Issues and Strategies for Sustainability of Family Planning Services in Egypt

A Background Analysis Paper

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The POLICY Project

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Executive Summary

The sustainability strategy process of the POP IV and Policy II Projects seeks to assist the Ministry of Health and Population (MOHP) with the development of a series of strategies, which ensure the long-term sustainability of the national population and family planning program, while at the same time meeting its programmatic goals.

The six-to-eight month process includes a series of events and activities, as follows: (1) an Executive Course in Financing and Economics (early February); (2) a one-day presentation on the lessons learned during the phaseout of USAID in Turkey (late February); (3) writing of 13 synthesis papers on sustainability-related issues (mid-March); (4) two 1-day meetings for discussion of the 12 papers and the key issues and questions that they raise; (5) the Sustainability Strategy Conference (proposed on May 3–4, 2001); and (6) ongoing planning activities with the MOHP and other key stakeholders, which leads to the development of a long-term sustainability strategy and a short-term action plan (May–September).

This paper is designed to serve as a key background document for the Sustainability Strategy Conference planned for May 3–4, 2001. It summarizes the findings of 12 individual situation analysis papers developed under four different subject areas namely: financial sustainability, institutional capacity, enabling environment, and sustainability of demand. It also incorporates the issues and concerns raised in sustainability meetings organized by the POLICY II and POP IV on March 22 and 27, 2001. The purpose of the paper is to provide information to help policymakers and stakeholders develop population program sustainability strategies in the conference.

The paper uses a conceptual framework of sustainability adopted from one developed by POP IV. It discusses a number of key factors influencing population program sustainability, key issues and challenges, and provides a comprehensive list of potential strategy-options under the four sustainability components namely financial sustainability, institutional capacity, enabling environment, and sustainability of demand. It also discusses feasibility issues for a couple of potential strategy-options in order to facilitate the feasibility analysis to be conducted by the conference participants.

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A Background Analysis Paper

1 Overview

This paper provides an overview of major issues facing Egypt's national population program, including a discussion of sustainability implications for the future. It reviews and discusses the significant factors that shape and define the current family planning program in Egypt and affect the program's likelihood for long-term sustainability.

This paper synthesizes the findings of 12 individual situation analysis papers developed under four different subject areas: financial sustainability, institutional capacity, enabling environment and sustainability of demand. It also incorporates the issues and concerns raised in sustainability meetings organized by the POLICY II and POP IV Projects in collaboration with the Ministry of Health and Population (MOHP) on March 22 and 27, 2001. The purpose of the paper is to provide background information to help policymakers and stakeholders develop population program sustainability strategies for a conference planned for May 3–4, 2001.

The paper is organized as follows. Section 2 assesses the context for population program sustainability in the current context. And section 3 presents the conceptual model of sustainability. Section 4 presents a number of issues and potential strategy-options under the four subject areas, to achieve sustainability.

2 Background

Egypt's population program is one of the great success stories in the world of family planning (Robinson and El-Zanaty, 1995). In 1980, total fertility was 5.3 and contraceptive prevalence 25 percent. By 2000, fertility had fallen to 3.5 and the CPR had increased to 56 percent. This remarkable change in behavior occurred in almost all segments of Egyptian society. In urban Lower Egypt prevalence increased from 43 percent in 1980 to 65 percent in 2000 while in rural Upper Egypt it increased from 4.4 percent in 1980 to 40.2 percent in 2000.

This dramatic demographic transition resulted from major changes in the attitudes and practices of Egyptian couples with regard to their fertility and from increased access to, and availability of quality family planning services in both the public and private sectors, especially the former. There are 5,144 units authorized to provide family planning services (Paper 10).

The success of Egypt's family planning program was also due in large measure to the political support from top leadership, including the president, as well as substantial donor support, notably from UNFPA and USAID.

With Egypt entering the realm of an "advanced transition" country (World Bank, 2000) and with an anticipated phaseout of donor assistance to the family planning program, especially from USAID, the continued sustainability of the program is a concern.

2.1 Population Momentum

Although fertility dropped to 3.5 in 2000, higher fertility in the past has left a legacy of a large cohort of children who will grow up and enter their reproductive ages in the next 20 years. In 1998, although the overall population growth rate was 2.2 percent, the rate of growth of the population aged 15–49 was higher at just over 3 percent. The number of married women of reproductive age (MWRA) is expected to increase from 10.5 million in 2000 to 14 million in 2015, a 40 percent increase (Moreland, 2000).

2.2 Demographic Goals

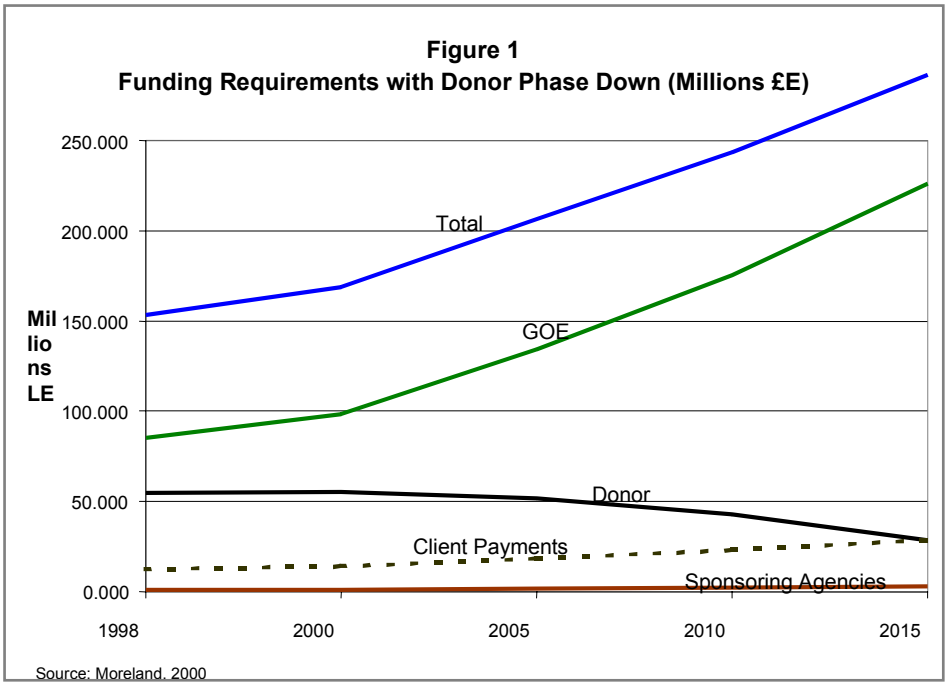
As of January 1, 2001, the population of Egypt was estimated to be 65.8 million, growing at an annual rate of 2.1 percent (1.85 percent urban, 2.26 percent rural). The projected total population is estimated to reach 77.4 million by 2010.

Egypt's national goal of achieving two children per family by 2015 will require a growing percentage of couples using family planning. This fact, combined with an expected increase in the number of women entering their reproductive years, means that an unprecedented increase in resources will need to be mobilized to meet the expected demand. If contraceptive use increases so as to achieve the fertility goal of a two-child family, the number of women using family planning will have to increase by nearly 4 million, a 70-percent increase over estimated 2000 levels (Moreland, 2000). In terms of contraceptives, if the current trend continues, Egypt will need 10 million more condoms, 1.3 million more injectable doses, 1.5 million more IUDs, and 9.6 million pill cycles per year by 2015 (Paper 3).

2.3 Donor Support and Required National Resources

Concern for the sustainability of the population program stems from the anticipated phaseout of foreign donors in the face of the continued expansion of the program that is required to meet Egypt's goals.

Figure 1
Funding Requirements with Donor Phase Down (Millions £E)



Source: Moreland, 2000

Egypt's population program has historically been dependent on donor support. Moreland (2000) calculated that in 1997–1998 "the GOE [government of Egypt] financed 53 percent of family planning (FP) services' costs vs. 47 percent from donors." However, recently many donors have suggested that fewer funds will be available in the future. USAID, as an example, has recently prepared a preliminary phaseout plan, which it suggests will be fully implemented by 2009. If USAID assistance declines to zero by 2010, the GOE's financial requirement has been estimated to increase to £E134.6 million annually by 2004–2005 and to £E175.7

million annually by 2009-2010 (Paper 7 and Figure 1). Population momentum and demographic goals, one inevitable and the other desired, combine to create a costly future, especially for the GOE/MOHP if it is to assume all of the increased cost.

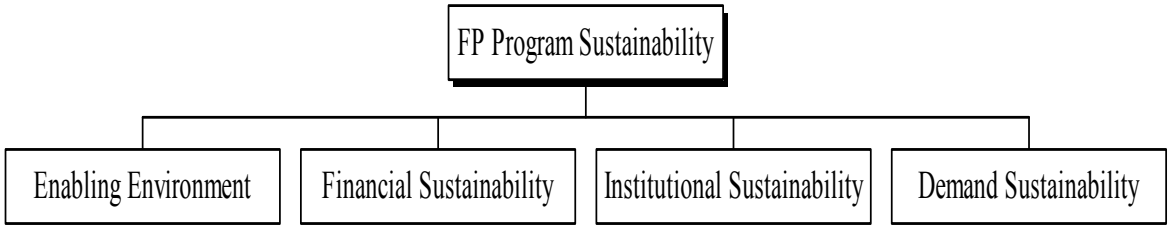
In addition to the financial gap that a donor phaseout might leave for the population program, there is also concern that program elements that have been successful in bringing about the success of family planning in Egypt may not be able to be maintained by the institutions responsible. Demand for family planning has, to a large extent, increased due to the media and information, education, and communication (IEC) campaigns that donor projects have supported. Institutional capacities in the form of trained health personnel, standards of practice, and clinic renovations and equipment, as well as management information systems, also require maintenance and expansion. In addition, political support as well as a favorable legal and regulatory environment must be maintained in the face of other competing social programs for the program to survive and flourish.

3 Approach to Sustainability

3.1 Sustainability: A Conceptual Model

Both the supply of and demand for family planning and health services must be sustained in order to achieve a viable, self-reliant system that perpetuates and improves on healthy outcomes. For a more detailed description of the conceptual model and the associated principles used herein, see POP IV (2000). For this paper and for the designing of an integrated sustainability strategy, we have simplified the POP IV framework to four main components, as shown in Figure 2. The sustainability model identifies four main components of system sustainability: Enabling Environment, Financial Sustainability, Institutional Sustainability, and Demand Sustainability. Although presented separately, the four components are, in fact, interrelated.

