent were using the pill. Only a small percentage were using traditional or natural family planning methods, condoms, or female sterilization while none of the people surveyed were using injections (depo-provera), male sterilization, or vaginal barrier methods.

The relatively low use of birth control methods, however, is not necessarily
due to a lack of knowledge about family planning or a desire for a lot of children as the government has suggested. According to the ECPS of 1984, 84 percent of the total number of respondents reported having knowledge of at least one contraceptive method (Sayed et al. 1985:111). Sixty-one percent of those respondents were women from rural Upper Egypt (Sayed et al. 1985:93-111). The ECPS also discovered that slightly over half of the currently married women surveyed wished to cease childbearing. Most of these women were between the ages of 25 and 29, and 80 percent of the women over the age of 35 definitely did not want more children. The majority of ECPS respondents felt the ideal number of children was three, there should be an interval of two or three years between births. Ninety-four percent believed that family planning should not be practiced before the first birth while a majority thought it should not be practiced until the couple had at least two children (Sayed et al. 1985:111). Only 30 percent of married couples, however, were using family planning methods, most of whom were using the pill (Table 4). About 26 percent knew about female sterilization and abortion, and about seven percent knew about male sterilization (Sayed et al. 1985:154) although these methods are not included nor promoted by the Egyptian government (Khalifa et al. 1982:86). Prolonged breastfeeding was the most commonly recognized traditional method of birth control. As of 1984, more than 90 percent of mothers breastfed their babies, although the duration of breastfeeding in urban areas was found to be shorter than in rural areas (Sayed et al. 1985:77).

The primary reasons for nonuse among the women that were surveyed by the ECPS(84) were: the desire for additional children, a lack of exposure to conception, and a lack of information about family planning (Sayed et al. 1985:163). Only a small number of women cited religious reasons, husband's disapproval, or concern about side effects (Sayed et al. 1985:163). Most users who had stopped using a method did so because they became pregnant while using the method or suffered from side effects (Sayed et al. 1985:185). Women who went to government-operated clinics not only had lower continuation rates than women who bought contraceptives from pharmacies or private physicians, but they were less informed about how to use the contraceptives properly (Sayed et al. 1985:185). The ECPS (84) indicated that the IUD users were better informed about their method and how to avoid failure than pill

<table>
<thead>
<tr>
<th>Contraceptive Method</th>
<th>Total Percent who Know of a Method</th>
<th>Total Percent Using a Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pill</td>
<td>84.9</td>
<td>16.5</td>
</tr>
<tr>
<td>IUD</td>
<td>74.9</td>
<td>8.4</td>
</tr>
<tr>
<td>Vaginal barrier methods</td>
<td>27.8</td>
<td>0.7</td>
</tr>
<tr>
<td>Condoms</td>
<td>21.5</td>
<td>1.3</td>
</tr>
<tr>
<td>Injections</td>
<td>35.3</td>
<td>0.3</td>
</tr>
<tr>
<td>Female sterilization</td>
<td>20.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Male sterilization</td>
<td>5.3</td>
<td>0</td>
</tr>
<tr>
<td>Prolonged breastfeeding</td>
<td>24.7</td>
<td>0.6</td>
</tr>
<tr>
<td>Rhythm</td>
<td>11.3</td>
<td>0.6</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>6.9</td>
<td>0.3</td>
</tr>
</tbody>
</table>

*Note: Data from Sayed et al. (1985:116, 154)*

users were. A majority of pill users did not know what to do if a pill was forgotten (Sayed et al. 1985:129). It was also shown that the median duration of IUD use was over 45 months whereas the median duration for pill users was only 24 months (Sayed et al. 1985:185).

Eight out of ten women purchased supplies (mostly the pill) from pharmacies, and IUDs were most often obtained from private doctors and hospitals (Sayed et al. 1985:233). The methods requiring clinical care were found to be more difficult for rural women. In one third of the couples who were using a method, the husband was in charge of obtaining supplies, primarily from pharmacies. The majority of women interviewed for ECPS(84) talked about family planning with their husbands, felt decisions about bearing children was a joint decision, and believed their husbands approved of family planning (Sayed et al. 1985:233). A small number of rural women believed their husbands were the sole decision-makers in the marriage and disapproved of family planning.
According to a more recent surveys, the number of Egyptians who know about and use family planning has increased, but there remains a large discrepancy between those who have knowledge and those who actually use a method. The National Population Council survey of 1988 (Stephens 1992:45) reported that 98 percent of married Egyptian, women aged 15 to 49, knew of at least one family planning method. Although the women desired an average of only 2.9 children, half of the women questioned in the survey were still not using any form of birth control. Another 1988 survey found that 97 percent of the respondents had affordable access to the pill, 84 percent had access to condoms, and 53 percent had access to female sterilization (WRI 1992:257).

In light of this data, it can be seen that general information about family planning and access to contraceptives is not a problem. Government access to family planning has in fact been successful, especially in the cities, but this has not affected the rural contraceptive prevalence rate. In the following section, by using a series of evaluative questions, I will address the cultural issues underlying the low family planning success rate that has occurred in rural Egypt. It will clearly show the government is biased toward westernization and modernization and is ignorant and impatient with traditional cultural attitudes and practices.
METHODOLOGY

This thesis is based on three main sources of information: published demographic surveys, published literature and ethnographic studies, and information gathered through in-depth interviews with Egyptian students living in the U.S. Global and Egyptian demographic data were gathered first from sources including U.S. Census Bureau reports, United Nations reports, the Population Reference Bureau's Population Datâ Sheet, the Egyptian Fertility Survey of 1980, the Rural Fertility Surveys of 1980 and 1984, and the Egypt Male Survey of 1991. Following this, ethnographic studies and other types of literature, including news reports, were used to supplement and verify the information I gathered from the surveys.

In the last step, I talked with Egyptian students about a number of topics including socioeconomic conditions in Egypt, Egyptian politics, urban life compared to rural life, Islamic beliefs in general, traditional and Islamic beliefs and practices related to reproduction and family planning, opinions regarding how family planning should be promoted, and the spread of AIDS. The interviews and discussions were unstructured, but by conducting an in-depth literature research first, I was able to ask specific and more knowledgeable questions. The information gained from the Egyptian students was used to both verify and supplement the published data.

All of the information from the publications and the interviews was then used to answer a series of questions based on a systemic evaluative method formulated by Duncan Earle (1992) to evaluate small community development projects. This thesis was in part used to test whether this method could be used to evaluate large national programs and policies. The questions cover the following topics:

1. community as unit
2. cultural logic
3. social solidarity
4. economic autonomy
5. political landscape
6. ecological harmony
7. health implications
8. sustainability

These topics, their related questions and the reasoning behind their usage will be described further in the following Evaluation section.
EVALUATION OF EGYPT'S NATIONAL FAMILY PLANNING PROGRAM

Community as Unit

Introduction

Development programs implemented in developing countries and modeled on Western approaches to development often assume the beneficiaries of a program are independent individuals with the power to make and execute their own decisions. This can result in program failure in cultures that are community and family oriented rather than individualistic. In order to properly implement a program, it is essential to not only identify the appropriate clients but also to investigate the social organization of a culture, a necessary step in both determining how the “clients” are influenced by other people and institutions and which social units (i.e. women, communities, organizations, etc.) can best act as cultural change agents. If the planned beneficiaries of a development program cannot take full advantage of the program due to a lack of power, autonomy, mobility, or other types of obstacles, then the program is clearly flawed and needs to be redirected toward a different or broader social category.

Family planning consists of two very important words: “family,” implying the family as a social unit, and “planning,” meaning decision-making. Therefore, in order for family planning to be successful, the “family” unit must be defined as well as the person(s) who is the primary “decision-maker” for the family. The Egyptian government has focused their family planning efforts almost solely toward women, thereby assuming that they have exclusive decision-making power over family size. In this section I will discuss why women have been the focus of Egypt's national family planning program; why this approach has been unsuccessful on a national scale; and why women, men and communities together should be the focus of program outreach as well as included in program planning, and implementation.
The Importance of Family and Community in Egypt

Because women throughout much of the world generally bear the primary responsibility for child care and household upkeep, they have also been made to bear the primary responsibility for excess population growth (Sachs 1994:12). Although Egyptian culture revolves around family and community, the Egyptian government has defined rapid population growth as a national economic problem essentially controlled by the reproductive activities of women. Most demographical research and surveys, education programs, and family planning services in Egypt have focused on women as individual recipients. In so doing, the government has failed to consider how little "control" Egyptian women actually have over their own lives and has instead assumed they are free from influence or control stemming from their husbands, families, communities, and political and socioeconomic institutions.

Contrary to this approach, Arab society throughout the Middle East, including Egypt, revolves around the community and most especially around the family unit. Family relationships are at the basis of every Egyptian's identity, and family ties are at the core of every Egyptian's life (Fluehr-Lobban 1990:24). Egyptians view their strength as stemming from the indivisible unity of the corporate social group while individualism is viewed as having little positive value and is often equated with "negative outcomes such as sexual license and social chaos" (Rugh 1985:33-34). Egyptians instead tend to define themselves in relation to others, as members of groups, or in the context of their structural roles (Rugh 1985:35). This traditional form of social organization is also legitimized by Islam which values family obligations and the collective good over individual rights (Said 1979:77).

Traditional Egyptian society is patrilineal and consists of patrilocal extended family groups that reside in the residence of the oldest male of the family. Upon marriage, a daughter leaves her father's household and moves into her father-in-law's house. For Egyptians, this extended family organization not only offers economic and emotional support to its members but also establishes each individual's identity and social position in the world (Fernea 1985:25). In exchange, each family member is expected to contribute to the support and maintenance of the family and to behave according to traditional codes of family honor (Fernea 1985:25).
For women, honor consists of courage, religiously, hospitality, and the maintenance of a chaste reputation. (Fernea 1985:26). Bad behavior can rupture family ties and lower the status of the group. According to Patai (1983:119), "Family bonds are so strong that all members suffer 'blackening of the face' after the dishonorable act of any one." Therefore, behavior which supports family cohesion is applauded (Rugh 1985:88).

Although extended family living arrangements are still the norm in many rural areas of Egypt, they have declined significantly in favor of nuclear family households, now comprising 84 percent of all households (Nawar, et al. 1994:18). Nuclear living arrangements, however, do not necessarily commence immediately after marriage. Housing is extremely limited and expensive in the cities, and even in rural areas where it is easier to build a new house, men must often work for a number of years to acquire enough money to build. The new demand for housing and modern appliances often leads young men to migrate to the Gulf countries in search of more lucrative employment. The rise in the number of nuclear households, however, has not diminished strong extended family ties. Family support is still highly valued and remains the focus of everyday life and a means of survival for many people, often leading nuclear families to set up their households close to other family members (Fluehr-Lobban 1994:24). Nothing as of yet has replaced the family as a source of socioeconomic support and alliance for a majority of people (Fernea 1985:26), and yet Egypt's family planning program has ignored this social unit at the heart of Egyptian social organization.

