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GENDER ASSESSMENT OF THE USAID/EGYPT HEALTH PROGRAM

AUGUST 2010

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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.

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EXECUTIVE SUMMARY

This report is the result of a gender assessment conducted for USAID/Egypt in preparation of their bridge strategy in health, which will run from 2011 to 2015. The Gender Assessment was conducted by a two-person team composed of Deborah Caro, a gender and reproductive health specialist based in the U.S., and Soumaya Ibrahim-Hubner, a gender and organizational development specialist based in Egypt.

USAID/Egypt is in the process of preparing a bridge strategy that will transition it from the end of its current strategy to its next phase, which is under discussion with the Government of Egypt. As part of this transition, the Office of Health and Population requested a gender assessment to inform their new programs. This gender assessment was prepared to examine how gender had been integrated into three of the Mission's programs: Health Systems 20/20 (Abt Associates), Takamol (Pathfinder International), and Communication for Healthy Living (Johns Hopkins University/Center for Communications Programs) and suggest ways to improve gender integration in the future. The gender assessment team also conducted two half-day gender trainings for the health and population team.

This report provides information on key issues on gender and health in Egypt as they relate to the Mission's program. It synthesizes information from personal interviews and meetings conducted during two weeks in country, an extensive review of project documents, and data sources and literature on health and gender relations in Egypt. As requested by the Mission, the team provided both program-specific and more general analysis and recommendations to provide USAID with the parameters to more effectively integrate gender in its programs and to address gender inequalities at a policy level.

Objectives of the Assessment

The objectives of this gender analysis were to identify key gender-based constraints to equitable participation and access to three of USAID/Egypt's health programs, provide specific recommendations on strategies for increasing accessibility and equity of the programs, provide recommendations to improve the Mission's health partners' operational practices and programmatic mechanisms in support of gender equality, and propose indicators for measuring gender-related impacts. Separate gender analyses were conducted for avian influenza programs and the other Mission sectors.

Methodology

The assessment team conducted this gender assessment using participatory approaches, including meetings with beneficiaries and interviews with USAID staff, grantees, and governmental, donor, and nongovernmental officials in each sector. The team made several site visits to the three program offices to discuss gender integration in their activities. They also visited communities receiving support from Communication for Healthy Living and Takamol. In combination with these processes, the team also reviewed project documents and consulted the literature on gender, gender-based violence, and female genital mutilation/cutting (FGM/C) in Egypt.

Summary of Key Gender Issues

Women's and men's different roles, normative behavior, and identities may restrict or facilitate their access to and use of health services, prevention of illness, and risk of morbidity and mortality. In Egypt, these differences are based on unequal control over resources and power, which result in women's and girls' lower social status and restricted rights and in turn, unhealthy practices and outcomes, including

- High-risk sexual behavior and increased exposure to sexually transmitted infections (STIs) and HIV;

- Limited access by both women and men to family planning services and use of contraceptive methods;
- Reduced access for women and their newborns to skilled providers during pregnancy, childbirth, and postpartum; and
- Increased experience of violence and practices that are harmful to girls' and women's physical and psychological health (USAID and National Council for Women, 2009).

Conversely, countries with greater gender equality have lower overall poverty rates. According to the 2009 Global Gender Gap Report (Hausman et al., 2009), when countries reduce gender inequality, they benefit from increased productivity and economic growth. Although Egypt ranks 126 out of 132 on the Gender Gap Index, it has made significant gains in sub-indices measuring women's relative economic participation and opportunity, as well as labor force participation, which reportedly has increased from 22 percent to 26 percent. Also, women's estimated earned annual income increased from US\$1,635 to US\$1,963 in the last five years. Women also constitute a greater share of professional and technical workers, legislators, senior officials, and managers. Additionally, Egypt, along with other countries in the Middle East, has been successful in reducing the gender gap in health education. Egypt ranks 117th on the girls education sub-index, 85th on the infant mortality rate, 58th on the total fertility rate (TFR), and 81st on the maternal mortality ratio (MMR).

Nevertheless, there are persistent gender inequalities in Egypt that continue to contribute to poor health outcomes of women and children, in particular, but that also affect men's health. Unequal power relations based on gender within families; communities; and health, education, judicial, and economic institutions also affect women's capacity to make optimal decisions about their healthcare and the prevention of illness for themselves and their children. For instance, the 2008 Demographic and Health Survey (DHS) reported that only 21 percent of ever married women had knowledge of danger signs during pregnancy and childbirth. Despite very public mass media campaigns and community-based interventions, 91 percent of married women ages 15–49 have undergone FGM/C. A recent survey of young men and women ages 15–29 reports that 71 percent of males and 49 percent of females believe that a girl must obey her brother even if he is younger. Young men also adopt gender behaviors that put them a risk of poor health, such as smoking.¹

Cross-Project Issues

The team reviewed each project and made recommendations for improving current activities, which vary according to the specific objectives and interventions of CHL, Takamol, and HS 20/20. All three programs were attempting to engage both men and women in activities, some of which included a focus on the relationship between men and women. There were also indications that some of these activities were having a positive influence on health outcomes, but as no data were collected on gender outcomes, it was impossible to draw any evidence-based conclusions about how women's empowerment, men's engagement, and youth social mobilization activities were contributing to health and equity outcomes. The assessment provides specific strengths and weaknesses of each project, as well as project-specific recommendations.

There were some findings that applied across all three programs. In general, the Gender Assessment revealed that the design and implementation of gender activities are not based on a gender analysis. The programs tend to focus on high-profile issues, such as FGM/C, without directly addressing the underlying gender inequalities behind these practices. The programs do not routinely report on gender-specific objectives, indicators, and benchmarks. The assessment found implementers to be positively focused on

¹ These are preliminary results from the Population Council and the Egyptian Cabinet Information and Decision Support Center. 2010. *Survey of Young People in Egypt: Preliminary Report*. Cairo: Population Council, Inc.

linking gender issues to achieving health outcomes, yet they lack the means to measure the extent to which health outcomes are improved by gender-focused activities. Even when projects collect sex-disaggregated information on indicators, they seldom analyze or report on the information, making it difficult to track gender-specific progress and changes. Finally, there is little emphasis on addressing practices based on differences in power, such as gender-based violence (GBV), sexuality, and unequal power within households and communities. The team saw opportunities to engage women and men, and adolescent boys and girls in addressing GBV through more participatory and advocacy-oriented actions at the community and district levels.

Some key entry points include taking greater advantage of setting quotas for the percentage of women's participation in Community Development Associations (CDAs) and other leadership roles; working more intensely with men on gender-equitable norms and to influence changes in FGM/C and early marriage practices; and increasing work with healthcare providers on gender-equitable norms as part of quality of care and treatment of each other to increase job satisfaction.

Recommendations

Global Health Initiative (GHI)

- Conduct a gender analysis as part of all new activity designs by making use of gender analysis tools and expertise, especially within Egypt.
- Integrate gender considerations in all health programs based on the findings of gender analyses.
- Improve research on and monitoring and evaluation (M&E) of gender by incorporating sex- and age-disaggregated data and gender-specific indicators into performance monitoring plans. Expand research on the relation between gender equality and health outcomes by submitting select project interventions to operations research protocols.
- Focus on adolescent girls and boys as equitable future partners.
- Involve both women and men in program design and M&E.
- Work more closely with governments to support gender equity by incorporating gender equality goals and gender health equity objectives into national strategies, health policies, and financing.

Structural/organizational changes

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- Include gender-specific objectives in Requests for Proposals/Requests for Applications and ask respondents to explicitly link gender and health objectives while measuring both outcomes independently.
- Encourage more regular collaboration on gender across projects and with other donors, nongovernmental organizations (NGOs), and government organizations as a learning process.
- Take advantage of GHI to take more of a life-cycle approach to programs, including a stronger focus on life skills planning for adolescents and an emphasis on health and engagement of older men and women.

Projects

- Gender issues should be incorporated into baseline data collection and analysis and M&E. This may require that key personnel have gender expertise or that a dedicated gender expert be on staff. In addition, projects should implement gender training for their staff.
- Encourage more deliberate and evidence-based linking of gender and culture in program design, moving beyond stereotypical explanations of practices. Projects should also take a more participatory approach to gender issues in communities.

- Gender should not just be a focus of activities within villages; it should also be part of quality of care and management training among providers and administrators and between providers and clients.
- Child health interventions should have a gender focus to ascertain differences in treatment and outcomes.
- Work with men should address gender-specific health issues related to men's social roles, such as stress, STIs, and accidents. Projects should stress a more equitable approach to gender relations.

ABBREVIATIONS

AC	AskConsult (program)
ANC	Antenatal care
AWSO	Arab Women Speak Out
CDA	Community Development Association
CEDAW	Convention on the Elimination of Discrimination Against Women
CEWLA	Center for Egyptian Women's Legal Assistance
CFRR	Center for Reproductive Rights
CHL	Communication for Healthy Living Project
CPR	Contraceptive Prevalence Rate
DAWAR	Village-based Men's Group
DHS	Demographic and Health Survey
EDHS	Egyptian Demographic and Health Survey
EONC	Emergency Obstetric and Neonatal Care
EWSO	Egyptian Women Speak Out
FGM/CFGM/C	Female Genital Mutilation/Cutting
FLE	Family Life Education
FP	Family Planning
GBV	Gender-based Violence
GDP	Gross Domestic Product
HIO	Health Insurance Organization
HIV	Human Immunodeficiency Virus
HS 20/20	Health Systems 20/20
ID	National Identity Card
IGWG	Inter-agency Gender Working Group
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MMR	Maternal Mortality Ratio
MOFP	Ministry of State for Family and Population
MOH	Ministry of Health
MSH	Management Sciences for Health
NCCM	National Council for Childhood and Motherhood
NERP	Nutritional Education Rehabilitation Program
NGO	Nongovernmental Organization
NHA	National Health Account
NMMSS	National Maternal Mortality Surveillance System
OB/GYN	Obstetrician/Gynecologist
PHC	Primary Healthcare Center
RH	Reproductive Health
SIS	State Information Service
SO	Strategic Objective
STI	Sexually Transmitted Infection
SYPE	Survey of Young People in Egypt
TFR	Total Fertility Rate
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
UNIFEM	United Nations Fund for Women
VHC	Village Health Committee

I. METHODOLOGY

The gender assessment was conducted by a two-person team consisting of Deborah Caro, a U.S. gender and reproductive health specialist, and Soumaya Ibrahim-Hubner, an Egyptian gender and organizational development specialist. The team spent two weeks between February 28 and March 12, 2010, interviewing USAID program managers, project staff, and gender and health experts in government, nongovernmental, and donor organizations. They reviewed project documents and Egyptian literature on health, gender, FGM/C, and GBV.

During the two weeks, they made two field visits, one to Fayoum in Upper Egypt with the Communication for Healthy Living (CHL) Project and another to Talkha district in the Dakahlia Governorate in Lower Egypt with the Takamol Project. Both visits gave the team the opportunity to speak to a wide range of local stakeholders, including men, women, and adolescent boys and girls who have participated in project activities, healthcare providers, community and district leaders, and community health workers and group facilitators.

During the course of the two weeks, the team also conducted two half-day gender workshops for the USAID health staff, which included the curriculum in the Inter-Agency Gender Working Group (IGWG) Gender 101 module and components of the Constructive Engagement of Men and the Gender-based Violence modules.

II. CONTEXT: KEY ISSUES AND ACTORS ON GENDER AND HEALTH IN EGYPT

Summary of Key Gender and Health Issues

Countries with greater gender equality have lower overall poverty rates. According to the 2009 Global Gender Gap Report (Hausman et al., 2009), when countries reduce gender inequality, they benefit from increased productivity and economic growth. Similarly, investments in girls' education translate into lower fertility rates; lower infant, child, and maternal mortality rates; increases in women's labor force participation rates and incomes; and increases in household educational investments in children (World Bank, 2007). On a programmatic level, accumulating information from evaluations indicates that addressing gender in programs improves reproductive health outcomes (Rottach et al., 2009).

Egypt, along with other countries in the Middle East, has been successful in reducing the gender gap in education and health. Egypt ranks 117th on the girls education sub-index, 85th on the infant mortality rate, 58th on the total fertility rate (TFR), and 81st on the maternal mortality ratio (MMR). Nevertheless, girls still lack equal access to education at all levels, except at the university level where they represent a greater percentage than boys. There are strong correlations between number of years of schooling and positive reproductive health outcomes and use of family planning. High educational attainment of both parents is the factor most protective of girls against FGM/C (Hassanin, 2008, p.28)

Women's employment in Egypt has a direct impact on their health—those not employed in the formal sector do not have access to health insurance, even if their husbands are so employed. Participation in the labor market, even in the informal labor market, increases women's access to and control over financial resources, thus expanding their access to and choice of healthcare. Income also increases a woman's ability to invest in the health and education of her children. The overall unemployment rate among young adults is 16 percent, with the rate for girls/young women almost three times (32%) that of boys (12%). Only 13 percent of young women are in the formal workforce, compared with 61 percent of young men

(USAID and National Council for Women, 2009, p. 13), even though young women now represent 56 percent of university students in the country.²

Although Egypt ranks 126 out of 132 on the Gender Gap Index,³ it has made significant gains in sub-indices measuring women's relative economic participation, opportunity, and labor force participation. Over the last five years, women's participation in the formal sector workforce has increased from 22 percent to 26 percent, and women's estimated earned annual income increased from US\$1,635 to US\$1,963. Women also constitute a greater share of professional and technical workers, legislators, senior officials, and managers but still lag behind men by 3 to 1, and on average, women's earned income is 25 percent of men's. For comparable work, women's wages are 20 percent lower than men's.