Figure 2: Simplified Sustainability Framework



Operational Definitions*:*

In order to operationalize the concept of "sustainability" and to monitor and evaluate its individual components and whether the program is achieving sustainability, the following definitions are used. Overall program sustainability is defined first, which is the main goal. To achieve overall program sustainability, four intermediate goals pertaining to the four components are required.

Family Planning Program Sustainability: *The national family planning program and its public, private and NGO institutions can provide current and potential clients with the information and services necessary to obtain the benefits of quality family planning on a continuous basis without external aid.*

Family planning program sustainability can only be attained if four intermediate elements of program sustainability are attained.

1. Enabling Environment: *National policies promote, laws and regulations allow, and plans sustain access to high-quality family planning services*.

An enabling environment supports the formulation and implementation of sound policy; ensures coordination and collaboration among donors and host governments to promote efficient and effective use of resources; and guarantees community participation and empowerment. It also ensures that laws and regulations do not hinder the supply of demand for services. Such a context or environment fosters the sustainability of other efforts for family planning and health service provision. Whereas the elements of an enabling environment are often considered directly associated with institutions and systems, they also apply to sustainability of demand issues. Increased community involvement fosters greater community support for family planning and health services and healthy behaviors.

Four aspects of enabling environment are relevant to Egypt: the policy process (encompassing policy formulation, implementation, and evaluation), legal and regulatory environment, health sector reforms, and community empowerment.

2. Financial Sustainability: *National financial resources (public and private) are sufficient to purchase the resources necessary to support the current and anticipated future demand for quality family planning services on a continuous basis*.

Local resources must be available in order to replace donor funding as it declines or is withdrawn and to finance increased demand. Under financial sustainability are public sector financing and private sector financing categories. Resource mobilization and efficient allocation and use of resources are sub-elements. All of these affect both public and private sector resources in the health system. Financial sustainability must also be supported by an enabling environment. For example, laws must allow cost recovery if that is the strategy chosen. Similarly, institutions must have the capability to collect and account for revenues so generated and demand should not be compromised.

3. Institutional Sustainability: *National family planning institutions (public, private, and NGO) have the capacity to provide family planning clients with quality services and contraceptives on a continuous basis whenever and wherever they are requested.*

One key element of the sustainability of the family planning program is the capacity of the service delivery system to meet the needs of clients. This means that the supply side must be able to provide quality services that reflect the needs and desires of those who wish to practice family planning. "Institution" is used in the broadest sense, going beyond the definition linked to a physical structure (four walls). In addition to the standard health institutions or clinics and hospitals are the organizing and managing institution, such as the MOHP, NGOs, and private sector institutions. Also included are institutions such as community health groups, households, and individuals.

Experience with institutions suggests that a very important factor in the sustainability of institutional strength is the presence of well-developed "systems." Institutions with well-developed systems are more likely to be effective and survive in the future than institutions without well-developed systems. Sustainable institutional capacity includes four categories: Planning and Management, Human Resources, Information Systems, and Logistics.

4. Demand Sustainability: *Continued growth in the proportion of couples of reproductive age that choose to space and limit their births by freely choosing effective and quality family planning methods that are appropriate for their individual circumstances.*

Demand sustainability has several components. The costs to users can affect demand as with any good or service. Costs to users not only include contraceptive costs and service fees incurred at the point of service (clinic), but also travel costs, waiting time, and laboratory costs in some cases. Demand growth involves a component generated by the growth in MWRA that is outside of programmatic and policy control (for the short term). A more important component of demand growth from the standpoint of

demand sustainability is increases in the propensity to use contraception as reflected in CPR. Increases in CPR can arise from changes in desired family size or from an increase desire to space births. Increases can also result from more or better information on accessing family planning services and contraceptives availability. In these cases, the role of IEC and the media are important.

In addition, supply and demand issues are interwoven. No service, whether public or private, can be provided unless there is a demand.

4 Key Issues Influencing the Sustainability of the Population Sector

The four main sustainability areas outlined above will be examined in this section in terms of key issues, favorable and unfavorable factors and potential strategies to achieve sustainability. Annex Tables 1 and 2 (found in Annexes II and III) provide a detailed strengths, weaknesses, opportunities, and threats (SWOT) analysis of the health and population sector.

Box 1
Enabling Environment: Issues and Challenges

Policy Process
- ✓ Involving key stakeholders
- ✓ Support at the highest levels of management
- ✓ Use of information in policymaking

Legal and Regulatory Environment
- ✓ Regulations and policies that govern the importation of products and protect local production
- ✓ Requirements for the registration of pharmaceutical products
- ✓ Controls over product pricing
- ✓ Availability of free or low-priced competitive products through public sector channels
- ✓ Quality control in public and private sectors
- ✓ Private practice by government doctors
- ✓ Laws governing the advertising of pharmaceutical products

Health Sector Reform
- ✓ Basic Service Package: (1) inclusion of FP services and (2) Role of the private sector in the delivery of basic service package
- ✓ Prepayment and social health insurance
- ✓ Family health fund
- ✓ Government subsidies and individual roster fee premiums
- ✓ Co-payment and user fee
- ✓ Accreditation of providers
- ✓ Integration of primary health care
- ✓ Incentive-based provider payment mechanisms
- ✓ New future role of the MOHP

4.1 Enabling Environment

Part of the success of Egypt's family planning program has been due to the favorable environment for the program. Political support for the program has been high. As recently as April 2001, President Mubarak stated that the population has remained the country's main problem, and the prime minister submitted a budget based on the same premise. Despite such high-level support, it is necessary to continually reinforce an enabling environment in order to ensure that family planning programs can function smoothly, adequate resources are actually disbursed, and laws, regulations, and cultural barriers do not impede progress. Thus, it is important that the program not fall victim to its own success and experience waning budgetary support in the coming years, especially as donor funds diminish in importance and other development challenges arise.

As far back as 1962, Egypt's National Charter declared that "population increase is the most dangerous obstacle that faces the Egyptian people" (Robinson and El Zanaty, 1995). Egypt, of course, was at the forefront of the 1994 International Conference on Population and Development (ICPD). While the basic tenants of Egypt's population policy and the ICPD are still relevant, the program's current status in the face of unprecedented demand for family planning in an era of health policy reform demands a policy review.

Thus, the sustainability strategy may be seen as an important component of the policy and the policy process.

There are a number of critical policy issues to be addressed if the program's sustainability goals are to be met. These cut across other sustainability areas and range from high-level population policy issues to lower level operational program policies at the clinic level. Box 1 above presents a list of some issues and challenges regarding the policy process, legal and regulatory environment, and health sector reform. For example, pricing policy in the public sector needs to be examined as an alternative and within the larger context of health sector reform. Similarly, policies regarding providers' roles in clinics and pharmacies may bear additional examination. Other policy issues and choices are outlined below.

Factors Influencing an Enabling Environment

Favorable Factors	Unfavorable Factors
Policy Process o Supportive leadership o Attention and concern of the top leadership	o Lack of continuity in leadership o Inadequate policy analysis capacity in the system o Not enough MOHP focus on long-term planning in relation to sustainability o Private sector in not involved in policy formulation o Information is not utilized effectively in policy making o Introduction of user-fees is a politically sensitive issue
Legal and Regulatory Environment o The legal and regulatory analysis conducted in 1993 played a major role in changing the law that prevented general practitioners from administering Depo Provera	o Lack of comprehensive legal and regulatory mechanisms for the private sector o Lack of incentive system for the private sector o No quality control program for the private sector; the private sector is not included in the Gold Star Clinic System o Government price controls on commodities restrict active private sector participation in the family planning sector o Requirements for annual import licenses for pharmaceuticals
Health Sector Reforms o Integrated primary health care "package," including family planning o Competitive bidding for service providers o Incentive-based provider payment systems o National health insurance and prepayments o Family health fund	o Unclear what mechanisms will be put in place under health sector reforms (HSR) to protect the poor, to encourage use of certain services and to serve under-served geographic areas

4.1.1 Strategies for a Sustainable Enabling Environment

An enabling environment supports the formulation and implementation of sound policy; ensures coordination and collaboration among donors, private sector, and government in the promotion of efficient and effective use of resources; and guarantees active community participation and empowerment.

A. Policy Process

Policy is defined as a deliberate decision binding the whole system to address a given issue in a certain way. Concern for and commitment to solving the problem, sound understanding of the problem (its gravity, distribution, and causes), and availability of at least some effective method for solving the problem are the prerequisite conditions for sound policy development. It is not enough merely to create a policy; it must be implemented, enforced, then evaluated to achieve the desired impact. The following are some potential strategy options for strengthening the policy process and developing a sound policy:

- Develop an advocacy strategy to communicate the long-term sustainability strategy/issues.
- Advocate unequivocal support and commitment for family planning by central and governorate leadership.
- Develop a well-conceived, analysis-based policy, which recognizes and involves the private sector and assigns them roles.
- Develop a sectorwide, long-term, family planning program sustainability strategy, which includes both public and private sectors.
- Involve all stakeholders to share common concerns and actively participate to broaden policy dialogue.
- Foster communication and open discussion based on sound information between public and private sectors to improve public—private collaboration in policymaking.

B. Legal and Regulatory Environment

Current practices and regulations in Egypt restrict the private sector's ability to respond to the market, causing unnecessary delays in registration and licensing. Some restrictions on the advertising of public health products discourage participation by the commercial sector in the production and marketing of public health commodities. The following presents a range of incentive and regulatory options/instruments for influencing the behavior of public and private health providers:

- Design a comprehensive incentive and regulatory systems/mechanisms for both public and private sectors.
- Lower legal and regulatory barriers to private sector participation by
  - Exempting contraceptive imports from import duty,
  - Relaxing government price controls on commodities.
  - Allowing commercial product promotion and distribution channels to sell contraceptives,
  - Reviewing the current practice of issuing yearly import licenses,
  - Revising/loosening the current laws governing the advertising of pharmaceutical products including contraceptives, and

- Allowing low-cost advertising of family planning products and services through broadcast media.

- Enforce regulatory controls to ensure safe and affordable service delivery by
  - Allowing the periodic re-licensing of medical practices,
  - Allowing doctors to work only in one sector,
  - Accrediting practitioners and facilities by professional bodies to conform to a defined minimum quality standard, and
  - Allowing the mandatory posting of physicians in rural and under-served areas (developing a set of reforms and incentives designed to encourage physician attendance at their rural assignments).
- Facilitate self-regulations among competing entities.

