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SA 5588

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TRIP PURPOSE: To review the 1989/90 and 1988/89 family planning cost studies with USAID and the NPC and make requested changes; to initiate the design of a study on pricing of family planning goods and services.

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1. SUMMARY

In accordance with her scope of work, the Consultant reviewed the 1988/89 and 1989/90 family planning cost studies with USAID/Cairo and the Resident Advisor for IDP. As a result, it was recommended that both years' studies be revised to emphasize that the focus of the studies is on the local operational costs to the government of Egypt if it were to cover all public sector costs itself. For the revisions, certain donor agency costs such as foreign technical assistance and overseas training were to be excluded. In addition, the information and data gathered and presented for the Egyptian Pharmaceutical Trading Company (EPTC) were to be revised: 1. to exclude certain assumptions about how pharmacies supplied by EPTC use their profit from the sale of contraceptive commodities, and 2. to be uniformly presented in both years of the cost study.

A good portion of the Consultant's efforts focused on collection of data and information for the pricing study on family planning goods and services. The study team contacted agencies within the service delivery and distribution systems as well as those involved with manufacturing of commodities and demographic research. Meetings were held with the Ministry of Health, the Cairo Health Organization, the Family of the Future, the Clinical Services Improvement Project, the Health Insurance Organization, the Egyptian Junior Medical Doctors Association, Organon and Schering pharmaceutical companies, the Egyptian Drug Organization, CAPMAS and the Cairo Demographic Center. The study team's general approach was to try to determine the socio-economic profile of the family planning clients served by the different agencies and to look at the effect of changes in prices of commodities and services upon demand. Further work with the DHS 1988 data on willingness to pay and economic levels of the respondents and development of additional questions on willingness to pay for the upcoming DHS 1992 might yield promising and insightful results.

2. CONSULTANT'S SCOPE OF WORK

To assist with efforts to study and analyze the sustainability and cost effectiveness of family planning programs in Egypt by addressing various factors, specifically:

A. Review the 1988/1989 and the 1989/1990 family planning studies with USAID/Cairo and the National Population Council and make requested changes. Since during this trip, the Director of IDP had just resigned, the family planning cost study review work was carried out with USAID and the Resident Advisor for IDP.

B. Review the separate analysis of the 1989/1990 family planning cost study showing how much funding would be needed to cover the basic costs of Egypt's family planning program if the government of Egypt had to assume all public sector costs.

C. Initiate design of the study on pricing of family planning goods and services. Identify and review relevant research and work undertaken by family planning agencies, manufacturing companies providing contraceptive commodities, and research organizations. Focus on two particular aspects: examples of the effect of price changes on demand and the economic profile of the target population of the various agencies and companies.

3. ACTIVITIES AND ACHIEVEMENTS

The Family Planning Cost Study

During 1989 and 1990, the Consultant was requested by USAID/Cairo and the National Population Council (NPC) to assist with the broad effort to study and analyze the sustainability and cost-effectiveness of family planning programs in Egypt. The Consultant was to assist with this effort by addressing various key factors, including the costs of family planning. Data was collected and prepared for presentation and in the course of 1990 several draft reports were submitted on the 1988/1989 family planning cost study. In December 1990 during the Consultant's first trip to Cairo after the arrival of USAID's new Director of the Office of Population, it was agreed by USAID, the NPC and the Consultant to revise the cost study methodology. The revisions in the methodology necessitated major changes in the cost study report. In early 1991, the 1988/89 cost study was revised in Durham, NC and by late March 1991, it was sent to the Cairo Mission and the NPC for review. On her May trip to Cairo, the Consultant presented the findings of the 1988/89 cost study to the USAID Mission and the NPC. During the same trip, the Consultant gathered data for the cost study for the second year 1989/1990. During the May 1991 trip, one of the recommendations agreed upon was the following:

Separate Analysis of the 1989/1990 Cost Study Data

It was requested by the NPC that a separate analysis (see Appendix B) of the 1989/90 family planning cost study data be undertaken by the Consultant after completion of the reports on the 1989/90 cost study. Using the 1989/90 prepared data, the separate analysis was to show how much funding would be needed to cover the local costs of Egypt's family planning program if the government of Egypt (GOE) were to cover all the public sector costs itself with no assistance from donor agencies. The analysis assumed that the GOE would not

have paid for overseas training or donor overhead. Based on these assumptions, the analysis subtracted overseas training and donor overhead from donor agency costs to determine the donor costs that would have been covered by the GOE if it had covered all the public sector costs. During the Consultant's present trip, this separate analysis was the catalyst for discussion on how the 1988/89 and 1989/90 cost study reports should be revised to emphasize that the focus is on local operational costs. The recommendations are discussed under part "4. Issues and Recommendations" of this trip report. The study team and USAID/Cairo reached the consensus that once this requested round of revisions was completed for both years, the cost studies should be ready to meet approval and be available for general distribution.

The Pricing of Family Planning Goods and Services

The USAID Mission informed the study team that, during 1991, the International Monetary Fund recommended that Egypt lift its subsidies from pharmaceutical products. In May 1991, prices of many pharmaceutical products increased except the prices of contraceptives which come in free to Egypt. (See Appendix C for summary of Egypt's Stabilization and Adjustment Program.)

The study team knows from its work on the family planning cost study that the government of Egypt (GOE) and foreign donor agencies are heavily subsidizing family planning goods and services to make them available to all Egyptians. For the GOE fiscal year 1989/1990, it is estimated that public sector funding for family planning amounted to roughly 53.5 million Egyptian pounds. The study team was requested by USAID and the National Population Council to research issues related to access to affordable family planning goods and services. This request was made in light of ongoing concerns both for efficient use of limited government resources and for a sustainable family planning program that equitably subsidizes those in need and at the same time minimizes the subsidies for those who are able to pay.

During the present trip, the study team undertook initial information gathering on the pricing of family planning goods and services. The study team contacted agencies within the service delivery and distribution systems as well as those involved with manufacturing of commodities and demographic research. Meetings were held with the Ministry of Health, the Cairo Health Organization, the Family of the Future, the Clinical Services Improvement Project, the Health Insurance Organization, the Egyptian Junior Medical Doctors Association, Organon and Schering pharmaceutical companies, the Egyptian Drug Organization, CAPMAS and the Cairo Demographic Center.

The study team's general approach when meeting with agency officials was to try to determine the socio-economic profile of the family planning clients served by the different agencies and to look at the effect of changes in prices of commodities (and services) upon demand. Detailed notes and findings from the meetings with each of these agencies are attached to this report in Appendix D.

4. ISSUES AND RECOMMENDATIONS

Revision of the 1988/89 and 1989/90 Family Planning Cost Studies

Local Operational Costs to the Public Sector

Based on the separate analysis of the 1989/90 data, during the Consultant's current trip, it was recommended that both studies for 1988/89 and 1989/90 be revised to emphasize that the focus is on local operational costs. The revised studies were to exclude donor agency expenditures on foreign technical assistance and overseas training to single out the costs to the GOE to run the program locally if it were to cover all public sector costs itself. Although foreign technical assistance and overseas training were to be excluded, other costs such as vehicles, commodities and the contraceptives, which are paid for by the

donor agencies with hard currency, were to be included in the cost studies. It was decided that the program could not be run locally without these items if the GOE were to cover all public sector costs. In addition, since the donor agency overhead was thought to represent a reasonable estimate of the additional overhead costs that would be incurred by the GOE if it were to cover all public sector costs, donor agency overhead was to be included. It was requested that the revisions of both studies be available to USAID/Cairo by October 1 (1989/90 study) and by October 15 (1988/89 study).

Pharmacies and the Egyptian Pharmaceutical Trading Company

In the 1988/89 cost study, the information on the Egyptian Pharmaceutical Trading Company (EPTC) and the pharmacies supplied by EPTC was presented together in one appendix. The 1989/90 cost study report presented information on both these groups in two separate appendices. The reason for the difference in presentation was that, in the process of gathering data for the second year, the study team received additional information which it then included in the form of two separate appendices, one on EPTC and the other on pharmacies supplied by EPTC. During the Consultant's present trip, because of USAID's disagreement with assumptions that the study team had made in the 1989/90 study about how pharmacies use profit from the sale of contraceptive commodities, the study team and USAID concurred that the calculations in the 1989/90 based on those assumptions would be removed.

As a result, the study team was to revise the second year's study along the lines of the first year's study with respect to the appendices pertaining to EPTC. However, from the study team's point of view, it was advisable that the following modification be made to the 1988/89 appendix on EPTC. In the original 1988/89 study, the team had not included the costs and CYP associated with the locally produced pills that EPTC distributed to pharmacies. Because the study team had received further clarification regarding the costs associated with the locally produced pills during the May and August 1991 trips to Egypt, the

team was professionally obligated to include the costs associated with the locally produced pills distributed by EPTC to the pharmacies as well as the CYP data under EPTC in both years' studies, 1988/89 and 1989/90.

The Pricing of Family Planning Goods and Services

The information reflected in the detailed notes in Appendix D indicates that the study team is at the beginning of the data collection process. At present, the study team does not have substantive answers to questions of affordability. Rather, the data and information collected thus far suggest that further work (see Appendix E) with the data, especially that from the DHS 1988 and the upcoming DHS 1992, might yield promising and insightful results.

It is recommended that the study team is continue to do a literature search on issues of willingness to pay and tariff design as well as to meet with professionals experienced in issues which pertain to questions of access to affordable family planning goods and services.

APPENDIX A

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APPENDIX A

PERSONS CONTACTED

Family of the Future

Dr. Khaled Abdel Aziz, Executive Director
Mr. Jestyn Portugill, Resident Advisor
Mrs. Nadia Abdel Fatah, Director of Sales
Dr. Salwa Rizk, Director of Product Management
Dr. Nabil Subhi, Financial Analysis Department
Ms. Nesma Raghav, Research Department

Drug Organization

Dr. Abdel Aziz Ghazal, Vice-President Laila Kamel, NPC/IDP Director

Ministry of Health

Dr. Nabil Nassar, Director General, Department of Family Planning
Dr. Badr El-Masry, Deputy Director, Department of Family Planning

Clinical Services Improvement Project

Mr. Said El-Dib, Manager for Planning and Evaluation

SOMARC. Porter/Novelli

Mr. Anton Schneider, Senior Account Executive

Cairo Health Organization

Dr. Samir Fayyad, Chairman

CAPMAS

Dr. Laila Nawar, Research Director

Cairo Demographic Center

Dr. Hussein Abdel-Aziz Sayed, Technical Director, Egypt DHS 1988

Schering

Dr. Sami Soleiman

Organon

Dr. Willem A.M. Daniels, General Manager

Dr. Adel Habib, Assistant to General Manager

USAID

Dr. Carol E. Carpenter-Yaman, Director, Office of Population

Mrs. Amani Selim, Program Specialist, Office of population

Mr. Arthur Braunstein, Project Officer, Office of Population

Mr. Mohamed Tourhan Noury, Population Finance and Procurement Officer

Ms. Marilyn Schmidt, Population Officer

Dr. Ashraf Ismail, Population Specialist

Ms. Laila Stino, Population Officer

Ms. Rasha Abdel-Hakim, Economic Specialist, Economic Directorate Analysis

E. Petrich and Associates, Inc.

Dr. Waleed ElKhateeb, Resident Advisor, IDP

Mrs. Margaret Martinkosky, Financial Management Consultant

Mrs. Omaila Abdel-Akher, Financial Management Consultant

Dr. Fatma El-Zanaty, Statistical and Sampling Coordinator Consultant

Ms. Rebecca Copeland, Resident SDP/MOH Management Consultant

Mr. Seymour Greben , Management Systems Consultant

APPENDIX B

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E. PETRICH AND ASSOCIATES, INC.