Gender Roles

Egypt's national program has not only ignored family ties, but it has failed to take into account the prevalence of strict gender roles which deeply effect the ability of women to become independent cultural change agents. When traditional gender roles are strictly upheld in Egypt, they greatly hinder a woman's independence and ability to obtain health care or family planning services (Abaza 1987:24). Unless a married couple has the financial means to set up a nuclear household, they live with the husband's extended family. Within this strictly stratified, extended family
environment, the youngest wives have the least amount of decision-making power and independence and are relegated to the role of laborers for the men and their mother-in-law. In very strict traditional families, young wives also have no privacy and are guarded by the family so they do not compromise the family honor (Brink 1987:139). In these cases, young wives are not allowed to leave the house without the permission of their husbands or mother-in-law or husband and without the accompaniment of a relative (Brink 1987:139). According to the Egypt Male Survey (EMS) or 1991, "as many as 55 percent of men in rural Egypt do not allow their wives to shop alone and only 40 percent allow them to shop with their husband (Sayed et al. 1992:40).

This lack of mobility is not only found in both urban and rural Egypt but extends to all social classes. Women married to well-educated men with middle to high incomes do not necessarily have greater mobility than poor women and are in fact often kept in seclusion and not allowed to work outside the house (Abaza 1987:68). The EMS (Sayed et al. 1992:40) found that male educational level had no bearing on approval for women leaving the home. 74 percent of the male respondents to the EMS also disapproved of women working (Sayed et al. 1992:41). As in poor areas of the U.S. and Latin America, the image of the housewife has become a status symbol for the lower classes, whereas a woman working for wages has become a sign of poverty (Abaza 1987:68-77). Being a housewife has become associated with the upper and middle classes where male wages are high enough to support a family.

Unemployed women in lower family hierarchical positions, however, are more financially dependent on husbands and other relatives for their livelihoods. In extended families, the mother-in-law usually controls the family budget, garnering wages from her sons. In nuclear families, much of the spending is controlled by the husband. As a result, unemployed wives and lower status wives may not have the financial means to pay for family planning services or contraceptives, especially if the person controlling the money does not approve of family planning. This enforces the lack of decision-making power on the part of women. Whether employed or not, however, women are expected to be obedient to their husbands, the major decision-makers of the family. The EMS found that 62 percent of the Egyptian male
respondents believed wives should not have decision-making power in the family and should not disagree with their husbands (Sayed et al. 1992:42).

In addition to providing labor to the family, new wives are also expected to become pregnant as soon as possible to prove their fertility. Once children are born, mothers are expected to not only continue the previous household activities but are also expected to provide all of the child care until they have daughters old enough to help. Rural women from agricultural families are expected to work in both the house and the fields, and apart from going to the market once a week, they are restricted to these two arenas (Abaza 1987:68). These activities and responsibilities take up a great deal of time, allowing little time to trips to the doctor or clinic and the ensuing wait time to be seen. As a woman begins to bear children, however, especially sons, her status rises, providing her greater independence, mobility, and power within the family. This is supported by the EMS which found that male approval for female mobility and employment increased with a woman's age (Sayed et al. 1992:40-41).

_Education for Women_

Another factor which greatly inhibits women from being successful change agents for population growth is the low rate of female literacy in Egypt. This lack of literacy and the lack of knowledge regarding Western biomedical concepts about sexuality, reproduction, and issues such as population growth, economics, and environmental degradation constrains their ability to understand the reasoning behind Westernized family planning and the use of modern contraceptives.

Despite the fact that primary education is compulsory and free in Egypt, secondary school is not compulsory and many girls in rural areas leave school when they reach puberty (Williamson 1987:131). The extra costs of school supplies, clothes, transportation, and tutoring can be so high that many families can only afford to educate a few of their children. In such cases, boys will be educated rather than the girls. The schools are also poorly distributed, lack the needed resources, have inefficient teachers, and are so crowded that they have two school shifts per day (Williamson 1987:131). As a result, school drop out rates are high, especially among children from poor families who need children to provide labor and bring in additional
family income.

Girls who are allowed to remain in school expect to have greater decision-making power for themselves, but once married, some are shocked to find that they are still treated as uneducated girls by their husbands and mother-in-laws (Brink 1987:142). Although Egyptian men are beginning to prefer educated wives, this is only due to their ability to provide better childcare, not because they believe in women's liberation or want to change the traditional husband-wife relationship (Brink 1987:142). Therefore, educated women do not necessarily possess greater mobility or autonomy than women who are not literate.

The lack of education for women, however, not only inhibits their knowledge of reproduction, but it complicates family planning initiatives for the simple reason that women who are not literate cannot read directions accompanying contraceptives regarding proper usage and side effects. Instead they must rely on personal verbal counseling, a service which has frequently been found to be lacking in Egypt. Therefore, unless education for women improves drastically and quickly in Egypt, a reliance on women as sole beneficiaries of the program will not succeed.

Families and Communities as Agents of Change

Family planning is unlikely to succeed in a stratified, patrilineal, community-based society such as Egypt's until it is promoted to families through communities. More importantly, population growth in any country is unlikely to stabilize until men begin to share fully in the responsibility of family planning (Sachs 1994:12). Contraceptive marketing, education, and medical services directed solely toward women in strongly patriarchal societies will have less effect because women may not have the decision-making power regarding the number of children they bear or whether they can use contraceptives (Sachs 1994:12).

When men have been involved in family planning programs, they have been found to be a positive influence on the program (Cochrane et al. 1990:336; Piotrow et al. 1992). In the orthodox Muslim societies of Pakistan and Bangladesh where wives are often confined to the home, husbands have been found to be integral to program success since they are the most likely recipients of contraceptive information and
supplies (Jacobson 1987:38). As in Pakistan and Bangladesh, Egyptian men are generally more educated, more mobile, and according to survey data want fewer children. The Egyptian Fertility Survey (EFS) of 1980 concluded that Egyptian husbands during the early 1980s did not have a higher preference for more children than their wives (CAPMAS 1980), and the EMS of 1991 (Sayed et al. 1992:47) found that 28 percent of urban men surveyed, and 22 percent of rural men, believed their families were too large. Urban men were found to prefer 2-3 children, while rural men prefer 3-4 children (Sayed et al. 1992:47).

The EMS of 1991 (Sayed et al. 1992:xiii) determined that 92 percent of men in Cairo, 89 percent in rural Lower Egypt, and 81 percent in rural Upper Egypt approved of family planning. The survey also found that men play an active part in obtaining family planning services, 70 percent of men were the decision-makers regarding the use of family planning, over one-third having accompanied their wives to family planning service centers, and about half had obtained contraceptive supplies themselves (Sayed et al. 1992:57-61). The type of contraceptive methods used, however, was primarily left up to the wife (Sayed et al. 1992:57). Few men were knowledgeable about male contraceptive methods, and the majority of those who knew about condoms, the withdrawal method, and sterilization disapproved of those methods (Sayed et al. 1992:57).

It is clear from the survey data that Egyptian men have the decision-making power over family size and the use of family planning. Yet, this information has not been integrated into Egypt’s family planning program. Although Egypt has been successful in making Egyptians aware of family planning and in making it more acceptable, it has failed to consider social organization and stratification in its program planning. The survey data does reveal a concern and interest in family planning by men. This suggests that family planning education for men would be an integral part of Egypt’s family planning program if it is accomplished through recognized and accepted means of communication. Due to Egypt’s separate gender roles, this would require the training and employment of men as family planning counselors. The majority of family planning workers, who are women, are only allowed to counsel other women, not men. For example, women have been harassed in Egypt when they have tried to hand out condoms to men (Caldwell
1993).

Allowing village leaders or local religious leaders, who are usually men, to have some responsibility in spreading family planning information through their communities has been found to be an important avenue, not only in influencing men but in spreading acceptance among the whole group (Jacobson 1987:38). Community-based programs which can offer extension workers, family planning education within the home, and will continue to monitor a community's needs would also be effective in enhancing communication between wives and husbands. This combined with community development, including women's programs, offer the only solution to sustainable and increased use of family planning.

Summary

In directing its efforts toward women, Egypt's family planning program has failed to consider the basic fundamentals of Egyptian culture: the importance of family and community, the importance of social stratification and status, and the presence of strict gender roles. The program has assumed that awareness and accessibility to family planning services are adequate to increase the usage of those services. It has had a certain amount of success, especially in urban areas of Egypt where the middle and upper classes are becoming more individualistic and westernized, but in rural Egypt and poor urban areas, where long-held beliefs about the role of women are prevalent, family planning has had only limited success.

With women's lack of mobility, education, decision-making power, and economic autonomy, the use of contraceptives may increase only slowly or not at all unless men are included in the program, both as counselors/providers and as beneficiaries. For this reason, community-based family planning projects, such as the Menoufia Project discussed previously in the population policies and programs section, have been more successful at increasing the usage of contraceptives than the widespread government program because they direct their services toward couples and offer personal counseling and family visits. This avoids the pitfalls of lack of mobility, improper contraceptive use, and bad choices due to a lack of education, while it promoting communication at a family and community level.
Cultural Logic

Introduction

Cultural beliefs and practices have often been viewed as detrimental to development, particularly when "development" is defined as Westernized modernization and industrialization. Strong traditional values and practices in this setting have been perceived as backward, ignorant impediments which must be changed. As Freedman (1987:59) states, "Deeply rooted elements in a culture, particularly those that affect the demand for children, can greatly inhibit family planning programs." Although this statement is true, it neglects to consider that cultural beliefs do not have to inhibit family planning programs if programs are planned and implemented in ways that are "culturally logical" to a society. As Nafis Sadik points out (1991a:11), "Cultural and religious values will not hinder family planning if the programs are appropriate to the community concerned."

Not only must development projects direct their efforts toward the appropriate social unit, but in order to be accepted by the intended recipients, projects must also be compatible with local culture and value systems. In this section I will show how the Egyptian government's views of family planning has impeded the acceptance of family planning; how it has failed to consider the importance of children to the status and socioeconomic health of women; and how traditional reproductive and medical beliefs have been ignored by Egypt's health care system.

The Government's View of Overpopulation versus the Public's View

The Egyptian government's view that the country's socioeconomic problems are a result of overpopulation, resulting in the need for fertility control, has not been widely accepted by Egyptians. When communicated and promoted solely as a population control measure, family planning in Egypt is in fact incompatible with traditional Egyptian culture. In her research in Egypt, Inhorn (1994:503) found there was a great deal of popular resistance to Western-style discourse of overpopulation and fertility control because it "sounds threatening and has genocidal overtones." A
21 year old Egyptian woman from a city near Cairo reported to me that she and other fellow Egyptian students are ambivalent toward the idea that Egypt is overpopulated. On the contrary, they believe that with increased production and industry, Egypt has the potential to feed all of its citizens and owns a land mass large enough to accommodate them. The Egyptian students also believe the Egyptian government has focused too much attention upon family planning as a means of population control and has placed too much blame upon rural Egyptians for having too many children while city dwellers are still having large families.