C. Proactive Role in Health Sector Reform

The MOHP is embarking on a series of broad health sector reforms that will affect how the system will be financed and will function in the future. These reforms may have an impact on family planning services, family planning financing, and human resource availability. Annex Table 2 (Annex III) provides a detailed description of the possible impact of health sector reforms on family planning program sustainability. The concepts and approaches to service delivery (integrated primary health care), resource allocation (national health insurance), and financing systems (competitive bidding for service providers), among others, will, if implemented, have dramatic effects on all of the programs of the MOHP:

- Include sustainability issues in strategic planning and HSR.
- Promote risk-sharing and collection of contributions, according to ability to pay under HSR.
- Expand social health insurance coverage under HSR:
  - Have payments for family planning subsidized either by GOE or by other members on a risk-pooling basis;
  - Have people who can afford to pay prepay a premium; and
  - Transform the social insurance program (HIO) into a financing organization.
- Design and implement an affordable package of basic health services, including family planning:
  - Have everyone enrolled entitled to a basic package of services, including family planning; and
  - Have self-referral to another provider covered on a fee-for-service basis; and have referral by the designated provider (gate keeper) free, or a nominal charge.
- Continue having government subsidize certain services, such as family planning, and certain population groups:
  - Which services, which people, and what mechanisms?
- Keep co-payments and user fees in effect to discourage unnecessary use and to generate revenue:
  - Increase out-of-pocket payments by members;
  - Prepay premiums as well as “registration” or “consultation” fees at time of receipt of services; and
  - Have no specific payments for family planning alone.
- Organize public and private service delivery into one system centered on a holistic family health approach.

4.2 Financial Sustainability

The overriding financial sustainability issue is whether resources will be forthcoming to meet the demands of the family planning system, especially in the public sector. In the face of other competing demands for public sector expenditures, it is important for the family planning program that the financial gap left by donor phaseout, currently paying for 47 percent of the costs, be replaced by national resources.

In general, two broad strategies can be adopted: (1) more resources brought to bear on the family planning sector budget, and/or (2) expenditures reduced. Within each of these strategies, there are a number of options the choice of which will depend on efficacy, impact on the program, and political acceptability. Public health expenditure is around 3 percent of total government expenditures. It is estimated that if the government were to assume the 47 percent of family planning costs paid by donors, family planning costs would amount to around 10 percent of total public health expenditures (Moreland, 2000). Given the increased emphasis on preventive care under the current health reform program of the MOHP, as well as other nonhealth development expenditures, can such an increase within the health sector be expected? The political will to allocate public resources must exist in the context of an enabling environment.

Box 2
Financial Sustainability: Issues and Challenges

Resources needed for

- ✓ Operations and management of the system
- ✓ Supervision
- ✓ FP commodities and supplies
- ✓ Training and capacity building
- ✓ Maintaining Gold Star system and improving qualityMaintenance
- ✓ IEC and advocacy
- ✓ Research and technical work
- ✓ Commodities and supplies for NGOs
- ✓ Ongoing implementation of strategic planning process
- ✓ New management information system (MIS) requirements and technology (often updated within three years)
- ✓ Programs to broaden method mix options and improve communications and counseling
- ✓ Ensuring proper environment for FP programs
- ✓ Supporting the local manufacture of FP commodities and supplies

The role of public, private, and NGO sectors is a financial sustainability issue because each sector has different financing systems. Although the private sector and the NGOs have been declining in importance, because they have higher cost recovery rates, increases in their market share offers an opportunity for financing. Other cost-recovery mechanisms within the public sector that are and should be studied include insurance and pricing structures geared to ability-to-pay.

Reducing costs is another finance strategy. At a system level, some of the elements of donor projects that are costly may not be continued when the projects cease, thus reducing costs. Such decisions, of course, must consider whether the program's performance will suffer. Other cost-cutting opportunities may be possible by examining resource allocations within the existing system through productivity and cost-effectiveness analysis. However, a crosscutting sustainability issue here is whether there is (1) the institutional capacity to generate and analyze the necessary information for such analyses, and (2) the political will to make the hard resource-reallocation decisions that can reduce costs.

Factors Influencing Financial Sustainability

Favorable Factors	Unfavorable Factors
Allocation and Use of Resources o Decentralized resource planning and management facilitate need-based allocation of resources	o Supervision and meetings are highly subsidized by USAID under the Gold Star system o Government resources are not targeted effectively o Competition between public sector and NGO/private sector o Private spending is regressive and favors the high-income groups. o Mobile clinics are underutilized o The generated revenue through sale of contraceptives is used to provide financial incentives to FP clinic staff o FP subsidies are benefiting the poor and nonpoor alike o Public funds go to cost-ineffective services o Financial information is not used in decision making
Mobilization of Resources o There is an increase in total real health expenditure per capita and it is likely to increase further o 50:50 split between public and private spending o Presence of HIO o Government provides contraceptives at nominal price to the private sector o Availability of multiple sources of contraceptive supplies.	o Heavy donor dependence o Low share of FP in total GOE health spending and household health spending o High dependence on donated and imported contraceptives o Projections indicate huge future demand for contraceptives o Nominal fee and low cost recovery o "Leakage" of subsidies to people who are willing and able to pay but do not have to

4.2.1 Strategies for Financial Sustainability

The population sector needs to mobilize additional resources from alternative sources and use the existing resources more efficiently in order to achieve financial sustainability. Box 2 presents a list of financial sustainability issues and challenges that need to be addressed while developing a financial sustainability strategy.

A. Mobilizing Additional Resources

The GOE alone cannot meet the growing family planning needs in the absence of donor support. It must recognize budget limitations and look for alternative sources of financing for moving progressively toward long-term financial sustainability. The potential sources of financing include the following:

- Increased government budgetary allocation for the family planning program.
- Expansion of HIO coverage.
- Increased user fees for family planning services and/or commodities, which includes
  - User fees for services and/or commodities;
  - Sliding scale fees;
  - Retention and use of revenue (providing incentives to providers/ offsetting cost of FP program/ improving quality of services/ depositing in the treasury);
  - Exemption criteria and mechanisms;
  - Establishment of effective financial management and organizational systems, and
  - Review and revision of existing mechanisms and structures.
- Increased private sector role in financing of FP services and commodities, including
  - Financing of commodity supplies through a combination of government subsidy and private investment;
  - Social marketing-subsidized products sold through commercial channels;
  - Private health insurance for employers and businesses; and
  - Private contributions.
- Introduction of community-based prepayment schemes.
- Establishment of community solidarity funds.
- Obtaining of another donor's support for donation of contraceptives.
- Establishment of revolving fund scheme for contraceptives.
- Review of the provision of contraceptives at nominal price to the private sector.

B. Efficient Allocation and Use of Resources

Efforts in improving system's efficiency and effectiveness can and will save resources, allowing them to go to priority programs and services. Efforts in this regard include the following:

- Promotion of the strategic use of resources, including
  - Targeting public sector resources;
  - Delegating responsibility to NGOs for geographic areas, populations, or specific family planning services; and
  - Encouraging wealthier clients to use private sector services.
- Inclusion of family planning in the basic services package.
- Local manufacturing of family planning commodities.
- Subsidizing family planning services and commodities, for target population/for all/no subsidies.
- Contracting out family planning service delivery to accredited providers.
- Maximization of cost-effective family planning interventions and method mix.
- Expansion and sustaining of the Gold Star system.

- Inclusion of private sector in the Gold Star system.
- Reduction of costs of meetings and supervision.

4.3 Institutional Sustainability

Box 3
Institutional Sustainability: Issues and Challenges

- ✓ FP leadership requirements: continuity, and capacity for policy analysis
- ✓ Scenario analyses and population projections
- ✓ Commodity procurement systems
- ✓ Reform of the organizational structure of the MOHP, with focus on integration, coordination, and communications
- ✓ Reforms in managerial capacity and systems, with emphasis on financing, regulation, accreditation, human resources planning, supervision, performance management, and incentive systems
- ✓ Information systems: utilization of information in decision making and planning

The ability of the health care system in Egypt in the public, private, and NGO sectors to deliver and have available contraceptives and services that clients require is, of course, fundamental. Institutional capacity refers to the capacity of the service delivery institutions to fulfill demand in a timely and appropriate fashion. Capacities must be in place at all levels—from the MOHP and central administration of an NGO or private hospital, to the clinic administrative and management units, to the services providers themselves. Any weaknesses in this chain will threaten the sustainability of the supply system and hence overall sustainability.

In the public sector, one of the critical issues is how family planning services, which are being provided in basically a vertical system, can continue to be provided and grow in a system that may become horizontal in light of reform efforts. Institutional safeguards must be introduced that to ensure that family planning services continue to receive the resources—human, clinical, and commodities—that are required. Another issue facing the public sector is how to ensure that qualified service providers are continuously available in clinics, especially rural ones. Other resource issues, such as availability of quality contraceptives at the clinic level, present challenges as the MOHP moves from donor-supplied commodities.

The MOHP also faces issues that will affect its long-term sustainability in defining who its client base is and how best to reach that client base. Strategies related to market segmentation and how best to achieve that are relevant here, as are strategies to reach "underserved" and "unserved" areas.

The private sector in Egypt consists of (1) private physicians and clinics that provide family planning services in connection with Ob–Gyn services, (2) public sector physicians who operate out of public sector facilities during "economic" hours, and (3) pharmacies that provide a large share of oral contraceptives in the Egyptian market. This mixing of public and private sectors poses a potential threat to the latter, since there is a built-in dependency. Another issue relates to quality. Research suggests that quality in the private sector, as viewed by clients, is deemed superior to that of the public sector, despite the substantial gains made under the QIP in the public sector. Hence, sustainability of the quality of services is important if the private sector is to maintain edge. Given that the private sector is by definition financially sustainable, its future share is important.

Factors Influencing Institutional Sustainability

Favorable Factors	Unfavorable Factors
Facilities o Extensive network of primary health care (PHC) facilities o Equal market split between public and private sector o Presence of a large number of pharmacies	o MOHP PHC facilities lack basic inputs, supplies, and drugs o NGO sector is small and has limited power o Lack of coordination between government and NGOs o Unequal spatial distribution of private sector clinics in rural/urban and lower/upper Egypt
Human Resources o Rich supply of qualified, trained and professional staff o Presence of well-developed FP/MCH in-service trainings for all categories of FP service providers.	o Geographical and functional mal-distribution of manpower o High quantity of FP staff that are allocated inefficiently o Weak capacity in strategic planning, investment management, cost accounting, and budgeting o Subjective decision-making processes and rarely information-based o Inadequate incentive schemes for personnel
Management Systems o Highly successful Gold Star Clinic System o Increase in public sector market share due to quality improvement o Good MIS	o Functional and structural fragmentation of the services delivery system o Incremental budgeting o Cumbersome procedures of releasing money by the Ministry of Finance (MOF) for MOHP activities

4.3.1 Strategies for Institutional Sustainability

Building institutional and human resource capacities to take on the responsibility of financing and delivering family planning services in the absence of financial and technical support from the donor is a challenge for the population sector. The system needs to be strengthened in the areas listed in Box 3 in order to realize the desired goal. This sustainability process actually provides an opportunity to build internal capacity in order that, over time, it becomes less vulnerable to hostile external shocks.