International Consultants in Management Development for the Health Services

MEMORANDUM

TO: Dr. Laila Kamel, Director, NPC/IDP

FROM: Dr. Elizabeth G. Heilman, Financial Management Consultant, EP&A
Egt

DATE: August 14, 1991

SUBJECT: Separate Analysis of the 1989/90 Family Planning Cost Study Data

At your request, the study team has prepared the attached analysis of the 1989/90 family planning cost study data to show what it would have cost Egypt in 1989/90 if the GOE had had to cover all public sector costs. We look forward to your comments and discussing the analysis with you.

cc. Dr. Carol Carpenier-Yaman, Director, Office of Population, USAID

**ESTIMATED PUBLIC SECTOR COSTS
OF THE FAMILY PLANNING PROGRAM IN EGYPT
TO THE GOVERNMENT OF EGYPT
JULY 1, 1989 -- JUNE 30, 1990**

At the request of the National Population Council, the study team has provided the following analysis based entirely on the 1989/90 family planning cost study¹. The analysis shows what the family planning program in Egypt would have cost the government of Egypt (GOE) in 1989/90 if the GOE had had to cover all public sector costs.

The results of the 1989/90 family planning cost study estimate that the "total" costs for that year were LE 60,195,215. Of these "total" costs, LE 22,119,937 (36.7%) were covered by the GOE; LE 32,015,500 (53.2%) were covered by donor agencies; LE 5,603,303 (9.3%) were covered client payments; and LE 456,475 (0.8%) were covered by non-governmental sponsoring agencies. Thus, the public sector, the GOE and donor agencies combined, covered LE 54,135,437, or 89.9% of the "total" costs.

If the GOE had had to cover all the public sector costs with no assistance from donor agencies, what would the cost have been to Egypt? To address this question, the following assumptions were made: 1. the GOE would not have paid for overseas training costs; 2. the GOE would not have paid for donor overhead costs; 3. all other public sector costs in 1989/90 would have been covered by the GOE. Based on these assumptions, overseas training and donor overhead costs were subtracted from the donor agency costs to determine the donor costs that would have been covered by the GOE.

Donor agency costs 1989/90	LE 32,015,500
Less donor agency items--by implementing agency:	
US training--MOH	LE (127,939)
US training--SIS/IEC	LE (182,770)
US training--Ain Shams	LE (72,949)
<u>Donor overhead--USAID and UNFPA</u>	<u>LE (1,924,307)</u>
Donor costs less training and overhead:	LE 29,707,535

If the GOE had had to cover all public sector costs in 1989/90, it would have had to provide funding totaling LE 51,827,472.

GOE costs (actually covered by the GOE 1989/90)	LE 22,119,937
<u>Donor costs (assumed by the GOE 1989/90)</u>	<u>LE 29,707,535</u>
Total GOE funding to cover public sector costs:	LE 51,827,472

¹The terms used in this analysis are the same as those used and defined in the 1989/90 family planning cost study. All the cost information in this analysis has been taken both from the appendices for the individual agencies as well as from the text and summary tables in the 1989/90 report.

APPENDIX C

Egypt's Stabilization and Adjustment Program

EAS: 7-31-91

I. Rationale:

The Government of Egypt (GOE) recently adopted, at the urging of the donor community, a comprehensive stabilization and adjustment program. The need for this program arises from the public sector-led and inward looking development strategy stressing social welfare objectives that Egypt has followed since the 1960s. This strategy created a legacy of state intervention and ownership, monopolization, and distortions in the incentive system for the real, monetary, and trade sectors resulting from price, foreign exchange, and trade controls. Price controls often set prices below costs contributing to the serious financial difficulties experienced by many public enterprises. Administratively controlled exchange and interest rates resulted in monetary imbalances in the form of loss of international reserves and an inevitable devaluation of the Egyptian pound, which has been accompanied by restrictions on trade and access to the foreign exchange market. Moreover, inward-looking trade policies, which provided high levels of import protection for many domestic economic activities, led to widespread distortions and inefficiencies, and greatly reduced the competitiveness of the economy.

By the late 1980s, these structural problems resulted in substantial macroeconomic imbalances. The economy experienced financial disequilibria in both the balance of payments and the fiscal budget. The government budget deficit reached 17 percent of GDP in FY89 and 24 percent in FY 90, with an undesirable effect on the inflation rate, which accelerated to 20 percent in FY 90. The current account deficits were approximate \$3 billion (6 percent of GDP) in FY 89 and 90. These macroeconomic imbalances resulted in growing external debt that reached close to \$50 billion in FY 90, annual debt service obligations of about \$6 billion or nearly half of foreign exchange earnings, and accumulating external arrears of \$11 billion, which jeopardize Egypt's external creditworthiness.

The GOE's stabilization and adjustment program is cushioned by significant balance of payment support. Specifically, the Paris Club meeting in May 1991 provided debt relief (effective over a three year period) worth 50 percent of the net present value of the GOE's official bilateral debt service obligation. This debt relief is expected to be worth approximately \$5.3 billion during the 18 month period ending June 30, 1992.* In addition, the Consultative Group, meeting in Paris in July 1991, pledged approximately

* This excludes GOE debt to the U.S., which was reduced by approximately 70 percent in early 1991 by the forgiving of debt on U.S. military sales.

\$4 billion in bilateral development assistance to Egypt for each of the next two fiscal years. To a significant extent, this debt relief and foreign assistance aims to support, and is conditional upon, GOE adherence to the stabilization and adjustment program.

II. Objectives:

The GOE's stabilization and adjustment program is defined primarily by the IMF Stand-By Arrangement, signed in May 1991, and the World Bank Structural Adjustment Loan (SAL), approved by its Executive Board in June 1991 and to be signed, tentatively, in September, 1991. The overall objective of the Stand-by and the SAL is to restore non-inflationary stable growth and external creditworthiness to Egypt. Specifically, the Stand-by aims to restore macroeconomic balance and reduce inflation -- thereby stabilizing the economy. This is to be achieved through the adoption of tight financial policies, prudent external borrowing policies, and the maintenance of competitive exchange rate policy. The SAL focuses on structural adjustment relating to price liberalization, privatization, and freer trade in order to stimulate sustainable medium-and long-term growth. The specific mechanics of the Stand-by and SAL are described below.

III. Mechanics of Implementation:

A. Stand by Arrangement

Priority Actions: Under the 18 month Stand-by, which amounts to 278 million SDR and runs from April 1, 1991 to September 30, 1992, the GOE will implement agreed policy actions by certain specific dates, both before and during the period of the arrangement. The GOE has already implemented the General Sales Tax, restored customs duty rates to the levels in effect in early 1989 (prior to their approximately 30 percent reduction), and increased domestic petroleum product prices and electricity prices.

The stand-by has set the following performance criteria to monitor progress in policy implementation and in the achievement of the objectives of the program:

Credit Ceilings: Quarterly credit ceilings are imposed on the stock of: a) net domestic assets of the banking system, b) net credit to the total nonfinancial public sector, and c) net credit to the central government, local governments, and the General Authority for Supply of Commodities for the end of-June, September, and - December 1991. Future ceilings are to be established based on the first review.

Net International reserves: Quarterly targets are also set for the net international reserves of the Central Bank of Egypt in 1991.

Arrears on external debt servicing obligations: The GOE is to eliminate \$11.4 billion of external arrears existing at the end of June 1990 and any new arrears incurred between June 1990, and the date of approval of the Stand-by, by December 31, 1991. No new external payments arrears are to be incurred.

External Borrowing: The increase in the stock of outstanding short-term debt for any public sector entity (except for normal import-related financing), and the contracting or guaranteeing by any public sector entity of medium-and long-term borrowing on non-confessional terms, is limited to quarterly levels.

Exchange and trade system: The unification of the exchange system will be completed not later than February 26, 1992. During the period of the Stand-by, the GOE will refrain from imposing additional restrictions on the availability of foreign exchange and from introducing or modifying multiple currency practices.

Two reviews of GOE performance under the Stand-by will be carried out to assess current performance and to reach understandings on future actions and specific performance criteria. The first review will be in October 1991, and the second in April 1992.

B. Structural Adjustment Loan:

The proposed loan amounts to US\$ 300 million, based on Egypt's balance of payments needs for FY 92-93 and is to be disbursed in two equal tranches. The first tranche will be disbursed upon loan signature (tentatively September 1991) while the second tranche will be made available upon the fulfillment of the second tranche conditions. Conditions for loan signature are based on the implementation of certain key policy actions relating to: i) the new public investment law, ii) cotton pricing, and iii) liberalized investment licensing. The first condition encompasses the promulgation of the new public sector law and the adoption of its executive regulations and by-laws. Establishment of the Public Investment Office, initial steps to convert the existing 37 public sector organizations into holding companies, liberalization of truck and bus tariffs, and elimination of centralized foreign exchange budgeting for public sector enterprises are additional steps to be taken in conjunction with the new law. The second condition is the increase of cotton prices for the 1991 crop to 60% of the world price. Finally, the third condition requires the extension of the liberalized investment licensing enjoyed by Law-159 companies to all enterprises.

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The first condition, pertaining to the new public investment law, and the third condition, relating to liberalized investment approval procedures, have essentially been met. However, the GOE has so far failed to satisfy the second condition by raising cotton procurement prices sufficiently. Loan signature will occur only after this crucial condition is met.

Other policy variables considered to be crucial for the success of the reform program have been selected as pre-requisites for the release of the second tranche of the SAL. These conditions include:

Fiscal/Monetary Policy: The achievement of a satisfactory external financing program, the reduction of budget deficit to 10.5% and 6.5% in 1991/92 and 1992/93 respectively, and the use of consistent monetary and exchange rate policies.

Privatization: Satisfactory progress in implementing the agreed upon FY91-92 privatization program, and the reorganization of two thirds of the existing public sector organizations into holding companies which would operate according to private sector market rules.

Price Liberalization: The liberalization of prices for industrial products no longer subject to high import protection.

Energy Prices: The increase of weighted average petroleum product prices to at least 56% of world prices by December 1991 and to 67% by second tranche release, and the increase of electricity prices to 69% of the economic cost of supply (LRMC) by second tranche release.

Cotton Prices: The increase of cotton procurement prices to at least 66% of international prices for 1992 crop, and the elimination of half of the remaining subsidies on fertilizers and pesticides in 1991/92.

Trade Barriers: The reduction of the production coverage of import bans (from approximately 22.7% to 10.6% of the output of tradeable goods), further import tariff reform to reduce tariff dispersion and averages, and the reduction of export bans.

APPENDIX D

MEMORANDUM

TO: Dr. Carol Carpenter-Yaman, Director, Office of population

FROM: Dr. Elizabeth G. Heilman^{EgH} and Mrs. Margaret Martinkosky^{M.M.}, Financial Management Consultants, EP&A

DATE: October 22, 1991

SUBJECT: Status of Preliminary Work on the Pricing Study

The government of Egypt (GOE) and foreign donor agencies are heavily subsidizing family planning goods and services to make them available to all Egyptians. For the GOE fiscal year 1989/1990, it is estimated that public sector funding for family planning amounted to roughly 53.5 million Egyptian pounds. The study team was requested by USAID and the National Population Council to research issues related to access to affordable family planning goods and services. This request was made in light of ongoing concerns both for efficient use of limited government resources and for a sustainable family planning program that equitably subsidizes those in need and at the same time minimizes the subsidies for those who are able to pay.

Initial information gathering on the pricing of family planning goods and services was undertaken during August and September 1991 by the study team comprised of Dr. Elizabeth Heilman, Ms. Margaret Martinkosky, Dr. Fatma El-Zanaty, and Ms. Omailma Abdel-Akher. The study team contacted agencies within the service delivery and distribution systems as well as those involved with manufacturing of commodities and demographic research. Meetings were held with the Ministry of Health, the Cairo Health Organization, the Family of the Future, the Clinical Services Improvement Project, the Health Insurance Organization, the Egyptian Junior Medical Doctors Association, Organon and Schering pharmaceutical companies, the Egyptian Drug Organization, CAPMAS and the Cairo Demographic Center.