Marriage and Family

Because of the importance of children and family, marriage in Egypt is almost universal, and it is viewed essentially as a means of procreation as well as an alliance between families. Marriages are usually arranged by parents, and first cousin marriages are regarded as the most preferred union (Fluehr-Lobban 1990:24). This not only insures the consolidation of family wealth but offers greater family security and protection for a woman and her children in case the marriage fails or the husband dies (Fluehr-Lobban 1990:24). Marriage is also necessary for Egyptians due to Islamic and Coptic condemnation of pre-marital and extra-marital sexual relations and the traditional requirement of virginity on the part of brides as proof of their virtue (Zenie-Ziegler 1988:115).

Because of the Muslim Arab fetish for virginity, girls must be isolated and married as soon as possible so that they will not arouse the desires of men, possibly leading to sexual indiscretions and a dishonoring of the woman’s family (Patai 1985:120; Zenie-Ziegler 1988:115-116). Thus, unmarried women of reproductive age have no status and are often the object of gossip and scandal (Zenie-Ziegler 1988:115-116). A woman’s entire education and the social guidelines laid down for her derive from this obsession with the preservation of virginity (Zenie-Ziegler 1988:102). It is still common in villages and poor urban areas for brothers, husband, and male other relatives to kill women accused of pre-marital or extra-marital sex on the basis of family honor. These cases rarely reach the courts, and women have few rights when it comes to abuse (Zenie-Ziegler 1988:103). When the respondents to
an early 1980s survey were asked why marriage was more important, 78.3 percent responded that marriage protects the reputation of the girl and stops people from gossiping (Tadros 1984:28).

Due to these sexual taboos, Egyptians have historically married at a young age which has contributed to a high fertility rate. Approximately 60 percent of Egyptian women between the ages of 20 and 24 are married (Courbage 1994:20), and although Egyptian law stipulates the legal marriage age for women is 16, underage marriages still commonly occur in rural areas (Abaza 1987:92). Some rural Egyptians are not even aware there is a law concerning marriage age (Abaza 1987:92).

Not only are young marriages preferred to protect the virtue of girls, however, but in a patrilineal society where women own few resources and contribute little to the finances of a family, daughters become an expense to their parents. In addition, marriage is also necessary in order to provide undisputable proof of the paternity of every child born for inheritance and status purposes. This is so important in Egypt's patriarchal society that the law prohibits unmarried pregnant women from keeping their babies (Zenie-Ziegler 1988:105). Illegitimate children are instead taken from their mothers and placed into orphanages where they have little hope of adoption, have no family name, and have little chance of acceptance in society (Zenie-Ziegler 1988:105). Children born within wedlock give permanence to the marriage, and many people feel a couple only becomes a family after they have had children (Rugh 1985:59). This contributes to the pressure placed on women to reproduce in order to be accepted.

Infertility

Couples are expected to begin producing children immediately after marriage to prove their fertility. Although knowledge about male infertility has spread through Egypt since the advent of semen analysis, rural and urban lower class Egyptians often still cling to the belief that women are at fault for all infertility problems (Inhorn 1994:503). It is also commonly held that all of a child's genetic information comes from the father while women are only nurturing receptacles (Inhorn 1994:503). As
described by Inhorn (1994:503), women are "blamed for failures in reproduction by virtue of their faulty bodies which fail to facilitate men's inherently superior, life-giving act." This has directly influenced the government's population policy which places the responsibility for childbearing and thus fertility control on women.

Female infertility is extremely socially stigmatizing and greatly feared because motherhood is the traditional socially sanctioned role for women, and each child born increases a woman's status (Inhorn 1994:487). Among the urban and rural poor, infertility is often attributed to kabsa, also known as mushahara (Inhorn 1994:487). According to Inhorn, kabsa, a folk belief that has been present in Egypt since non-Islamic times, is the "binding" of a woman's reproductive system due to exposure to a symbolically polluted individual while the woman was in a reproductively vulnerable state. Polluted individuals include menstruating women, men knicked while shaving, dead bodies, gold, and meat (Inhorn 1994:495). Kabsa most commonly affects newly circumcised girls, new brides, women who recently aborted or miscarried, and women who recently gave birth (Inhorn 1994:489). Women who believe in kabsa will often avoid clinics and hospitals where they have a greater chance of running into polluted individuals.

Kabsa can be overcome through rituals recommended by female family members or dayas (traditional midwives), but the ideal way to prevent kabsa altogether is by isolating a woman going through a transition for the duration of that change. Religiously literate Islamists find such pre-Islamic folk beliefs to be heretical, but illiterate Muslim women, who represent a vast majority of Egypt's female populace, regard the beliefs as natural and complimentary to Islam (Inhorn 1994:497). Physicians and health care providers working in rural areas often know little of traditional beliefs and know nothing of kabsa or women's fears of hospitals as polluted places (Inhorn 1994:498).

Infertility is not only a form of social ostracism for women, but can decrease the status of the whole family and can threaten its economic well-being. Traditionally, a large number of children has increased the status of parents and insured the security of their parents in old age. Egypt's long history of high infant and child mortality made it especially necessary for women to bear many children to insure the survivability of a few. Even though infant and child mortality has been
greatly reduced and the need to produce a large number of children is no longer as necessary for child and family survivability, the habit of having large families continues (Middle East 1993:23). Children are so important that it is still common for a man to either divorce a wife who does not produce children, especially sons, or marry more wives.

Sons are especially important because they will continue their family lineage, inherit the family's wealth, and are expected to support their parents in old age. Women do not gain respect from their family until they have produced a son to carry on the family name, and although the number of Egyptian women entering the work force is increasing, a son's support is still an economic necessity. Thus, as has been discovered in survey data, the number of sons in a family has a direct impact on whether a couple uses contraceptives (Aly and Shields 1991:369). Couples will often wait until at least one son has been born before practicing family planning, and families with daughters often have a higher fertility than families with sons (Aly and Shields 1991:353-369).

Summary

In essence, Egypt's government has failed to link the prevention of unwanted pregnancies with the importance of a couple's ability to produce the healthy children that they do want. Government family planning clinics in rural areas have been found to be understaffed, under-supplied, mismanaged, and they supply little counseling and little actual health care for women. Contraceptives are offered with little regard for improving the reproductive health of women, and problems of infertility have been ignored by the health care system. By placing the blame for overpopulation primarily on rural women and charging them with the goal of fixing it, they have neglected to face the fact that rural women must reproduce to be accepted by their families and to secure their socioeconomic future.

Thus, Egypt's family planning program not only is incompatible with rural beliefs, but it directs attention toward the wrong social category. Family planning, especially when promoted as "fertility control" or "population control" will never be acceptable to many Egyptians because not only does it contradict their beliefs about
reproduction and sexuality, but it aims to stem their only form of social and economic security.

Social Solidarity

Introduction

As I have illustrated in the previous two evaluative sections, Egypt's family planning program has not focused on the appropriate social unit, nor has it been compatible with Egyptian cultural logic. This indiscretion not only results in an unsustainable program but can create more conflict rather than improve the level of social solidarity. Ideally, development programs should bring people and communities together rather than create or increase socioeconomic and political divisions.

Egypt's family planning program has not promoted cooperation within families, communities, or between the government and its populace. Furthermore, the program has created a gulf between traditional health care providers and the modern biomedical establishment and has fueled arguments between the secular government and religious conservatives.

Family Solidarity

As already discussed under Community as Unit, Egypt's family planning program has not been especially successful in offering services to both men and women, nor has it placed emphasis on community-based services. As a result, the program has not facilitated communication between married couples and with other family members. Men especially lack the necessary information allowing them to make informed decisions and share in the responsibility of planning their families.

According to the Egyptian Male Survey of 1991 (Sayed et al. 1992:xiii), 84 percent of Egyptian married men approve of family planning, and 70 percent make the decisions as to whether to use a family planning method. Even with this high approval rate; however, the both the EMS (Sayed et al. 1992:xiv) and the Rural
Fertility Survey of 1982 (Stycos et al. 1988:69) found that on average only 40-50 percent of the respondents had discussed their fertility preferences with their wives. This percentage was even lower for rural Egypt (Sayed et al. 1992:xiv). The RFS82 also found that only 53 percent of the wives surveyed believed their mother-in-law approved of the use of family planning (Stycos et al. 1988:71).

What these two surveys reveal is that over the span of a decade, family planning decision-making within the family and communication between wives and husbands about family planning essentially remained unchanged. Young women are specifically taught that "the goal of marriage is the harmonious union between two extended families for the production of children" (Lane and Meleis 1991:1202). Therefore, since the movements and actions of younger wives are greatly dominated by their husbands and mother-in-laws, women are not free to make their own choices about family planning.

Disrespect for Traditional Health Care Practitioners

The lack of family and community involvement has also left local town leaders, religious leaders, traditional healers, and dayas (traditional midwives) outside the sphere of the government program. In particular, the chasm between traditional caregivers and scientifically trained medical personnel has been widened by the family planning program. Formal medical establishments and policymakers tend to believe that informally trained health practitioners cannot be effective deliverers of family planning services or any other type of health care (Ross et al. 1987:344). Egyptian government clinics and hospitals which cater to the rural and urban working lower classes are staffed mostly by upper-middle/upper-class physicians and staff from urban backgrounds who do not understand or respect the traditional beliefs of their clientele (Inhorn 1994:498). For example, Inhorn (1994:498) found that most of the obstetritition-gynecologists she interviewed in Lower Egypt had never heard of the traditional belief that infertility is caused by kabsa. Therefore, they did not understand that kabsa is one of the reasons rural women refused to enter hospitals, especially for childbirth. Because hospitals house new mothers, bleeding women, male visitors, the dead, and other polluted individuals,
women would be at risk for getting *kabsa*, resulting in infertility (Inhorn 1994:498).

Popular medicine in Egypt includes traditional practitioners, such as barbers, *dayas*, and sheikhs, who provide informal medical alternatives for peasants. The lower classes only trust modern medical physicians with emergencies and certain types of health care, whereas they prefer the approach taken by traditional healers for other types of health problems. Some avoid physicians altogether because they have received humiliating treatment in hospitals and clinics (Abaza 1987:92). Traditional women especially often find it embarrassing to be examined by a male doctor (Abaza 1987:94, Stycos et al. 1988:181).

particularly concerning the more personal subjects of reproduction, infertility, and even abortion, women prefer to obtain advice and care from female relatives, friends, and *dayas* (Abaza 1987:95). *Dayas* are women who live in the community, are well-known and respected, are trusted by both urban and rural women, and offer personalized care to women at a much lower cost than either government or private doctors (Sukkary 1981:31). *Dayas*, however, are now practicing their craft illegally. Originally they were trained and licensed by the government and were allowed to deliver babies and give injections throughout Egypt. In 1969, however, the government-sponsored educational programs for *dayas* were discontinued, all licenses for the *dayas* were revoked, and radio programs warned women against using "ignorant, unskilled, and often dangerous *dayas*" (Sukkary 1981:28).