A. Human Resource Capacity

Egypt's public health care system has a rich supply of professional human resources. The commitment and active participation of professional staff is highly desirable in the sustainability process. The whole system needs to be energized by empowerment.

- Rationalization of staffing patterns.
- Development of new MOHP roles in national policymaking and sectoral planning and in regulation, accreditation, and quality assurance (QA).
- Development of output-based performance evaluation systems.

- Building of managerial capacity in strategic planning, resource allocation, management and use, human resources development, and supervision.
- Development of capacity and skills to use analytic information in decision making and program planning initiatives.
- Building of technical and managerial capacities of private sector/NGO providers.

B. Management and Institutional Capacity

An important factor in the sustainability of institutional strength is the presence of well-developed systems. Institutions with well-developed systems are more likely to be effective in the future than are institutions without systems. Sustainable systems contribute to sustainable quality, which also contributes to the population's satisfaction, attitude, and continued use of services.

- Building of capacity to design, implement, and enforce regulatory policies and mechanisms.
- Reorganization of the organizational structure of the MOHP, focusing on integration, coordination, and communications.
- Institutionalization of analytic skills necessary for successful logistics planning (commodity and budget forecasting to procure the right kinds and right amounts of contraceptives at the right time).
- Institutionalization of the National Health Accounts (sources and uses of funds) approach.
- Building of capacity in need assessment and priority setting.
- Development of coordinated procedures for funding and procurement of contraceptives.
- Balancing of the mix of resources to ensure a closer match between skills and functions.
- Establishment of better match between public-private roles, and capabilities, which includes
  - Assigning public and private sector roles in consideration of market size, demand for family planning services and commodities, and the ability and willingness of consumers to pay for family planning services and commodities;
  - Defining which sets of services each sector can handle most effectively, and ensuring that the work done in each sector complements the work done in the other; and
  - Defining MOHP's stewardship function.

4.4 Sustainability of Demand

Demand is the fundamental engine of the family planning system. Unless Egyptian couples continue to want to control their fertility and use family planning methods, the other components of the system are irrelevant. Understanding the demand side and capitalizing on this knowledge is the key to making the service delivery system responsive. As defined previously, sustainability of demand is defined here not merely as growth in demand, but more specifically, as an increases in CPR. With a current CPR of 56 percent and a goal of 70 percent to reach replacement-level fertility in

Box 4
Sustainability of Demand: Issues and Challenges

- ✓ Utilization of FP service by poor
- ✓ Demand of FP services and commodities
- ✓ Equity in resource distribution
- ✓ Protection mechanisms for poor
- ✓ Community participation and empowerment
- ✓ Defining FP needs
- ✓ Awareness generation and advocacy at the community level
- ✓ Willingness and ability to pay
- ✓ Attitude and behavioral changes

2015, sustainability of demand requires achieving an additional 14 percent prevalence.

This 14 percent increase will necessitate identifying population groups that are not currently using contraceptives but want to limit or space their births (unmet need.) According to the 2000 EDHS, unmet need was 11.2 percent. Therefore, if unmet need were completely erased, CPR would come close to that required to reach replacement-level fertility. Reaching these prospective client groups and successfully getting them to receive services is the demand challenge. The major provider groups in Egypt—public clinics, private physicians and clinics, pharmacies, and NGOs—all have different but overlapping client bases in terms of socioeconomic status (SES.) Unmet need for spacing and for limiting require different methods and have different service requirements and different IEC and mass media strategies. Similarly, within spacers and limiters, there are different SES groups. Given the market segmentation between the provider groups, demand strategies will differ. What is important for sustainability is that these strategies be developed and carried out in order that, to the largest extent possible, unmet need is met.

While satisfying unmet need is necessary to raise CPR, it is probably not sufficient. It is unlikely that any country will ever have, or even want to have, zero unmet need. If as much as 90 percent of unmet need is met, that leaves another 5 percent increase in CPR in order to achieve 70 percent. Where will this 5 percent come from? Some may come from the momentum of Egyptian society to move to a system in which smaller families are the norm, especially through improvements in female education. The demand challenge is also to capitalize on this. A potential source of new demand is young married couples, especially those that have yet to start families.

A crosscutting sustainability issue is that of the future role of media advertising and IEC efforts that have been supported by USAID. With a large segment of the population still illiterate, the use of television as a means of communication is an efficient strategy. Sustainability issues are whether the SIS and the MOHP can and will continue to collaborate in the absence of USAID and whether these institutions have the capacity to carry on with the media and IEC to reach new audiences in order to sustain demand.

Factors Influencing Sustainability of Demand

Favorable Factors	Unfavorable Factors
o A large number of FP clients are actually paying for FP services o A larger number of clients are willing to pay than actually pay o Public health care system is affordable and poor are exempt from fees o Households are the single most important source of health financing o The poor rely more on MOHP facilities than the rich	o Increasing demand for contraceptives o Households spend the bulk of their funds in private sector, especially in pharmacies, and to a lesser extent private clinics o No clear criteria for means testing and exemptions o The poor spend a higher percent of their income on health than the rich o Lower use rates of all health services by lower income groups

4.4.1 Strategies for Sustainability of Demand

Sustainability of demand is an essential ingredient in the sustained flow of benefits. Community-based strategies for generating community support, protecting the poor and needy groups, segmenting the market, creating demand, and promoting healthy behaviors can support the sustainability process significantly. This section presents a number of demand-side strategy options that address the issues and challenges listed in Box 4.

A. Market Segmentation

The private sector shares 50 percent of the responsibility of financing and delivery of family planning services. Thus, Egypt holds a strong advantage over countries struggling with initial market segmentation efforts. Currently, the market is well segmented across the providers supplying family planning services (Smith et al., 1998).

- Price segmentation in the pharmaceutical market.
- Identification and targeting of "needy" groups deserving of public subsidies, such as
  - Poor, rural residents who have a high unmet need; and
  - Poor people in rural areas and people living in Upper Egypt.

B. IEC and Advocacy

Advocacy is usually performed by NGO sector. In Egypt, however, the NGO sector is weak and fragmented. Much IEC work has been led by donor efforts.

- Creation of demand for family planning services through effective IEC and advocacy.
- Encouragement of the poor to use family planning services.
- Changing of the sense of entitlement to free family planning services for everyone.
- Creation of effective Egyptian IEC and advocacy capacities.

C. Protection of the Poor/Disadvantaged

The MOHP program is currently using three methods to protect the poor: (1) direct targeting by providing waivers on demand; (2) use of exemptions implemented by place, time, and service type; and (3) prices that are fixed below cost (Paper 5). Effective protection mechanisms can ensure equitable access to family planning services and commodities on a continuous basis.

- Designing and implementation of effective means-testing mechanisms for the poor, such as
  - Service providers verifying the eligibility of prospective patients;
  - Authorized public representatives issuing indigent certificates;
  - Issuing health cards to poor families;
  - Self-selecting by those identifying themselves as poor and in need of free services; and
  - Community responsibility of identifying the poor.
- Identification of the poor and disadvantaged with precision and directly subsidize them in proportion to their inability to pay.
- Improvement of the accessibility and quality of family planning services in Upper Egypt and rural areas.
- Determination of the percentage of women need fee waiver and subsidized care.

D. Community Support

Long-term sustainability cannot be achieved without active community participation and support in decision making. Community support and empowerment are crucial in maintaining long-term demand for family planning services. This section provides some community-based strategy-options.

- Mobilization of the community and facilitation of its active participation in the management and support of the local health system.
- Perpetuation of demand for family planning and health services and healthy behaviors through NGOs, field-based staff, and community-based organizations.
- Designing of stable, effective, locally based, and supported mechanisms for stimulating demand or for promoting healthy behaviors.
- Involvement of local organizations capable of designing, implementing, and evaluating a communication campaign promoting healthy behaviors.
- Involvement of the community in identifying needs and setting priorities.

5 Conclusion

Sustainability requires more than simply replacing donor money. Both the supply of and demand for family planning must be sustained to achieve a viable, self-reliant system that perpetuates a sustained flow of benefits.

This paper has discussed a number of issues, challenges, and strategy-options for achieving the sustainability, under four components of sustainability. All four components—enabling environment, financial sustainability, institutional sustainability, and sustainability of demand—while considered as independent, are highly interrelated and work in close association toward this goal.

Development of an overall sustainability strategy should take into account relationships that exist between these components. In addition, there are a number of crosscutting issues (e.g., private sector, health sector reform, etc.) that need to be included under each component.

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Annex I

Feasibility Issues

In the development of a long-term sustainability strategy the selection of a sound, cost-effective, and feasible option among alternative strategies is important. An assessment of feasibility takes into account financial, technical, sociopolitical, and managerial feasibility of alternative strategies. This annex discusses some feasibility issues for a couple of potential strategy options.

1. Nationwide Expansion of Cost Sharing Schemes

One strategy that is often considered when dealing with sustainability is cost sharing. Such a strategy touches on all four substrategies. Nationwide expansion of cost sharing schemes can have access and affordability implications (demand) for the lower middle income and lower income population groups. However, a NPC (1997) study reveals that family planning clients actually pay for services and are willing to pay more. Moreover, family planning consumes a low proportion of household expenditures (i.e., less than 0.2 percent).

In the absence of adequate mechanisms to ensure access to indigent populations, expansion of user fees can face resistance from the public, the People's Assembly, opposition parties, and the press (enabling environment.) Expanded cost sharing programs would have low opposition expected from donors (Paper 5).

User Fees

Advantages	Disadvantages
▪ Can offset costs and help provide substantial financial support to program	▪ Politically sensitive
▪ Potential source of self-generating revenues of FP services (as opposed to relying on GOE budget for funds)	▪ Considerable historical resistance
▪ Market will allow clients to select providers based on perceptions of price and quality (segmentation)	▪ Revenues are used for providing financial incentives to the providers
▪ Greater advantage of quality improvements for poor	▪ Can negatively affect demand of services
▪ Free up government resources to focus on those who cannot afford to pay	

Source: Paper 7

Cost recovery with quality improvements in the GOE facilities can reduce market share for private practitioners, including dual-employed MOHP physicians who will oppose changes.