Our general approach when meeting with agency officials was to try to determine the socio-economic profile of the family planning clients served by the different agencies and to look at the effect of changes in prices of commodities (and services) upon demand. Notes from the meetings with each of these agencies are attached to this memorandum.

The information reflected in the accompanying notes indicates that the study team is at the beginning of the data collection process. At present, the study team does not have substantive answers to questions of affordability. Rather, the data and information collected thus far suggest that further work with the data, especially that from the DHS 1988 and the upcoming DHS 1992, might yield promising and insightful results.

The study team is continuing to do a literature search on issues of willingness to pay and tariff design as well as to meet with professionals experienced in issues which pertain to questions of access to affordable family planning goods and services.

Notes on Clinical Services Improvement Project

The Clinical Services Improvement Project (CSI) provides family planning and other gynecological services to women through its system of primary and sub centers in upper and lower Egypt. By the end of 1990, CSI was operating approximately 93 centers and planned to open 65 additional centers for a total of 158. By 1995, CSI plans to cover a substantial portion of its costs through revenue earned from the fees collected from clients for all of its services.

CSI has self-efficiency plans based on projected patient caseloads and fees for service. The plans call for scheduled fee increases for various services based on the length of time a given center has been operating. (See Table 4 of Appendix A.) During the first two years a center is operating, no fees increase for FP services. In the third year of operation, fees increase between 15% and 20%. For example, the fee for IUD and insertion changes from LE 12 to LE 14; injectables, from LE 5 to LE 6; Norplant, from LE 10 to LE 12; pills, from LE 5.25 to LE 6.25; and other methods, from LE 5.4 to LE 6.4.

According to discussions held with Mr. Said El Dib, CSI's Planning, Evaluation and MIS Manager, the FP service fees were due to increase in the first six primary centers in January 1991. The managers of these six clinics were reluctant to increase the service fees because they were afraid that, as a result, CSI would lose clients. The managers said that they might lose clients to competitors such as the MOH, CEOSS and other agencies. Therefore, fees were not increased in five of the six primary centers. The manager of the primary center in Tanta did decide to institute the scheduled increase for family planning services. The increases were only in effect for a three-week period in February 1991. The manager changed the prices back to the original amounts after three weeks because the staff and manager perceived that demand for the services was decreasing. The statistics for this period do not show a decrease in utilization. (See Appendix B, Tables 1, 2 and 3.) Table 1 shows the daily numbers of new acceptors (a total of 237 for the month). This total (237) is comparable to the total number of new acceptors for December 1990 (250), January 1991 (233), and March 1991 (244). (See Table 3.)

Because the price increase was for such a short period of time (only 3 weeks), the study team feels that it is difficult to draw conclusions with regard to changes in demand for the services.

The fee schedule is somewhat different with regard to "other services." These services are scheduled to increase approximately 33% from an average of LE 5.25 per user in the first year of operation to an average of LE 7.00 per user in the second year of operation. (See Appendix A, Table 4.) Mr. Said El Dib told us that the six primary centers which opened in 1988 did increase "other services" fees on schedule in January 1990. These primary centers are all located in urban areas. The "other services" include certain laboratory tests, pap smears, and treatment of infections. The price increases were about LE 1-2. (See Appendix C, Table 1 for a list of services and the price increases.)

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An analysis of the number of new other services clients and the revenue generated by other services procedures from the third quarter of 1989 through the fourth quarter of 1990 are enumerated below. (See Table 2 in Appendix C. Table 2 data are derived from Tables 3-7 which were provided by CSI staff.)

1. The number of new "other services" clients appears to follow the same pattern as the new FP clients. When the number of FP clients increase, other services clients increase. When the FP clients decrease, the other services clients decrease. Mr. Said El Dib reported that CSI does not currently market or promote the "other services" component of its operation. All media and promotional campaigns are aimed at the family planning services.
2. The percentage of other services clients as compared to total clients remained relatively stable for the period before the price change and after the price change in January 1990. The range varies between 44% and 50%.
3. Revenue generated by other services procedures increases over the time period as shown in Table 2. But revenue generated by FP services also increased over the same period and there were no price increases in FP services. Revenue generation is a function of different factors, including patient mix and numbers of patients served. These clinics were establishing their client base and reputations during the period, and patient load will naturally increase as the clinic is better known and more established. Thus revenues should increase over time when patient load increases.
4. The percentage of revenues generated by other services as a component of total revenues remained relatively stable for the period before the price changes and after the price changes, fluctuating between 38% and 31%.

What, if any, conclusions can we draw from the above analysis of other services statistics on number of clients and revenue generated before and after the price changes in January of 1990?

1. There does not appear to be a long-term decline in new other services clients after the price increases in January 1990. Although there is a decrease in the second quarter of 1990, this decrease may be attributable largely to the lunar month of Ramadan which tends to decrease client demands for services. In 1990 Ramadan started at the end of March and ended toward the end of April. By the fourth quarter of 1990, the number of new other services clients returns to the level in the first quarter of 1990.
2. The percentage of other services clients and the percentage of other services revenue remains relatively stable.

3. We may be able to conclude that an average increase of 33% in the fees of other services procedures had no appreciable effect on demand for these services.

The study team set out to investigate price changes for family planning goods and services. At CSI, we found price changes with regard to other GYN services, not family planning. Can we generalize from CSI's experience with raising other services fees and say that raising FP services will have little or no effect on utilization, as it seems to have had little or no effect on other GYN services? Constraints on making this generalization follow:

1. The other services component of CSI's operation deals with curative services. Women who seek these services come to the clinic with a medical problem of some nature, either an infection or some GYN dysfunction. The other services are diagnostic in nature (laboratory tests) and/or curative (treatment of infection). Studies have shown that people are more willing to pay for curative services than for preventive services.
2. Family planning services are preventive in nature. They are provided to healthy women who want to prevent or delay normal pregnancy. In order to determine whether women will pay more for this type of service, we must study price changes for these services. We must also determine the economic situation of the women and how this affects their willingness to pay for services.

The study team was also investigating whether service providers had data on the economic status of the target group they were serving. In discussion with Mr. Said El Dib regarding this matter, he said that it was generally assumed that CSI was serving women in the middle-income range. He provided us with copies of two studies which CSI had conducted to analyze the effect of two media campaigns they had conducted. These studies attempted to get a socio-economic profile of the respondents, which were new clients to the CSI clinics (Primary Centers in urban areas). The studies categorized women by age, the number of living children, education level and work status. The studies did not ask for any income data. The first study conducted found that 26.4% of the women were illiterate and 63% of the women were not employed. (See Appendix D.) The second study conducted in early 1990 found that 39.7% of new clients were illiterate and 77.8% were not employed. (See Appendix E.) As the second study points out on page 9 (Appendix E), CSI attracts more educated women than illiterates. Illiterates represent 39.7% of the new clients as compared to the national average of 44.7% for urban females.

Although these studies provide interesting data on educational levels, they do not provide information for determining the economic status of CSI's client population.

Notes on Central Agency of Public Mobilization and Statistics

The study team contacted Dr. Laila Nawar at the Central Agency of Public Mobilization and Statistics (CAPMAS) to find out if any studies had been conducted with regard to the prices charged for family planning goods and services and, if so, had questions been included with regard to the economic status of the respondents. She informed us that CAPMAS had conducted a study assessing the quality of family planning service delivery in Egypt and that questions had been asked regarding family planning method cost and socio-economic levels of the respondents.

The quality assessment study was conducted in nine governorates of Egypt, including those in both upper and lower Egypt. (See Table A of Appendix F.) The family planning units selected were located in rural and urban areas. Three agencies were studied - the MOH (90 units), the EFPA (25 units) and CSI (5 units), for a total of 120 units. The family planning units selected in the nine governorates were chosen in order to get as broad a cross-section of units as possible with regard to: 1. the socio-economic level of the population served; 2. whether or not the center had been upgraded; 3. the number of working days and hours, etc. (See page 5 of Appendix F.)

Three different questionnaires were designed for the assessment:

1. The first set of questions was to be answered by the family planning center's doctor/director. (120 respondents)
2. The second set was designed for the center's clients. (1,188 respondents)
3. The third set was designed for non-users of the MOH, EFPA or CSI units. (1,440 respondents)

Two of the questionnaires contain questions which pertain to pricing of family planning goods and services and the economic profile of the respondents. The three relevant questions are discussed below:

1. The second questionnaire was designed for the family planning centers' clients. Approximately 10 clients from each clinic were asked these questions. Of the total 1,188 respondents, 455 clients were asked the question: "What do you think of the family planning method cost?" According to Dr. Nawar, these 455 clients were continuing users of the clinics and had visited the clinics on the day of the study to be resupplied with contraceptives. Table 16 in Appendix F gives the percent and numbers of distribution of clients according to the method currently used. Although the study team did not verify the following with Dr. Nawar, it is reasonable to assume that these 455 respondents are users of pills, condoms, foaming tablets, injections or creams and jellies. Users of these contraceptives must purchase continuing supplies, whereas IUD users may

keep the same IUD for an average of 2.5 years. It is also reasonable to assume that a majority of these 455 respondents are pill users. Table 16 of Appendix F shows that of the total client respondents, 423 use pills, 11 use condoms, 15 use foaming tablets, 7 use injections and 1 uses creams or jellies.

Thus the question, "What do you think of the family planning method cost?" relates mainly to pill costs. Table 1 in Appendix G shows the tabulation by numbers and percentages of the respondents' answers categorized by agencies (MOH, EFPA and CSI). Because the number of responses for CSI is so small, only 14, it is not valid to draw any conclusions from CSI's data.

The largest number of respondents were in the MOH units, 385 clients. The EFPA units had 56 respondents. It is interesting to note that a majority of both the MOH and EFPA respondents thought the method cost is cheap: 51.4% and 66.1%, respectively. Only 4.4% of the MOH respondents thought the method cost is expensive and none of the EFPA respondents thought the cost is expensive.

2. The first questionnaire was used to interview the directors of the family planning units. Two questions relating to the socio-economic level of the clients served by the family planning units are discussed below:
 - A. The directors were asked: "What do you think is the socio-economic level of the people served by your family planning unit?" The answers to this question are tabulated in Table 2 of Appendix G. In the MOH and EFPA units, the perception of the directors is that a majority of the clients are in the medium range with regard to their socio-economic level: 75.6% and 80%, respectively. The directors of the MOH and EFPA units rank 23.3% and 16% of their clients, respectively, in the low socio-economic level.
 - B. The directors were also asked the question: "What do you think is the educational level of the clients served by your clinic?" The directors were given a choice of five answers and asked to choose one. Table 3 in Appendix G tabulates the results of this question. It is difficult to draw any conclusion from this question, as the five answers are not necessarily separate and discrete choices. For instance, answers one and three overlap. Number one says, "The majority are illiterate" and number three says, "Approximately 50% illiterate and 50% can read and write." There should be only one answer regarding illiteracy. As a result, the responses to this question are not particularly useful.

What conclusions can we draw from the answers to the questions relating to cost and socio-economic levels? It has already been discussed why question three regarding educational levels is not so useful. The second question on the directors' perception of the socio-economic levels

of the clients is interesting, but is not based on any "hard" data. It is based on subjective opinion. The first question on whether the client, who is actually at the center to purchase contraceptives, thinks the method cost is cheap, suitable or expensive, gives us the most information regarding the prices of contraceptives. The fact that the majority of respondents think the method cost is cheap (MOH - 51.4%, EFPA - 66.1%) suggests that prices could possibly be raised for the oral pills. (It was assumed that the majority of the 455 respondents were oral pill users.)