The rationale for addressing gender in reproductive, maternal, and child health programs has been to enhance health outcomes for women and girls, as well as boys and men. While at present there are numerous sociocultural factors that limit health equity for all in Egypt, no set of cultural practices are homogeneous or unchangeable and, even in greatly unequal gender systems, there is always room for negotiation and change. Power and sexuality are important dimensions of gender inequalities that must be at the center of any analysis of gender relations and taken into consideration in designing programs. This report identifies both current gender-based constraints and opportunities for change.

Gender-based Constraints and Barriers to Family Planning and Reproductive and Maternal Health

Women's and men's different roles, normative behavior, and identities may restrict or facilitate their access to and utilization of health services, prevention of illness, and risk of morbidity and mortality. In Egypt, as in most societies around the world, these differences are based on unequal control over resources and power, which result in women's and girls' lower social status and restricted rights and in turn, unhealthy practices and outcomes, including

- High-risk sexual behavior and increased exposure to STIs and HIV;
- Limited women's and men's access to family planning services and use of contraceptive methods;
- Reduced access for women and their newborns to skilled providers during pregnancy, childbirth, and postpartum; and
- Increased experience of violence and practices that are harmful to girls' and women's physical and psychological health (USAID and National Council for Women, 2009).

The *Shadow Report* from the Center for Reproductive Rights (CFRR) (according to the Convention on the Elimination of Discrimination Against Women, or CEDAW) highlights some of the areas of continuing concern in maternal health grounded in gender inequality. The report cites the 2007 National Maternal Mortality Surveillance System, which indicates that 72 percent of maternal deaths in Egypt occurred in health facilities. This shows that more than a quarter of women who experience life-threatening complications are still not even arriving at healthcare facilities, and that those who do are not

² The list of authors and contributors to this document is quite lengthy. The Preface lists the following contributors: Dr. Hoda Rashad, Dr. Sahar El-Sheneity, and Dr. Mulki Al-Sharmani (Social Research Center at the American University of Cairo); Dr. Fatima El-Zanaty and Associates; Dr. Sara Loza, Dr. Iman Soliman, and the research team (Social, Planning, Analysis, and Administration Consultants; SPAAC); Nihad Abu Komsan (Egyptian Center for Women's Rights); Dr. Enas Abu Youssef (Women and Media Center at Cairo University); Amina Shafeek, Dr. Adel Abdel Ghaffar, and Mafouz Abdel-Rahman; Samah Shah, Gihan AbouZeid, Susan Somach, Jerome Gallagher, Garrett Dorer, Lisa Marie Chavez, and additional team members in Cairo and Chemonics in Washington, DC (Combating Violence against Women).

³ The Gender Gap Index is a composite of different indices comparing men's and women's relative economic participation, educational attainment, health and survival, and political empowerment.

benefiting from high-quality practices, as the same survey shows that 81 percent of women who die in childbirth die of avoidable factors (Center For Reproductive Rights, 2009, p. 4).⁴

According to international human rights agreements, these problems represent a violation of women's right to a safe pregnancy and birth and the right to high-quality emergency obstetric and neonatal care when complications arise. Also of concern is that only 57.4 percent of rural women have access to adequate antenatal care, as compared with 80.5 percent in urban areas. The 2008 Demographic and Health Survey (DHS) also reported that only 21 percent of ever married women had knowledge of danger signs during pregnancy and childbirth. In addition, there appears to be no national monitoring of standards for postabortion care. There is also little indication of immediate access to contraceptive methods for women receiving postabortion care. Recent policies supporting integration of obstetric and family planning (FP) services in primary healthcare centers may address the access issue in the future.

Recent evidence of high discontinuation rates and the plateau since 2005 of the contraceptive prevalence rate (CPR) for modern methods at 60 percent also raise questions as to some researchers' conclusions that FP programs without explicit gender interventions are sufficient for achieving lower fertility levels. However, there are still serious access barriers to family planning, including limitations on women's access to health insurance and some user fees in public health facilities. The 2008 DHS reports that 44 percent of the surveyed women stated that a lack of funds prevented them from seeking treatment for a health problem, and 40 percent said that they did not seek care because a female provider was not available.

The persistence of gender-based barriers to both maternal and reproductive health/family planning highlights the critical need for monitoring and evaluation of the attributional effects of gender-integrated health programs. It is not enough to provide programming on multiple levels while measuring only health outcomes. Also, is not enough to measure women's empowerment and men's engagement activities only by assessing changes in women's agency and decisionmaking or men's more equitable attitudes and actions; programs need to determine whether gender-integrated programs actually will lead to better and more sustainable health outcomes, even if each one is a legitimate end in its own right.

Adolescents, Sexual Education, and Early Marriage⁵

Adolescents in Egypt are subject to health and economic constraints and opportunities in highly gendered ways. A recent survey of more than 15,000 Egyptian youth ages 15–29 (Population Council and the Egyptian Cabinet Information and Decision Support Center, 2010, p. 8) reveals that boys are at higher risk of ill health from smoking (26%) than young women. Four in five girls are circumcised, although incidence appears to be declining among younger girls 10–14 (66%) compared with older women in the cohort ages 22–29 (93%). Regardless of age, the majority of girls and young women (56%) and boys and young men (93%) had not discussed puberty-related changes with their families. This is particularly true of both boys and girls in the poorest quintile (80%) as compared to those from families in the wealthiest

⁴ The poor practices included inappropriate use of oxytocin contributing to ruptured uteri; lack of routine blood pressure monitoring of women admitted to hospitals, resulting in missed cases of eclampsia and pre-eclampsia; and lack of management of the third stage of labor, resulting in failure to prevent postpartum hemorrhage. In addition, according to the DHS, the C-section rates in both public and private sector facilities are higher than 30 percent (El-Zanaty and Way, 2008). This is twice the international standard necessary for responding to obstetric and neonatal emergencies, which has an upper limit of 15 percent. In addition, 55 percent of women delivering in hospitals left prior to 24 hours postpartum, only 33 percent of hospitals had adequate supplies for normal deliveries, and only 18 percent of those facilities targeted to deal with complications were adequately supplied.

⁵ This information on adolescents comes from the Survey of Young People in Egypt (SYPE). The findings cited here are taken from the Preliminary Report, which was published in February 2010]. A full report is due out in August or September 2010. The survey and the preliminary report provide sex-disaggregated information on virtually all indicators.

quintile (65%). Adolescent girls and young women ages 15–24 also experience high rates of sexual harassment from strangers (42%) and, among unmarried girls, sexual initiation is often coerced (Bruce, 2007).

There are many ways in which early age of marriage affects girls' health and well-being throughout the lifecycle. In Egypt, not only do about a third of girls marry before the legal age of 18—and the number is even higher in rural areas—but they also tend to marry partners who are 5–10 years older. Early marriage signifies early pregnancy and childbirth, which in turn correlates with higher risks for obstetric and neonatal complications. Women who marry at an early age are also likely to experience spontaneous abortions, lose a fetus or infant late in pregnancy, and have more pregnancies over their lifetime than women who marry in their twenties. The Youth Survey (SYPE) reports that 63 percent of married women in the age group 15–21 have one child and 29 percent have two. Few newly married women use family planning. According to the SYPE, 72 percent of married women ages 15–17 had never used family planning. The babies of very young mothers are more apt to be underweight, and these mothers have higher rates of still birth. In Egypt, only 23 percent of women who are married and under the age of 20 use contraception, compared with the average of 60 percent CPR for all married women.

Girls who marry older partners⁶ have less decisionmaking power in the household than older women, especially as new wives. They tend to have less mobility and consequently less access to health services and information. Many married adolescent girls have limited or no peer networks, restricted social mobility, low educational attainment (and virtually no schooling options), and limited access to modern media and health messages (Erulkar et al., 2004, cited in Bruce, 2007).

In general, the messages promoted by USAID-sponsored programs in Egypt have stressed that early marriage leads to the health and educational consequences of early pregnancy for girls. These are important messages, which appear to be taking hold, especially among the fathers of adolescent girls. Girls now appear to have more choice about their prospective marriage partners. Fathers also expressed that their premarital discussions with potential marriage partners for their daughters include inquiries about whether their prospective sons-in-law are willing to allow their new wives to continue their schooling.

Surprisingly, SYPE finds that young people's attitudes toward gender roles are highly inequitable and, in some cases, more so than their parents, as indicated by the 2008 Egypt DHS (for DHS, see El-Zanaty and Way, 2008, pp. 37–45; 202–206). Table 1 shows some of these gender roles and attitudes.

Although USAID/Egypt does not plan to continue its current HIV activities under the new Bridge Strategy, high levels of migration and changes in sexual behavior, especially in urban areas, argue for increasing knowledge of HIV among young people. The SYPE found that 34 percent of females ages 10–29 have never heard about HIV/AIDS. In rural areas, 34 percent of all youth have not heard about HIV/AIDS. Adolescent girls in rural areas have the least accurate HIV knowledge.

⁶ SYPE finds that more than 40 percent of women are married by age 24, while only 6 percent of men are married by that age.

Table I. Gender Roles and Attitudes⁷

	Sex	Agree %	Disagree %	Don't Know %	Total %
Educating boys is more important than educating girls	M	35.0	64.3	0.7	100
	F	13.9	85.4	0.6	100
Boys should do as much domestic work as girls	M	27.2	72.3	0.4	100
	F	41.0	57.9	1.1	100
A girl must obey her brother's opinion even if he's younger than she is	M	71.1	28.4	0.5	100
	F	49.1	49.8	1.1	100
The husband alone mainly should decide on how household money is to be spent	M	61.5	38.1	0.4	100
	F	37.3	61.4	1.3	100
A woman should obtain her husband's permission for most things	M	86.0	13.7	0.4	100
	F	74.7	24.4	0.9	100
Girls/woman who are harassed deserve it if they are dressed provocatively	M	79.6	19.9	0.5	100
	F	72.9	26.3	0.8	100
Even though Shari'a (Islamic Laws) grants girls/woman the right to inheritance, in some cases girls should not get their share so as to keep the money in the family	M	8.4	88.3	3.3	100
	F	14.2	84.0	1.8	100
When the girl works, she will get better marriage opportunities	M	31.8	65.6	2.5	100
	F	46.8	49.8	3.5	100

Gender-based Violence

The Egypt Violence against Women Study (USAID and National Council for Women, 2009) and the 2008 Egyptian Demographic and Health Survey (EDHS) demonstrate that physical violence is widespread within Egyptian social institutions, including families, schools, and workplaces.

Several critical issues were identified and presented by the CEDAW Coalition at the CEDAW Committee Pre-session meeting on November 10–14, 2008. The reports pointed to recent progress in addressing violence against women by raising community awareness about the magnitude and breadth of the phenomenon. There has also been noticeable growth in programs and services and advances in protection through the passage of new laws, including the amendment to the Child Protection Law that criminalizes performance of FGM/C by medical and traditional practitioners.

This progress is evidenced concretely by

- Establishment of an Ombudsman office, with branches in some governorates, to receive women's complaints. Most of the complaints are about gender-based violence;
- Establishment of many shelters (state and nongovernmental organizations);
- Extensive efforts to address the issue of female genital mutilation (state and nongovernmental organizations) and the criminalization of FGM/C (the new Children's Code);

⁷ Population Council and Egyptian Cabinet Information and Decision Support Center, 2010, p. 21.

- Raising the age of marriage (new Children's Code); and
- Efforts of the Coalition of NGOs to work on a draft law to criminalize domestic violence.

In spite of progress in some areas, women continue to experience GBV, possibly at a greater rate than in the past, as indicated by increased incidence of reported sexual harassment.⁸ In addition, punishment for reported cases often is lenient, as a result of the considerable discretion that judges (all of whom are men) are allowed in sentencing based on anti-rape, anti-trafficking, and anti-incest laws. The penal code, Article 17, gives a judge the right to minimize verdicts with no limitations.