The constitution stipulates that free medical care is a basic right for all Egyptians. Nationwide expansion of cost-recovery systems is not the preferred MOHP policy. Even in the event of supporting the use of fee-for-service systems on a large scale, the GOE will only authorize charging modest or minimal fees. Moreover, the GOE still pledges its commitment to support—at least in theory—indigent populations and is not likely to eliminate subsidies for this purpose until an alternative social protection mechanism is in place.

The WHO (2000) recommends against user fees in public health facilities. According to the WHO, user fees can impose regressive payments, in which those least able to contribute pay proportionately more than the better off. Furthermore, user fees for preventive and primary care, especially for interventions for the public good, deter the use of services by those most needing them (Musgrove, 1996).

Nationwide expansion of cost-sharing schemes is a controversial issue. This decision needs the following information and analyses:

- Research to assess the impact of possible contraceptive price changes on use, method, and provider choice, program effectiveness, and levels of revenue generated (Paper 4).
- Research to examine the relationship between subsidy, price, use, and program effectiveness (Paper 4)

Experience in other developing countries suggests that user fees when implemented with effective mechanisms to protect the poor can produce very positive and encouraging results in terms of cost recovery and improvement in the quality of services. An institutional capacity issue that is raised by user fees is the capacity of the clinics and health offices to collect the revenues and to account for them.

2. Involving the Private Sector in the Achievement of Sustainability Goals

Increasingly, policymakers and analysts in developing countries are noticing the role of the private sector in delivering health and family planning services, because governments alone cannot meet the growing demand for health and family planning services and commodities; the private sector has already a major stake in health care and family planning service provision; and because of changing perspective of the international community in favor of greater private sector participation. There is a growing consensus that a better match between the role of the public and private sectors and their respective capabilities need to be established. In such a redefined role, the public sector would largely perform a stewardship function and create an environment in which the private sector can help the state achieve its goals in the health and population sector.

In Egypt, the private sector shares the responsibility of delivering and financing family planning services and commodities. As a result, its involvement is important in the ongoing strategic planning process and future health sector reforms.

The private sector is the preferred source of care for the richer section of the population. Encouraging the private sector to play a greater role would allow the government to refocus its efforts to reach the poorest and neediest populations.

Most private providers are likely to react negatively to reforms that enhance the MOHP's role in the regulation, accreditation, and quality control of private services. If, for example, the proposed strategy is likely to make the MOHP and public sector providers more competitive by improving the quality of services at MOHP clinics, the private sector may react by altering prices, services, or quality. On the other hand, if the proposed strategy attempts to expand the role of the private sector in the provision of family planning services by improving the business environment, the strategy is likely to be embraced by private providers (Paper 8).

NGOs have the potential of becoming active and effective participants if invited to join the debate. The MOHP is appreciative of the role of the NGOs in community mobilization, advocacy, and monitoring. MOHP's current view, however, is that NGOs need to be viable enough to raise their own funds and provide quality services if they are to become extensively involved in service delivery. Lack of communication and trust between the public and private sector and lack of information about the market may impede active participation of the private sector in planning and implementation.

The following information identifies market niches and determines the public/private roles in the delivery and financing of family planning services and commodities:

- Sources and uses of funds.
- Market segments by income, source of care, and family planning needs.
- Relevant policies, laws, and regulations.

- Willingness to pay and ability to pay.
- Provider market structure, market niches, and market potential.

Government's stewardship role becomes important in ensuring the achievement of equity goals, harnessing the full potential of the private sector, and preventing unnecessary market failure. A private sector strategy involves all four substrategies. It responds to demand in as much as clients who are able and willing to pay for services will receive them. By the same token, it is a financial sustainability strategy in so far as the private sector must fully cover its costs. Institutionally, the private sector also is sustainable since its competitive structure forces it to develop internal support systems, and it must offer services that are of relatively high quality that paying clients want. Finally, perhaps the biggest challenge facing the private sector is a favorable environment. Such a dominant position of the public sector laws and regulations governing the private sector may hinder it rather than help it; however, this situation would need to be reviewed. Lastly, public and popular support for a larger public sector role would need to be generated.

Annex II

Annex Table 1: Public Health and Population System Diagnosis

STRENGTHS	WEAKNESSES
Inputs	
Health Care and FP Facilities o One of the most extensive PHC network in developing world. It allows 99 percent of population to live within a 4-kilometer radius of any health facility (Paper 10) o Grassroots level network of rural health units linked to rural health centers or hospitals (Paper 10) o MOHP clinics act as social safety net. In MOHP facilities, the poor and near poor are served at low or no price. CSI is established to serve middle class, not the poor. Its fees are significantly higher and no fee waivers are issued to the poor (Paper 5).	o More health care and FP facilities are located in urban and well-developed areas
Human Resources o Public sector providers can be categorized as permanent, seconded from other sector and contracted (Paper 1) o Eager, well-trained staff who, if mobilized, can serve as effective change agents (Paper 10) o Rich supply of professionals – Egypt has a ratio of one physician for every 525 persons. There is one MOHP physician per 1265 persons (Paper 10). o Physician/nurse ratio is comparable with industrialized countries. The physician/nurse ratio is 1.63 for the total, 2.24 in PHC, and 1.4 in preventive services (Paper 10).	o Female practitioners are not enough (Paper 9). o Geographical and functional mal-distribution of manpower. There are generally more physicians and nurses in richer areas (Paper 5). o High quantity of FP staff that are allocated inefficiently. High Doctor/nurse ratio limits systems' ability to use professionals for what they are trained for, instead using them for lower level duties and activities (Paper 6) o Lack of manpower planning, job-design, or career planning capacity (Paper 10) o Most physicians have more then one job, with usually one in private and one in public sectors. About 89 percent have multiple jobs. 73 percent have two jobs, 14 percent have three jobs, and 2 percent have 4 jobs. In MOHP facilities, 53 percent of physicians have multiple jobs (Paper 10). o In rural areas the physician providing private care and the physician providing public care are usually one and the same. This implies that there is no effective distinction between the private provider market and the provision of public care in rural areas. It is more or less same in the urban areas (Paper 10).

STRENGTHS	WEAKNESSES
Equipment and Supplies	○ MOHP primary health facilities lack basic inputs, supplies and drugs (Paper 6)
Health Care and FP Expenditure ○ Egypt spends 4.3 percent of its GDP on health. Total real health expenditure per capita increased from £E 126 in 1990/1 to £E 148 in 1994/5—an 18 percent real increase (Paper 4). ○ Real per capita expenditure for health is expected to grow at 4–5 percent per annum during the next decade (Paper 4). ○ About 38 to 41 percent of health sector financing derives from public sector sources. The remaining financing comes from private sector sources, with households dominating at 51 to 55 percent. The role of firms as a source of financing is growing with contributions estimated to have increase from 2 to 5 percent of the total. Donor financing is declining as a source of financing for the sector, from 4 to 3 percent of the total (Paper 4). ○ The HIO finances and provides services to about 33 percent of the population (Paper 4).	○ FP spending in FY 1994 accounted only for 1.3 percent of total health expenditure. This spending comprises 1.7 percent of total GOE health spending; less than 0.2 percent of household expenditure; less than 0.3 percent of sponsoring agency spending; but 16 percent of total donor health sector expenditure (Paper 4).
Process	
Goal	○ Unrealistic and unachievable goal of providing free health and FP services to all.
Leadership	
○ Supportive leadership (Paper 8). ○ Positive policy environment for FP. Fixing population problem is the foremost priority of the MOHP. The MOHP is aware of (Paper 8): • USAID's plan to phaseout • The need for quality improvement • Need to involve private sector	○ Lack of continuity in leadership. ○ Health directorates–principal Government level actors–have little policy or decision making authority (Paper 10). ○ Inadequate capacity in policy analysis and development functions (Paper 10). ○ Not enough MOHP focus on long-term planning in relation to sustainability (Paper 8)
Process (Planning and Management)	
Policy and Planning ○ Health sector is going through a strategic planning process at all three levels. Bottom level planning is co-existent with national and province level planning (Paper 1). ○ The following policy reforms are under active consideration of MOHP (Paper 2). • Periodic re-licensing for medical practice • Decreasing the number of medical and	○ Private sector in not involved in policy formulation (Paper 8). ○ Information is not utilized effectively in policymaking (Paper 8). ○ Lack of comprehensive legal and regulatory mechanisms for the private sector (Paper 9). ○ Lack of incentive system for the private sector (Paper 2). ○ Lack of communication and trust between

STRENGTHS	WEAKNESSES
pharmacy school graduates and increasing the support staff e.g. nurses and technicians • Allowing doctors to work only in one sector • Support the private sector participation in health service delivery o Exempting contraceptive imports from import duty is under active consideration (Paper 9). o Decentralized planning and implementation (Paper 1). o Programs are relevant to local needs, established accountability at Governorate level (Paper 1). o Integration of health and FP services is taking place (Paper 12). o Health sector reform is likely to push for integrated primary health care "package," including family planning (Paper 12). o Government provides contraceptives at nominal price to the private sector (Paper 9).	public and private sector (Paper 9).
Organizational Structure o Decentralized structure (Paper 10).	o Organization structure is complex. Units are vertically organized with little communication and interaction. At present there are 29 uncoordinated government and public entities along with NGOs, numerous private vertical programs such as family planning (Paper 6). o Authority levels are not well defined and are tend to be centralized (Paper 10). o Integration between family practice and FP is not fully developed (Paper 6). o Functional and structural fragmentation of the services delivery system (Paper 6)
Managerial Capacity and Systems o Some impressive management capabilities being developed in MOHP population sector (Paper 10).	o Weak capacity in strategic planning, investment management, cost accounting, and budgeting (Paper 10). o Weak management systems, policies and procedures (Paper 10). o Subjective decision-making processes and rarely information-based (Paper 10). o Lack of participatory decision-making (Paper 8). o Reluctance by managers to take advantage of autonomy they are allowed (Paper 10). o Lack of clear delineation between strategic and operational functions (Paper 10).