*Dayas* are seen as an impediment to progress by the government and the modern health care establishment and as a result have lost clients and feel alienated from their own society (Sukkary 1981:27). Thus they do not support family planning. Only 25 percent of the wives interviewed during the second Rural Fertility Survey of 1984 stated their local midwife approved of family planning (Stycos et al. 1988:71). *Dayas*, on the other hand, would be a socially acceptable and inexpensive means of providing personalized family planning counseling and contraceptive supplies to their clients. This would, however, require acceptance by the government and the reinstatement of their training and certification. This would not only enhance the quality of family planning services but would enhance the quality of primary health care available to women, especially in rural regions. The lack of respect for traditional health care beliefs and practitioners, on the other hand, will only hinder the
further development of the health care system Egypt and will lead to further distrust of the government.

Islam and Family Planning

The approval or disapproval of family planning by village leaders and local imams can greatly inhibit or promote the use of contraceptives as well. The fact that fatwas (religious laws) support the use of modern contraceptive methods does not prevent rural and urban villagers and clergymen from raising their own objections to it (Weeks 1988:19). As Warwick (1982:84) states, "While Islamic leaders in Cairo were issuing statements supporting contraception, Imams in the villages were proclaiming its immorality. There have even been incidents of murder against people involved in the promotion of family planning in Egypt (Middle East 1993:24). Regarding an interview with a rural physician, Warwick (1982:156) cites, "religious leaders here do not approve of family planning.... One word from the local sheikh equals ten words from me, and therefore, I am in a weak position trying to make them understand the concept of family planning since the religious leaders themselves are not convinced." Another family planning client told Warwick (1982:156-157), "the sheik and the imam have been telling us 'How dare you try and decide how many children you will have. What if God turns around and takes away those you already have?""

Whether the Imam approves of family planning or not is of great importance, especially for men who listen to his teachings at the mosque. Since women are not allowed to go to the mosques, what uneducated women understand of religion is what men want them to know (Mitsuka 1993:25). Therefore, many Muslim women believe their religion denies them the right to use birth control (Mitsuka 1993:25). Men who do not have an extensive knowledge of religious teaching and religious law, on the other hand, are not in a position to dispute fundamentalist teachings and can be just as susceptible to conservative imams who say that contraception is haram (forbidden by the Koran) (Middle East 1993:25).
Summary

We can see from this discussion that Egypt's family planning program has: (1) failed to increase communication between couples, (2) alienated traditional health practitioners, and (3) neglected the influence of religious leaders. As a result, the program has created social disharmony at not only the household level, but at the local, regional, and national levels as well. The government has failed to gain acceptance from the most influential people in society, and it has further strengthened the link between family planning and the government's secular-religious struggle. In their struggle to gain political voice, religious leaders are using family planning to gain support against the government by emphasizing family planning as a Western attempt to undermine Muslim culture. Also, by alienating traditional practitioners, the government has alienated a rural culture based on ancient traditional practices and has failed to support and create a system which is economically more viable to rural and poor Egyptians.

Economic Autonomy

Introduction

In order for a family planning program or any socioeconomic development program to be successful, it must not only approach the proper beneficiaries and complement their beliefs, but it must be of benefit to them economically. Although this is repudiated by totalitarian governments which fear the empowerment of their people, economic autonomy allows people to make their own choices, especially important when dealing with matters of reproduction. It has been proven in China, with the forced one child plan, and in India with forced mass sterilizations, that removing reproductive choice only results in greater anger toward a government.

In Egypt where children contribute to the household economy, family planning is seen as a contradiction. Children in Egypt provide social security for the future; they provide labor to farming families; they bring in wages to poor families, especially widows; and they serve to protect women from divorce and polygamy. Therefore,
until the responsibilities for these needs can be served by some other institution, children will remain beneficial to the Egyptian family.

Children as Social Security

At the local level, family planning has economically benefitted the Egyptian upper classes who already have a substantial financial base. Contraceptives have allowed both professional and non-working women to have fewer children, thereby allowing them to continue in their own careers or pursue other interests. Fewer children and a greater income has also enabled parents to provide better health care and a better education for their children resulting in a brighter economic future for their family. For the majority of Egyptians, however, who belong to the rural and urban working classes, family planning does not have an economic incentive. Children, especially sons, are an economic necessity for many families, and some lower class working women believe that more than two children, especially boys, are an economic necessity (Zuhur 1992:69).

The Egyptian government had hoped that a decrease in infant mortality, improved health care, and an increase in income sources would decrease the need for more children. In actuality, income sources have decreased, the decrease in infant mortality has allowed families to raise more children, and better health care has merely increased lifespans and thereby population numbers. This, combined with a strained national economy and an inadequate social security system, has failed to decrease the need for children as social security. As was found in an early 1980s survey, 66.5 percent of the respondents viewed children as a source of income (Tadros 1984:33).

According to Lewnes (1992a:108), as many as 1.5 million Egyptian children work, making up about 10 percent of Egypt's work force. The data though does not include the thousands of children living on city streets and hawking wares or the 71 percent of rural children who work in agricultural jobs (Lewnes 1992a:110). Although Egyptian law has banned the employment and training of children under the age of 12, children continue to provide cheap and easily manipulated labor (Lewnes 1992a:110). Work also offers children a chance to learn a trade and in today's Egypt
where many college-educated people are unemployed, families find this more logical than an education that does not guarantee employment (Lewnes 1992a:110).

*Employment for Women*

In addition to the expectation that decreasing infant mortality would reduce birth rates, it was also expected that as women in Egypt became more educated, moved into the formal work force, and began marrying at an older age, fertility would decrease. The education system, however, has been unable to provide the needed services and most women are not literate or received little education. As of 1990, only 34 percent of Egyptian women were literate while the male literacy rate had risen to 63 percent (World Resources Institute 1992:254). According to the same data report, only 1.3 percent of Egyptian women and 5.5 percent of men over the age of 25 had some college education.

The marriage age has increased, especially in the cities, but not necessarily because more girls are staying in school. This is more a result of unemployment and low wages that make it impossible for young men to save the necessary money for a dowry. Young men sometimes have to wait until they are in their 30s to marry. The economic situation of the 1980s and early 1990s has also made it more difficult for women to find paid employment even though it has in turn made it necessary for many women to generate income to support their families. According to National Population Council data from 1988, as many as 25 percent of the households in Cairo are female-headed households (Lewnes 1992b:94).

Women constitute about 13.5 percent of the formal employment sector in Egypt, but this does not include the growing number of women who are involved in agriculture or other types of informal labor such as sewing and handicrafts, raising poultry, selling old clothes, and running vegetable stands (Lewnes 1992b:94). For these women, especially those involved in farming, children provide an important source of household and agricultural labor. Recent economic developments and the proliferation of informal sector activities, such as construction, carpentry, vehicle driving, shops, hashish smuggling, and the black market in foreign currency have contributed to non-agricultural employment opportunities for men and has led to their
growing abandonment of farming (Abaza 1987:13). This increase in informal activities and employment abroad has led to an increase in the number of female-headed households in rural Egypt (Toth 1991:214). Left to take care of the fields in addition to child care and additional home-based production activities, it would seem that women would be gaining a certain amount of independence and economic autonomy. Rural women, however, make little profit from their work in the fields when their money is still controlled by their husbands.

The greater involvement of women in agricultural work has also demeaned the status of agricultural production since it is now being viewed more and more as women's work. The importance of agricultural production to the survival of Egypt, however, has not translated to a higher status for women, and they have not been given aid or support in this important endeavor. They must rely on the help of their children to reap meager benefits from farm work, supporting rural views of children as a socioeconomic benefit.

*Divorce and Polygamy*

In addition to supporting Egyptian women in their labors, the presence of children also discourages divorce, a devastating occurrence in Egypt which can leave dependent women destitute (Rugh 1985:178). The possibility of divorce for Egyptian women can be frightening. Divorce is acceptable and easy under Islam making the divorce rate relatively high in Egypt, especially in the urban areas (Rugh 1985:177). According to the United Nations (1992:745), approximately one in 5.5 marriages ended in divorce in the mid-1980s, most occurring when couples were young, and over half occurring during the first two years of marriage (United Nations 1992:806). The greatest numbers of divorces occurred when the husbands were between the ages of 25 and 29 and the wives between 20 and 24 (United Nations 1992:758-759), and most occurred among childless couples (Rugh 1985:177). These data show that children are clearly a deterrent to divorce.

Unfortunately, Egyptian divorce law, which is governed by the *Shari'a*, grants men the right to divorce a woman at any time for any reason. Men have merely to say "I divorce you" three times and obtain a certificate from a magistrate, while
women, on the other hand, must hire a legal representative, take her husband to
court, and must have substantial proof that her husband has abused her or has not
provided for her or her children. Rarely does a woman win the case (Rugh
divorced or not, are required to financially support their sons until the age of 25 and
their unmarried, widowed, or divorced daughters. A wife, on the other hand, receives
alimony for only one year (Rugh 1985:179). In reality divorced men often do not pay
any alimony or child support, forcing women to find work, rely on financial help from
their children and relatives, or even resort to living on the streets (Rugh 1985:179).

Polygamy, which is allowed for Muslims, is also feared by women and can
raise fertility for the same reason as the fear of divorce. Polygamy is more common
among the lowest income levels and is as high as 10 percent in rural areas (Zenie-
Ziegler 1988:123). According to the Koran and Egyptian law, men can marry as
many as four wives at the same time, but they must be able to provide adequately
and equally for each wife. Polygamy can raise fertility by creating a status
competition between wives to bear sons or children and can also increase a wife’s
need for children as social security in case of neglect, abandonment, or divorce (BBC
1993b; Znie-Ziegler 1988:122). It has been found, however, that the presence of
children, especially sons, will provide enough status and economic responsibility for
men that they do not have the need for more wives.

Summary

The lack of education and career opportunities for women and the social
unacceptability of unmarried women has served to insure women’s continuing
dependence on husbands and sons for their financial well-being. Although the
greater accessibility of education in urban areas for both genders has decreased the
economic need for sons, employment opportunities remain more plentiful for men
(Tadros 1984:32). Although it is becoming more acceptable for women to work
outside the home, the traditional and idealized role for women remains that of wife
and mother while men are the financial supporters of the family.

Under these economic uncertainties, family planning does not offer all women
or families greater economic autonomy. As long as women have few legal rights, laws remain unenforced, unemployment increases, and inflation rises, children will be a necessity both to men and women. The lack of employment opportunities for women and the lack of social security for the elderly will only continue to enforce the need for children, especially sons who are not only a greater status symbol than girls, but have a greater chance of employment in the long run.

Therefore, because of worsening economic conditions and the lack of integration with development programs that would better the socioeconomic condition of the poor, Egypt's family planning program has been unsuccessful in increasing economic autonomy. Having a large number of children may be seen as a detriment to rural families, providing more mouths to feed, but on the other hand, without some other way of meeting economic obligations, fewer children will not benefit Egyptian families.

Political Landscape

Introduction

As mentioned previously in the section on Social Solidarity, Egypt's family planning program has not promoted solidarity at a local or national level and has actually increased tensions between religious and political leaders. Due to economic inequities, social discontent, and tight government control, Islamic groups have been fighting for political acceptance for decades. Unsuccessful government-induced development schemes, including family planning, have merely fueled the Islamist argument that secularization and democratization are not appropriate avenues for the Muslim world. This battle has produced a country ruled by a secular government which has allowed for many Muslim laws to remain intact in order to keep the peace. Many of these laws greatly inhibit women's rights and support traditional gender roles, encouraging the need for children.