Although this study was designed to assess quality of care issues and not to address the prices to be charged for family planning goods and services, it has provided us with a glimpse of what family planning clients think about the price they pay for contraceptives. Further information needs to be gathered regarding clients' willingness to pay for contraceptives before any concrete recommendation can be made to raise or lower prices of contraceptive commodities.

Notes on Health Insurance Organization

The Health Insurance Organization (HIO) delivers health care services to approximately 3.2 million beneficiaries in the private and public sectors. Under Egyptian social insurance legislation, laws 32 and 75, passed in 1975, beneficiaries are persons eligible to receive health services and social benefits. Beneficiaries along with their employers contribute to financing HIO's activities through payroll deductions. HIO also sells services to non-beneficiaries on a fee-for-service basis when HIO clinics and hospitals have excess capacity not needed to serve beneficiaries.

With funding from USAID, HIO began providing family planning services to beneficiaries and non-beneficiaries on a fee for service basis in 1988. HIO operates approximately 40 family planning clinics currently.

The study team met with HIO officials to discuss pricing issues with regard to family planning goods and services and to find out information on the economic profile of the clients served by HIO. HIO beneficiaries are upper-middle- and lower-middle-class government employees. Although HIO could not provide economic data on the non-beneficiary population served, officials perceived that the non-beneficiaries are also in the middle-class category.

With regard to pricing and price changes, HIO gave us the following information:

1. Initially in 1988 when the family planning project began, beneficiaries and non-beneficiaries were charged 2 LE for IUDs and LE 8 for IUD insertions for a total of LE 10.
2. In the fourth quarter of 1989, HIO reduced these prices. They charged beneficiaries nothing for the IUD and LE 3 for insertion. Non-beneficiaries were charged LE 2 for the IUD and LE 3 for insertion for a total of LE 5.
3. During the third quarter of 1990, HIO conducted an intensive media campaign with many TV spots. They also printed brochures advertising HIO services and offering a 25% discount on charges for goods and services if the client would bring in the brochure when obtaining the family planning services. The 25% discount in effect made the price for an IUD plus insertion LE 2.25 for beneficiaries and LE 3.75 for non-beneficiaries.

HIO officials stated that demand for family planning services increased after each of these price decreases. In Appendix H, Table 1, there is a graph by quarter showing the average number of new acceptors per clinic including all clinics in the project (Tables 2 to 7 show this data for each region). The graph shows that the average number of new acceptors did increase after each

price reduction. How much of this increase is attributable to just the price decrease is debatable. Other factors affecting utilization of family planning services include the following:

1. Throughout the period represented by the graph, new clinics were being established and their new acceptors served might have increased the average number of new acceptors for all clinics old and new, because, initially all acceptors at new clinics would be new as opposed to continuing acceptors.
2. The length of time each clinic has been operating impacts on the number of new acceptors. After a clinic has been operating a certain length of time, it will ideally establish a reputation and make its presence known to the public, and utilization will increase.
3. The second price reduction was accompanied by an intense media campaign advertising the FP services provided by HIO. Some of the increased demand is probably attributable to increased awareness of the services available.

It can probably be assumed that part of the increase in utilization of family planning services can be attributable to the decrease in prices, but it is difficult to quantify the portion without more detailed analysis.

HIO told the study team that they plan to integrate family planning services into the basic HIO health services. They are planning to integrate the FP services with the OB-GYN services as well as train general practitioners to provide FP services. HIO officials stated that there is a recognition that preventing births will save HIO money in the long run by averting the costs associated with pre-natal care and delivery.

Notes on Egyptian Junior Medical Doctors Association

The Egyptian Junior Medical Doctors Association (EJMDA) is a private, non-governmental professional association of physicians. Combining USAID funding with its own resources, in October 1989, EJMDA began a family planning (FP) project. The objectives of the project include the recruitment and training of private practice physicians in FP services; the monitoring of trainees' performance in the field; the development of FP guidelines for private practitioners; and, the provision to physicians of continuing education in FP practices. EJMDA is concentrating most of its training efforts on junior physicians from rural areas both in 14 governorates in Upper Egypt and in 4 governorates in Lower Egypt.

With regard to the pricing study, Dr. Amr Taha, who assists in the operation of EJMDA's family planning project, indicated that no formal data existed on the economic profile of clients served by EJMDA. However, he felt that the patients were not poor. The clients would be from middle class and would probably be wives of laborers in industry, wives of farmers wealthy enough to pay the fees, and employed women.

Dr. Taha said that the fees charges by EJMDA's junior physicians in the rural areas for an IUD plus insertion would range from LE 10-15. (The IUD would most likely be a Copper T 380 or a Copper T 200, purchased by the physician from a local pharmacy.) Services provided to a woman deciding to use oral contraceptives would cost in the range of LE 5-10. This fee would cover only the examination, after which the woman would purchase the oral contraceptive at a local pharmacy.

Dr. Taha stated that the services of EJMDA physicians are in competition with those of CSI clinics and suggested that EJMDA physicians had raised fees for the IUD and insertion to the LE 10-15 range because CSI charges LE 12. He felt that EJMDA physicians could compete favorably with FP clinics in rural areas for a number of reasons: 1. individual physicians are perceived to have better quality services; 2. the notion of a family doctor is comforting; 3. the husband knows the physician and, as a result, will be more likely to allow his wife to be examined by the male physician; and 4. the individual physician can provide continuity of care, whereas, at a family planning clinic, the client may not see the same physician on return visits.

Through its FP project, EJMDA was also training some senior physicians who practice in rural areas. These senior physicians would likely charge in the range of LE 25-40 for an IUD plus insertion. In general, regarding prices charged by private physicians for an IUD and insertion, Dr. Taha estimated that senior physicians in urban areas outside of Cairo would charge LE 50-60 and within Cairo the range would be LE 80-100.

Notes on Cairo Health Organization

The Cairo Health Organization (CHO) operates as a profit-making institution under the supervision of the Minister of Health. CHO serves family planning clients in outpatient clinics in ten of its hospitals in and around Cairo.

CHO's director indicated that CHO used to provide its family planning services for free and that after its new agreement with USAID, it started charging fees for family planning services. CHO charges LE 2 for services other than the IUD and injections. These services include counseling and laboratory work. The charges for IUD services are LE 5. The director observed that once CHO had changed to a system of fees for services, most of the users at the CHO clinics became IUD users. (The study team presently has insufficient data on CHO to confirm the phenomenon described by the director.) The director estimated that LE 20 for IUD services would cover all the costs associated with servicing an IUD user: LE 10 would cover the costs of the staff that directly service the IUD user and another LE 10 would cover the support management costs. The director did not know how the flow of IUD users at CHO clinics would be affected if the service charges were raised above LE 5.

No information was available on the economic profile of CHO family planning clients.

Notes on Schering Company

Schering is one of the pharmaceutical companies that plays a large role in the provision of contraceptive commodities. Raw materials provided through Schering are used by the Chemical Industries Company (CID) in Egypt to manufacture four types of oral contraceptives: Anovlar, Primovlar, Microvlar and Triovlar. Schering also imports the Nova T IUD into Egypt. Dr. Sami Soleiman of Schering met with the study team.

Microvlar. The retail price of a strip of the low dose oral contraceptive, Microvlar, is set by the Ministry of Health (MOH) pricing committee at LE 0.35. When the retail prices of many pharmaceutical products were increased in May 1991, the price of Microvlar was raised to LE 0.45. However, one week later, the MOH returned the price of Microvlar to LE 0.35. Dr. Soleiman suggested that perhaps the MOH wanted to show that it was not interested in increasing its profit. Increasing its sales level at roughly 10% annually, approximately 4 million strips of the low dose oral contraceptive, Microvlar, were sold during the last year.

Primovlar and Anovlar. Both these standard dose oral contraceptives retail for LE 0.10 per strip. Their prices have been fixed by the MOH pricing committee for so long that they are not subject to retariffication. About 2 million strips of Primovlar and 2.5 million strips of Anovlar have been sold annually for the last few years. Since the low dose preparations (such as Microvlar) take up the market increase in oral contraceptives, that is why the annual sales level of these standard dose preparations has remained the same. Dr. Soleiman commented that the MOH receives such favorable terms from the German bank on the loan for the raw materials used in the pill production that the MOH does not need to set high retail prices for the commodities. However, if prices for these two commodities were raised, it probably would not affect demand because the current price of LE 0.10 per strip is so low. Sometimes the government is more conservative than it needs to be. Dr. Soleiman further suggested that it might not be until 1993 that pharmaceutical prices would be raised since retariffication just occurred in May 1991.

Triovlar. The retail price of this triphasic oral contraceptive was increased from LE 0.90 to LE 1.20 in May 1991. The target of its sales level is about one fourth of the volume of Primovlar. Dr. Soleiman indicated that the smaller sales volume of Triovlar is due not only to its high price, but also to other factors. It is more difficult for the uneducated woman to take the triphasic and this is what makes the sales level of Triovlar so low. In addition, Microvlar, which has high sales levels, was introduced well before Triovlar.

Nova T. The Nova T IUD is not tariffied by the MOH. There have been four prices for the Nova T IUD since 1985, dependent upon the cost of each consignment that came into Egypt. One of the prices was LE 16. About 10,000 Nova Ts are sold annually. Schering will probably withdraw it from the market.

Schering is in the process of registering for the new oral contraceptive, Genera, to be manufactured by CID. Since it will be much more expensive than what is currently available, it will most likely have a low market share. With this commodity, Schering is going after the higher income market.

Dr. Soleiman made a few comments about the raw materials that are used in the production of Primovlar and Anovlar. The raw materials will continue to come in which will assure the continued production of these commodities. Even though the prices on these two pills are set so low, CID would not necessarily hesitate to continue manufacturing the pills if the manufacturing costs were to rise. CID might except some areas that run at a loss because in other areas they are making profits to balance it out. In other cases, a company might slowly get out of a loss item and replace it with a new and similar profit item, but this is difficult to do for oral contraceptives.

Notes on Organon Pharmaceutical Company

Organon is a Dutch pharmaceutical company which has been doing business in Egypt since the 1960s. The only contraceptives which they are selling in Egypt are the Multi-Load 250 and the Multi-Load 375. The current retail prices are LE 40 for the Multi-Load 250 and LE 45 for the Multi-Load 375. During 1989/90, Multi-Load's distribution level reached approximately 8,000 pieces; and, in 1990/91, approximately 10,000 pieces. These IUDs are being distributed by approximately 23 Organon salesmen in Egypt. The Organon salesmen are targeting IUD sales to private physicians. Organon officials stated that their IUD market was marginal, and that they were not even breaking even on their sales. Their goal is to break even. It is the low cost of the Copper T-380 IUD (LE 2.00) that keeps the price of the Multi-Load down. The officials stated that the market for the Multi-Load IUDs are women in the high-income bracket which they estimate to be approximately 3 million women.

Because the Multi-Load is not a drug, it is not subject to the rigid price controls set for drugs. The retail price can change within certain parameters. For example, each time a new consignment of IUD's enters the country, the price can change based on the price of the consignment. The price changes, however, must be registered and approved by the government's tariffication committee.

Organon officials told the study team that they are attempting to get approval from the GOE to sell a low-dose contraceptive pill called Marvalon. Organon is having a great deal of trouble getting this pill registered. The GOE is insisting that clinical trials be conducted on 10,000 Egyptian women to prove the safety and efficacy of Marvalon. Organon officials stated that Marvalon is currently sold throughout the world and is Organon's most popular low-dose pill. If Organon is successful in getting Marvalon registered, they plan to have the Nil Company manufacture the pill.

Organon officials told us that they had been hoping to interest the Dutch government in providing a grant or loan to help subsidize the manufacture of Marvalon, but Organon was unsuccessful in convincing the Dutch government to provide the grant. Organon stated that if Marvalon is finally approved in Egypt, the market for the pills will have to be women in the higher-income bracket because of Marvalon's estimated higher cost to produce. The officials could not give us an estimate on what the price might be.