STRENGTHS	WEAKNESSES
	○ Minor role in health care financing, provider regulation, and accreditation. Ministries of Health lack capabilities to perform the regulatory functions effectively (Paper 10). ○ Inadequate incentive schemes for personnel (Paper 10). ○ Inadequacies in the technical competence of many providers. Lack of provider training and experience with newer FP methods (Paper 9).
Monitoring, Supervision and Performance Evaluation ○ Highly successful Gold Star Clinic System for quality improvement. It is developed and managed through the USAID-funded SDP (Paper 10). ○ Government market share grown by 10 percent in last 5 years. This increase is mainly attributable to improvement in the quality of services (Gold Star Program) (Paper 10).	○ Lack of output-based performance evaluations (Paper 6). ○ Supervision and meetings are highly subsidized by USAID under the Gold Star (Paper 10). ○ No effective and transparent system of accountability. Providers, financiers, regulators are often not held accountable for their actions. Moreover, communities are not empowered to demand accountability (Paper 12). ○ No quality control program for the private sector. The private sector is not included in the Gold star Clinic System (Paper 10). ○ Under the gold star program, clinics that lose their status continue to display their Gold Star sign, although they are not entitled to do so (Paper 10).
Resource Allocation and Use ○ Overall, 24 percent of expenditure is allocated to payment of salaries and other personnel expenses, 12 percent is for contraceptives, 54 percent is for other recurrent inputs,[1] and 10 percent is for investment-related expenses (Paper 4).	○ Mobile clinics are under-utilized (Paper 10). ○ Budget and expenditure priorities are de facto being dictated by historical spending patterns (Paper 5). ○ MOHP facilities are under-utilized. Hospital bed occupancy rate is under 50 percent (Paper 6). ○ The generated revenue through sale of contraceptives is used to provide financial incentives to FP clinic staff (Paper 5). ○ FP subsidies are benefiting the poor and non-poor alike (Paper 5). ○ Government resources are not targeted effectively. The distribution of health resources, particularly MOHP health resources, favors the wealthier sections of the

[1] The most significant categories of other recurrent expenditure are marketing/media (20%), administration (3%), training (3%), special projects and research (3%), and general operating expenses (2%).

STRENGTHS	WEAKNESSES
	population. Annual per capita spending on health services is nearly 8 times as high for the richest quintile of people than for the poor. About 16 percent of the share of public subsidies benefits the poorest quintile population in Egypt while 24 percent of the benefit of subsidies benefits the richest quintile (Paper 5). o Per capita health expenditures are urban-biased; public expenditures on urban residents are 66.6 percent greater than those for rural residents (Paper 7).
Resource Mobilization o Multiple sources of financing: donors, GOE, cost recovery and cost sharing.	o FP services are primarily funded by GOE and donor support. Overall, the GOE provides 55 percent of total financing for family planning services, donors provide 36 percent, and clients provide 8 percent (Paper 4). o New cost sharing and risk sharing mechanisms are underdeveloped and under-utilized. Total revenues generated from fees are less than 6 percent of the FP program costs. Only 25 percent of these revenues were generated in MOHP clinics (Paper 12).
Information System	
o Well equipped (Paper 11). o Highly trained staff (Paper 11). o The project has in-house capacity to maintain the current system. It is being maintained with a very limited support form POP4 (Paper 11). o A substantial amount of information regarding finance, logistics management, service delivery, training, quality, etc. is recorded, reported, and analyzed (Paper 11).	o Insufficient technical personnel (Paper 11). o Information regarding the private sector is not included (Paper 11). o Information is not utilized effectively in decision-making (Paper 3b).

ANNEX III

Annex Table 2: Public Health and Population System Diagnosis

OPPORTUNITIES	THREATS
Environment	
Private Sector o Equal market split between public and private sector. Private sector provides (Paper 2). • 46 percent of all IUD insertions (2000). • 90 percent of oral contraceptives (2000). • 81 percent of injectables (2000). o 50:50 split between public and private spending (Paper 4). o Presence of a large number of pharmacies (population pharmacy ratio = 3,226). Almost all of contraceptive methods are available in these pharmacies (Paper 2). o There are total 96582 private clinics in Egypt. Number of population per clinic is 678. Ob–Gyn clinics are 15 percent of the all the private clinics (Paper 2).	o Only 42 percent of the FP related private clinics, including Ob–Gyn, general practitioners, internal medicine, pediatrics, and skin and venereal provide FP services. Only 75 percent of the Ob–Gyn and 13 percent of the general practitioners provide FP services (Paper 2). o NGO sector is small and has limited power. NGOs are the source of 7 percent of IUD insertions and 3 percent injectables (Paper 2). o Lack of coordination between government and NGOs (Paper 2). o Competition between public sector and NGO/private sector (competition is an inefficient way to use limited resources) (Paper 2) o Unequal spatial distribution of private sector clinics in rural/urban and Lower/Upper Egypt. Private expenditures on urban residents are skewed at 90.6 percent higher than those of rural residents (Papers 2 and 7). o Private spending is regressive and favors the high-income groups. Private expenditures for top 40 percent were 65.5 percent in 1995 (Papers 5 and 7).
Donors o Highly successful programs have been developed and managed through the USAID-funded SDP	o USAID is planning to phaseout (Paper 7). o High dependence on donated and imported contraceptives (Paper 4). o Currently, the USAID is the only donor providing assistance for the procurement of contraceptives for the Egyptian family planning program. Assistance is estimated at £E 10.3 million. If USAID assistance declines to zero by the year 2010, and the GOE must be responsible for the full financial costs of contraceptives at public sector and NGO facilities, then the GOE's financial requirement for contraceptives increases to £E 12.4 million by 2004/5, and £E 23.2 million by 2009/10 (Paper 4). o MOHP direct service costs alone are likely to

OPPORTUNITIES	THREATS
	increase by a minimum of 34 percent in the next nine years and up to 78 percent if the current trend continues (Paper 7).
Political Environment o Political system is supportive and committed (Paper 8). o MOHP is realizing the need for greater, positive role of NGOs in the delivery of FP services (Paper 8). o MOHP is in favor of cost recovery from those who can afford to pay (Paper 8).	o Introduction of user fees is a politically sensitive issue (Paper 8).
FP Clients/Population–Out-of-Pocket Expenditure o A large number of FP clients are actually paying for FP services (Paper 3). o A larger number of clients are willing to pay than actually pay. The NPC (1997) survey shows that about 75 percent of the current FP users are willing to pay more and continue using contraception (Paper 3). o Public health care system is affordable and poor are exempt from fees. The poor and non-poor are provided highly subsidized FP services (Paper 5). o Households are the single most important source of health financing. They control the flow of funds to providers (Paper 4). o The poor rely more on MOHP facilities than the rich. The MOHP services favor the poor (Paper 5). o A large number of Egyptians are both able and willing to pay more for some pharmaceutical products than the current MOHP-set price indicate (Paper 9).	o If the current trend continues, by 2015 Egypt will most likely need almost 10 million more condoms than it currently obtains, 1.3 million more injectable doses, 1.5 million more IUDs, and 9.6 million pill cycles per year (Paper 3). o The FP clients will be required to pay more in the absence of donor support. A total client payment for family planning commodities from all sources in 1998 is £E 12.4 million (Moreland, 2000). Starting from this base, payments by clients to private sector sources are estimated to increase to £E 16.8 million in 2000/1, to £E 22.7 million in 2004/5, and to £E 26.7 million in 2009/10 (Papers 4 and 7). o Households spend the bulk of their funds in private sector, especially in pharmacies, and to a lesser extent private clinics (Paper 4) o No clear criteria for means testing and exemptions (Paper 5). o The poor spend a higher percent of their income on health than the rich. Households in the lowest quintile spend 13.8 percent of their income on OP care, compared with 8.1 percent of income spent by HH in highest income quintile (Paper 5). o Lower use rates of all health services by lower income groups (Paper 5). o Significant disparity in contraceptive use among geographic regions (Paper 9).
Legal and Regulatory Environment o Increasing awareness regarding the regulatory role of the MOHP (March meetings).	o Government price controls on commodities restrict active private sector participation in the FP sector (Paper 9). o Requirements for annual import licenses for pharmaceuticals (Paper 9).

OPPORTUNITIES	THREATS
Suppliers and Manufacturers of Contraceptives o Availability of multiple sources of contraceptive supplies. Private sector get contraceptives from government, directly from companies and also from pharmacies (Paper 1). o Contraceptives are obtained from multiple sources including donors, manufacturers and are also imported (Paper 1).	
Ministry of Finance	o Cumbersome procedure of releasing money by the MOF for MOHP activities (March meetings).
Ministry of Higher Education	o Trains and appoints a higher number of physicians than are actually required in the health sector (Paper 10).
The Constitution	o Constitution stipulates that free medical care is a basic right for all Egyptians (Paper 8).
Common Perceptions, Attitudes and Beliefs	o Providing and funding FP services, with or without donor support, is commonly perceived as only the MOHP's responsibility (Paper 8).
Demographic Profile	o Egypt is in an advanced stage of demographic transition (Paper 7). o Population growth is mostly due to momentum (Paper 7). o Substantial unmet need for FP among married women of reproductive age (16 percent) (Paper 9).
Economy o During 2000s, real per capita incomes may increase by up to 3 percent, and real government expenditures by up to 6 percent. These increases will result in increased financial resources in both the private and public sectors for family planning services, including contraceptives (Paper 4).	

Sources: This table summarizes the findings of 12 individual situation analysis papers listed in the Reference section, Papers 1–12.