In addition, family planning particularly has been attacked as being a Western attempt to reduce the numbers of Muslims. This section will show that although imams and other religious leaders have great influence in the communities of Egypt,
the government has neglected to include them in development program planning and implementation, as well as the larger political sphere. This in turn has negatively affected the acceptance of family planning.

Islamic Law and Political Conflict

Hosni Mubarak’s political administration views family planning as a necessity to improving economic development and quality of life. However, it has failed to support legislation, such as women's rights, that would create more favorable conditions under which family planning could become more culturally and economically acceptable. In all Muslim countries, social relationships are governed by the Shari'a (Koranic law), and legislation concerning marriage and family life are based on the suras (verses) of the Koran and the hadiths (the reports of Mohammed’s worlds and actions by his followers) (Zenie-Ziegler 1988:109).

Under foreign occupation, Western codes for the most part replaced the Shari’a in Middle Eastern countries except in matters of personal status (Najjar 1992:62). After independence, these countries readopted Koranic law to varying degrees. Egypt was one country which retained much of its Western influence and did not adopt strict Shari’a law after it gained independence from Britain in the 1950s. In fact, the Egyptian government took over control of the mosques and also abolished the Shari’a courts (courts for matters of personal law such as divorce and marriage based on Shari’a law) and replaced them with national courts. Court and mosque officials were then appointed by the government. Traditionalist Muslims, however, hold that Islam can only reach its full potential in an Islamic state ruled by Muslims and governed according to Shari’a law. The linking of Islam with politics is also seen as a necessary form of opposition to Western attempts to privatize Islam and make it a purely individual matter (Watt 1988:89).

During Nasser’s socialist regime, a series of new laws were enacted to transform Egypt into a socialist state. Egypt drew away from Islamic law and began to adopt Western codes. A new constitution gave women the right to vote and stand for public office, a new labor code gave them equal pay for equal work, and educational laws gave them access to equal educational opportunities (Kader
1987:147-148). In 1979, the People's Assembly under President Sadat enacted Law 44 which amended the Personal Status Law of 1929. According to the new law, women were given the right to divorce a husband if he took a second wife, and divorced women who had custody of young children could remain in the marital house until the children were of legal age (Kader 1987:138). A new electoral law also reserved 30 seats in the People's Assembly for women. These new laws, however, brought about only limited change due to cultural resistance regarding gender roles and the sexual division of labor inside and outside the home (Kader 1987:148). There were also contradictions between the opportunities offered to women by the laws governing work and the laws governing marriage and family life. For example, one law required women wishing to make journeys without their husbands to obtain their husband's authorization, and according to another law, women could hold ministerial posts but could not be governors or judges (Zenie-Ziegler 1988:110-113).

The authoritarian nature of Egypt's political power, worsening economic trends and inequalities over the past decade has fueled government opposition by a variety of conservative Islamic idealists and extremists who believe the country's problems could be cured by a return to the application of strict sharia law. Over the past several decades, the ulema (religious leaders) lost importance in the community and in politics, and most have consequently had a strong desire to regain something of their old power. To achieve this they have encouraged and fostered a reassertion of Islamic fundamentalism among the masses (Watt 1988:43). They have not necessarily recovered their political power, but they have increased the prevalence of the traditional Muslim world view (Watt 1988:43).

In 1980, President Sadat, who sought to gain political support from the rising Islamic tide, passed an amendment to the constitution that made it mandatory that all Egyptian laws be consistent with Islamic principles and rules (Najjar 1992:63). This amendment opened a floodgate of demands and pressures by Islamists that have been agitating Egyptian society ever since (Najjar 1992:63). During the early 1980s, the Islamist rebellion that took place in Upper Egypt and Cairo pressured the government into allowing them to work inside the political system. They allied themselves with the New Wafd party in 1984 and the Labor party in 1987 which
allowed them in each election to appear as the opposition in the Assembly (Hatem 1992:244). Essentially this created a very conservative legislature on social issues, discouraging the state from supporting women's issues and in 1985 causing the cancellation of the 1979 Personal Status Law and the 1979 electoral law that entitled women more seats in the Assembly (Hatem 1992:244).

President Mubarak has been criticized for giving way to Islamist demands in order to gain political support. There is, however, a growing awareness among moderate Egyptians that Islamic culture is being superseded by Western values, institutions, and practices (Najjar 1992:63). Because efforts at democracy and socialism have not succeeded in solving Egypt's problems, they have instead been blamed for causing the decline in quality of life (Najjar 1992:64). The success of the Iranian revolution and their implementation of strict Sharia laws is seen by some Egyptians as a sign that a return to this type of system is the way to solve Egypt's problems (Najjar 1992:64). Mubarak's crackdown on Islamists in the past several years has in fact only assisted its growth. Islamic militants in 1992 launched a campaign to overthrow the government and set up a strict Islamic state. Since then, more than 400 people have been killed in political violence (Reuters 1994a). In a study of two militant Islamic groups in Egypt, Saad Ibrahim (1982:120-121) found that both groups believed the government had been defeated by the "enemies of Islam - the Christian West, Jewish Zionism, and atheist communism and has made humiliating concessions to them." They also believe that because the government does not follow the Shari'a and has adopted Western legal codes, Egypt will suffer from "moral decay, poverty, disease, illiteracy, and radhila (the spread of vices)" (Ibrahim 1982:121).

Since 1992, Mubarak has expanded police powers, criminalized some types of political dissent, had thousands of Egyptians arrested or detained, and has limited the formation of new parties. The Islamists have also been excluded from political forums and elections in an attempt to lessen their power and public voice. Among the issues that the fundamentalists have been extremely vocal about are women's rights and governmental support for family planning. The dissolution of Law 44, which amended the 1929 Personal Status Law, in 1985 was viewed as a victory by the Islamists. According to Ibrahim (1982:121-122), the militants concede that men
have neglected women's rights, but on the other hand, they insist that a woman's rightful place is in the home and that her first obligation is to her husband and to the socialization of true Muslim children. The militants also believe women should wear the veil, the genders should be separated in public places, and they support the application of *hudud* (Islamic legal penalties) with regard to sexual offenses (Ibrahim 1982:121-122).

The liberalization of women's roles is seen as a threat to the family. They often point to the social problems related to the breakdown of the family in the West and the "failure of Western women to achieve the lofty goal of 'SuperMom'" (Zuhur 1992:133). The Islamists believe the Muslim family can only survive under strict observance of *sharia* values and regulations. Men must have authority over their family and protect them, and in return females and children must respect and obey men. In short, the Muslim family is "built around obedience, complementarity, protection, and respect, not around equality, competition, and self-reliance" (Ibrahim 1982:122).

Family planning as a government policy then, especially when promoted as "population control" is viewed by Islamists and more traditional Muslims as a Western threat to Islamic culture. They believe that "overpopulation" is a myth created by the superpowers. Egypt's problems instead rest on the unequal distribution of wealth and goods and services. Furthermore, they believe the superpowers do not want Egypt to redistribute its wealth because they want Egypt to remain dependent on the West (Zuhur 1992:87). They believe Western countries have promoted contraceptives in Muslim countries in order to control the spread of Islam, and some Islamists have called for an increase in births to increase the size of and strengthen the *umma* (Muslim community) (Zuhur 1992:88). In further defiance of government policy, they have also circulated materials which state that women who work will become infertile or suffer a reduced reproductive capacity (Zuhur 1992:88-114).

Less visible Islamic groups have gained in popularity through their development of social welfare programs, banks, health clinics, and other types of social services. These services are much more efficient than government services, are less expensive, and have proven that the needs of a "modern" world can be met through properly applied Islamic ideals. The Islamic health care clinics, for example,
provide better care for a fraction of the cost of private hospitals, and the clinics are cleaner, better equipped, and better staffed than the government clinics.

Summary

Since the Koran itself was written before the invention of modern contraceptives, it states nothing about them, but according to the hadith, Mohammed vehemently condemned female infanticide and supported the practice of 'azl, also called coitus interruptus or the withdrawal method (Ahmed 1988:19; Musallam 1983:16). The Grand Mufti of Al-Azhar University has also decreed that all modern contraceptives are acceptable in Islam. The hadith, however, are interpreted quite differently among different Islamic groups, and the acceptance of contraception varies from not at all to total acceptance. Therefore, the support of family planning by the government of Egypt is necessary to insure some type of countrywide availability of services and supplies, but without quality service, improved overall health care, and the cooperation of Islamic community leaders, little headway will be made.

The need for good family health, especially the health of children is heavily emphasized in the Koran. Along with the traditional health practitioners, Islamic leaders in their roles as community leaders and educators, need to be educated about family planning and its role as a health measure rather than believing it is instead a Western form of population decimation. Also, since Islam is a part of the cultural logic of most Egyptians, a development program which defies Islam goes against the very basics of a belief system so prevalent in much of today's world.

As the Egyptian government wrestles over its huge mismanaged public sector and its slow conversion to privatization, the Islamists have already proven they can do what the government could not by creating culturally acceptable service institutions. The Egyptian government has failed to recognize this and the large amount of influence religious leaders have in their communities. In this way, Egypt has unnecessarily politicized family planning in a country where not only has the earliest evidence of contraceptives been found (Musallam 1993), but a country where Islam had historically accepted family planning long ago.
Ecological Harmony

Introduction

One important aspect of development programs that has not always received enough attention but has been receiving more and more consideration recently is the importance of environmental sustainability and the promotion of sustainable resource management and environmental education. Only recently have environmental variables been linked to population programs. Clearly, population growth and failed development programs have had a detrimental effect on Egypt's environment. Yet the importance of this issue has not been communicated to the general public nor associated with the need for family planning.

Water Pollution

Egypt's limited natural resources mean environmental good health is crucial to the health of the population. The main environmental issue is that the increasing population and standards of living are resulting in a shortage of land and water and a reduction in the cleanliness and purity of land, water, and air (Hopkins 1992:1). It is predicted that Egypt will soon be facing a water shortage. Much of the population lacks clean water, and water and sanitation projects have been unable to keep pace with the demand. Egyptians are absolutely dependent on the Nile River and the land surrounding it, and the population density in the Nile Valley and Delta is threatening its future.

According to Hafez (1992:5), the Nile provides 98 percent of Egypt's water or a flow share of 55.5 billion cubic meters per year. This averages out to a per capita share of 1,000 cubic meters per year. By 2025, the per capita share of water will be less than 350 cubic meters per year (Hafez 1992:5). This amount may decrease even faster due to pollution and increased usage by land reclamation projects which use enormous amounts of water to turn the desert into productive farmland. The Nile has been severely polluted by untreated sewage and industrial wastes including pesticides and heavy metals which threaten the health of Egyptians, fisheries,
economic development, and tourism (Hafez 1992:5-6).