Notes on Family of the Future

Family of the Future (FOF) is one of the main agencies for distributing contraceptive commodities within Egypt. It markets and distributes contraceptives to pharmacies, private doctors and clinics throughout Egypt. During the last decade, FOF has sold IUDs, condoms, foaming tablets and oral contraceptives. We talked with FOF both about its experience with price changes and their effect upon demand as well as about the economic profile of FOF's target population. What we learned is discussed in the following sections:

Pricing of Contraceptive Commodities

Although FOF sells several kinds of contraceptive methods, the one method concerning which FOF has price change experience and supporting data over time is the condom. Since 1985, FOF has distributed golden tops which have been supplied free by USAID. On December 22, 1987, FOF doubled the price of condoms from 6 pieces for LE 0.25 to 6 pieces for LE 0.50. The data in Chart A below shows that the condoms distributed (or the net sale of condoms) from 1984 through 1990 was:

CHART A'

Quantity of Condoms Distributed Yearly
by FOF Shown with Annual Percentage Changes

Year	Quantity of Condoms Distributed	Annual % Change in Quantity Over Preceding Year	Annual % Change in Quantity Over 1987
1984	6,848,504		
1985	12,018,186	75.49%	
1986	13,615,491	13.29%	
1987	16,201,206	18.99%	
1988	15,889,968	(1.92%)	
1989	15,772,558	(0.74%)	(2.65%)
1990	16,557,744	4.98%	2.20%

*Data for this chart comes from Appendix I, Table 1.

During the period 1985-1987 the number of pharmacies FOF distributed commodities to doubled from 4,000 to 8,000. The increased levels of distribution in these three years compared to 1984 reflect the dramatic increases that were occurring in market demand. Also, in 1986 and 1987 FOF concentrated marketing distribution efforts on rural areas.

In 1988, after the price increase in late 1987, the quantity of net sales of condoms, as shown in Chart A, decreased by 1.92% compared to the 1987 sales level and again the quantity of net sales of condoms decreased further in 1989 by 0.74% compared to the 1988 sales level. By 1990, the sales level was up 2.2% over the 1987 sales level. Even if the decrease in sales levels for the two years 1988 and 1989 was attributable solely to the price increase, sales decreased only by about 2.65% when comparing the 1989 sales level, the lowest level after 1987, to the 1987 sales level. It is possible that other factors in addition to the price increase may have had some effect upon the sales levels of condoms during 1988 and 1989. During 1988 and 1989, internal management changes in FOF may have adversely affected its sales levels. Also, the figures in Charts B and C below indicate that FOF's sales volumes in other methods, specifically IUDs and Norminest, were increasing during the period from 1987 through 1989.

CHART B*

Quantity of IUDs Distributed Yearly
by FOF Shown with Annual Percentage Changes

Year	Quantity of IUDs Distributed	Annual % Change in Quantity Over Preceding Year	Annual % Change in Quantity Over 1987
1987	273,422		
1988	338,007	23.62%	
1989	396,325	17.25%	44.95%

*Data for this chart comes from Appendix I, Table 1.

CHART C*

**Quantity of Norminest Distributed Yearly
by FOF Shown with Annual Percentage Changes**

Year	Quantity of Norminest Distributed	Annual % Change in Quantity Over Preceding Year	Annual % Change in Quantity Over 1987
1987	1,407,422		
1988	1,866,583	32.62%	
1989	1,783,299	(4.46%)	26.71%

By 1989, IUD net sales increased more than 40% compared to 1987 sales. In the same period, Norminest sales increased over 26% compared to 1987 sales.

Based on the data provided by FOF and staff comments, it appears that the price increase in condoms in late 1987 did not have a substantial effect on decreasing demand for the commodities. Rather, the decreased demand was for a period of 2 years and thereafter sales increased over the 1987 level. It is difficult to determine precisely the reason for the decrease in condom demand, whether it was the price increase alone, or in combination with FOF management changes and increases in the sales of IUDs and Norminest.

Economic Profile of FOF's Clientele

Tops: FOF's current market for Tops is chiefly comprised of men who live in urban areas, are of all ages, have completed secondary school and are middle and upper middle class. More specifically, condoms are used by the upper middle (34%), middle (41%), and lower middle (25%) class. The lowest socio-economic levels are not users. (Page 55 of FOF's Annual Marketing Plan 1991/92, May 21, 1991.)

Norminest: FOF does not have economic profiles of Norminest users. However, FOF indicates (page 14 of the Annual Marketing Plan 1991/92) that 62.1% of current users of oral contraceptives are rural, and just over half of them have not completed secondary school. Thirty percent of the users work outside the home.

*Data for this chart comes from Appendix I, Table 1.

IUDs: FOF does not have economic profiles of Norminest users; however, FOF indicates (page 35 of the Annual Marketing Plan 1991/92) that the IUD target market is almost the same as that for the pill.

Foaming Tablets: According to FOF research (page 69 of the Annual Marketing Plan 1991/92), 40% of foaming tablet users belong to the middle socio-economic class; 34%, to the lower socio-economic class; and, 26% to the higher socio-economic class.

Notes on Cairo Demographic Center

The Cairo Demographic Center (CDC) carried out Egypt's 1988 Demographic and Health Survey (DHS). One of the pricing study team members, Dr. Fatma El-Zanaty, was the Sampling Coordinator for DHS 1988 and is holding a comparable position for Egypt's DHS 1992. DHS 1988 was carried out in 21 of Egypt's 26 governorates. From the 10,528 households selected for the DHS sample, 9,867 were considered to be eligible. Of the eligible households, 9,805 households were successfully interviewed and 8,911 ever-married women between the ages of 15 and 49 years of age were interviewed. Based on numerous discussions involving the DHS Sampling Coordinator, the study team developed its thinking about use of existing DHS 1988 data and about possible questions for inclusion in DHS 1992.

DHS 1988 data indicates that of the 37.8% of currently married women using any contraceptive method, 15.3% are using the pill, and 15.7% are using the IUD. Because of the dominant role of these two methods among contracepting women, the study team focused its discussions on DHS data on the pill and IUD. After reviewing the DHS 1988 questionnaire, the study team wanted to use DHS 1988 data to determine: a. the socio-economic background of the pill and IUD users; b. what pill-users are paying now for commodities; and c. how much pill users are willing to pay for their commodities.

Economic levels. Looking at the whole sample of currently married women, we wanted to categorize the respondents into economic levels based on data gathered from seven household questions 17, 18, 21, 35, 53, 54 and 55 (see Appendix J). Using data gathered from questions 17 and 18, we requested a computer run for education of the women to determine the scores with a percentage in each category. In addition, we requested a computer run of question 21 on the occupational codes for currently married women and their husbands to show the nine categories of work status and then classify the responses with a percentage in each category. To get more of a picture of the economic level of the respondents, we requested a tabulation of question 35 on whether the dwelling is owned by the household or not. We also requested a run for questions 53, 54 and 55 all of which deal with goods privately owned by the respondents. The responses from these three questions are to be tabulated all together. The mean number of items owned by each household will serve as the basis for setting up three economic categories based on interval estimates. (For example, 3 items owned or less=low; 4 - 10=middle; and, > 10=high.) The study team thinks that tabulation and matching of these data results from the seven questions will allow for categorization of the respondents by economic levels. The study team will then see how the pill and IUD users fit into the economic levels.

Willingness to pay. The DHS 88 individual questionnaire question 343 (see Appendix J) does ask a series of questions which are designed to determine the maximum amount of money that the female respondent is willing to pay for a cycle of pills. (No such question was asked of IUD users.) The study team requested the tabulation of the results of this question. (See results in

A

Appendix J.) In addition, the study team decided to request the tabulation of results for question 342 (see Appendix J), in which the pill user indicates how much one cycle of pills usually costs her. The results of 342 are to be matched with 343 to give an idea of how much pill users usually pay and how much they are willing to pay for a cycle of pills. The results of the willingness to pay data will be matched with the results of the data on economic levels to give some idea of the economic profile of users and their willingness to pay.

Question 343 asks the 1296 pill users if they would buy a pill cycle if it cost 25 piasters. If the response is yes, the questioner continues with successively higher amounts (50 piasters per cycle, 75 piasters, 1 pound, 2 pounds, and more than 2 pounds per cycle) until the answer is no or until the highest amount is reached. The results of the tabulation of the responses to question 343 indicate that 98% of the respondents were willing to pay 25 piasters per cycle; 95% were willing to pay 50 piasters; 88%, 75 piasters; 82%, 1 pound; 67%, 2 pounds; and, 56%, more than 2 pounds.

The study team awaits the tabulation of the responses to the other questions to begin to put the responses to question 343 into the context of economic status. Based on the results of the DHS 88 data, the study team will propose any additional questions it would like to see included in Egypt's DHS 92 along with a description of the benefits to be obtained.

Notes on Ministry of Health and Its Drug Organization

Through a pricing committee, the Ministry of Health (MOH) controls the prices of many contraceptive commodities. Prices for commodities such as Triovlar and IUDs brought into the country by companies looking for profit are not regulated by the MOH pricing committee. All contraceptives which are used in the national family planning program are controlled by the MOH pricing committee.

Working under the Ministry of Health, the Egyptian Drug Organization has a department for setting prices of pharmaceutical products in Egypt. The tariffication department uses the following formula:

	+	Cost of raw materials	
		<u>Cost of packaging</u>	
	=	Subtotal #1	
	+	20.0% of subtotal 1 for	} indirect costs of manufacture administrative/financial costs marketing costs research costs scientific office costs
	+	30.0%	
	+	15.0%	
	+	3.0%	
	+	<u>11.6%</u>	
	=	Subtotal #2	
	+	<u>15.0%</u> of subtotal 2 for profit	
	=	Price to distributor	
	+	7.8% distributor mark-up	
	+	5.0% sales tax	
	+	1.0% stamp tax	
	+	<u>4.5%</u> cost of credit accounts with retailers (this amount is discounted if retailer pays cash)	
	=	Price to retailer (pharmacist)	
	+	<u>20.0%</u> pharmacy mark-up	
	=	Price to Consumer	

For many of the contraceptive commodities, prices are determined based not on the above detailed formula, but rather on policy issues of concern to the government of Egypt (GOE). The GOE is providing certain levels of goods and services at very low costs and is thereby trying to assure availability to the majority, if not all, of the people.

APPENDIX A

Clinical Services Improvement Project

Table # 4 explains Fee for Service Schedule by the center's operating period.

Table # 4
Fee for Service Schedule

	FAMILY PLANNING					OTHER RELATED SERVICES
	IUD	INJECTABLE	NORPLANT	PILL	OTHERS	
FIRST FULL YEAR OF OPERATION	12	5	10	5.25	5.4	5.25
SECOND YEAR OF OPERATION	12	5	10	5.25	5.4	7
THIRD YEAR OF OPERATION	14	5	12	5.25	5.4	7
FOURTH YEAR OF OPERATION	14	5	12	5.25	5.4	7
FIFTH YEAR OF OPERATION	14	5	12	5.25	5.4	9.5
SIXTH YEAR OF OPERATION	16	7	14	7.25	7.4	9.5
SEVENTH YEAR OF OPERATION	16	7	14	7.25	7.4	9.5

Table # 4 explains the following:

1. Other Services fee is increased from 5,25 LE. to 7 LE. in the Second year of operation.
2. Family Planning Services fee is increased from 12 LE. to 14 LE. (IUD) and from 10 LE. to 12 LE. (Norplant). The fee paid for other contraceptives (Injectable - Oral Pills - Others) is increased by 1 LE. in the Third year.
3. There is no increase in fees the Fourth year.
4. Other Services fee is increased again from 7 LE. to 9,5 LE. in the Fifth year.