Over the last several years, the number of women fleeing domestic violence in shelters and rehabilitation centers has increased, as has the number of complaints to the Ombudsman's office. In response, the Coalition of NGOs has requested the following changes in policy:

- Criminalization of sexual harassment, whether in the workplace, educational institutions, or on the street;
- Criminalization of domestic violence, which is still considered a private matter that is not recognized in the law;
- Criminalization of institutional violence against women, with no statute of limitations;
- Enforcement and strengthening of penalties for violence against women during different stages of electoral processes;
- Expanded provision of services with funding for women victims/survivors of violence by the state, and NGOs, such as shelters; psychological rehabilitation services; treatment services (including the testing of sexually transmitted diseases, emergency contraception, and pregnancy tests); and training for service providers; and
- Legalization of abortion in cases of rape and incest.

During the CEDAW meetings, the Center for Egyptian Women's Legal Assistance (CEWLA, 2009) highlighted other issues for concern and the need for policy reform. These include forms of violence that are based on institutionalized social practice, such as the following:

- Honor killings
- Depriving women of inheritance
- Inequality under the Nationality Law
- Sexual violence towards women
- Female genital mutilation/cutting
- Rape and incest

Honor killings: Although not universally accepted, the murder of a woman accused of sexual impropriety at the hands of her family still occurs. Sentencing of honor killings is lenient and carries a short sentence often based on the judge's personal beliefs rather than the penal code.

Depriving women of inheritance:⁹ Because of women's severely limited economic opportunities, the denial of a women's right to inheritance can bar any chance of economic independence from either her natal family or her husband upon divorce or his death. Although Islamic Laws clearly state, "Women and Men have the same rights and duties," families pressure women to cede their inheritance to their brothers, and those who refuse may be perceived to have committed "a crime" or "dishonored" their own

⁸ It is often hard to tell whether increased reporting of violence signifies an increase in its occurrence or women's greater willingness to report GBV.

⁹ A member of the gender assessment team was informed that the National Council for Women is preparing a legislative proposal that would strengthen women's capacity to exercise their rights to inheritance, but they had not issued a draft of the legislation at the time of the gender assessment report.

reputation and that of the family. The notable outcome of this discriminatory practice and violation of rights is that women represent only 2.7 percent of all landowners in Lower Egypt, 9.3 percent of landowners in Upper Egypt, and 6.4 percent of the total landowners in the border provinces.¹⁰

Inequality under the Nationality Law: Previously, children of Egyptian women married to non-Egyptian men were denied citizenship, while the children of Egyptian men married to non-Egyptian women were citizens. In 2004, Act No. 154 amended the Nationality Law, making all those children citizens who are born to an Egyptian parent married to a non-Egyptian parent. However, the children of Egyptian mothers married to Palestinians continue to suffer from difficulties in the implementation of the law; this impedes the children's access to Egyptian nationality. In 2003, the President of the Republic of Egypt instructed the Minister of Interior Affairs to facilitate the naturalization procedures for children of Egyptian women married to foreigners, according to certain guidelines and conditions. The exceptions are children with special needs and the children of Egyptian women married to Palestinians, on the grounds that this is a decision of the Arab League created to preserve their Palestinian identity. When Law No. 154 of 2004 was issued to amend the Citizenship Act, it provided the legal precedent for eventually eliminating exclusion of children of Egyptian women married to Palestinians so as to achieve equality before the law, especially as there is no formal decision issued by the League of Arab States and nothing in Egyptian law to prevent dual nationality.¹¹

Sexual violence toward women: Sexual violence is “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship with the victim[survivor], in any setting, including but not limited to home and work” (United Nations Fund for Women [UNIFEM], www.endvawnow.org). It includes touching or intended physical contact, telephone calls or messages with a sexual content, through mobile phones or Internet, written or oral. Sexual harassment can also occur within an unequal power relation; for example, when a man or woman demands sex in return for a work promotion.

Sexual harassment is not defined in the Egyptian penal code. It falls broadly under Articles 268 (indecent assault, by force or threat, or attempted assault), 278 (indecent and shameful public acts), and 279 (indecent acts with a woman anywhere). Therefore, to qualify as a crime, it must meet the evidentiary requirements of a sexual assault or rape. Recently, a judge in Cairo made a path-breaking decision to sentence a man to three years hard labor for repeatedly groping a woman on a city street, and awarded the victim about \$900 in damages. However, Egyptian law does not provide for an order of protection to shield women from known perpetrators (e.g., husbands, other family members, or acquaintances) and Egyptian labor laws do not address harassment or violence in the workplace. If a physical or sexual assault occurs, its prosecution falls under the penal code (USAID and National Council for Women, 2009, pp. 41–42).

Incest: A field study conducted by the Center for Egyptian Women's Legal Assistance in the Sohag Governorate (CEWLA, 2009, p. 15) found that 39.3 percent of the study sample reported were experiencing sexual harassment from a male relative or relatives. Women interviewed for the study reported multiple forms of incest:

¹⁰ The State Department's 2006 International Religious Freedom Report (<http://www.state.gov/g/drl/rls/irf/2006/71420.htm>). states, “Inheritance laws for all citizens are based on the Government's interpretation of Shari'a. Muslim female heirs receive half the amount of a male heir's inheritance. Christian widows of Muslims have no automatic inheritance rights, but may be provided for in testamentary documents.”

¹¹ It was only a recommendation to give the Palestinians in any Arab country Palestinian citizenship rights for their particular circumstances so they could be protected from occupation and expulsion from their homeland. Nevertheless, the exclusion continues.

- Sexual harassment by touch (47.2%)
- Verbal sexual harassment (25%)
- Visual sexual harassment (22.2%)
- Rape (5.6%)

Results of the study show that sexual harassment by a close relative is most likely to be perpetrated by the husband's brother (36.1%); a sister's husband (13.8%); a brother, a cousin, or husband's uncle (8.3%); a paternal uncle, maternal uncle, or father-in-law (6%); and least likely by the father, the son, or a mother's cousin (2.8%).

These figures underline the pervasiveness of different forms of GBV within both the domestic and public spheres of life, and demonstrate the breadth and seriousness of GBV-related crimes.

Female Genital Mutilation/Cutting

Female genital mutilation/cutting is a common practice in Egypt, where, according to the EDHS 2008, 91 percent of women ages 15–19 have been subjected to genital cutting. Over the last 15 years, women's organizations, international donor organizations, and the Egyptian government have made numerous efforts to address this issue. The overall impact of these efforts is not yet totally clear, but there are indications from the 2008 EDHS of a change in attitude and in practice among the population since 2000. At that time, the overall rate of FGM/C for ever-married women was 97.3 percent, which means the rate has declined about 6 points in almost 10 years. The most notable decline is among ever-married women ages 15–19 (from 99.1% to 80.7%) and ages 20–24 (97.4% to 87.4%).

Attitudes with regard to intention to circumcise a daughter have also changed. In 2000, 75.3 percent of ever-married women reported supporting the continuation of FGM/C, while in 2008 that percentage had dropped to 63 percent. Men's attitudes are quite similar to women's. Interestingly, both women and men underestimate the other's opinion on continuing the practice. A significant proportion of women (45%) and men (60%) continues to believe that the practice should continue because husbands prefer their wives to be circumcised. Slightly more than a third of both men (38%) and women (34%) believe that FGM/C prevents adultery. Not surprisingly, a greater percentage of women (48%) than men (32%) state that FGM/C can lead to a girl's death and that it leads to complications in childbirth (EDHS 2000, Chapter 14 and 2008, Chapter 15).

In 2008, the Egyptian government issued Law No. 126, amending some provisions of the Children's Act. This new law included Article 242, which criminalizes performing FGM/C with a penalty of imprisonment of not less than three months and not more than two years, or a fine of not less than one thousand pounds and not more than five thousand pounds. This applies to anyone who performs the operation on a young girl or young woman. There is still no compelling evidence that the amended law has had a significant impact on FGM/C, especially in Upper Egypt (Hassanin, 2008, p. 30).

Until recently, many programs designed to eliminate FGM/C have concentrated educational messages on the health and psychological risks of FGM/C for girls. Mass media and community mobilization messages publicized the adverse health consequences and encouraged parents to cease the practice out of concern for their daughters' health and well-being. This approach did not always have the desired effect of stopping FGM/C, and in some cases simply moved parents to seek out medical professionals to perform the operation under clinical conditions. In addition, local activists and program implementers have worked with religious leaders to highlight the message that FGM/C is not mandated by the Koran or Bible and continuing the practice is not part of being a good Muslim or Christian.

The beliefs that lead people to continue FGM/C are varied, and implementers cannot address each one individually. In other countries in the region, the most successful approaches have involved inquiries into the local meaning of the practice, coupled with engaging communities in a dialogue about potential health risks and religious beliefs. By focusing on the meaning and importance of FGM/C to the people who practice it, programs and countries have had success in finding alternative practices that still address the cultural significance of FGM/C.¹²

Further areas where programs may find success in eliminating the practice include the following:

- Harnessing the influence that mothers, grandmothers, mothers-in-law, fathers, and prospective husbands have on women and their choices by making them champions for giving up the practice.
- Addressing GBV and FGM/C more extensively in nursing and physician training. USAID has just completed and introduced a new pre-service curriculum that include the topics, and in-service training on FGM/C for doctors in all governorates is now underway.
- Working with mothers and fathers of boys to decrease demand for the wives of their sons to be circumcised. Conversations in communities and with experts at organizations working on FGM/C indicated that parents and boys who do not demand that their future spouses be circumcised are less likely to circumcise their daughters and sisters.

III. USAID'S HEALTH PROGRAM

The current USAID/Egypt Office of Health and Population strategy was slated to end in 2011, but a bridge strategy is in place that will potentially enable activities until 2015. The bridge strategy will operationalize the Global Health Initiative (GHI), with a special emphasis on a female-centered approach for women and girls. The GHI builds on evidence that a focus on gender equity in the context of health programs results in stronger and more equitable health outcomes. At the core of the GHI is an approach centered on women and girls that entails the following:

- Conducting a gender analysis as part of all new activity design
- Integrating gender considerations in all health programs
- Improving research and M&E on gender
- Focusing on adolescent girls
- Involving both women and men in program design and M&E
- Working more closely with governments to support gender equity

The USAID/Egypt Office of Health and Population bridge strategy will focus on five governorates in Upper Egypt. Activities will build on Egypt's progresses over the past 30 years but will focus on addressing under-served populations for which there still are gaps in maternal and child health and family planning indicators (the poor, women with little or no education, and select geographic areas). There will be a greater focus on sustainability and appropriation by the Ministry of Health (MOH) and the Ministry of State for Family and Population (MOFP) at the governorate and district levels.

The current portfolio consists of approximately 22 different activities. The Mission requested the gender assessment to focus on three major projects—Health Systems 20/20 (HS 20/20), CHL, and Integrated Reproductive Health Services (Takamol)—plus a number of other smaller activities. The three projects support strengthening different dimensions of the health system. HS 20/20 focuses on integrating health financing with governance and operations initiatives to build national capacity for long-term sustainability of the health system. CHL is a cross-cutting communications program that aims to improve family

¹² The most notable example of this is the Tostan Program in Senegal, but there are other examples in Kenya, Burkina Faso, and other countries. (Evaluations of these experiences are available at <http://www.popcouncil.org/topics/FGC/Mc.asp#/Resources>.)

planning, reproductive and maternal health, and avian influenza prevention, as well as change high-risk and harmful practices, such as FGM/C, early marriage, and smoking. The Takamol Project promotes an integrated model for strengthening maternal/child health, family planning, and reproductive health services. In conjunction with the MOH, it works to strengthen human resource capacity at the level of district hospitals and primary healthcare centers. Both Takamol and CHL strengthen health governance and accountability at the governorate, district, and community levels and improve access to and use of health information at all levels of the health system.

Over the course of the two weeks, the gender assessment teams met with program implementers to review the different activities focused on addressing gender inequalities. The strengths and weaknesses of each project are reviewed separately. In addition, the team analyzed how gender is addressed as a cross-cutting issue across USAID health programs, the health system, and at a national level in Egypt to identify some of the major advances, challenges, and opportunities for the future.

Review of Findings by Program

I. Health Systems 20/20

Brief description

Health Systems 20/20 is a five-year leader with associate cooperative agreement (2006–2011) managed by USAID’s Global Health Bureau (USAID/GH), which offers USAID-supported countries help in solving problems in health governance, finance, operations, and capacity building. Health Systems 20/20 integrates health financing with governance and operations initiatives. This integrated approach focuses on building capacity for long-term sustainability of system strengthening efforts. The project acts through global leadership technical assistance, brokering and grant making, research, professional networking, and information dissemination.