Annex IV

Annex Table 3: Planned Reforms and Possible Impact on the FP Program

Planned Reform	Possible Impact on the FP program
Financial Coverage and Benefits	
Social heath insurance coverage will be expanded. People will pre-pay and be entitled to a basic package of services.	▪ Payment for FP will either be subsidized by GOE or by other members on a risk-pooling basis. ▪ People who can afford to pay will pre pay a premium of a set amount.
An affordable and cost-effective package of basic health services based on the priority health needs of the population will be designed and implemented.	▪ Everyone enrolled will be entitled to a basic package of services, which will include FP. ▪ Self-referral to another provider will be covered on a fee-for-service basis. Referral by the designated provider (gate keeper) will be free or at a nominal charge.
The out-of-pocket expenditures will be reorganized to promote risk sharing and to collect contributions according to ability to pay.	▪ Facilitates payment based on ability and access to services based on need. ▪ Basic services for the poor will still be subsidized by the government. ▪ Mechanisms for protecting the poor have yet to be formalized. ▪ A consultation fee will remain and fees for certain services and for drugs will exist to discourage unnecessary demand. ▪ A nominal registration fee will replace fees for FP commodities and services. ▪ FP providers are now paid incentives based on accumulated user fees. If user fees are eliminated incentive payments specifically for FP will stop. Will this reduce the incentive to provide quality services?
Sustainable financing will be ensured through Family Health Fund (FHF) to act as the sole financier of the basic benefit package	▪ HIO will be transformed into a financing organization and its resources (government subsidies and individual roster fee premiums) will be used to finance health and FP services. ▪ There may no longer be a FP vertical earmark.
Government will continue to subsidize certain services such as FP and certain population groups.	▪ The GOE indicates it will subsidize services and certain people, which services, which people and what mechanisms are yet to be worked out. ▪ In the Alexandria pilot scheme, GOE assumed that FP services and the poor would be subsidized as they had been by government but FP was included in the basic benefit package.
Co-payments and user fees will remain in effect to discourage	▪ This may increase the out-of-pocket payment by members. ▪ It may mean pre-payment of premiums as well as payment of

Planned Reform	Possible Impact on the FP program
unnecessary use and to generate revenue.	"registration" or "consultation" fees at time of receipt of services. Depending on price elasticity of demand, pre-payment, registration fees and commodity and service fees may have a negative impact on utilization. ▪ No longer would there be specific payments for FP alone. ▪ Unclear what mechanisms will be put in place to protect the poor, to encourage use of certain services, and to serve under-served geographic areas.
Government may pay the roster fee for the poor.	▪ Unclear whether GOE will also subsidize the registration/consultation fee at time of receipt of service.
Health Services Delivery	
Public and private service delivery will be organized into one system centered on a holistic family health approach.	▪ FP services would be incorporated into the integrated service program of Family Health Centers and other contracted providers. ▪ There is the possibility that some services (e.g., FP) could be contracted out, at present the only alternative being explored is integrated service delivery of the entire basic package of services.
The MOHP health facilities' infrastructure will be consolidated into three types (Family Health Unit (FHU), Family Health Centre (FHC), and district hospital (DH) to provide the basic package at the district level.	▪ There is no mention of stand-alone FP service providers. ▪ It is unclear what would happen with designated FP providers, fixed clinics, mobile clinics, Gold Star clinics, CSI clinics and so on. ▪ People will pre-pay for services in a designated FHU. People will need to obtain services from this provider so choice of FP provider may in future be limited. ▪ People may be able to self-refer to other providers if they are willing to pay for the services on a fee-for-service basis.
Provision of the package will be based upon competition and choice among the different public and private providers under the single (NHIF).	▪ FP service delivery will be integrated into a basic package of services. ▪ May facilitate more efficient and effective use of both public and private sector resources and services. ▪ Public, private and NGO providers will compete for the right to deliver this integrated package of services. ▪ At present there is no thought to maintaining the vertical nature of the FP program and it's dedicated financing and service delivery system. ▪ It is unclear what will happen to FP service provision in pharmacies and physician private practices. ▪ It is unclear what will happen in poor urban and rural areas with few existing providers and people too poor to pay premiums and co-payments.

Planned Reform	Possible Impact on the FP program
	▪ It will facilitate the use of scarce government resources on priority interventions and objectives.
Providers will be paid using an incentive-based provider payment mechanism.	▪ FP providers have been paid, in the past, on a combination of incentive payment scheme, government and donor subsidies. ▪ In the future, contracted providers will be paid on an incentive payment scheme that encourages certain types of provider behavior and discourages other types of behavior.
All providers will be accredited before they can participate in the program.	▪ At present not all providers have to be accredited (i.e., have to meet certain quality and other standards of performance). ▪ In the future such an accreditation program will exist and accreditation will be a "pre-qualification" to receive a contract to deliver the basic service package.
Organizational Structures and Effective Management Systems	
The role of MOHP will be strengthened in strategic planning, regulation and coordination of the health sector at all levels. MOHP will gradually phase out of the role of provider and financier of services towards a role of arbiter, policy maker, regulatory and orchestrator of the health system	▪ Now, the MOHP is a provider, a financier a policy maker, a regulator and a supervisor of services. In the future it will focus on policy making, regulation, supervision and control. ▪ This means that direct service delivery by MOHP staff may eventually stop and those services be contracted to accredited providers.
The health workforce will be of the right size, place, mix and level of skills to meet the needs of the population served.	▪ Existing MOHP manpower is extensive but under utilized, poorly paid and there are many physicians. ▪ In the future under health reform, the number, type and distribution of health manpower will be better planned. ▪ MOHP staff may need to be reduced since MOH will no longer be a provider of services and financial incentives for providers will dictate appropriate staffing levels and types. ▪ It is unclear what will happen to currently employed MOHP manpower in the new system.
Affordable quality drugs	
Drugs, commodities and medical supplies will be made available	▪ Currently donors supply the bulk of FP commodities and supplies. ▪ In the future they will be financed through a combination of government subsidy and private investment.
MOH will ensure that there will be rational prescribing, dispensing and consumption	▪ Presumably FP commodities will be dispensed alongside other drugs and medical supplies in Family Health Units (FHU), Family Health Centres (FHC), and district hospitals (DH). ▪ How MOHP will control the distribution, prescription, use and

Planned Reform	Possible Impact on the FP program
	consumption of FP commodities in pharmacies, private physician practices and other non-contracted sites is unclear.
Vertical health programs	
Vertical health programs such as family planning will no longer be financed, managed, delivered, monitored and evaluated vertically and independently with its own staff. FP services will be integrated into Family Health Units (FHU) and Family Health Centre (FHC). Stand-alone FP clinics will be integrated into these delivery settings and family physicians and support staff will provide FP services.	▪ FP services will become part of the basic package of services and staff and service delivery sites will be incorporated into integrated service delivery units.

Source: Paper 12.

Annex V

Selected Tables

Table 1
Percentage of Currently Married Women with Unmet Need for Family Planning, Percentage Using Contraception, and Total Demand for Family Planning, Egypt 2000

Region	Unmet Need	% Using Contraception	Total Demand	% Of Demand Satisfied
Urban Governorates	7.2	62.7	70.7	89.9
Urban Lower Egypt	8.8	64.9	74.6	88.2
Rural Lower Egypt	8.8	61.4	71.1	87.7
Urban Upper Egypt	10.7	55.4	67.2	84.0
Rural Upper Egypt	18.7	40.2	60.2	68.9
Total	11.2	56.1	68.2	83.6

Source: Paper 3.

Table 2
CPR Required to Achieve Fertility Reductions

Year	TFR	CPR
1998	3.4	51.8
2000	3.3	53.8
2005	2.9	58.6
2010	2.6	63.4
2015	2.1	69.1

Source: Paper 3.

Table 3
Projection of MWRA and Family Planning Users, 1998–2015 (millions)

Year	MWRA	Family Planning Users
1998	9.93	5.12
2000	10.51	5.63
2005	11.80	6.88
2010	12.89	8.12
2015	14.08	9.54

Source: Paper 3.

Table 4
Percentage Distribution of Users by Method and Source, 1998

Source	Condom	Female Sterilization	Injectable	IUD	Pill	Other
Public	4.5	51.8	76.0	55.5	9.9	47.9
Pharmacy	80.6	0.0	3.8	0.0	81.0	16.8
NGO	0.5	1.2	7.1	10.9	1.6	8.8
Private Doctors and Clinics	0.0	47.0	11.1	33.6	7.4	26.3
Other	14.4	0.0	2.0	0.0	0.0	0.2
Total	100	100	100	100	99.9	100

Source: Paper 3.

Table 5
Percentage Distribution of Users by Source, 1998-2015

Year	Public Source	Pharmacy	NGO	Private Doctors and Clinics	Other
1998	2.46	0.84	0.44	1.38	0.02
2000	2.66	1.00	0.46	1.42	0.03
2005	3.16	1.08	0.56	1.77	0.03
2010	3.73	1.28	0.66	2.09	0.04
2015	4.39	1.51	0.78	2.46	0.04

Source: Paper 3.

Table 6
Projected Commodity Requirements (millions of units)

Year	Condom	Injectable	IUD	Pill
1998	10.75	1.54	1.92	11.18
2000	11.82	1.69	2.08	12.29
2005	14.44	2.06	2.49	15.02
2010	17.06	2.44	2.90	17.74
2015	20.04	2.86	3.43	20.84

Source: Paper 3.

Table 7
Current User Fees for FP by Provider Organization

Method	SDP/MOHP		THO/MOHP		EFPA		CSI	
	Method	Service	Method	Service	Method	Service	Method	Service
IUDs								
Copper T380	2		2	2	2	5	2	7-15
Plastic IUD			1	3	0.20	5	1.20	12.5-15
Copper T-7			15	5				
Multi-load 250	14		16	4			11-14	20-29
Multi-load 275	16		20	5			14-16	24-40
Nova-T			50	5				
ORAL PILLS								
Anovar			0.80		0.10		0.58	5-9
Promovlar	0.65		0.80		0.65		0.65	5-9
Ovral			0.80		0.10			
Ovulin								
Noridette	0.95		0.80		1		0.95	5-9
Microvlar	0.65		0.80		0.65		0.65	5-9
Norminest								
INJECTABLES								
Noristerate	3.50		3.50	2	3.50	3	3.50	3-15
Depo-provera	3.50		3.50	2	3.50	3	3.50	3-15
BARRIER METHODS								
Condoms	1.65/100		0.75/4		0.05		0.05/3	
Foam tabs	0.20/20				0.25		0.25	5-9

Source: Paper 5.

Table 8
Mean Visit Cost by Element, Source and Method (£E)

Source	Method cost	Consultation cost	Lab cost	Total cost
MOHP				
Pill	0.83	0.11	0.06	1
IUD	3.91	0.36	0.06	4.33
Injectables	3.87	0.14	0.02	4.03
EFPA				
Pill	0.85	1.08	0.03	1.96
IUD	6.88	2.18	0.08	9.14
Injectables	5.32	1.77	0.05	7.14
CSI				
Pill	1.46	3.37	1.21	6.04
IUD	12.91	3.42	0.70	17.03
Injectables	8.18	1.36	0.26	9.80

Source: Paper 5.

Table 9
Financial Allocations of Donors to Population and Health Projects in Egypt During the Late 1990s

Donor Agency	Financial Allocation $ (millions)	Time Period of Allocation
UNFPA	14.2	1992-96
UNICEF	5.2	1995-00
WHO	0.6	1996-99
World Bank (WB)	20.7	1997-02
European Community (EU)	15.9	1994-00
UNDP	1.0	1991-96
USAID	62.0	1992-97
Canada/CIDA	8.5	1996-99
Netherlands	8.3	1996-00

Source: Paper 6.