There is also rising concern about pollution along the Red Sea and the Mediterranean coast. The Gulf of Aqaba, at the northeastern tip of the Red Sea, is especially at risk because the strained economies of Egypt, Israel, Jordan and Saudi Arabia are all competing for the Gulf's resources. New tourist resorts, fish farms, desalination plants, and mineral export facilities have triggered an increase in oil spills, sewage dumping and thermal pollution, and an influx of toxic chemicals (Sachs 1993:6). Widespread coastal erosion and saltwater incursion is occurring along the Mediterranean because the Aswan Dam prevents the annual Nile floods which produced sediment that was carried all the way to the coast (Stanley and Warne 1993:628). According to Stanley and Warne (1993:628) almost all of the Nile's water is being diverted throughout the valley and delta for irrigation and industrial and municipal use, and the little water which does reach the sea is polluted agricultural runoff and industrial and municipal waste that spills into coastal lagoons. This has caused a sharp decline in fish populations along the coast (Stanley and Warne 1993:633). Lake Manzala, one of the Northern Lakes and once Egypt's leading fish producer, is also very polluted (Hafez 1997:7).

Land Degradation

With a land mass that is 96 percent arid desert, usable land is also decreasing at a devastating rate. The combination of unchecked population growth, an increase in industrialization, and the lack of coherent and enforceable land-use policies, has resulted in the conversion of agricultural lands to non-agricultural uses, destroying some of Egypt's most fertile land forever (Hafez 1992:4). Although it is now illegal to build on the green land near Cairo, the government has been unable to enforce the law. With 1,000 people a day searching for housing in Cairo, fines and prison threats have been unable to stop people from building illegally, and officials are easily bribed by people wanting to build homes or add illegal floors to buildings (BBC 1993). Almost 3 million people live in the tombs of the City of the Dead and another million are roof-top dwellers (BBC 1993).

The government has had little choice but to accept the increasing number of
illegal settlements even though they have no facilities and sewage is being dumped into the Nile and the canals. Cairo has a huge waste problem, and the largest public health project in the world will only provide sewage for one million Cairo residents (BBC 1993). Unfortunately, that many people are added to Cairo every year. Waste, however, is not merely an urban problem. Egypt's villages have been growing rapidly, and they are generating growing amounts of sewage and solid wastes that are frequently poured untreated into the canals (Arafa 1992:65).

It is estimated that 12 percent of Egypt's green land was lost between 1950 and 1984, resulting in an average of about five square inches of green space per person (BBC 1993). Of the green land that is in use by agriculture, much more is being lost to desertification and soil pollution due to the overuse of chemical pesticides, fertilizers, and civic and industrial wastes carried to the soil through irrigation (Hafez 1992:5). Poor irrigation systems are also causing water-logging, salinization, alkalination, and an increase in water-borne vector diseases like schistosomiasis (Hassan 1992:13). These factors have led many farmers to migrate to the cities, further aggravating the overcrowded situation.

The relationship between high population growth rates and the decrease in and degradation of environmental resources has been acknowledged at the national government level in Egypt and reflected in their policies, but the information has not been passed on to the public. The level of environmental awareness is very low in Egypt (Gomaa 1992:25; UNFPA 1992:3), and the relationship between population and the environment has not been emphasized in education programs (UNFPA 1992:3). Therefore, the public is not seriously aware of the extent of natural resource limitations, and arguments to that effect merely raise suspicions that efforts to slow population growth are merely another way in which the government is seeking to protect the lifestyle of the rich (Ethelston 1994:2).

In addition to family planning, population redistribution has been an important part of Egypt's population policy as well. The Egyptian government has attempted to redistribute the population through the resettlement of people to reclaimed lands and to desert cities. However, these projects have been unsuccessful. Reclaimed lands have been degraded by mismanagement and the lack of control of chemical, pathological, and biological sources of pollution (Bishay 1992:50). Bishay (1992:53)
estimates that 5-6 million acres of newly developed desert land will be needed by 2025 to accommodate the excess population, and this would be impossible because there would not be enough water. The desert cities, like the 10th of Ramadan, have attracted some settlers because they are cleaner, quieter, and safer than Cairo and have better housing. The 10th of Ramadan, however, which was built to accommodate half a million people only has a population of 15,000 (BBC 1993). Egyptians have criticized the new cities for being a Western style solution that do not take traditional values into account. Resettled people feel detached from the family and the community structure and interaction present in the cities and villages which they say are more alive (BBC 1993). It is important to recognize the link between people and social space just as it is important to link family planning with traditional values.

Summary

As can be gathered from recent environmental data, rapid population growth is having devastating effects on Egypt's environment. However, development programs, such as the Aswan Dam, implemented to counteract the socioeconomic effects of population growth, have instead led to environmental catastrophe and are beginning to negatively affect the country's economic viability. The most negative factor in environmental degradation, however, is the lack of public awareness. If the lack of environmental resources is used as a reason to promote family planning, it will not succeed if people are unaware of the problem and believe its merely another government trick. This illustrates the lack of systemic thinking and cooperation in planning between the bureaucratic sections of Egypt's political system.

Health Implications

Introduction

Because family planning involves the control of reproduction, primarily by artificial means that can have minor to major effects on the body, the promotion of
contraceptives should be integrated with overall health care. Unfortunately, because the majority of contraceptives must be used by women who often have little status, the physical side effects of contraceptives may not be taken seriously. Because modern contraceptives have been developed and tested in industrial countries, little is known about the different types of side effects which may affect women living in developing countries who are more likely to be malnourished and suffer from more health problems.

In the case of Egypt, family planning has not been promoted as part of health care but rather as a solution to national economic problems. Many Egyptians remain unaware of the health risks of repetitive pregnancies, poor hygiene, and sexually transmitted diseases. In this section, I will discuss the negative implications this approach to family planning has had on Egyptian women and how it has contributed to a fear of contraceptives and the neglect of women's health overall.

Childbearing

Childbearing is dangerous for women, especially when done frequently and combined with poor health conditions, uncertain nutrition, and poor medical care (Jacobson 1987:19). Yet women's health before, during, and after pregnancy are essential for the development and well-being of their children and cannot be over-emphasized.(Jacobson 1987:19).

Ninety-nine percent of maternal deaths occur in developing countries (Jacobson 1987:19), and the maternal death rate remains high in Egypt where repetitive and closely spaced pregnancies are prevalent, especially in rural areas. According to the World Bank (1993:83), babies born in Egypt within 18 months of the last birth have triple the risk of dying than if they were born 18-24 months after the previous birth. In an early 1980s survey, approximately 35 percent of the female respondents believed that the interval between pregnancies should be less than 24 months (Moustafa et al. 1981:377). Most of these women were from the lower classes, and according to a more recent study, economic standing was found to be an important factor in child survival (Casterline et al. 1992:257). Casterline et al. (1992:257) found that children from the upper third of the income distribution had a
35 percent greater chance of survival.

Prevailing medical opinions favor spacing pregnancies to allow restoration of the mother's health, safeguard the health of the baby, and enable the mother to breastfeed without the added burden of a new pregnancy (Omran and Standley 1981:40). Although lower birth intervals are related to higher rates of prematurity, low birth weight, neonatal mortality, and lower physical and intellectual development of children, studies have shown that these health risks are greatly reduced through increasing birth intervals and limiting the number of pregnancies (Omran and Standley 1981:42-47).

Pregnancy wastage also increases with the number of pregnancies, especially after five births and is greater among women under age 20 and over age 35 (Omran and Standley 1981:160). Of 4,861 women respondents in an Egyptian survey, 46.2 percent had lost live-born children. Of these women 29.7 percent lost one to two children, and 16.5 percent had lost 3 or more. It was also found that the women who had higher losses had a greater number of pregnancies (Omran and Standley 1981:312-314). According to Omran and Standley (1981:30), some of the health risks associated with high parity in developing countries include mortality and morbidity from hemorrhaging, sepsis, toxemia, rupture of the uterus, and anemia. High parity is also linked to gynecological problems such as prolapse, cervicitis, cervical erosion, and cervical cancer (Omran and Standley 1981:30).

However, when over 5,000 Egyptian men and women from both urban and rural areas were asked to give their opinion regarding the advantages of having a small family, 76.3 percent believed a small family would be less of an economic burden while only 29.7 percent believed it would give parents the opportunity to provide better health care and nutrition for each family member (Tadros 1984:34). Only 7.9 percent of the respondents believed a small family would be healthier for the mother because of the reduced housework demand, and only 3.1 percent believed that fewer births would improve a woman’s health (Tadros 1984:34). This reveals an extensive lack of public health awareness, especially regarding women's health. It also supports the previous argument that children are perceived as an economic advantage rather than a disadvantage.
Infant and Child Morbidity and Mortality

Egypt was the first developing country to supply potable water on a national scale, and it has a higher per capita number of doctors, nurses, clinics, and medicine than most other developing countries (El-Katsha et al. 1989:1). Yet its rate of infant mortality remains as high as those countries with less sophisticated health care infrastructures, and diarrheal disease is still reported as a major cause of death (El-Katsha et al. 1989:1). Rural and lower class children tend to have the highest mortality rates with 65 percent of child deaths occurring before the age of five (Omran and Standley 1981:196-197). A greater number of child deaths also occur when the mother is under the age of 25, revealing the importance of women's education in family health care (Omran and Standley 1981:196-197).

Parasitic disease, eye diseases, and malnutrition are also prevalent among both children and adults. In a survey of 2,612 urban and rural Egyptian children, all were found to be anemic, and 66.9 percent of the rural children and 50.1 percent of the urban children had parasitic infections (Omran and Standley 1981:232-237). The same survey also revealed that the reporting of childhood fevers or diarrhea by mothers decreased with increasing family size (Omran and Standley 1981:236). In other words, as the number of children in a family increased, women had less time to take children to a physician or clinic, resulting in poorer health for the children.

This level of poor health is due to the poor living conditions found in rural villages and lower class urban neighborhoods where there is no system for waste disposal, trash is thrown into the streets and canals, and latrines and sewage systems are often backed up in both villages and cities. Public awareness about the connection between proper hygiene and health is also low. In a survey of two Delta villages, women were found to have their own popular beliefs about the cause and treatments of disease (El-Katsha et al. 1989:86). For example, drinking too much cold water or eating too many sweets is the cause of diarrhea, and although most of the women had learned about rehydration salts from television, they preferred to use home remedies unless the salts were specifically prescribed by a doctor. Unfortunately, the mothers usually waited several days before they took a sick child to the doctor, and often it was too late (El-Katsha et al. 1989:87).
Health and Contraceptives

Poor health can also be a very large barrier against the adoption of contraceptive use and continuance of use. Physicians who are not adequately trained in reproductive and women's health and are not fully knowledgeable about all aspects of contraceptives may actually do more harm than good. Medical histories, pelvic exams, and other medical tests are essential to improving the health of women to insure minimal side effects through the use of contraceptives. This requires sensitivity on the part of physicians, especially rural male physicians who may have women patients who feel it is improper for a male doctor to examine a female patient.