USAID/Egypt requested technical assistance from Health Systems 20/20, led by Abt Associates, Inc., to support the MOH’s efforts to strengthen key dimensions of the health system, including financing, human resources, and monitoring quality of care. The project builds on 10 years of USAID assistance to health reforms in Egypt through the Partners for Health Reform (PHR) and Partners for Health Reform Plus (PHRplus) projects (1997–2006). In September 2008, Health Systems 20/20 opened a local office in Cairo to manage a three-and-a-half year \$10 million project focusing on the following technical areas:

- *Workforce Planning*: Develop a long-term workforce plan for the MOH and establish a sustainable workforce planning program.
- *National Health Accounts (NHA)*: Produce NHA estimates for 2007–08 and 2008–09 and institutionalize NHAs as a routine exercise to monitor health system performance.
- *Health Insurance Organization (HIO)*: Build the HIO capacity as a payer to expand health insurance coverage.
- *Preventive Care Assessment Study*: Review the sustainability and institutionalization of USAID’s investment in the preventative care sector.
- *Cash Transfer Benchmarks*: (1) Develop a verification plan based on discussions with the relevant stakeholders that meet USAID’s legal requirements for cash transfer disbursements. (2) With MOH support, assess the MOH’s ability and means to meet the benchmarks.
- *Case Study on Health Sector Reform*: HS 20/20 is preparing a case study of health reform in Egypt in response to a request from the MOH to USAID/Egypt.

Activities on gender

Currently, the project has no specific gender-focused activities. The gender assessment team spent time with the project staff exploring different opportunities for assessing and addressing gender within the

context of their programmed activities. The team met with each work group to discuss potential gender issues that relate to their work.

Entry points and opportunities

Workforce planning: The MOH currently does not have an effective internal workforce planning mechanism. HS 20/20 is working with the MOH to address some of the current challenges of the health workforce, including excess capacity in some facilities, imbalances in the distribution of the workforce by both specialty and health facilities, and the less-than-optimal quality of pre-service training. The newly formed MOH/HR Taskforce, with support from HS 20/20, is developing a computerized analytical tool that will allow the MOH to assess the need for human resources at hospitals and primary health facilities according to need and demand of the population. The tool will help to assess

- The current supply and distribution of the workforce by age, sex, and years of experience by specialty;
- An estimate of the real supply needed according to workload indicators; currently, there are estimates by hospital but not department (the methodology for this calculation is being developed); and
- Analysis of supply and demand for medical staff, technicians, and administrators.

HS 20/20 analyzed 10 medical departments and evaluated how much time should be spent by people in each area of medical specialty. The capacity-building component involved determining which types of healthcare workers and specialties are needed to improve functioning of health facilities in a cost-effective and sustainable manner for delivery of quality services. The analysis also assesses how to structure an incentive system to ensure quality performance, retention, and promotion of people within the system.

There are a number of potential gender-related implications of the workforce analysis that have not been incorporated sufficiently into the HS 20/20 analysis, although the project staff expressed interest in trying to address them. There is little research or knowledge on the status of women within the health workforce; the main known characteristic is that it is doctor dominated. Although all ministries, including MOH, have a gender opportunity office, most people interviewed had no idea of its function.¹³

In the last five years, universities and technical schools have begun admitting men to nursing programs and in some cases are experiencing such demand for spaces that they must limit male enrollment.¹⁴ Although men are still a minority of all nurses, gendered patterns in the division of labor are quickly emerging in the nursing workforce. Most nurses trained at the technical level, most of whom are women, take on many non-nursing activities such as delivering x-rays and blood from one place to another in hospitals. Men nurses tend to gravitate toward orthopedics, operating room positions, and ambulance jobs, where they are needed to lift and move patients.

Salaries for men and women in nursing are the same, except that men appear to be more able to work overtime or work two jobs, while women are limited to one shift per day because of their household domestic work obligations.¹⁵

¹³ During the assessment, the team was not able to locate this office, as no one contacted in the MOH could point the team to a specific individual to speak to in the gender opportunity office.

¹⁴ The gender team discovered that in some non-university nursing schools, such as in Luxor, men are accepted into nursing school classes once every three years, although this is not a national policy.

¹⁵ The Mission recently funded a new modestly sized activity carried out by Management Sciences for Health (MSH) to train nurses in management skills and supervision through enhanced infection control measures. Currently, 95 percent of nurses are women, but that is changing. The primary focus of the new activity will be on hospital nurses, but the Mission is considering expanding the activity to include health center nurses.

During conversations with HS 20/20 staff, the Head of Nursing, and the Director of Hospital Nursing at the MOH, the gender assessment team identified the following gender issues for workforce rationalization as those that potentially may affect female and male health workers differently:

1. **Mobility:** Are men and women equally able to leave their home and families to work at a facility far from home?
2. **Advancement:** What is the process for getting promoted? What characteristics or criteria are valued for advancement, and are they equal for men and women? Why are there no women who are heads of medical departments of hospitals?¹⁶
3. **Seniority:** Is seniority based on time (i.e., months, years) or number of hours worked? Do men, who are often assigned to work longer hours, then gain seniority more quickly?
4. **Pay:** Men and women in the same category have different earning opportunities even if their base salary or hourly rates are the same. Men have more opportunity for overtime because of women's non-remunerated/household obligations and issues around safety (especially working at night).

Preventive care assessment study: The assessment examines the impact of USAID and MOH investments in select programmatic areas and the prospects for sustainability. HS 20/20 is collaborating with the MOH in evaluating the performance of three main MOH preventive health programs: family planning, maternal and child health, and infection control. The study will examine and provide feedback on the effectiveness, efficiency, equity, and sustainability of these programs. It will include data collection from about 60 healthcare facilities. The assessment provides the opportunity to explore gender issues that affect the quality of care and gender-based constraints to access under the new model. There are some indications that the integration of family planning with other health services has decreased the use of FP services. It would be useful to assess whether this integration has created additional gender-based access barriers.

Case study of health sector reform: This study focuses on the following six areas of services:

- Implementation of health reform
- Upgrading of ambulance services
- Upgrading of nursing education programs and strengthening of existing services
- Piloting of insurance and service reform (e.g., Suez Pilot in Egypt)
- Evolution of the Family Planning Model
- Capacity building in health sector management

The major gender issues to consider with regard to the case study are how health sector reform has affected women's and men's access to services, their relative abilities to pay for services, and the quality of services for both genders. In addition, as discussed above with reference to workforce planning, it would be useful to examine the gender implications of upgrading nursing education programs and service to ascertain if this has resulted in expanded and equitable opportunities for both men and women. A similar question arises regarding capacity building in health sector management, particularly whether women have been afforded equal opportunity for training and promotion.

Recommendations

- For the Workforce Planning Process, incorporate an analysis of the prospective gendered impact of reductions and relocation of human resources within the health system. Some issues worth pursuing include the following:

¹⁶ This was a preliminary finding of the HS 20/20 analysis of the health workforce, according to interviews with HS 20/20 staff..

- Are there gendered patterns of segmentation in the health workforce, and if so, what is the cause (policies, prevailing gender norms about work, or other gender-based constraints, such as mobility, domestic responsibilities, or security)?
- Assess the different implications of a change in assignment for men versus women. Are women adversely affected more than men because of their greater roles and responsibilities for household chores and childcare?
- What are the implications of more men moving into nursing, particularly at higher skill levels (university-trained nurses) in terms of women's and men's opportunities for management positions and selection of shifts and areas of specialization?
- Assess why there are so few women occupying upper-level hospital management positions.
- Examine whether women and men with comparable training and years of experience have comparable earning capacity within the system and whether seniority confers equal access to benefits in terms of selecting better positions, health insurance, retirement, etc.
- How can improvements in the quality of the NMMSS be made?
- For the Preventive Care Assessment, focus on potential differences in satisfaction on the part of male and female clients. Ensure that women are interviewed apart from accompanying spouses about how they are treated and their preferences, so as to guarantee that the opinions given are the women's. Also examine:
 - Whether the sex of the provider matters in terms of client satisfaction.
 - Whether female or male providers differ in their practices (i.e., in the number and types of diagnostic tests offered in antenatal care or the quality of care).
 - Whether women and men incur different costs for the same procedures; different but comparable procedures; or medicines taken for chronic or long-term conditions (for instance, whether women who do not have an ID card are excluded from receiving free monthly supplies of drugs needed for long-term or ongoing care).¹⁷

Possible future lines of work for HS 20/20

The following points provide context on possible future areas of work for HS 20/20 and the potential integration of gender issues in those areas—which USAID might consider supporting. These areas build on HS 20/20's current work program.

Health insurance: If HS 20/20 has the opportunity to provide technical assistance on the new proposed law to provide universal health insurance for all families, it is prepared to assist with establishing the medical audit and financial management teams. The current law insures those employed in the formal sector and their children but not their spouses. Because most women in Egypt do not work or work only in the informal sector, women are much less likely to have health insurance than men. Men who work in the informal sector also are unlikely to have access to health insurance. Children who are in school are insured through a school-based insurance scheme. Out-of-school children with neither parent working in the formal sector are uninsured. This group is likely to comprise more girls than boys, as girls are more likely to be out of school. HS 20/20 has the opportunity to explore the gender implications of the current and future legal framework and assess whether there are ways to reduce discrimination against women who either do not work or work in the informal sector and out-of-school children, most of whom are girls.

- For the Insurance Consultation, first assess the implications of the new law for increasing or decreasing access for those groups currently excluded, especially women and men who do not work in the formal labor market, women who do not work at all, and out-of-school children who do not have a parent working in the formal sector (mostly girls, as girls constitute 80 percent of the out-of-school youth). Second, look at how insurance programs currently treat men's and women's health needs: Are they comparable and equal? For instance, do men and women have

¹⁷ This was an issue that came up during the Takamol site visit.

equal access to coverage for the same procedures and for different but comparable procedures? Are audits, particularly of maternal and neonatal deaths, applied with the same rigor as audits of cases where men's deaths are involved?

Improving information: the National Maternal Mortality Surveillance System: One area that merits further exploration according to the CFRR CEDAW Shadow Report is the quality of information collection, analysis, and reporting under the National Maternal Mortality Surveillance System (NMMSS). A reliable and functioning surveillance system is critical to supporting women's rights to safe pregnancy and delivery and access to emergency obstetric and neonatal care (EONC). The CFRR Report highlights weaknesses in the system (Center for Reproductive Rights, 2009):

- Lack of transparency: The MOH does not publish a complete dataset, only the MMR. There is no information about causes or geographical patterns of mortality within the country.
- Shortcomings in secondary analysis: No analysis is performed to demonstrate the relationship between education or poverty and maternal mortality.
- Disciplinary practices toward healthcare providers compromise the quality of the data: Policies that open providers to criminal liability are obstacles to conducting truthful audits and accurately reporting causes of death.
- Less precise information from rural areas: Data on vital events from rural areas are less reliable because collection methods are less rigorous and accurate.

National Health Accounts: One possible entry point for HS 20/20 in National Health Accounts and gender is to use the findings of the UNIFEM gender budgeting exercise to inform HS 20/20's work on National Health Accounts. The donor share of the health budget has declined considerably—from 4 percent in 1995 to 0.6 percent currently; and about 4.75 percent of the gross domestic product (GDP) is spent on health in Egypt.¹⁸ UNIFEM is financing a gender-budgeting exercise in Egypt to ascertain to what extent national investments and expenditures benefit women and men equally and are budgeted to address gender differences and inequalities. To date, the exercise has found that the proportion of the national health budget benefiting women is approximately 41 percent, which is slightly less than women's overall share of national accounts (43%). HS 20/20 has the opportunity to use the results of this budgeting exercise to assist the MOH and the Ministry of Finance to ensure that future budget allocations within the public sector benefit men and women more equitably.¹⁹

The UNIFEM budget exercise is looking at two dimensions of the health accounts. The first examines the health workforce, and the findings are relevant to the workforce analysis discussed above. The gender budgeting exercise examines the extent to which men and women are given equal opportunities in employment in the sector, including the right to occupy leadership posts, the right to promotion to all positions without discrimination, and access to training opportunities in Egypt and abroad. The second dimension of the gender-budgeting analysis analyzes the extent to which the budget addresses gender-based differences and needs, strengthens gender-equitable opportunities in the sector, and the gendered impact of public expenditures.²⁰ The overall objective of the budgeting exercise is to assess how budget appropriations affect the social and economic opportunities of men and women.

¹⁸ About \$100 per person in Egypt is out-of-pocket spending, which is about the highest in the region. In Jordan, 85 percent of people are covered by health insurance. In Egypt, 80 percent of healthcare visits occur in the private sector in Egypt, and 26 percent of health spending is on pharmaceuticals.

¹⁹ The source for this information is from three pages from UNIFEM without a reference or date, titled "Features of the Application of Budget Responding to Gender for Fiscal Year 2009/2010" from the Ministry of Finance.

²⁰ UNIFEM/Egypt. n.d. "Features of the Application of Budget Responding to Gender for the Fiscal Year 2009/2010."

- For National Health Accounts exercises, refer to UNIFEM’s work on gender budget analysis, currently underway with the Minister of Finance, to assess how national resources are allocated by sex and to what extent men and women benefit from public expenditures.