Table 10
EGYPT - Distribution of Family Planning Expenditure by Input, 1997/8

	1997/8				
	BAB I	**BAB II**		**BAB III**	**TOTAL**
		Contraceptives	**Other**		
NOT-FOR-PROFIT					
GOE	25,970,410	769,500	44,249,197	9,366,345	80,355,452
Client Payments	7,277,915	422,430	1,694,515	87,816	9,482,676
Sponsoring Agencies	57,882	27,277	690,463	151,712	927,334
Donor	4,384,165	11,970,980	35,197,003	6,606,087	58,158,235
Sub - Total	**37,690,372**	**13,190,187**	**81,831,178**	**16,211,960**	**148,923,697**
% Of Total w/BAB III	25.3%	8.9%	54.9%	10.9%	100.0%
% Of Total w/o BAB III	28.4%	9.9%	61.7%		100.0%
FOR PROFIT					
GOE	0	3,048,500	0	0	3,048,500
Client Payments	0	2,431,554	131,435	0	2,562,989
Sponsoring Agencies	0	0	0	0	0
Donor	0	0	3,353,171	0	3,353,171
Sub - Total	**0**	**5,480,054**	**3,484,606**	**0**	**8,964,660**
% Of Sub - Total	0.0%	61.1%	38.9%	0.0%	100.0%
GRAND TOTAL					
GOE	25,970,410	3,818,000	44,249,197	9,366,345	83,403,952
Client Payments	7,277,915	2,853,984	1,825,950	87,816	12,045,665
Sponsoring Agencies	57,882	27,277	690,463	151,712	927,334
Donor	4,384,165	11,970,980	38,550,174	6,606,087	61,511,406
Total	**37,690,372**	**18,670,241**	**85,315,784**	**16,211,960**	**157,888,357**
% Of Total w/BAB III	23.9%	11.8%	54.0%	10.3%	100.0%
% Of Total w/o BAB III	26.6%	13.2%	60.2%		100.0%

Notes: The BAB II categories with the highest expenditure are: marketing/media (31.1 million), administrative (5.0 million), training (4.7 million) general operating expenses (2.8 million), special projects (2.2 million), and research (1.8 million).

Source: Paper 4.

Table 11
EGYPT - Financial Projections for Contraceptives for the Family Planning Program, 1997/8–2009/10

	1994/5	1997/8	2000/1	2004/5	2009/10
FINANCIAL REQUIREMTS - Health Sector 1/					
GOE	1,576.0	1,733.6	1,907.0	2,307.4	2,792.0
Other	1,843.0	2,027.3	2,230.0	2,698.3	3,265.0
Client Payments	3,819.0	4,200.9	4,621.0	5,591.4	6,765.6
Donors	215.0	236.5	260.2	314.8	380.9
TOTAL	7,453.0	8,198.3	9,018.1	10,911.9	13,203.4
FINANCIAL REQUIREMTS - FP Program 2/					
Salaries/Incentives		37.7	41.5	50.2	60.7
Contraceptives		18.7	31.5	42.5	49.9
Other Recurrent		85.3	93.8	113.5	137.4
Capital		16.2	17.8	21.6	26.1
TOTAL		157.9	184.6	227.8	274.1
Amount GOE		82.4	97.5	120.3	144.7
% GOE		52.8%	52.8%	52.8%	52.8%
ESTIMATES COST - Contraceptives 3/					
Public			12.7	17.2	20.1
NGO			1.9	2.7	3.1
Private Doctor			5.7	7.5	8.9
Pharmacy			10.6	14.5	17.0
Other			0.5	0.7	0.8
TOTAL (*)			31.5	42.5	49.9
SOURCES OF FP FINANCE - Contraceptives 4/					
GOE		3.80	4.18	12.36	23.22
Sponsoring Agencies		0.03	0.00	0.00	0.00
Client Payments		2.90	16.82	22.68	26.71
Donors		12.00	10.33	6.30	0.00
TOTAL		18.73	31.33	41.34	49.92
GOE CONTRACEPTIVES AS % OF					
GOE Health			0.2%	0.5%	0.8%
GOE FP Program			4.3%	10.3%	16.0%
CLIENT CONTRACEPTIVES AS % OF					
CLIENT Health Expenditure			0.6%	0.9%	1.3%

Notes: (1) Financial requirement for the health sector projected from 1994/5 NHA figures inflated at 5 percent p.a.; (2) Financial requirements for FP program projected from 1997/8 figures inflated at 5 percent p.a., contraceptives from line (*); (3) contraceptive financial requirements based on estimates from a paper by Moreland (2000) with corrections to include freight (10%) and inflation in the cost of methods (5% p.a.); (4) sources of FP Finance: GOE is inflated at 5 percent p.a. for 2000/1 and 2004/5, and is the total for public sector and NGOs for 2010; (5) sponsoring agencies are assumed to remain at zero; (6) client payments for 1997/8 from Rowan et.al. study, estimates from 2000/1 to 2009/10 is sum of costs at private doctors and private pharmacies from SPECTRUM study; and (7) donor contributions are assumed to decline by half by 2004/5 (inflated from 2000/1), and to decline to zero by 2009/10.

Source: Paper 4.

Table 12
Sources of Modern Family Planning Method - Percentage of Clients

Segment	1988	1992	1995	1997	1998	2000
Public Sector	**23.1**	**35.0**	**35.7**	**40.9**	**47.9**	**48.4**
• MOHP						
✧ Urban Hospital		8.5	10.6	10.9	8.4	8.2
✧ MCH Center						7.0
✧ Urban Health Unit		13.7	13.1	11.7	19.0	13.9
✧ Rural Hospital		1.9	0.9	2.5	2.2	0.9
✧ Rural Health Unit		7.3	6.3	8.1	10.0	13.9
✧ Mobile Unit					2.9	2.5
✧ Other MOHP		0.4	0.9	4.8	2.4	0.0
• Teaching Hospital		1.0	1.9	1.0	0.8	0.6
• HIO/CCO		2.0	0.9	1.1	1.4	0.7
• Other Governmental		0.2	0.9	0.7	0.8	0.7
Private Sector	**74.2**	**63.4**	**62.7**	**58.1**	**51.9**	**51.5**
• NGO/PVO Clinics	0.5					
✧ EFPA		1.3	6.0	3.2	1.6	2.0
✧ CSI		4.6	2.5	2.7	2.3	2.8
✧ Other NGO/PVO		0.8	0.7	0.3	1.0	0.3
• Mosque/Church Health Unit		2.6	0.2	2.5	3.9	2.1
• Private Hospital/Clinic	0.5	2.6	2.7	4.1	2.0	2.8
• Private Doctor	20.3	23.0	25.0	24.8	24.3	23.8
• Pharmacy	53.4	28.3	23.0	20.3	16.8	17.7
• Other Vendor	0.6	0.2	0.0	0.2	0.0	0.0
Other	**2.0**	**1.2**	**0.2**	**0.5**	**0.2**	**0.3**
• Other	2.0	0.1	0.1	0.1	0.0	0.1
• Friends/Relatives		1.1	0.1	0.3	0.2	0.2
Don't Know		**0.4**	**1.4**	**0.5**	**0.1**	
Total Percent	100.0	100.0	100.0	100.0	100.0	100.0

Source: Paper 10.

Table 13
EGYPT – National Health Accounts, Sources to Intermediaries, 1990/1 and 1994/5

SOURCES/ Intermediaries	1990/1 *	%	1994/5 **	%
MOF/NIB	**1,206**	**29.0%**	**2,581**	**34.6%**
MOH	647	15.5%	1,337	17.9%
THIO	60	1.4%	97	1.3%
MOE	270	6.5%	517	6.9%
MOSA	7	0.2%	6	0.1%
HIO	64	1.5%	434	5.8%
Other Ministries	158	3.8%	190	2.5%
SIO	**370**	**8.9%**	**448**	**6.0%**
HIO	280	6.7%	448	6.0%
Other	90	2.2%		0.0%
Firms	**70**	**1.7%**	**364**	**4.9%**
Firm Schemes	n.a.		364	4.9%
Syndicates	**30**	**0.7%**	**26**	**0.3%**
Syndicate Schemes	n.a.		26	0.3%
Households	**2,304**	**55.3%**	**3,819**	**51.2%**
HIO	19	0.5%	39	0.5%
Other	2,285	54.9%	3,780	50.7%
Donors	**185**	**4.4%**	**215**	**2.9%**
MOH	135	3.2%	142	1.9%
HIO	0	0.0%	12	0.2%
Other	50	1.2%	61	0.8%
TOTAL (Nominal)	**4,165**	**100.0%**	**7,453**	**100.0%**

Notes:

Population (millions); GDP Deflator (1995 = 100)

*/ DDM (October 20, 1995) National Health Accounts of Egypt, Table 1.2

**/ DDM (May 1999) The Distribution of Health Care Resource in Egypt:
Implication for Equity - An Analysis Using a National Health Accounts Framework, Table 1

Source: Paper 1.

Table 14

EGYPT National Health Accounts, Intermediaries to Institutions, 1994/5

Inter-mediaries	Institutions														
	MOH Facilities	Teaching Hospitals	University Hospitals	Other Public	NPC	HIO	CCO	Private Hospitals	Private Clinics	Pharma-cies	NGOs	Other Domestic	Other Foreign	TOTAL	%
MOF				11	20		15							46	0.6%
MOH	1,305	14	30	4		1	11	42		17	3		52	1,479	19.7%
THIO		97												97	1.3%
MOE			517											517	6.9%
MOSA											6			6	0.1%
HIO	17	3	30	6		530	28	71		237	6		5	933	12.4%
Other Ministries				190										190	2.5%
Firm Schemes		2	1				221	23	57	60				364	4.8%
Syndicate								20	5	1				26	0.3%
Private Insurers			1					5	5	5				16	0.2%
Households	80	1	2	2	1	49	49	120	670	2,396	70	340		3,780	50.3%
Foreign Donors		2	26		5		3				25			61	0.8%
TOTAL	**1,402**	**119**	**607**	**213**	**26**	**580**	**327**	**281**	**737**	**2,716**	**110**	**340**	**57**	**7,515**	**100.0%**
% Of Total	**18.7%**	**1.6%**	**8.1%**	**2.8%**	**0.3%**	**7.7%**	**4.4%**	**3.7%**	**9.8%**	**36.1%**	**1.5%**	**4.5%**	**0.8%**	**100.0%**	

Source: Paper 1.