Although they cause few side effects, barrier methods such as condoms, cervical caps, diaphragms, contraceptive sponges, along with spermicides, and natural family planning methods, such as the rhythm method, have not been promoted in Egypt. According to Mhran (1989:23), barrier methods and natural family planning methods are not preferable because they are not as reliable as the pill or IUD, and they interfere with normal sexual relations perceived as necessary in marriage. Both cervical caps and diaphragms are also less convenient because they require pelvic exams in order to be properly fitted. Contraceptive sponges are more convenient because they do not require physical exams, but they require initial moistening with water, an unsafe proposition for women who do not have easy access to clean water.

Because of their greater reliability, the IUD and the pill have received the most support from the Egyptian government and are the most widely available contraceptives in Egypt. The IUD has the advantage of requiring little thought or planning and allowing spontaneous sex. On the other hand, it requires insertion by a trained person, and there is a risk of breakthrough bleeding, ectopic pregnancies, pelvic infections, and allergic reactions to copper with ParaGard (Copper T380A) type IUDs (Policar et al. 1992:15-16). Breakthrough bleeding and lengthy menstruation are drawbacks in Muslim society because Muslim men are forbidden from having intercourse with women when they are bleeding. Some Egyptian women with IUDs are also at greater risk of pelvic infections, such as pelvic inflammatory disease (PID) if they have been exposed to parasitic diseases and other infections.
The birth control pill requires more education and discipline in order to use it properly. It also has more side effects and should not be used by women who are lactating, smoke, have heart disease, high blood pressure, blood clots, liver disease, diabetes, cancer, gallbladder disease, mononucleosis, or sickle cell anemia (Boston Women's Health Book Collective 1984:240-241; Policar 1992:11). It is very important, therefore, for a woman interested in the pill to be examined and questioned by a knowledgeable health worker, to be counseled on how to take them correctly, and to be told what to do if certain side effects appear. Oftentimes, side effects such as weight gain, headaches, depression, spotting, or nausea can be controlled by merely switching to a different type of pill. Thus in order for the pill to be most effective, the many different types of pills produced should be available, and health care workers should be knowledgeable about the various types and be able to prescribe the right type for each particular patient according to her health status and lifestyle. The pill does have a number of advantages which include the regulation and shortening of the menstrual period, a decrease in menstrual cramps, a decrease in iron deficiency anemia, and it may offer some protection against ovarian and endometrial cancers, ovarian cysts, and benign breast tumors (Policar 1992:11). The newer low-dose pills are in fact being touted by Planned Parenthood as being "much safer than pregnancy" (Policar 1992:11).

Poor counseling, education, and supplies have contributed to pill failure and discontinuation rates among Egyptian women. It has been documented that pills are often taken incorrectly. Women will take them every other day or only when they have sex, or they may take them all at once (Entwisle et al. 1988). This can increase side effects, not to mention the risk of pregnancy. Improper medical attention and counseling can also be dangerous for poor women who may have infections or diseases that will make taking the pill unsafe. For example, the pill may be a dangerous choice of contraception for women with schistosomiasis, a common parasitic disease among rural Egyptians which attacks the liver. The poor nutrition of some women is also a factor to consider because the pill increases a woman's nutritional requirements (Boston Women's Health Book Collective 1984:244).

Norplant and Depo-Provera injections are more convenient than the pill because they cannot be misused. Norplant can provide contraception for up to 5
years with 99.8 percent reliability, but it can cause prolonged menstrual periods and spotting between periods (Findlay 1990:59). Depo-medroxy progestrone acetate (DMPA), better known as Depo-Provera, is an injectable contraceptive that lasts for three months and has been used successfully in many developing countries. It is as reliable as the pill but can cause the same side effects as the pill and Norplant including weight gain, hair loss or gain, depression, irregular or heavy periods, and cannot be used by lactating women (Boston Women's Health Book Collective 1984:248).

Breastfeeding is the most highly effective natural contraceptive and is very acceptable and highly encouraged in Egypt to promote birth spacing. The Koran specifies that there should be 30 months of breastfeeding between children. As more and more women begin working outside of the home, however, breastfeeding becomes a less reliable form of birth control. Women should be made aware of what other sources of birth control can be safely used as a backup method while they are breastfeeding.

Egypt is one of the few Islamic countries which allows abortion but only in the case of fetal abnormality, rape, incest, or to save the life of the mother (Jacobson 1991). There is a concern in Islamic nations that clandestine abortions are fairly frequent and may be an explanation for high maternal mortality rates (Weeks 1988:24). Egyptian women do get illegal abortions for various reasons including economic hardship (Abaza 1987:96; Inhorn 1994:504). Safe abortions, on the other hand, can be had in Egypt by middle and upper class women who can afford it, or they can go abroad to get an abortion (Inhorn 1994:504; Zenie-Ziegler 1988:105). Poorer women who have many children will often resort to overworking, carrying heavy loads, or falling down stairs, and if that does not work they will call on a local midwife (Abaza 1987:96) In many cases women will suffer hemorrhaging, infections, and even death (El-Mallah 1978:58). If a woman in Egypt dies in the hospital after attempting an abortion at home, the persons responsible are sought out and interrogated, making women reluctant to seek competent medical help in cases of infection after an abortion (Lynch 1984:43).
Condoms and STDs

Condoms, which in addition to contraception provide the best protection against STDs have not been strongly promoted in Egypt because of their association with STD prevention and the Islamic belief that sexual relations between spouse should be uninhibited. AIDS has been present in Egypt since at least 1986 and even though the numbers of cases has been growing steadily, awareness has not. The number of AIDS cases in Egypt was estimated at 29 in 1993 (WHO 1994:1). The number of HIV positive people was estimated to be 307 in 1994 (Miles 1994:35) while another report claimed that 178 Egyptians had died from AIDS that same year, 167 Egyptians were infected with the HIV virus or had AIDS, and 227 infected foreigners had been deported from the country (Reuters 1994:1). The Ministry of Health maintains that 60 percent of the HIV infected Egyptians were infected by blood transfusions received in the Gulf states while most of the others contracted the virus through heterosexual relations (Miles 1994:36).

Overall, the numbers of people infected with the HIV virus are low compared to the numbers found in other countries, but there is growing concern that the number of HIV and AIDS cases in Egypt has been extremely underreported (Miles 1994:36). Infected people may be unaware that they are infection or afraid to approach physicians or family members due to sexual taboos regarding pre-marital, extra-marital, and homosexual sex. Egyptian men and women who are having sexual relationships with foreigners are especially at risk because they do not know about the dangers. They may spread the virus to their spouse once they marry and then to their children.

The Egyptian government has launched a health awareness campaign to educate the population about the dangers of AIDS (Reuters 1994:1). The program itself, however, is so hung up on sexual taboos that they are denying there is even a problem to deal with. As Miles (1994:36) reports,

"Sawson El Sheik, spokeswoman for the Egyptian Aids Society, goes as far as to say that homosexuality does not exist at all in Egypt and that so-called 'illegal sexual relationships' (meaning sex outside marriage and non-consensual sex) are 'limited.' Such relationships, she argues, contradict the teachings of Islam, therefore they don't happen."
A recent seminar on AIDS held in Cairo by the Islamic Organisation for Medical Science also upheld the reasoning that Egypt is quite free of AIDS because Muslims follow Islamic teachings (Miles 1994:36).

In actuality, drug use is on the rise in Egypt (Shannon et al. 1991:9), prostitution exists and is increasing among poor women (Zenie-Ziegler 1988:107), pre-marital and extra-marital relationships occur by the thousands behind closed doors, and an increasing number of Egyptian men are having homosexual relationships because they cannot afford to get married until they are in their 30s (Miles 1994:36). European homosexual men have reported that discreet homosexual behavior is tolerated and frequently occurs in Islamic countries (Schild 1992:182). Prostitution, which has only been illegal in Egypt since 1949, is also quite discreetly present and although the Egyptian government continues to deny the existence of prostitution, the Ministry of Social Affairs has run a rehabilitation program for prostitutes since 1960 (Zenie-Ziegler 1988:106-107). More recently the sex trade has been reinstated for the benefit of rich Arab visitors from the Persian Gulf and wealthy Egyptians and draws upon lower class girls and village girls who migrated to the city only to end up in poverty (Zenie-Ziegler 1988:106). These rich Arab clients from the Gulf countries also use prostitutes in places such as East Asia where AIDS is spreading at an overwhelming pace.

Nonetheless, Egypt's AIDS campaign is making some progress, regardless of the fact that it is sidestepping the subjects of "deviant" behavior and offering only vague advice. The campaign, which is headed by the Ministry of Health and the Ministry of Education with help from the WHO, is primarily targeting heterosexual married couples and Egyptians traveling out of the country. Television, radio, and newspaper messages warn against the dangers of extra-marital sex, and leaflets for travelers warn against having "illegitimate and unsafe sexual contact" (Miles 1994:37). More promising are the booklets which have been printed for school children which do include a small message about the ability of condoms to provide some protection against the disease (Miles 1994:37). In addition, a telephone helpline that provides frank details about HIV/AIDS has received thousands of calls (Miles 1994:37). The Ministry of Health, however, believes promoting condom use is
"unthinkable" because it does not conform to the prevailing social code and would offend too many people (Miles 1994:37).

**Family Planning and Health Care**

Egypt's population policy, driven by impending demographic disaster, has failed to connect family planning with health care and has failed to promote it as a reproductive right rather than merely a part of the political agenda. Instead the program has been clinic and supply-oriented, driven by improving the statistical use rate of contraceptives in order to reach specific fertility goals. Following the Western urban model, Egyptians have been expected to hear or read about contraceptive methods through the media, make their own choice about what method would be best, and then go to the nearest pharmacy or health care facility to obtain a method.

Yet family planning, primarily based in Egypt's government public health care clinics, has been mismanaged and inefficient. The staff that are present do not understand rural traditions and do not treat their rural patients with the respect, personal care, and attention that they need, leading people to prefer traditional healers and midwives. Some rural women are not only unable to rely on these clinics for quality family planning services, but also do not rely on them for pre-natal and post-natal care or other health services unless there is an emergency. Women may receive no information regarding nutrition, hygiene, and infant and child care, often leading to disaster in the form of maternal deaths, miscarriages, stillbirths, child deaths, and feelings of inadequacy and shame. Even when information is available, if it is in written form, it is of little use to the majority of women who are not literate.

More importantly, women are not receiving proper medical examinations and counseling to determine which contraceptive methods are best for them. Instead, they are obtaining contraceptives without the detailed knowledge regarding reproduction required to make well-informed choices. Maher Mahran (1989:23) has stated that, "Counseling is one of the main pillars of family health and an important component of family life education. Indeed, family planning services cannot be effective without good counseling, and a woman who comes for this service should not be regarded as a patient." Today, however, only an estimated 33 percent of rural
Egyptian women live in communities that have a family planning field worker (World Bank 1993:83).

Summary

The lack of regard for women’s health and reproductive health in general has only contributed to the lack of trust in Egypt’s formal medical system. Better basic health care for Egyptian women is essential to raising health standards, and family planning motivation cannot be separated from health conditions or from expectations for child survival (Lynch and Fahmy 1984:47). Combined with the lack of community-based family planning and development projects, the lack of extension workers and the alienation of traditional healers have all contributed to the failure of Egypt’s family planning program.