Photo courtesy of
CHL 2009 Annual

2. Communication for Healthy Living (CHL)

Brief description

“Healthier, Planned Families” is the Strategic Objective (SO) 20 through which USAID/Egypt contributes to the government of Egypt’s efforts to reduce population growth; reduce maternal and child mortality; prevent infectious and non-communicable disease; and strengthen prevention, detection, and responses related to avian and pandemic influenza. CHL is the principal SO 20 vehicle for affecting broad-scale behavior change across health areas.

Objectives

The CHL Project supports health communication and behavior change on a national scale through mass-media campaigns and at the community level through activities with local branch offices of the Ministry of Information, State Information Service (SIS), as well as MOH and MOFP outreach workers and through local NGOs (including CDAs.) Community outreach activities take place in select governorates and districts. In addition to working with the three implementing ministries, CHL also works with the private sector. Activities range from mass-media campaigns to community events and interpersonal communication at the household level.

CHL adopts a multisectoral approach in its operational structure; as part of a unified strategy at both national and local levels, CHL interventions integrate health areas in communications and social mobilization. The project organizes its components according to major partners, such as the public and private sectors and NGOs; in this way, each entails separate management and budgetary considerations. CHL has three main areas, with their corresponding objectives (see Table 2):

Table 2. CHL Project Result Areas and Objectives

	Result Area	Objective
A	Strategic Information and Coordination	To provide improved strategic information and coordination for an effective health communication program
B	Communication for Improved Health Outcomes	To increase adoption of health behavior and demand for health services, specifically <ul style="list-style-type: none"> ○ Family planning and reproductive health ○ Maternal and child health ○ Other public health threats (such as infectious disease—e.g., hepatitis; healthy lifestyles; non-communicable diseases—e.g., tobacco-related, breast cancer, heart disease) ○ Avian and pandemic influenza preparedness
C	Strengthened Capacity and Sustainability	To develop institutional, technical, and financial sustainability to implement health communication program in the public, NGO, and commercial sectors, as well as establish public demand for good health

CHL's Community Health Program: One aspect of the CHL Project is to improve the health of the people of Egypt through a community program that includes advocacy, empowerment, and alliance building to promote and facilitate greater participation by all sectors of communities in their own health and well-being. The project endorses community leaders through various activities that contribute to reaching specific health behavior objectives and strives to build a civil society to engage in a process of identifying and solving problems in communities. The overall approach positions health as an entry point for building civil society and civic participation at the local level, where each household is recognized as the producer of its own health.

To accomplish those objectives, the CHL community health program adopts the “Life-Stage Approach,” which segments the family according to age or stage-appropriate needs and addresses the household as a key decisionmaking unit. CHL uses an integrated health package that includes activities for newly married couples; FP counseling, safe pregnancy, birth preparedness, and postpartum home visits; and infant/child health and nutrition sessions. The Community Health Package messages include the importance of communication, ensuring safe pregnancy and delivery, proper postpartum care, neonatal and infant care, hygiene, and family planning and birth spacing. CHL and Save the Children are fully implementing the program with 212 community development associations (CDAs) in villages and communities through FY 2009.

Public Sector Support: CHL supports the public sector through technical assistance to the MOH, MOFP, and SIS. This includes technical assistance for specific health communication activities in areas of family planning/reproductive health (RH), maternal and child health (MCH), and infectious diseases. Strategic communication priorities are organized through the Executive Steering Committee in the MOH. It coordinates among all national stakeholders, e.g., the relevant MOH sectors (Healthy Mother/Healthy Child, Population/Family Planning, Infectious Disease and others, such as the Health Education Directorate), the SIS/Information, Education and Communications Center, MOFP, NGOs, and the private sector. Its goal is to coordinate health communication priorities, strategies, and programs for the MOH.

Private Sector Support – “AskConsult”: In addition, the organization’s technical assistance to the private/commercial sector program includes support for capacity building, planning, and implementation and direct support for activities designed to strengthen and promote the “AskConsult” private sector marketing association. CHL private sector interventions seek to engage the commercial sector as an active partner in the national health program. The objectives of the AskConsult (AC) program are to improve the quality of family health information and services in the private sector and to strengthen private sector sustainability.

AskConsult recognizes the significant role of the private health sector as a provider of services in the field of family health. The AC program seeks to increase the private sector’s role in achieving the government of Egypt’s goals in improving the health status of Egyptians. In Egypt, because of the respect accorded pharmacists and the abundance and accessibility of pharmacies, they are able to act as “walk-in health information centers,” with the pharmacist serving as a front-line healthcare provider for tens of millions of citizens. Pharmacists act as a source of health information and products as well as an important link referring family members to qualified physicians.

Strategically, AC is a unified health communication platform with multiple delivery systems. AC is implementing an integrated marketing communication campaign including TV and radio advertising, public relations events, the web, provider and client-educational materials, sales promotion visits, pharmacy training, and community outreach. CHL works with local subcontractors to implement integrated marketing communication campaigns promoting health products and services through the affiliate network of over 30,000 AC private pharmacies and doctors.

Activities on gender

The review of the CHL activities for the gender assessment is principally confined to review of the community components of the project. The limited time available for the gender assessment and training did not permit a more extensive review of project activities, particularly of the public and private sector mass media and social marketing components.

Establishment of a village health committee: Based on identified community needs, together with the Village Council and the Primary Healthcare Unit (PHC), the CDA forms a Village Health Committee (VHC), which develops activities designed to address the needs. The CHL-supported CDAs appear to draw heavily from input and participation from members of the more localized Dawar organizations, which are traditional groups of male village elders. It was not clear to what extent the CDAs also drew from the *Arab Women Speak Out* Committees. Women's presence in civil society group meetings is not sufficient to guarantee their equal and effective participation. CHL's partner, Save the Children, could do more through village assessments to examine the nature of women's and men's participation and the process through which decisions are made to more fully understand whether women and men have equal opportunity to influence community decisions.

Community leadership/ Arab Women Speak Out (AWSO): The program focuses on empowering women to make better decisions regarding their own health and cultivates leaders in the community to promote healthy behavior. AWSO graduates are recruited as volunteers to implement specific outreach activities to spread health messages. In FY 2009, 12,846 women attended AWSO meetings in the community health program, and 329 volunteers were active, including 72 working on FGM/C awareness in longstanding and newly added communities in the Upper and Lower Egypt governorates. While the AWSO activity acknowledges gender inequality, it focuses more on women's practical needs rather than on their strategic interests, such as increased political participation, access to resources, and decisionmaking and legal status. The program has been effective at stimulating discussion about FGM/C, the importance of girls' education, and the negative consequences of early marriage for young girls. However, there is little focus on the power inequalities that contribute to these practices. Some AWSO program members from villages in which the project operated previously now volunteer for FGM/C activities in their own villages and in villages new to the program in Minya, Qena, and Fayoum. Thirteen volunteers participated in a training-of-trainers workshop in the second quarter of 2009, and subsequently trained 72 others. In the third and fourth quarters of FY 2009, CHL and Save the Children held 184 AWSO classes on FGM/C in about 24 villages in Minya, Fayoum, and Qena governorates, reaching 4,299 women. An improvement in the participants' attitudes about and knowledge of FGM/C was measured by pre- and post-tests. Table 3 summarizes the results of the tests in FY 2009, quarter 4.

Table 3. Change in Attitudes by Women in AWSO Classes on FGM/C²¹

Participants tested before and after classes by AWSO volunteers supported by CHL partner Save the Children in Minya, Qena, and Fayoum, Q4 FY09		
Item	Pre-Test	Post-Test
Percentage opposed to FGM/C	>12%	>44%
Percentage willing to participate in FGM/C prevention activities	14%	>27%
Percentage advising peers to not have their daughters undergo FGM/C	>12%	>36%
Percentage planning to have her daughter undergo FGM/C	<55%	>26%

Source: Save the Children quarterly report to CHL for Q4, FY09

²¹ From JHU/CCP. October 2008–September 2009. *Communication for Healthy Living Project Health Communication Partnership Annual Progress Report*, p. 17.

During a field visit, participants told the gender assessment team that they are now able to negotiate more effectively with their husbands about some decisions in the household, but gave few concrete examples. It was not clear whether AWSO influenced changes in FGM/C practice. It might be more effective to complement the messages to be about women's son's ideas on FGM/C, rather than their daughters. If women are moved to discourage their sons from demanding that their prospective brides be circumcised, changes in practice might be greater and occur more quickly. Additionally, targeting older women and men with these messages might be more effective in that they can influence their sons' decisions. These messages addressing demand for FGM/C, rather than supply, might be an interesting approach to try in the final years of the program.

Community leadership/Dawar meetings for men: The Dawar program (meetings of male community members and leaders) is aimed at changing male behavior and attitudes towards family health and securing their support for the health outreach activities occurring in their villages. In addition, Dawar meetings are used to help males identify and follow a process for meeting the needs of their villages. The Dawar has come to include villagers of widely ranging age and social status and have become a forum to find consensus on village development issues, render binding decisions, and mobilize resources. The Dawar tends to perpetuate the continuation of historical patterns of gender division of labor, as men and older people are the decisionmakers. In this context, CHL can be seen to unconsciously take advantage of rigid gender norms and existing imbalances in power to achieve its health program objectives. Thus, the patriarchal mode of decisionmaking is reiterated, marginalizing women and isolating them from the decisionmaking process by not dealing with them as equal partners in community politics. The Takamol approach to men's groups provides an alternative, which exposes men more effectively to information on health and gender relations. The forum of the Takamol men's agricultural extension groups also supports more interaction and discussion between the facilitator and the participants and among participants. The outcomes indicated that Takamol men's group participants were more open to considering change. The caveat to this comparison is that the Takamol group observed was in Lower Egypt, while the outcomes observed in the CHL Dawar groups were in Upper Egypt. Regional differences may account for differences in outcomes as well.

Family health interventions/Visits to newlyweds: CHL recognizes that marriage is the foundation of family life -- the threshold of events and practices and that, within a short period, will have life-long effects on family health. These include decisions about having children, husband-wife communication on health, how to manage pregnancy and delivery, proper postpartum care, neonatal and infant care, and the successful initiation of family planning and practice of birth spacing. The marriage event is the strategic entry point for family health information, and CHL's Newlywed Initiative (Mabrouk) responds to this. Although a multilevel campaign, at the community level household visits introduce the health activities available in the community and provide counseling on family health issues.

The project reflects recognition of local gender differences, norms, and relations and their importance to health outcomes in project design, implementation, and evaluation. This recognition relies on general awareness of gender differences and aims to address gender equity in health outcomes. The counseling process acknowledges and tries to stimulate discussion about the role of gender norms and inequities, but the core of the program focuses on integrated FP/RH and MCH. The messages are covered in the nationally disseminated "Mabrouk" (Congratulations) book, and supplemental CHL materials are referenced and distributed during classes and meetings.

CHL sponsored 1,578 home visits to newlywed couples in FY 2009; all received premarital counseling, and more than 85 percent received a Mabrouk booklet (a package of health messages on behaviors they can adopt to ensure a healthy family). These visits strive to examine, question, and change rigid gender norms and imbalance of power as a means of reaching health and gender-equity objectives. In theory, the

visits are designed to counsel the couple, but in practice, men often are not present because of work obligations or migration.

Family health interventions/Antenatal care, safe delivery classes, and postpartum visits: These community-based activities are directed at women who are pregnant or have just given birth. Key health messages follow MOH guidelines and have adapted a positive deviance approach.

Nevertheless, men continue to be the gatekeepers of women's health by making decisions about whether or when women can seek care for themselves and their children. If women cannot make the decision to seek care, they are at particular risk during pregnancy, labor, and in the postpartum period.

Family health interventions/Child health: The Nutritional Education Rehabilitation Program (NERP) from CHL and Save the Children is for mothers with identified at-risk children. The purpose of this activity is to decrease malnutrition in children ages 6-24 months. The child nutrition programs that target malnourished children have not addressed the gender imbalances contributing to child malnutrition. The gender assessment team discovered in its field visit to Fayoum that many more girls than boys were represented among malnourished children in the groups. Staff was not aware of this, since the program information collected and reviewed is not disaggregated by sex. Disaggregating even simple attendance information and noting what gender-based factors may be contributing to the difference in girls' and boys' nutritional status may illuminate significant patterns.²²

Strengths and weaknesses of the CHL approach to gender²³

Most of CHL's interventions appear to accommodate to gender differences without directly addressing imbalances in power relationships and decisionmaking, although a few have the potential to be gender transformative. CHL has focused almost exclusively on health outcomes without adequately demonstrating how the activities with men's and women's groups contribute either to health outcomes or to more equitable gender relations. While activities such as AWSO and Dawar groups have the potential to influence changes in gender relations, without gender-specific indicators or impact measurement, it is impossible to establish whether or not they are having an effect, or how. CHL has the potential to implement a gender-transformative initiative through its counseling of newly married couples by initiating discussions of family planning and economic decisionmaking. The potential impact of CHL activities to produce significant changes in gender relations is more likely to happen if both men and women are fully and jointly engaged in reproductive decisionmaking and more equitably share responsibility for their children's health and nutritional outcomes.