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5. Family Planning Services fee is increased from 14 LE. to 16 LE. (IUD) and from 12 LE. to 14 LE. (Norplant). The fee paid for other contraceptives (Injectable - Oral Pills - Others) is increased by 1 LE. in the Sixth year.
6. There is no increase in fees in the Seventh year.
7. It reflects the gradual increase in Fee for Service so that this increase will not result in clients turning away from CSI centers and to always keep fees of offered services lower than that of Private Clinics.

APPENDIX B

Clinical Services Improvement Project

TABLE 1

CLINICAL SERVICES IMPROVEMENT PROJECT

No. Of New Clients And Service Fee Income
TANTA Primary Center
FEB. 1991

New clients

DAY	FAMILY PLANNING			OTHER SERVICES		
	CLIENTS	REVENUE	AVERAGE	CLIENTS	REVENUE	AVERAGE
2	13	207.95	16.0	9	85.00	9.4
3	2	84.00	42.0	8	89.00	14.8
4	8	158.00	19.8	5	57.00	11.4
5	4	142.45	35.6	7	91.00	13.0
6	7	126.00	18.0	5	50.00	10.0
7	6	123.00	20.5	6	72.00	12.0
9	13	235.05	18.1	10	165.00	16.5
10	13	184.00	14.2	10	153.00	15.3
11	6	91.05	15.2	5	69.00	13.8
12	3	64.55	21.5	12	92.00	7.7
13	3	101.35	33.8	3	31.00	10.3
14	4	58.00	14.5	4	36.00	9.0
16	13	184.25	14.2	9	131.00	14.6
17	14	253.60	18.1	8	102.00	17.0
18	12	206.35	17.2	7	69.00	9.9
19	10	149.70	15.0	8	90.00	11.3
20	12	194.45	16.2	13	127.00	9.8
21	6	101.25	16.9	6	79.00	13.2
23	21	305.05	14.5	18	161.00	8.9
24	16	202.85	12.7	5	60.00	12.0
25	9	141.35	15.7	11	92.00	8.4
26	6	99.20	16.5	8	107.00	13.4
27	21	233.95	11.1	2	35.00	17.5
28	15	144.80	9.7	5	25.00	5.0
TOTAL	237	3,792.20	16.0	180	2,068.00	11.5

TABLE 2

CLINICAL SERVICES IMPROVEMENT PROJECT

DAY	FAMILY PLANNING					OTHER SERVICES				
	TOTAL CLIENTS	FREE CLIENTS	NET CLIENTS	REVENUE	AVERAGE	TOTAL CLIENTS	FREE CLIENTS	NET CLIENTS	REVENUE	AVERAGE
2	31	6	25	207.95	8.3	17	4	13	85.00	6.5
3	12	2	10	84.00	8.4	14	2	12	89.00	7.4
4	23	7	16	158.00	9.9	15	5	10	57.00	5.7
5	21	5	16	142.45	8.9	12	1	11	91.00	8.3
6	21	6	15	126.00	8.4	11	3	8	50.00	6.3
7	12	0	12	123.00	10.3	9	0	9	72.00	8.0
9	33	8	25	235.05	9.4	27	6	21	165.00	7.9
10	21	4	17	184.00	10.8	23	5	18	153.00	8.5
11	16	7	9	91.05	10.1	15	2	13	69.00	5.3
12	13	2	11	64.55	5.9	19	5	14	92.00	6.6
13	17	6	11	101.35	9.2	7	2	5	31.00	6.2
14	16	9	7	58.00	8.3	9	2	7	36.00	5.1
16	26	8	18	184.25	10.2	23	6	17	131.00	7.7
17	29	9	20	253.60	12.7	11	1	10	102.00	10.2
18	27	7	20	206.35	10.3	13	3	10	69.00	6.9
19	25	2	23	149.70	6.5	17	4	13	90.00	6.9
20	29	5	24	194.45	8.1	26	5	21	127.00	6.0
21	14	5	9	101.25	11.3	10	1	9	79.00	8.8
23	48	13	35	305.05	8.7	27	3	24	161.00	6.7
24	33	6	27	202.85	7.5	12	4	8	60.00	7.5
25	29	9	20	141.35	7.1	23	5	18	92.00	5.1
26	19	5	14	99.20	7.1	23	7	16	107.00	6.7
27	33	3	30	233.95	7.8	10	3	7	35.00	5.0
28	26	8	18	144.80	8.0	7	2	5	25.00	5.0
TOTAL	674	142	432	3,702.20	8.6	380	81	299	2,068.00	6.9

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TABLE 3

**No. Of New Clients And Service Fee Income Generated
For Gharbia (PC 1988)**

Month	F.P.			O.S.		
	Clients	Revenue	Average	Clients	Revenue	Average
Dec. 1990	250	3,273.4	13.1	314	2,595.0	8.3
Jan. 1991	233	3,536.8	15.2	262	2,847.0	10.9
Feb. 1991	237	3,663.4	15.5	180	2,068.0	11.5
Mar. 1991	244	3,465.0	14.2	162	1,682.0	10.4
Apr. 1991*	205	2,707.1	13.2	109	1,145.0	10.5

- The decrease in April 1991 may be attributable to the lunar month of Ramadan which, in 1991, began in March and ended in April. Ramadan, the Islamic month of fasting, consistently seems to lower the demand for FP goods and services.

APPENDIX C

Clinical Services Improvement Project

TABLE 1

الخدمات الصحية

السعر المقترح	السعر الحالي	الخدمة
٢	٢	(١) كشف عام general exam
٥ ✓	٢	(٢) تنظير عنق الرحم in situ (٢)
٥ ✓	٢	(٣) اكتشاف الحمل Pregnancy detection (٣)
٤ ✓	٢	(٤) فحص قبل الزواج Prenatal (٤)
٤ ✓	٢	(٥) فحص دوري Periodic exam after 40 yrs. of age (٥)

المطبات الصغرى

٥	٥	(١) تركيب لوليب insertion هلال (١)
٥	٥	(٢) نزع لوليب removal هلال (٢)
١٢ ✓	١٠	(٣) عينة من بطانة الرحم Pap smear (٣)
		بدون بنج
١٥ ✓	١٠	(٤) كي عمق الرحم treatment (٤)

تحاليل

٢	٢	(١) بول كامل urinalysis (١)
١	١	(٢) هيموجلوبين hemoglobin (٢)
٢	٢	(٣) صورة دم الشحم blood count (٣)
٢	٢	(٤) براز كامل stool specimen (٤)
٨	٥/٥	(٥) سائل صوي spinal fluid analysis (٥)
١٠	١٠	(٦) صوى بعد الجوع blood sugar after 12 hours (٦)
٢	٢	(٧) افرازات مهبلية culture (٧)
٥	٢	(٨) اختبار حمل pregnancy test (٨)
٢	٢	(٩) سرعة ترسيب sedimentation rate blood coagulation (٩)
٢	١	(١٠) فصيلة دم blood typing (١٠)
٢	٢	(١١) عامل Rh factor (١١)
٢	٢	(١٢) سكر في الدم sugar levels (١٢)
١	١	(١٣) سرعة تجلط blood coagulation (١٣)

**CLIENT AND REVENUE (LE) DATA OF
SIX CSI PRIMARY CENTERS* BY QUARTER
3RD QUARTER 1989 - 4TH QUARTER 1990**

CLIENT AND REVENUE CATEGORIES	3rd Quarter 1989	4th Quarter 1989	1st** Quarter 1990	2nd Quarter 1990	3rd Quarter 1990	4th Quarter 1990
New FP Clients	2,534	3,982	4,480	3,223	4,153	3,778
New Other Services Clients	<u>2,490</u>	<u>3,453</u>	<u>3,796</u>	<u>2,785</u>	<u>3,252</u>	<u>3,742</u>
Total New Clients	5,024	7,435	8,276	6,008	7,405	7,520
% of Other Services Clients to Total Clients	<u>50%</u>	<u>46%</u>	<u>46%</u>	<u>46%</u>	<u>44%</u>	<u>50%</u>
Revenue from FP Clients	23,797	39,886	46,728	35,325	47,710	45,117
Revenue from Other Services Clients	<u>14,759</u>	<u>18,687</u>	<u>24,916</u>	<u>20,180</u>	<u>21,856</u>	<u>26,609</u>
Total Revenues	38,556	58,573	71,644	55,505	69,566	71,726
% Of Other Services Revenue to Total Revenues	<u>38%</u>	<u>32%</u>	<u>35%</u>	<u>36%</u>	<u>31%</u>	<u>37%</u>

* These primary centers (PCs) opened in the fourth quarter of 1988 and had price increases in their "other services" in the first quarter of 1990. All these PCs are located in urban areas in lower Egypt (in Tanta, Al-Mansura and Giza) and in upper Egypt (in Minya, Assiut and Sohag).

** Prices of "other services" were increased in January 1990.

TABLE 3

**No. Of New Clients And Service Fee Income Generated
1st Group (PC's 1988)**

Quarter	F.P.			O.S.		
	Clients	Revenue	Average	Clients	Revenue	Average
4th Qtr. 1988	971	8,670.6	8.9	1,599	6,534.9	4.1
1st Qtr. 1989	1,802	17,715.2	9.8	2,471	13,517.3	5.5
2nd Qtr. 1989	1,884	17,168.9	9.1	2,069	12,543.8	6.1
3rd Qtr. 1989	2,534	23,796.7	9.4	2,490	14,759.3	5.9
4th Qtr. 1989	3,982	39,886.3	10.0	3,453	18,687.0	5.4
1st Qtr. 1990	4,480	46,727.7	10.4	3,796	24,915.6	6.6
2nd Qtr. 1990	3,223	35,324.7	11.0	2,785	20,179.5	7.2
3rd Qtr. 1990	4,153	47,709.6	11.5	3,252	21,855.5	6.7
4th Qtr. 1990	3,778	45,117.2	11.9	3,742	26,609.0	7.1
1st Qtr. 1991	3,606	46,492.0	12.9	3,316	27,227.5	8.2
2nd Qtr. 1991	3,410	50,153.5	14.7	3,074	26,289.8	8.6

TABLE 4

**No. Of New Clients And Service Fee Income Generated
1st Group (PC's 1988)**

Center	E.P.			D.S.		
	Clients	Revenue	Average	Clients	Revenue	Average
4th Qtr. 1988						
Minia	137	1,128.0	8.2	199	791.6	4.0
Asuit	122	879.1	7.2	273	1,165.4	4.3
Sohag	240	2,114.8	8.8	516	1,749.0	3.4
Giza	92	819.7	8.9	144	605.0	4.2
Gharbia	198	2,074.2	10.5	304	1,347.0	4.4
Dkahlia	182	1,655.0	9.1	163	877.0	5.4
TOTAL	971	8,670.6	8.9	1,599	6,534.9	4.1