Essentially, Egypt’s government family planning program has failed to take into account the whole health profile of Egyptian women. It has ignored the fact that birth control is a health issue and the fact that many contraceptives are not simple to use and can cause serious physiological problems. Much of this approach lies in the problem that contraceptives were developed in the West for Western women. Most of what is known of both the positive and negative health effects of contraceptives has been derived from North America and Europe, and direct extrapolation from experience in industrialized countries to other settings might well prove inappropriate (Jiggins 1994:154). Egyptian women suffer from nutritional and other health problems which are not as prevalent in industrialized countries. By failing to take these health factors and the opinions of contraceptive users into account in the planning and implementation process, Egypt’s government has promoted the view that population control is more important than good health. This has led to distrust by rural women and has further bolstered Islamist political arguments against family planning.
Sustainability

Introduction

The final section of this evaluation deals with the subject of sustainability. Sustainability, or the continuance of the program after implementation, is a requirement for program success. Family planning programs must be sustained as a permanent service in order to obtain long-term population goals and to progressively improve health. If the program cannot be sustained or the services fluctuate in quality and accessibility as Egypt's program has, population growth will continue to grow rapidly or will stabilize at a rate that is still too high, aiding further in the progression of socioeconomic, political, and environmental problems.

Sustainability

It is true that Egypt's population program has resulted in a drop in the overall fertility rate, and population growth has decreased. However, as stated by Findlay and Findlay (1987:76), "Family planning policies, while they may appear to be modestly effective in reducing rates of population growth, do not remove the problems of under-development." By adopting a western form of family planning and modern contraceptive methods, Egypt has become dependent on western countries for funds and contraceptives for their family planning services. This greatly affects the financial sustainability of Egypt's program. For example, USAID was supplying birth control pills to Egypt's Family of the Future (FOF) program at very low cost during the 1980s. The FOF program came to an end in 1990, however, when USAID stopped supplying contraceptives. In addition to the supplies that are donated, Egypt will have to buy pills from other countries at a higher cost and charge customers more or they will have to manufacture their own supplies. Egyptians are therefore dependent on the government and its economic ties with other countries in order to receive a steady supply of contraceptives. The manufacturing of their own contraceptives would provide Egyptians with jobs, the cost could be controlled and the profit would stay in Egypt. Also Egyptians might be more receptive to using...
modern contraceptives if they were manufactured at home, and were providing jobs for Egyptians.

The program is also overly-bureaucratic and governed by an innumerable number of ever changing government agencies. Often these administrators have little knowledge of family planning and have a multitude of tasks before them, some which may seem much more important than family planning. Except for a few failed attempts, the program has not been integrated into development strategies, and it is based on a biomedical health care model which requires a sophisticated health care infrastructure. Because of the heavy government control of the program, few non-governmental or volunteer grassroots projects have been allowed to exist although they are growing in number. The government has preferred to staff their clinics and hospitals, especially in rural or poor urban areas, with reluctant urbanites who have little respect, understanding, or patience for rural traditions. Furthermore, extension and social workers, specially trained in family planning methods, have received little support while traditional midwives have not been used to the program's advantage.

Even though governmental support for family planning is essential to its continuance, and the program through sheer demand will be sustained in some form for years to come, Egypt's policy needs to be restructured and reoriented toward the current and potential users of family planning. Economic inequities and poor resource management are equally important detriments to the success of family planning. The Islamic health clinics are a good example of a grassroots model which has succeeded where the Egyptian government has failed. These clinics are cognizant of what the people, especially the poor, need and want, they are compatible with cultural beliefs and values, and they promote social solidarity and a sense of community.

Summary

Egypt's national family program is not sustainable because: (1) it is centralized and relies heavily on fluctuating foreign aid, thereby decreasing its stability, (2) it is inefficient and has been mismanaged, and (3) it has not been integrated with other socioeconomic development efforts. In addition, it is not
sustainable because it has not considered all of the issues surrounding family planning in a systemic and holistic way. As presented in this evaluation: it has focused on the wrong beneficiaries and clients who have a direct impact on program outcome; it has violated cultural logic; and it has not improved social solidarity, economic autonomy, political conflicts, ecological harmony, or health care. In order to become sustainable, Egypt's family planning program will have to promote regional and community-based programs which are less reliant on foreign aid and national politics and can be integrated with local belief systems, health care, environmental and health education, and economic development projects that will better the socioeconomic condition of Egyptians.
CONCLUSION

Although the economic and ecological theorists may never come to an agreement as to whether or not the world is facing an overpopulation disaster or what particular cause of population growth should become the new population paradigm, what is certain in the case of Egypt is that there is a demand for family planning services that exceeds the supply. Although the fertility rate has been declining, there is clearly much room for improvement. The Egyptian government has, to its credit, supported the right to family planning services and the use of contraceptives, and it is well-known that government support of family planning greatly aids in its success (Findlay and Findlay 1987; Sadik 1991). However, the process by which the Egyptian government has formed and implemented its population policy has lacked some important features required for an efficient, equitable, and sustainable program.

While political leaders have been concerned with larger issues, such as overpopulation, urbanization, and economic growth, many Egyptians have approved of and have supported family planning not because of the larger issues, but because it benefits their personal lives in some way. For Westerners, the limitation of family size is usually a personal choice based on various reasons including household economics, employment, health, and emotional variables. It has little to do with concern for the national debt or the greater good of the planet. Therefore, it is absurd to expect people in the developing world to think, unlike ourselves, that they must limit their family size because of overpopulation or to benefit the current political administration. However, calculations based on global and Egyptian demographic show that if the expressed needs of all men and women who want but do not yet have access to information, services, and contraception were to be met, then the rate of continuing contraceptive use would be sufficient to achieve the United Nations’ medium range population projection (Jiggins 1994:149).

For all its good intentions, Egypt’s population policy has taken a contraceptive-led, target-driven approach that is overly centralized and overly dependent upon the current political agenda. This has unnecessarily made it a convenient target for political opposition groups and has alienated traditional and
poor Egyptians whose lives have not been bettered from a socioeconomic standpoint by merely using some form of birth control. Furthermore, the program has focused on family planning as merely a means to an end, population control, rather than integrating family planning into the health care system.

Another way of viewing family planning in Egypt is as a technology transfer problem. Not only has a process for formulating population policies been transferred that is deficient on many counts, but the technology itself (contraceptives) have been improperly marketed, the technical assistance (training for health care providers and counseling for users) has been less than necessary, the types of contraceptive technologies marketed were not developed with Third World health problems in mind, and the primary source of the supply is dependent on the government and foreign aid donors. There is a great need for the development of new types of contraceptive technologies and a need for in-depth medical research on the physiological effects of contraceptives on women in developing countries. This may boost incentives for more scientific research on contraceptives, especially in the private sector, in both industrialized and developing nations. In sum, first world contraceptives have been improperly translated into third world contexts.

Providing both women and men with the services and choices they want is more likely to maintain Egypt's fertility decline. This includes not only a reorientation of family planning services, but improved health care, and a substantial increase in other types of socioeconomic development projects. If an evaluation of this type serves any purpose, it is to provide policymakers and program planners with supplemental qualitative information and a synthesizing analysis that will heighten awareness of program inefficiencies and flaws which are not clearly apparent in raw quantitative data and non-holistic ethnographic data. This evaluation demonstrates the need for policymakers and planners to be aware of and sensitive to:

- the social unit which will most greatly benefit from the program and/or influence program outcome;
- the cultural views and beliefs of clients, providers, and policymakers;
- traditional health care practices and practitioners and how they might be best included in the process;
- social and economic stratification and its impacts on program outcome;
• political and social conflicts and how to minimize their negative impact on program outcome;
• the health status of the clients and implications for the modifying and adjusting programs to local health conditions;
• the educational needs of clients and providers and how to best address those needs.

What has also become clear is that Egypt’s own population policymaking process needs to be restructured to include more holistic and qualitative research and client participation in the development and implementation of programs. In addition, Egypt’s population policies and programs should be implemented in coordination with participatory development. This would require a restructuring of their development policies. Without this integration, the program will not diminish women’s (or men’s) dependency on children as a source of status and security, and it will further degrade the environment by causing the poor to utilize whatever resources necessary to meet their demands. The program also places the blame for population growth squarely on women and the poor to the exclusion of their roles as producers in the development process while at the same time expecting them to solve the social and economic problems they “created.”

“To date, far more has been spent to curtail women’s fertility than to improve their health and productivity” (Jacobson 1992:13). This is especially true in Egypt where health care and development projects, especially those that will benefit women and rural Egyptians, are insufficient. The important role of women in agriculture in Egypt and their socioeconomic difficulties, while supplying the state with much of its agricultural produce, has been ignored as part of the economic development equation. Until agriculturalists can be guaranteed economic security that does not rely on support from their children, only then will birth control be viewed as a benefit by this sector. Likewise, without facilitating an understanding of the relationship between responsible family planning and women’s health, many Egyptians will continue to be denied essential information to make sound decisions about having children.
Specific Recommendations

Specific recommendations for changes in Egypt's population policy and family planning program that resulted from this evaluation are as follows:

- A restructuring of the policymaking process that takes into adequate consideration the social, economic, political, environmental, and health contexts of most Egyptians.

- The integration of family planning services with primary and reproductive health care. The elimination of government-run clinics which are not used and/or are mismanaged so that money can be both redirected toward those types of family planning services which have been successful and can be used to increase subsidies for contraceptives for poorer Egyptians. Greater government support for family planning programs sponsored by NGOs and PVOs.

- The acceptance, legal legitimization, and inclusion of traditional midwives, dayas, in family planning and health care programs, both as outreach workers and service providers.

- Expansion and improvement of the raidat rifiat program including their training as development workers as was originally planned and training in preventive health care.

- A more reliable supply of all types of contraceptives and educational outreach to provide consumers with the information required to make informed decisions about which contraceptives would be most useful for their needs. The expansion of contraceptive manufacturing within Egypt.

- Improved education for family planning and health care providers regarding proper counseling techniques, the proper use of contraceptives and other birth control methods, side effects, and other health implications of birth control alternatives.

- An increase in participatory regional and community development efforts including water and sanitation projects; literacy programs; health programs; education, training, and credit programs for women; and environmental and resource management programs, together with explicit linkage of these efforts with family planning.

The new population paradigm of the United Nations favors reproductive health and the empowerment of women over "population control." Since Egypt's population policies have evolved according to global trends in population research
and goals, it is expected that Egypt will soon be announcing its new Reproductive Health/Family Planning Program. Hopefully, this will be a positive step toward integrating family planning into Egyptian health care, making it more acceptable to traditional Egyptians and political and religious factions. This will only be effective, however, if the program is planned and implemented in such a way as to include participation by the beneficiaries and traditional and biomedical health care workers, include a change in focus from an individualistic emphasis on women to an emphasis on family and community, and include integration with other socioeconomic development programs. It will not succeed if it directs attention toward health care as a sector of society separate from the whole cultural system complete with its traditional and religious beliefs, social and economic stratification, political conflicts, economic dependencies, and environmental problems.
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