Strengths

- The annual implementation plan of FY 2010 places a special emphasis on those youth and communities with special



Minister of Family & Population Moushira Khattab speaks at the Doctors Against FGM/C conference organized by CHL. Menoufiya. Governor Samy Amara is at right.

²² Determining whether this is a demographic pattern would require a more scientific data collection process than was conducted during the assessment. It is impossible to know whether girls receive less nourishment or poorer medical care. The DHS indicates that feeding patterns are similar for boys and girls, but girls are less likely to be taken to the doctor when they get sick.

²³ It is important to note that these observations are solely related to the Community Health Program that is implemented through Save the Children. This does not take into account USAID/Egypt Mission support for technical assistance to the government of Egypt or CHL's work in the private sector. These components are equally important but could not be adequately assessed during the assessment due to time constraints. The only source of information on those activities was project documents and comments from project staff; the team did not have access to a more independent source of information or documentation.

health needs, such as underserved rural communities or other economically or socially disadvantaged groups, to achieve long-term impact on the health status of Egyptians.

- The gender-sensitive materials disseminated by the program use gender-sensitive images, such as portraying fathers holding their babies.
- CHL's work against the medicalization of FGM/C appears to be a good strategy for engaging doctors in the fight against FGM/C. In May 2009, CHL helped the government of Egypt launch "Doctors against FGM/C," an initiative that trains physicians to more effectively communicate the potential physical and psychological harm of female circumcision.
- CHL's objective of improving gender equality cross-cuts its results in family planning, maternal and child health, and other public health threats. The organization still needs to develop and report on indicators that demonstrate progress and impact.
- Engaging men as health promoters in Dawar groups is positive, but additional training for facilitators is required to more effectively communicate health messages in a forum that is often focused on other community needs perceived to be of higher importance.
- The FY 2009 Annual Report mentioned the need for cooperation between women and men and religious leaders to provide counseling to their communities on the topics of family planning and maternal and child health. During the last year, the program conducted 733 training seminars and workshops on the role of circumcision in religious practice, in which approximately 55 percent of the participants have been women. These seminars have been particularly influential in convincing people that neither Islam nor Christianity demand female circumcision as part of religious practice. Additionally, approximately 16 percent (20 of 122) of the religious leaders trained in Ismailia, Aswan, and Minya have been women.
- In its avian influenza activities, CHL addresses the productive role of women.²⁴
- The CDAs facilitate VHC meetings, which are attended by older men and women for the purpose of monitoring the program and providing linkages with other public sector services. In the future, these activities can focus on strengthening women's leadership and decisionmaking roles.

Weaknesses

- The programs do not engage men in discussions or activities around their roles as fathers; attention is focused entirely on infants and mothers.
- Similarly, the Dawar emphasis on men's leadership has not been effective in directing discussion topics to health and gender equality in the same way as AWSO women's groups. This reinforces the notion that women are passive recipients of program interventions, while men's importance precludes dictating to them. Both genders should receive the same degree of respect in choosing and leading discussions. While involving men in the health sector and encouraging them to make decisions to improve health in their households and communities is a positive dimension of the program, it should not be done in a way that reinforces men's exclusive power and decisionmaking. The more than three to one representation of men to women in the VHC in FY 2009 is evidence of this imbalance of power. Likewise, the total of women's participation (1,398) in the Dawar compared to men's (9,888) is highly skewed if the Dawar are not merely a men's

²⁴ Avian influenza was covered in another independent gender assessment.

educational group, like AWSO, but a real decisionmaking body for the community. Moreover, the quality of women's participation and integration into the Dawar meetings has not been assessed. Are they merely present or do they have a voice and influence?

- Young men are invited to participate in the Dawar, but not young women, thereby reinforcing unequal gender roles in community decisionmaking.
- The number of participants reached through the home visits in the newlywed initiative reveals a huge gap between young men who participated (1,651) and young women (30,702). Clearly, most of the counseling was not to couples but only to new wives without their husbands, which severely limits the impact of the messages.
- The documents reviewed reveal that there is a wide use of gender and undefined social terms that hide inequalities. Also, the failure to consistently report sex-disaggregated project data restricts analysis of the gender impacts of the program. For example, terms such as “board members” of CDAs does not specify if they are men or women. Those roles traditionally are mainly assumed by men, especially in rural areas. Also, information is collected on changes in women’s attitudes about FCM/C but not about men’s.
- The program focuses too narrowly on women of reproductive age and their partners. Decisionmakers within the household include older women and men, who also have different health needs and have the capacity to influence young men and women, girls and boys. Women who are mothers-in-law participate in AWSO activities, but messages tend to focus more on their role as mothers of girls than their roles as mothers of boys or as mothers-in-law. A lifecycle approach would expand access to information and engage important decisionmakers in the dialogue.
- All indicators measure outcomes for women only. Even the nutritional indicators for children were not sex disaggregated and therefore will not capture any gender inequalities in nutritional outcomes. During a field visit, the gender assessment team observed that there were many more girls than boys identified as underweight and nutritionally at risk. The DHS also shows gender differences in treatment of diarrheal disease. Girls are taken to health centers at a much lower rate than boys when they are sick. If health indicators are not sex disaggregated, there is no way to catch differences in health-seeking behavior and outcomes at the project level.

Entry points and opportunities

- The Mabrouk Initiative (Newlywed Initiative) for young married couples already includes guidance on the importance of family health and husband and wife communication; this can also be a direct entry point for discussing violence against women.
- The AWSO curriculum, used primarily for women’s awareness raising, devotes a chapter to domestic violence. If this were adapted to incorporate more of an advocacy approach, it could be used to lobby for solutions at the community and district levels. In addition, it could be adapted to use with men so that they also examine the consequences of GBV for their communities and households.
- Research findings on breast cancer and avian influenza show that women are diagnosed late, which is indicative of women’s lower status in general, their incapacity to decide to seek care, their lack of control over resources, and their socialization to sacrifice and place themselves in a lower status than the men and others in the family. This information can be used in the

awareness-raising sessions and to suggest new initiatives and venues to encourage women to go for routine pap smears and breast exams.

- Dawar has become a forum comprised of village elders and villagers of widely ranging ages and social status. The expansion of Dawar to include a greater number of actors than the village elders has been a positive force in democratizing decisionmaking. It is not clear to what extent opening up the Dawar has also contributed to greater gender equity. The Dawar may or may not be the appropriate mechanism for addressing the inclusion of women in community governance. The CDA might lend itself better to promoting gender diversity and equity, as it is not explicitly identified as a men's organization. Takamol's approach of working separately with men's and women's groups and then integrating the participation of both in the CDA seems more effective.

Project-specific recommendations

1. Gender discrimination starts early in the lifecycle, as indicated by the discovery of more girls in the malnutrition intervention programs. Therefore, the Mabrouk Initiative counseling sessions and rehabilitation classes for nutritionally at-risk children should more directly address the gender inequities that prevent women (e.g., cancer, avian flu, and labor and delivery) and girls (nutrition) from receiving adequate healthcare over their lifespan. If a predominant preference for boys is detected, then the project needs to direct more attention to this fact and raise awareness.
2. Older women are significant decisionmakers in the household in their roles as mothers-in-law. The project would benefit from developing specific outreach activities to this group of women. Activities could include (i) counseling on health, nutrition, and menopause; (ii) discussions of their roles in influencing their sons' decisions about whether a marriage partner has to be circumcised; and (iii) decisions to circumcise their children's daughters (i.e., granddaughters). The messages and topics of discussion in the AWSO groups could more deliberately speak to women's roles as mothers-in-law.
3. Encourage male and female community members to join in the decision-making process of their villages. CDA-based activities should focus from the beginning on developing women's leadership and active participation. CHL can adopt a step approach by using some kind of quota system for inviting participation of men and women and supplement it with separate leadership skills building for men and women. The measure of women's equal participation should be an indicator that assesses the extent to which decisions about health priorities and investments reflect women's priorities.
4. Introduce gender sensitivity as one of the selection criteria of the CDA. For example, the project can announce that the CDA showing the highest amount of gender sensitivity (such as in balanced board membership composition or gender-sensitized orientation) will score higher on the gender sensitivity scale and hence be more likely to receive funding for their proposals.
5. Capacity building of the CDA provides an opportunity to sensitize and introduce it to the main gender conceptual rationale by explaining the added value the CDA can reap from adding women into its decisionmaking portions and having a gender balance throughout its initiatives.
6. In the community leadership components, the content of the AWSO and Dawar activities should mirror each other. Information provided to women in AWSO groups should be similar to the content and emphasis of messages directed toward men in the Dawar groups. The project should not be more directive in the women's groups than they are in men's groups. Both should receive similar information within a similar timeframe. Men's and women's time should be similarly respected. Messages on FGM/C should also emphasize the importance of influencing the marriage preferences of boys for uncircumcised prospective brides, as well as women's and men's attitudes about forgoing

circumcision of their daughters. Similarly, messages to both men and women should emphasize the value of educating daughters and delaying the age of marriage.

7. It is important to acknowledge men as caregivers for their children. Thus, it is crucial to highlight the importance of fathers' roles in raising their children and in the wellness of the entire family. Fathers need to become aware of children's nutrition and health and disease prevention.

Suggested indicators

- Percentage of male and female participants of the CDA
- Percentage of suggestions brought forward and adopted in the CDA by women participants
- Percentage of women/men reached through the home visits
- Percentage of boys/girls in nutritional counseling activities
- Percentage of adolescent boys who state that they will not insist their wife is circumcised
- Percentage of mothers attending the nutrition classes reporting to have shared the information with their husbands
- Number of indicators measuring men's active participation in the program's initiatives
- Number of images with fathers as caregivers used in the program fliers
- Percentage of women/men in CDA and VHC leadership positions

3. Takamol

Brief description

The Integrated Maternal and Child Health/Family Planning/Reproductive Health activity (Takamol) was awarded in 2006 to Pathfinder International. This activity integrates components formerly under two different programs, Tahseen and Healthy Mother/Healthy Child. The word "Takamol" means integration in Arabic. Takamol promotes an integrated model for MCH/FP/RH services. Takamol works with and through the MOH to reduce fertility and improve health outcomes for mothers and newborns.



Photo courtesy of Debbie Caro.

The model emphasizes community mobilization and civic participation in local primary healthcare and on the boards of hospital facilities as driving forces for change, and presents ways to strengthen and sustain mechanisms to support change, such as diverse and capable facility management board and linkages with other health and non-health services and projects.

The project works in 179 primary healthcare units in 11 Upper and Lower Egypt governorates, selected urban poor areas in Cairo and Giza, and district hospitals in Lower Egypt. The primary activities of the project include upgrading PHC and obstetrics/gynecology (OB/GYN)

departments in district hospitals; clinical training for healthcare staff and on health education for outreach workers; management training for healthcare staff and CDA board members; mobilizing different community groups through CDAs, literacy classes, community health education, women's groups, and youth groups; linking women's groups to microfinance programs; engaging men through agricultural

extension groups; and outreach and engagement of religious leaders around topics such as FGM/C and early marriage.

Activities on gender

Gender is one of two cross-cutting themes in the Takamol Project. The original scope of work for the project stated,

“This project will help to strengthen safe motherhood, infant health, and reproductive health programming by addressing gender-related barriers that decrease access to and compromise quality of maternal and child health services especially at service delivery and community levels. It will build on lessons learned in male involvement and participation strategies and address barriers to women’s ability to access critical health services in a timely fashion to save lives of mothers and newborns. The Offeror should incorporate gender issues into as many of its activities and training opportunities as possible, discuss how it will significantly boost women’s general participant in as many activities as possible, and track the impacts and benefits on women.”

Takamol has a number of activities designated as gender-related activities, including all of its health education activities, its social mobilization activities, and part of its clinical training activities. These activities include messages about gender equity and make an effort to involve both men and women. In addition to multiple health issues on family planning, maternal and neonatal health, and child health, the activity focuses on two issues, FGM/C and early marriage, which subject girls and adolescent girls to practices that limit their rights, decisionmaking, and agency. Early in the project, Takamol began work on GBV with the development of a manual, which was translated into Arabic. It has distributed this manual to organizations for use in implementing GBV training.

A visit to one community in the Talkha district in Dakahlia Governorate in Lower Egypt provided a brief glimpse into how a number of individuals, selected by the project to provide their opinions to a gender assessment team member, view the set of activities underway. The assessment team member was also able to observe a meeting of a men’s agricultural extension group and speak separately to several members of the CDA.