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TABLE 5

**No. Of New Clients And Service Fee Income Generated
1st Group (PC's 1989)**

Center	F.P.			O.S.		
	Clients	Revenue	Average	Clients	Revenue	Average
1st Qtr. 1989						
Minia	205	1,903.7	9.3	303	1,889.0	6.2
Asuit	316	2,575.2	8.1	368	2,261.0	6.1
Sohag	485	4,024.9	8.3	542	2,806.3	5.2
Giza	87	958.1	11.0	183	1,055.0	5.8
Gharbia	354	4,346.2	12.3	681	3,582.0	5.3
Dkahlia	355	3,907.2	11.0	394	1,924.0	4.9
TOTAL	1,802	17,715.2	9.8	2,471	13,517.3	5.5
2nd Qtr. 1989						
Minia	254	2,481.1	9.8	263	1,741.0	6.6
Asuit	271	2,259.7	8.3	304	2,193.0	7.2
Sohag	478	4,002.5	8.4	542	3,218.0	5.9
Giza	85	816.3	9.6	108	662.0	6.1
Gharbia	532	4,831.2	9.1	524	2,967.0	5.7
Dkahlia	264	2,778.1	10.5	328	1,762.8	5.4
TOTAL	1,884	17,168.9	9.1	2,069	12,543.8	6.1
3rd Qtr. 1989						
Minia	346	3,265.6	9.4	389	2,138.0	5.5
Asuit	373	3,118.2	8.4	382	2,448.0	6.4
Sohag	549	5,147.1	9.4	568	3,641.0	6.4
Giza	145	1,444.9	10.0	149	944.0	6.3
Gharbia	747	6,982.4	9.3	639	3,232.0	5.1
Dkahlia	374	3,838.6	10.3	363	2,356.3	6.5
TOTAL	2,534	23,796.7	9.4	2,490	14,759.3	5.9
4th Qtr. 1989						
Minia	480	4,775.5	9.9	641	3,334.0	5.2
Asuit	455	4,234.9	9.3	405	2,553.2	6.3
Sohag	824	7,855.4	9.5	565	3,276.0	5.8
Giza	381	3,697.7	9.7	272	1,517.1	5.6
Gharbia	1,149	11,674.0	10.2	807	4,093.0	5.1
Dkahlia	693	7,648.9	11.0	763	3,913.8	5.1
TOTAL	3,982	39,886.3	10.0	3,453	18,687.0	6.4

TABLE 6

**No. Of New Clients And Service Fee Income Generated
1st Group (PC's 1988)**

Center	F.P.			O.S.		
	Clients	Revenue	Average	Clients	Revenue	Average
1st Qtr. 1990						
Minia	412	4,121.0	10.0	555	3,558.0	6.4
Asuit	473	3,974.6	8.4	499	3,648.1	7.3
Sohag	807	8,082.2	10.0	619	4,305.0	7.0
Giza	519	5,339.0	10.3	437	2,903.0	6.6
Gharbia	1,373	14,933.4	10.9	684	4,323.0	6.3
Dkahlia	896	10,277.6	11.5	1,002	6,178.5	6.2
TOTAL	4,480	46,727.7	10.4	3,796	24,915.6	6.6
2nd Qtr. 1990						
Minia	335	3,854.7	11.5	323	2,385.5	7.4
Asuit	341	2,973.2	8.7	428	3,582.4	8.4
Sohag	595	6,635.5	11.2	443	3,578.0	8.1
Giza	359	3,895.0	10.8	318	2,218.0	7.0
Gharbia	890	9,683.4	10.9	624	3,775.0	6.0
Dkahlia	703	8,282.9	11.8	649	4,640.7	7.2
TOTAL	3,223	35,324.7	11.0	2,785	20,179.5	7.2
3rd Qtr. 1990						
Minia	462	6,128.4	13.3	453	3,329.0	7.3
Asuit	520	5,214.6	10.0	494	3,842.0	7.8
Sohag	706	8,091.3	11.5	543	3,624.0	6.7
Giza	490	5,323.5	10.9	405	2,934.0	7.2
Gharbia	1,114	11,920.7	10.7	523	2,753.0	5.3
Dkahlia	861	11,031.2	12.8	834	5,373.5	6.4
TOTAL	4,153	47,709.6	11.5	3,252	21,855.5	6.7
4th Qtr. 1990						
Minia	383	5,172.3	13.5	424	3,167.0	7.5
Asuit	396	4,653.4	11.8	504	4,182.0	8.3
Sohag	672	7,982.1	11.9	671	4,622.0	6.9
Giza	626	6,395.5	10.2	496	3,303.0	6.7
Gharbia	987	11,197.5	11.3	780	5,566.0	7.1
Dkahlia	714	9,716.4	13.6	867	5,769.0	6.7
TOTAL	3,778	45,117.2	11.9	3,742	26,609.0	7.1

TABLE 7

**No. Of New Clients And Service Fee Income Generated
1st Group (PC's 1988)**

Center	F.P.			D.S		
	Clients	Revenue	Average	Clients	Revenue	Average
1st Qtr. 1991						
Minia	329	4,269.0	13.0	384	2,620.0	6.8
Asut	442	5,539.6	12.5	471	4,255.0	9.0
Sohag	780	8,682.5	11.1	663	4,752.0	7.2
Giza	578	6,125.7	10.6	488	3,297.5	6.8
Gharbia	714	10,665.2	14.9	604	6,597.0	10.9
Dkahlia	763	11,210.2	14.7	706	5,703.0	8.1
TOTAL	3,606	46,492.0	12.9	3,316	27,224.5	8.2
2nd Qtr. 1991						
Minia	255	4,214.3	16.5	368	2,596.0	7.1
Asut	484	6,960.4	14.4	458	4,334.0	9.5
Sohag	719	9,881.3	13.7	650	4,874.0	7.5
Giza	484	6,345.6	13.1	402	3,250.8	8.1
Gharbia	843	11,371.1	13.5	485	4,788.0	9.9
Dkahlia	625	11,380.9	18.2	711	6,447.0	9.1
TOTAL	3,410	50,163.5	14.7	3,074	28,289.8	8.8

APPENDIX D

Clinical Services Improvement Project

**PRELIMINARY REPORT ON:
EVALUATION OF THE FIRST MEDIA CAMPAIGN**

**Dept. of Evaluation,
Research, and Planning
Clinical Service Improvement
Project**

March 1989

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1. Importance of the study:
 - A. Evaluating the various kinds of media used in the first media campaign.
 - B. Prioritizing the sources of referral to the centres: Medical sources - outreach activities - relatives and acquaintances - mass media components.
 - C. Identifying the general characteristics of the clients of the centres: Age - Number of children - Marital Status - Employment - Previous usage of methods of contraception. This information will be useful when planning and executing the components of the second media campaign.

2. Methodology of the study:
 - * The sample is composed of clients utilizing CSI for the first time during the months of December 1988 and January 1989, with a maximum of 200 clients per centre (100 for family planning services and 100 for other services) in each of the project clinics (totalling 6 centres in 6 governorates). Therefore, the total samples is 1200 woman.

3. Research tools:
 - * A questionnaire was used (attached is a copy of the questionnaire and instructions for filling it) which includes 3 parts: identifying information - sources from which the beneficiary knew about the centre - some details about the components that were implemented during the first media campaign.
 - * A questionnaire was designed in cooperation with the Research Dept., the Media Dept. and the Outreach Dept. A pretest was conducted and the questionnaire was modified into its final form.
 - * The receptionists were trained to fill in the questionnaire and outreach supervisors were trained to review them.

4. Means of Collecting the Data:
 - * The questionnaire was filled out by the receptionists in the centres through personal interviews with the clients.
 - * The field questionnaires were then reviewed by the outreach supervisors.
 - * The activity was carefully supervised through frequent field visits by central Outreach, IEC, and Planning /Research/ Evaluation Departments.

5. Analyzing the Data:

- * The data was checked at the central headquarters and codified. The codes were checked, then entered into the computer. Manual tests were conducted to check the accuracy and consistency of the data. Then, the data was summarized, tabulated and some indicators were calculated in the form of percentages. This was all done by the Department of Planning, Evaluation, Research and Information Systems. Correct questionnaires totaled 1,120.

6. Preliminary Results:

The results are presented in tables and charts as follows:

- * Tables 1 - 5 describe the clients interviewed in terms of:
 - 1) age
 - 2) no. of living children
 - 3) level of education
 - 4) employment status
 - 5) family planning status
- * Table 6, 6.1, and 6.2 rank the various sources of referral to the clinics, and look at the relationship between clients' age, number of children, governorate, and other factors, and source of referral.
- * Table 7 (and Chart 1) looks at clients who mentioned friends and relatives as their source of referral.
- * Tables 8-12 look at the distribution of clients in terms of:
 - exposure to TV spots vs other TV programs
 - exposure to newspaper ad
 - recall of slogan
 - recall of logo
 - exposure to flier
- * Tables 13, 13.1, and 13.2 (and Chart 2) look at the distribution of clients in terms of TV as a source of referral.

TABLE 1. CLIENTS' AGE

AGE	FAMILY PLANNING		OTHER SERVICES		TOTAL	
	FREQUENCY	%	FREQUENCY	%	FREQUENCY	%
15 - 20	10	1.8	15	2.7	25	2.2
20 - 25	92	16.8	127	22.4	220	19.6
25 - 30	146	26.6	166	29	312	27.9
30 - 35	160	29.2	124	21.7	284	25.3
35 - 40	89	16.2	91	15.9	180	16.1
40 - 45	43	7.9	33	5.8	76	6.8
45 - 50	7	1.3	5	0.8	12	1.1
50 & more	-	-	8	1.4	8	0.7
NO ANSWER	1	0.2	2	0.3	3	0.3
TOTAL	548	100	572	100	1120	100

The age range 25 to less than 35 comprised more than 50% of first time clients, whether family planning clients (55.8% of total family planning clients) or other clients (50.7% of total other clients).

TABLE 2: NO. OF LIVING CHILDREN

NO. OF CHILDREN	FAMILY PLANNING		OTHER SERVICES		TOTAL	
	FREQUENCY	%	FREQUENCY	%	FREQUENCY	%
NONE	9	1.6	178	31.1	187	16.7
1	80	14.6	83	14.5	163	14.5
2	134	24.4	118	20.6	252	22.5
3	111	20.3	73	12.8	184	16.6
4	94	17.2	50	8.7	144	12.9
5	52	9.5	27	4.7	79	7.1
6 & MORE	63	11.5	26	4.6	89	7.9
NO ANSWER	5	0.9	17	0.3	22	2.0
TOTAL	548	100	572	100	1120	100

First time clients with 2 living children comprised 24.4% of total family planning clients and 20.6% of clients of other services.

TABLE 3: CLIENTS ACCORDING TO EDUCATION

EDUCATION STATUS	FAMILY PLANNING		OTHER SERVICES		TOTAL	
	FREQUENCY	%	FREQUENCY	%	FREQUENCY	%
ILLITERATE	157	28.6	139	24.3	296	26.4
LITERATE	84	15.3	78	13.6	162	14.5
PRIMARY OR PREPARATORY	18	3.3	37	6.5	55	4.9
SECONDARY	192	35.1	200	35	392	35
POST SECONDARY	96	17.5	117	20.4	213	19
NO ANSWER	1	0.2	1	0.2	2	0.2
TOTAL	548	100	572	100	1120	100

First time clients with a secondary school education are the majority - 35.1% of family planning clients and 35% of clients of other services.

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TABLE 4: CLIENTS ACCORDING TO EMPLOYMENT STATUS

EMPLOYMENT STATUS	FAMILY PLANNING		OTHER SERVICES		TOTAL	
	FREQUENCY	%	FREQUENCY	%	FREQUENCY	%
WORKS	184	23.6	930	40.2	414	36.9
DOES NOT WORK	362	66	340	59.4	702	62.7
NO ANSWER	2	0.4	7	0.4	4	0.4
TOTAL	548	100	572	100	1120	100

Housewives represent the largest percentage of clients. They are 66% of total family planning clients and 59.4 of total clients requesting other services.

**TABLE 5: CLIENTS ACCORDING TO USE OF
FAMILY PLANNING METHOD**

STATUS	FAMILY PLANNING		OTHER SERVICES		TOTAL	
	FREQUENCY	%	FREQUENCY	%	FREQUENCY	%
CURRENTLY USING	120	21.9	125	21.9	245	21.9
EVER USER	241	44	159	27.7	400	35.7
NEVER USER	184	33.6	287	50.2	471	42
NO ANSWER	3	0.5	1	0.2	4	0.4
TOTAL	548	100	572	100	1120	100

The clients who currently do not use family planning methods (ever users and never users) are 77.7% of total new clients, whether family planning or other clients.