Strengths and weaknesses of gender approach

Much of the information provided below is based on conversations with the Takamol project staff and interviews with different individuals and groups during a field visit to Dakahlia in Lower Egypt. The individual interviews were with people preselected by the project and were only three to five minutes long, so the information that emerged is not based on either a valid quantitative or qualitative methodology for assessing changes in gender relations and practices. They do provide a window on information on the kinds of topics under discussion in Takamol activities.

Strengths

Project design: The design of the project appears to encourage participation by men and women, and adolescent boys and girls. The project has created a variety of outreach mechanisms, including some that engage men and women separately, such as the group Egyptian Women Speak Out (EWSO), agricultural extension groups, and health outreach activities; and others that engage them together (literacy classes, family life education (FLE) for adolescents, CDAs and PHC/hospital boards, and couples counseling).

Messages reach diverse stakeholders: The project has integrated general messages about women’s and men’s equality throughout several activities; anecdotal evidence points to these as having an effect in some households. Individuals selected by the project for interviews mentioned changes in treating sons and daughters more equitably with regard to household chores and schooling. Based on the reported increase in knowledge of basic health messages, the health outreach workers appear to be effective in

bringing information to women in their households. They also will occasionally intervene with husbands to convince them to allow their wives to go to the PHC or attend classes.

Importance of addressing women's livelihood constraints: The project's decision to link EWSO to a source of microcredit provided some women with income over which they had more control. The opportunity to earn extra income for the family also appeared to increase men's support for women's participation in activities outside of the home.

The project's work with men has contributed to raising awareness and initiating change in some practices: The men's groups appear to provide a much-needed forum for men to access information and talk about issues they previously had little access to, especially with regard to family planning, FGM/C, GBV, and early marriage. The assessment team member heard several men in the group stating that having the chance to talk about these issues in a group helped them to talk about them with their wives. They also mentioned that they now seek their daughters' approval for the choice of her husband. A few said that, although they are still arranging marriages for their daughters before they can finish school, they now prevail on their husbands to allow their new wives to continue their education after marriage. In Dakahlia, the men interviewed stated they are more convinced to make changes when the religious leaders say the Koran permits the change.

The project stimulated discussion of early marriage and FGM/C in communities: According to project implementers and the information gathered informally during one field visit, the messages about early marriage and FGM/C seem to have stimulated discussion and reflection on these issues among both men and women. As discussed above, men are changing their attitudes about their daughters' role in choosing a husband and staying in school. It was not clear from the discussion that they were convinced that their daughters should delay marriage until they are older. The agricultural extension agent who we observed during the field visit did speak against physical and psychological violence against women and coerced sex. There was no immediate response from the men who were listening, and the topic did not come up in their questions.

There is some indication based on brief interviews during field trips conducted during the assessment that men are also considering the value of delaying pregnancy for girls who marry young. Interventions in women's and men's groups, however, have not taken on some of the other consequences of early marriage that contribute to women's poor health and lack of access to health services throughout their lifetimes. When they marry young, girls experience the consequences of social isolation, lack of decisionmaking, and little control over economic resources.

FGM/C was mentioned by the agricultural extension agent. He said that FGM/C is illegal, causes bleeding and psychological trauma for the girl, and is "not good for one's sexual life." He ended the message by saying that men must have an opinion about FGM/C because they have the final say about what happens to their daughters. Otherwise, the biggest change appears to be increased dialogue among husbands and wives around health topics, especially spacing of children and smoking. Most of the questions during the session were about the relative benefit of different types of contraceptives. The agricultural extension agent referred the men to the doctor present in the group meeting for more information. Participants also stated that husbands and wives consult each other more about the children and financial issues, two topics that previously were the predominant domain of women and men, respectively. Women said that EWSO groups helped them to negotiate more effectively with their husbands.

While EWSO provides many positive opportunities for participants, including strengthening social networks, connecting them to new economic opportunities, improving their negotiation skills, and increasing their access to ID and voter cards that expand their rights as citizens, it is not clear that the

women who are most isolated, marginalized, and poorest are engaged in EWSO and other social mobilization activities.

Project engagement of religious leaders has influenced public opinion on a number of gender and women's health issues: Engagement with religious leader also appears to have a positive effect on men's and women's attitudes about different health practices. The imam that we interviewed stated that when he responded to a woman who inquired whether the Koran supports spacing of children, he told her of a passage about breastfeeding for two years before getting pregnant again. He spoke about other topics on which he had been consulted, such as on girls having a say in whom they marry. He cited a passage about Mohammed annulling the marriage of a woman who was not consulted about the choice of her husband prior to marriage. He also found support for more equal relations between men and women. He referred to a passage in the Koran that is frequently misinterpreted to support men's superiority. He said the passage only refers to men's economic responsibilities to their families, and that there is nothing in the Koran that states that daughters should not be educated. Takamol has done similar work with Christian religious leaders, but the assessment team did not have an opportunity to interview them.

Youth activities are most likely to produce change in gender norms and practices: The most notable influence of the social mobilization activities appeared to be among the youth. Both boys and girls reflected on changes in their own lives that had come about as a result of their participation in program activities. Both boys and girls spoke about boys assuming more responsibility for chores within the household. Girls convinced their mothers that their brothers should learn to serve themselves and not be waited on by their sisters. Boys stated that they were no longer ashamed of doing housework. Boys and girls also stated that girls should receive the same access to healthcare and education as boys. Several girls indicated that the practice of early marriage was more difficult to change. Both girls and their parents worried that they will not find a suitable mate if the girls wait until they are older to marry or that they might get pregnant before being married.

Weaknesses

No indicators or impact measurement of changes in gender norms and practices: Many of the activities appear to be well attended and the messages seem to resonate with the participants. Nevertheless, project documents and staff do not clearly articulate specific gender-based barriers or constraints that they are addressing in the activities. The project does not report to USAID on most gender indicators to measure the impact of women's and men's participation or report sex-disaggregated indicator data on participation in training, educational, or management activities (e.g., health facility management), although they collect the information. It is impossible to know how many women and men actually participate in these activities and whether participation is becoming more equitable. In one community the team visited in Dakahlia, the head of the CDA demonstrated that women's participation in the CDA assembly has been growing but that participation on the board is still inadequate. If similar information was reported routinely by Takamol to USAID, the latter would be in a stronger position to demonstrate how program investments were contributing to achieving more equitable representation and decisionmaking by men and women.

Although Takamol collects the following information about women (and not about or from men), it is not reported to USAID:

- Percentage of women who know the dangers of FGM/C
- Percentage of women who intend to circumcise their daughters
- Percentage of women who do not intend to circumcise their daughters
- Percentage of women who know about the right age of marriage
- Percentage of women who know about the dangers of early marriage
- Percentage of women who have an ID

- Percentage of women who are illiterate
- Percentage of women who know the right timing of children’s vaccinations
- Percentage of women who visit the PHC
- Percentage of women who know about the different contraceptive methods
- Percentage of women who know about healthy birth spacing
- Percentage of women who intend to space their children
- Percentage of women who know the importance of breastfeeding
- Percentage of women who know the importance of premarital counseling
- Percentage of women who intend to go for premarital counseling
- Percentage of women who delivered at home, at hospital
- Percentage of women who know the importance of thyroid tests for the newborn

The data collected are rolled into an aggregate indicator “Percent improvement in community participants’ knowledge of key MCH/FP/RH messages.” As the information is not collected from men, it is not clear whether this indicator also reflects improvements in men’s knowledge, and adolescent boys’ and girls’ knowledge, but the project does not appear to be collecting this information. It would be useful to fully sex-disaggregate data or collect complementary data on men’s attitudes and practices, which may involve some rewording of indicators and data collection questions. This is particularly important where the programs are working with men’s groups and youth groups composed of both boys and girls.

The list has two potentially powerful indicators of women’s empowerment: literacy and possession of an ID card, which reflect the acquisition of a skill (literacy) and an asset (ID card) giving rights to women to access and use the formal economic and legal structures of the country. Prior to the project, women said they did not know about voting and ID cards. The ID card alleviates several access barriers for women, such as access to bank accounts, registration of births and deaths of one’s children, access to medicines that are taken on a regular basis from the PHC, and access to a voting card that permits voting and running for office. Literacy allows women to access information that empowers them to make informed decisions about a host of issues, including health, politics, and economic opportunities. In several interviews in both Takamol and CHL communities, women stated that they are now more able to negotiate with their male partners. Prior to the conclusion of the programs, it would be useful to understand how this has come about and how the project has helped to strengthen women’s bargaining positions within the household and potentially within communities.

The other indicators on the list measure valuable knowledge, but without being linked to higher-level indicators that demonstrate impact—such as access to health services or decreased practice of FGM/C and early marriage—these indicators do not show whether gender-based barriers have been surmounted.

A recent evaluation of the project did not assess the contribution of the gender-focused activities on meeting program objectives. Therefore, there was little available information for examining whether the particular activities implemented are addressing the access barriers referred to in the original scope of work. There is also little evidence of the activities having been selected based on a gender assessment that identified the specific barriers to be addressed. Through interviews with program staff, the gender assessment team concluded that the activities focused on men and women were developed based on staff impressions of what was needed rather than on real analysis. Although the project collected information on a number of gender-informed indicators, it does not report this information to USAID, and the information is not analyzed.

While some of the activities under the project do address gender-based constraints, its approaches are not based on an assessment of actual constraints and the factors contributing to them. A gender assessment would help to answer a number of questions that arise in reviewing the apparent results of the project. For

instance, the projects has identified FP discontinuation rates as a problem, yet project staff seem to have very little understanding of how gender relations and gendered decisionmaking in the household may affect women's decisions to discontinue use of family planning. By unearthing the specific roots of barriers such as this, the barriers can more easily be addressed. The project could explore whether women are constrained by either mobility or decisionmaking autonomy to seek additional information or care; whether they feel intimidated about asking questions in their initial counseling visits and therefore end up with a method they are not happy with; or whether transportation costs or other expenses limit their ability to return for additional information and services. Apart from those who decide to have another child, perhaps the rest of the women do not return for FP services because of time constraints, because they were treated poorly by the health services before, or because their mobility outside of the household is constrained by their husbands. According to the interviews in Dakahlia, one major change is that men previously regarded family planning as a woman's issue but now appear to feel they have a role, as well. Takamol has gotten men involved; the question is whether the form of involvement makes them supportive of women's decisionmaking or empowered to make the decision for women, rather than jointly.

Another place the project is taking actions without adequate analysis of the situation is with regard to client rights and satisfaction. Women who attend FP or antenatal care (ANC) visits on their own may not feel empowered to ask questions, especially of a male doctor, or to make decisions without their husband present. It was also not always clear from gender assessment team interviews in clinics whether either information women provide or their choice of method are confidential. Some providers indicated that if a woman's husband asked for information about her visit he was entitled to it even without her prior consent. Others indicated that when men accompany women to FP/ANC visits, the men did most of the talking. This raised questions about whether women have a say about method choices, whether doctors are trained to address the woman as well as the man when they both attend counseling sessions or ANC visits, and if there are differences between female and male providers in this regard. The project staff mentioned that there is some evidence that PHCs run by women doctors are more likely to facilitate women's independent access to and greater choice of contraceptive methods. Some of these changes may reflect the change from FP provision through separate clinics to provision through PHCs.

Clinical training on gender does not deal with gender relations and barriers within the health services: It is important to consider gender in both clinical and management training. There should be greater focus on the constraints and opportunities faced by men and women in clinical practice and in management, as well as an emphasis on how these affect the quality of care. For instance, are women passed over for higher management positions because of others' perceptions about their ability to do the work, concerns about security during night-time hours, or perceptions that their domestic responsibilities will not allow them the time to dedicate to more challenging positions? Conversely, are men expected to work longer hours because of the assumption that all their domestic and childcare responsibilities are covered by their wives?

Gender training within the context of pre-service and in-service training should also help providers identify gender-based constraints their clients face in seeking care and carrying out instructions given by providers for their care and that of their family members. For instance, instructions to a pregnant woman to eat certain foods or greater quantities of food can be difficult to follow if she does not control resources or is the last one to eat after everyone else has been fed. Likewise, encouraging men to participate in FP counseling may not be possible if they cannot take time off from work during the hours the clinic is open. Providers often overlook the way gender roles and status affect their clients' capacity to successfully address their health needs.

In both the CHL and Takamol projects, FGM/C and early marriage messages are too top-down and not based on an understanding of the cultural meaning and social importance of the practices: There have been a series of

singular but different messages around these two practices in both Takamol and CHL; they have been based on a basic communications tenet that the simpler the message, the more likely it is to be effective in changing attitudes and behaviors. The projects have promoted a series of messages about FGM/C related to health concerns, legal repercussions, and religion (the message that FGM/C is not required by either Islam or Christianity). All three projects have had some effect in reducing FGM/C, especially in the younger cohorts.

For FGM/C, the message about adverse health consequences reduced practice among a small number of adherents. Less than half of women and less than a third of men believe that the practice can lead to the girl's death; therefore, the harmful practice message may not be overly persuasive, especially as deaths from FGM/C are relatively rare events.

The effect on a majority of parents, however, has been to seek out the services of medical providers instead of traditional birth attendants (dayas). The government of Egypt has now addressed the medicalization of FGM/C by making it illegal for a doctor or other medical practitioner to perform these. Yet, the 2008 DHS found that three-quarters of daughters ages 0–17 of women interviewed were circumcised by a trained medical professional.²⁵

The religious message promoted by Takamol (and CHL), in combination with other messages emphasizing health concerns and illegality, focuses on how FGM/C is not sanctioned by either Islam or Christianity, and therefore is not required for people to be religious. Messages about girls' rights also may not be any more compelling for the practitioners. The 2008 EDHS reveals that 45 percent of women and 60 percent of men state that husbands prefer their wives to be circumcised as a reason for the practice, and 34 percent of women and 39 percent of men state that circumcision of girls prevents them from committing adultery once married. Even if these are the only two reasons for or meanings of the practice—which is doubtful—Takamol does not seem to be addressing them directly through its health messages.

Similar limitations arise with interventions on early marriage. It appears that the major concerns are preventing girls from becoming pregnant prior to marriage and ensuring that girls find appropriate spouses in a timely way. Takamol's messages to delay marriage so that girls can stay in school seem to have resonated with some fathers who now encourage their daughters' new husbands to allow them to continue their education after marriage, while delaying their first pregnancy. While the delay in first pregnancy is likely to have positive health outcomes, it fails to address the gender issue of older men marrying younger women, which often reinforces the man's dominance and control and constrains the woman's ability to negotiate and make autonomous decisions within the household.

While Takamol has stimulated considerable discussion about the practice, it is not evident that it has affected changes in practice. The short timeframe of only 1–1.5 years in a village makes it difficult to see and document a change in practice. It is possible, however, to engage local communities in a problem-solving methodology within a year's time that leads to local commitments and follow-through. The CDAs certainly lend themselves to this type of participatory process; a more concerted focus on FGM/C with CDAs from the beginning may be more productive than focusing on behavior change communication in women's groups. The FGM/C-Free Village Movement, run by the National Council for Childhood and Motherhood (NCCM), funded by UNICEF and UNFPA, and recently evaluated by the Population Council, may provide a viable alternative approach, depending on the evaluation's findings. Additional

²⁵ Egypt Demographic and Health Survey 2008, p. 201. The law was passed in June 2008 as an amendment to Child Law number 2, which states that the practice of FGM/C will be punished by not less than three months and not more than two years imprisonment or a fine of not less than 1,000 or more than 5,000 pounds for anyone who has caused the injury. The results of the DHS do not yet reflect the law, as data collection preceded its passage.

exploration through qualitative research methods of some of the EDHS findings about why people feel it is important to continue the practice might yield additional information that would serve as the basis for more effective program interventions on this issue. Without a cultural and gender analysis of the meaning of FGM/C and early marriage, it is difficult to engage different stakeholders in a discussion about why they might decide to change longstanding, and apparently meaningful, practices.

An increasing number of interventions have engaged communities in a collective and participatory inquiry into the social importance of these practices in other contexts. For the most part, their success is due to the willingness of project implementers to grapple with complexity, rather than to seek a simple unified message.²⁶ They may also offer some useful approaches for identifying the local meaning of FGM/C and early marriage, as well as some alternative, less invasive, or less harmful practices, or ways to forgo them altogether. Approaches that engage whole communities in making decisions about practices, rather than relying on convincing individuals or individual households to make changes, tend to be more successful. It would be worthwhile to design a comparative evaluation of project activities on FGM/C to the whole village approach supported by NCCM with UNFPA support.²⁷

Entry points and opportunities

Take better advantage of the gender expertise within the project: Takamol has a gender specialist on staff who could conduct the necessary analysis to fill in many of these gaps and answer some of these questions. In the event that much of the information the project has been collecting is sex disaggregated, the gender specialist could analyze it for gender differences in attitudes on various dimensions related to health and gender relations. She can also identify some targeted research questions, such as investigating local cultural meanings and the social importance of FGM/C and early marriage. Another possible topic is to assess whether there are specific gender-based reasons behind the high FP discontinuation rates, such as pressure to have more children, women's limited capacity or permission to ask questions during FP counseling, or their restricted mobility to return to the health center when they are not satisfied with their contraceptive method.

It would be worthwhile to systematize information on gender-related outcomes from EWSO, men's agricultural extension groups, literacy groups, and adolescent FLE groups to understand more broadly, and less anecdotally, possible outcomes beyond changes in attitude, such as comparing time use data from boys and girls who have participated in the FLE activities with those who have not. For example, are boys who participated helping with domestic chores more than boys who have not? Are girls who have participated spending less time on such chores and more time on homework? Or, are women who have participated in EWSO groups and started businesses more involved in making decisions about investments and expenditures in their households (or other decisions) than women who have not participated? Do the wives of men participating in the agricultural extension groups use ANC and FP services more regularly than wives of men who have not participated? It may still be too early to see some of these impacts but it is worth trying to move beyond individual stories to more deliberate and representative documentation of outcomes.

The curricula of EWSO and the Men's Agricultural Extension Program provide a framework for expanding discussions on gender: There is room for additional scope in topics (GBV, power, masculinities, decision-making, etc.) and increasing participation in the curricula for these activities by drawing on and adapting many existing participatory methodologies.²⁸ There are also opportunities to increase the exchange of information between groups of men and women through the CDAs and PHC Boards.

²⁶ UNICEF, 2008.

²⁷ The Population Council recently completed a midterm evaluation of the government's FGC/M Free Village Program, but it is not yet available to the public, as it is undergoing review by the government of Egypt.

²⁸ Warmi (RH/MH); Raising Voices and SASA (GBV/HIV); and Stepping Stones (HIV), to name a few.

Project-specific recommendations

- The topic of GBV can be introduced through FP/ANC visits and expanded in EWSO and pre-marital counseling if the work is done at the local level to ensure that appropriate services are available across different sectors.
- Takamol should report on its gender indicators and should sex disaggregate all child health indicators, as well as all indicators measuring leadership, decisionmaking, and access to health services.
- FGM/C messages and curricula should be based on an inquiry into local cultural meanings and social importance of the practice. The methodology should change from a health education focus to a participatory action planning approach. CDAs should become more engaged in discussions and problem solving around FGM/C and GBV.
- Youth activities should reincorporate the life skills planning activities that were so successful under Ishraq.²⁹
- Microfinance activities should link, where appropriate, with other programs that can provide business skills training and more rigorous assessments of the market.

Suggested indicators

The following existing indicators should be amended to include both men and women and adolescent boys and girls, and they should be reported as sex-disaggregated percentages and numbers.

Illustrative indicators for consideration, based on current indicators, include the following:

- Percentage of women and men who intend to circumcise their daughters
- Percentage of women and men who do not intend to circumcise their daughters
- Percentage of adolescents (boys and girls) who state that they do not intend to circumcise their daughters
- Percentage of women, men, and adolescents (girls and boys) who know about the legal age of marriage (18 years) in Egypt [amended from “right” age of marriage]
- Percentage of women, men, and adolescents (girls and boys) who know about the dangers of early marriage
- Percentage of women and men who know the right timing of children’s vaccinations
- Percentage of women and men who know about the different contraceptive methods
- Percentage of women and men who know about healthy birth spacing
- Percentage of women and men who intend to space their children
- Percentage of women and men who know the importance of immediate breastfeeding to six months
- Percentage of women and men who intend to go for premarital counseling
- Percentage of women who can decide independently to visit the PHC
- Percentage of women and men who recognize sex-appropriate signs of STIs
- Percentage of women who have an ID

Time use is a sensitive indicator of gender equality. The youth survey conducted in 2009 provides time-use information broken down by sex. Young women ages 22–29 indicated having the greatest share of housework. They spend an average of three hours per day on housework, compared to 30 minutes spent by young men in the same age group. Adolescent girls and young women also spend twice as much time as adolescent boys and young men in caring for the elderly or younger children. Young men spend double (2 hours/day) the amount of time spent by young women (1 hour/day) in socializing with friends or playing sports. The survey found no sex differences in the amount of time spent on religious activities or

²⁹The gender assessment team came to understand that youth activities left out many FLE skills to shorten their curricula.

watching TV; however, only 5 percent of young women compared with 15 percent of young men have access to the Internet.

While time-use studies are difficult for projects to implement, it is possible to track changes in the division of labor by using indicators like the ones listed below. These are based on changes discussed by interviewees during the visit to Dakahlia.

Additional suggested indicators include the following:

- Percentage of men who state they perform at least two domestic tasks in their households (e.g., helping children do homework or get ready for school, cooking, cleaning, washing dishes—to be defined by local context)
- Percentage of women who state that their husbands perform at least two domestic tasks in their households (e.g., helping children do homework or get ready for school, cooking, cleaning, washing dishes—to be defined by local context)
- Percentage of adolescent girls who serve their brothers food
- Percentage of adolescent boys who serve themselves food
- Percentage of women and men who state that men have a right to use violence against a woman if she burns food, neglects children, argues with him, talks to other men, wastes money, or refuses to have sex with him

The Youth Survey suggests some other possible indicators for tracking changes in gender equitable-attitudes:

- Percentage of women, men, and adolescent girls and boys who agree that a girl should obey her brother's opinion even if he is younger than she is
- Percentage of women, men, and adolescent girls and boys who agree that the husband alone should decide on household expenditures³⁰

Cross-project Issues

- Gender activities are not based on a gender analysis; the focus is on high-profile issues rather than issues identified through analysis. Projects lack gender-specific objectives or benchmarks/indicators.
- Even when projects are collecting sex-disaggregated information on indicators, they do not analyze or report on information—therefore, there is no way to track gender-specific progress and changes.
- The focus on gender is exclusively instrumental for achieving health outcomes—but there is no way to even measure the extent to which health outcomes are improved by gender focus.
- Violence against women could be discussed during FP/ANC visits and elaborated on in AWSO/EWSO and premarital counseling.

General Recommendations

Global Health Initiative

- Conduct a gender analysis as part of all new activity design by making use of gender analysis tools and expertise, especially within Egypt.

³⁰ Interestingly, a higher percentage of adolescent boys and girls (slightly more than 60%) agreed with this statement when responding to the Youth Survey than did older men and women responding to questions about actual decisionmaking in the household with regard to women's and men's earnings and expenditures (see 2008 E DHS report, pp. 37–42).

- Integrate gender considerations in all health programs based on the findings of gender analyses.
- Improve research and M&E on gender by incorporating sex- and age-disaggregated data and gender-specific indicators into performance monitoring plans. Expand research related to the relation between gender equality and health outcomes by submitting select project interventions to operations research protocols.
- Focus on adolescent girls and boys as equitable future partners.
- Involve both women and men in program design and M&E.
- Work more closely with governments to support gender equity by incorporating gender equality goals and gender health equity objectives into national strategies, health policies, and financing.

Structural/Organizational Changes

USAID

- Include gender-specific objectives in requests for proposals/requests for assistance and ask respondents to explicitly link gender and health objectives while measuring both outcomes independently.
- Encourage more regular collaboration on gender across projects and with other donors, NGOs, and government organizations as a learning process.
- Take advantage of the Global Health Initiative to take more of a lifecycle approach to programs, including increasing the emphasis on life skills planning for adolescents and health and engagement of older men and women.

Projects

- Gender issues should be incorporated into baseline data collection and analysis, as well as M&E. This may require that key personnel have gender expertise or that a dedicated gender expert be on staff. In addition, projects should implement gender training for project staff.
- Encourage more deliberate and evidence-based linking of gender and culture in program design, moving beyond stereotypical explanations of practices. Projects should also take a more participatory approach to gender issues in communities.
- Gender should not just be a focus of activities within villages but should also be part of quality of care and management training among providers and administrators and between providers and clients.
- Child health interventions also should have a gender focus to ascertain differences in treatment and outcomes.
- Work with men should also address gender-specific health issues related to men's social roles, such as stress, STIs, and accidents. A more equitable approach to gender relations should also be stressed.

APPENDIX A: CONTACTS

Last Name	First Name	Organization	Position
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APPENDIX B: TRAINING MATERIALS

Agenda Day I: Monday March 8, 2010

12:00 – 12:20	Welcome, Introductions, and Objectives of the Training
12:20 – 13:00	Vote with Your Feet
13:00 – 14:00	Introduction to Basic Concepts and the USAID Gender Requirements <input type="checkbox"/> Sex and gender exercise <input type="checkbox"/> Puzzling through gender concepts <input type="checkbox"/> USAID gender requirements and opportunities
14:00 – 14:15	Break
14:15 – 15:00	Gender Integration Continuum with Case Study Analysis and Discussion
15:00 – 16:00	Gender Analysis <input type="checkbox"/> Unpacking gender analysis frameworks <input type="checkbox"/> Evaluation of the day (plus/minus/delta)

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