APPENDIX E
Clinical Services Improvement Project

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I. STUDY BACKGROUND

1. INTRODUCTION

The Clinical Services Improvement Project (CSI) of the Egyptian Family Planning Association has been carrying out a multi-media campaign for promoting its services in a number of clinics in Lower and Upper Egypt governorates. The media campaign relies on mass media in the form of T.V., radio, press publications, street billboards; face to face interpersonal communication through local activities of community leaders, public meetings, home visits, and letters; and on word of mouth media through relatives and friends, this include the husband, male, and female relatives and friends. Mobile microphones have been recently introduced as a promotional channel.

In order to assess the success of the promotional activities, evaluations have been carried out by means of finding out new clients' source of knowledge on clinics. The first round of evaluation was carried out by CSI Department of Planning, Research and Information Systems for the months of November, December 1988 and January 1989. The second round of evaluation was carried out for the period of June, July, and August 1989.

This report presents the findings of the third round of evaluation that covers the period of November, December 1989, and January 1990.

The first two rounds of evaluation covered the six clinics that were opened during October 1988, mainly in Sohag, Assiut Minia, Giza, Gharbia (Tanta City) and Dakahlia (Mansoura City). The analysis compared clinics from Lower Egypt (with Giza clinic operationally included within this category) with clinics from Upper Egypt as well as comparing new clients who came to the clinic for family planning service with new clients who came for other services such as pregnancy testing, gynaecological care, prenatal care, etc.

By August 1989, CSI opened six new clinics at Alexandria, Kafr El Sheikh, Sharkiya (Zagazig City) Beni Suef, and Qena. Other sub-clinics were opened in secondary cities of the main old clinics.

It has been decided by CSI management to include in the third round evaluation all main clinics: the six new clinics and the six old clinics. Sub-clinics were excluded from this evaluation.

2. OBJECTIVE OF THE EVALUATION

The main objective is to evaluate the executed local and national communication/promotion campaign activities through:

- a. prioritizing sources of knowledge of CSI clinics during the research period; and:
- b. identifying the general socio-demographic characteristics of new clients during the period under study.

3. EVALUATION METHODOLOGY

The evaluation is based on data collected from new clients at the clinics during the month of January 1990. A structured interview schedule was filled out by the clinic receptionist. New clients are those receiving the clinic services for the first time whether family planning or non-family planning services.

Through systematic random sampling, a sample proportional to size of new clients was selected from each clinic for a total of 1,200 cases.

An interview schedule originally designed for the first round evaluation and slightly modified for the second round was used for this round of evaluation. A translated copy of the interview schedule is presented in the appendix.

Clinic receptionist were trained by CSI officials in administering the interviews. The training included receptionists of old clinics (Sohag, Assiut, Minia, Giza, Gharbia, and Dakahlia) and of new clinics (Qena, Beni-Suef, Sharkia, Qalubia, Kafr El Sheikh and Alexandria).

SPAAC has reviewed the data, computer processed and analysed the data, and wrote the final report.

In the process of reviewing the data, it was discovered that Dakahlia had used the unmodified interview schedule of the first round. The decision was made to exclude Dakahlia from the analysis, thus reducing the old clinics to five instead of six.

Table (1) presents the number of new clients by clinic, the size and proportion of selected sample from each type. The total sample is 24 percent of the total population of new clients and individual clinic samples range from 22-26 percent of their respective population of new clients.

The report presents the national and local promotional activities, the analysis of collected data from new clients which compares old versus new clinics, family planning service clients versus non-family planning service clients, and clinics of Lower Egypt versus clinics of Upper Egypt. Findings of the third round evaluation is compared with findings of the first and second rounds for identification of differences & trends. Summary of findings and recommendations are presented in the last section.

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III. STUDY FINDINGS

1. GENERAL CHARACTERISTICS OF NEW CLIENTS

Data collected from sampled new clients of the eleven CSI clinics have been analysed to compare differences that exist between old and new clinics, between family planning and non-family planning service clients, and between clinics of Lower and Upper Egypt. T Test has been used for statistical significance at 95% level of confidence.

1.1. AGE STRUCTURE

CSI clinics, in general, have attracted, during the period under study, relatively young new clients with an overall average age of 29.4 years (Table 4). Almost half of the new clients (49.2%) are within the age brackets of 20-24 years (22.6%) and 25-29 years (26.6%).

There are no statistical significant differences in the age structure of new clients of old and new clinics or between new clients of Upper and Lower Egypt clients.

There are, however, significant differences in age by type of services, as the average age of family planning service clients is almost one year higher than the average age of non-family planning service clients (29.8 years and 28.9 years respectively).

The main differences in age structure of family planning and non-family planning service clients are the greater concentration of non-family planning clients in the age bracket 20-24 years (27.5% as compared to 18.3% of family planning clients), and less concentration in the age bracket of 30-34 years (18.4% versus 23.4% for family planning clients).

1.2. NUMBER OF LIVING CHILDREN

New clients of CSI clinics have on average a relatively small number of living children (2.7 living child). Less than half (47.2%) have less than three living children and around two thirds (66.5%) have less than five children. Still a significant proportion (16%) have five children or more.

Clients of old and new clinics do not differ in terms of number of living children, but statistically significant differences exist between clients by type of service and by region.

Over one quarter of non-family service clients have no children (27.5%) and less than one fifth (18.7%) have more than four living children while over one fourth of family planning service clients (26.6%) have at least five living children.

Similarly, new clients of Lower Egypt clinics have on average less living children (2.5 living child) than clients of Upper Egypt clinics (3.0). The main differences are that 40 percent of Lower Egypt clinic clients have between one and two living children and only 17.2 percent have more than four children, while for Upper Egypt clients, 29.2 percent have between one and two children and 29.3 percent have more than four living children.

1.3. EDUCATIONAL LEVEL

As shown in (Table 4), CSI clinics also attract more educated women than illiterates. Illiterates constitute almost 40 percent of new clients which is slightly lower than the National illiteracy rate of urban females of 44.7 percent.

In general, there are no statistically significant differences between clients of old and new clinics nor clients of family planning and non-family planning services. Yet clients of new clinics tend to be slightly more represented in the barely can read and write category and less represented in the illiterate category as compared to old clinic clients (16% versus 9.4% respectively for read and write and 35.9% versus 44.6% for illiterates).

The greatest differences however, are between clients of Lower and Upper Egypt clinics. Upper Egypt clients have higher proportion of illiterates (49.5% versus 31% in Lower Egypt), and lower proportions of those with intermediate education (21.9% versus 33.2%) and with high education (8.9% versus 13.2% respectively).

1.4. WORK STATUS

Less than one fourth of new clients of CSI clinics are working women. There are no statistical differences between old and new clinics in terms of proportion of clients working nor between family planning nor non-family planning service clients. The significantly lowest proportion of working women is among clients of Upper Egypt (18%) as compared to Lower Egypt clients (25.7%).

1.5. USE OF CONTRACEPTIVE METHODS

The majority of sampled new clients (68.6%) are not current users of contraceptives. They are either ever users (32.5%) or never users (36.1%).

There are statistically significant differences between the different sub-groups in terms of contraceptive use. Old clinics attract more never users of contraceptives than new clinics (39.2% versus 33.7% respectively), and new clinics attract more current contraceptive users than old clinics (34.7% versus 26.7%). New family planning service clients tend to be more concentrated among ever users (38.8%) and current users (32%), while less than half (45.3%) of new non-family planning service clients are never users of contraceptives and over one fourth only (29.2%) are current users and one fourth (25.2%) are ever users.

1.6. SUMMARY OF GENERAL CHARACTERISTICS OF NEW CLIENTS OF CSI CLINICS

In general, CSI clinics have attracted, during the period under study, new clients that are on average relatively young, with relatively small number of children, with a reasonable level of education, with high proportions of working women, and a reasonable balance between current contraceptive users, ever users, and never users. This does not mean that CSI clinics do not attract older women, women with five living children or more, illiterates, and non-working women. These categories, however, are less represented among CSI new clients.

Comparing characteristics of new clients between the different sub-groupings, indicates that the least differences exist between old and new clinics. The main difference between them is in the contraceptive use status of clients. New clinics attract more current contraceptive users than old clinics and less never-users.

As for differences between family planning and non-family planning service clients, non-family planning service clients tend to be younger, with higher proportion of women with no children, lower proportions of women with high parity, and higher proportions of never users of contraceptives. Such clientes are excellent targets to be motivated towards contraceptive use either for spacing or for termination of child bearing.

The greatest differences exist between characteristics of Upper and Lower Egypt clinic clients. New clients of Upper Egypt clinics have higher proportions of illiterates, lower proportions

of working clients, higher proportions of mothers with more than four living children, and higher proportions of clients who have never used any contraceptive.

2. NEW CLIENTS' SOURCE OF KNOWLEDGE ABOUT CSI CLINICS

2.1. METHODOLOGY

New clients have been asked about their sources of knowledge of CSI clinics (i.e., sources from which they learned about the clinics). The source which was spontaneously mentioned by them was recorded accordingly; clients were then probed on their knowledge from other sources in order to ascertain coverage of remaining sources. When clients mentioned more than one source-of knowledge they were asked to identify which was the last source-of-knowledge they were exposed to. When only one source was mentioned, it was considered the last source.

2.2. SOURCE OF KNOWLEDGE

Percentage distribution of sampled new clients by source of knowledge as a total and by type of clinic (old versus new clinics), by type of service (family planning versus non-family planning service clients), and by region (Lower and Upper Egypt clinics) are presented in Tables (5), (6), and (7) sequentially.

T.V. ranks as the highest and most mentioned source of knowledge whether mentioned spontaneously or after probing. More than four out of five new clients mentioned T.V. as a source of knowledge about the clinic (82.5%). Female relative/friend is the second most mentioned source of knowledge (44.7%). Other sources of knowledge in a descending order of percentages of clients who mentioned them as source of knowledge spontaneously and after probing are: street billboards (21.54%), community leaders (15.9%), publications (15.5%), Home visits (13.9%), husbands (11.2%), male relatives/friends (10.4%), and meetings (9.1%). Letters (5.7%), radio (4.2%), and mobile street microphones (3.4%) have had minimum effect in reaching new clients.

Old and New clinics are similar in that the T.V. is the most frequently mentioned source of knowledge for new clients (81% and 83.7% respectively). Among other sources of knowledge whether from local activities or other mass media channels, differences do exist between old and new clinics as expected. With the exception of home visits, mobile street microphones, and street billboards, all other sources were mentioned more often by new clients of old clinics than those of new clinics (See Figure I).

TABLE (1)
 PERCENTAGE OF SAMPLE SIZE TO
 TOTAL NUMBER OF NEW CLIENTS
 DURING THE MONTH OF JANUARY 1990

CLINIC	TOTAL NO OF NEW CLIENTS (COLLECTED CASES) NO.	%	SAMPLE SIZE NEW CLIENTS (ANALYSED CASES)	% OF SAMPLE TO TOTAL NEW CLIENTS
<u>OLD CLINICS</u>				
Sohag	518	10.4	115	22.2
Assiut	329	6.6	77	23.4
Minia	339	6.8	83	24.5
Giza	318	6.4	76	23.9
Gharbia	650	13.0	169	26.0
<u>NEW CLINICS</u>				
Qena	494	9.9	111	22.5
Sharkia	492	9.6	121	24.6
Beni-Suef	419	8.4	100	23.9
Alexandria	688	13.7	174	25.3
Qaliubia	427	8.5	98	23.0
Kafr-EL-Sheikh	328	6.6	76	23.2
TOTAL	5002	99.9	1200	24

TABLE (2)
 TOTAL FREQUENCY OF BROADCASTING
 T.V. SPOTS FOR THE MONTHS OF
 NOVEMBER-DECEMBER, 1989 & JANUARY, 1990

MONTH	CHANNEL 1	CHANNEL 2	TOTAL
November	12	10	22
December	12	9	21
January	8	3	11
TOTAL No. of times	32	22	54

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AGE	MARITAL STATUS	ELIGIBLE WOMEN	EDUCATIONAL STATUS			
			ONLY FOR THOSE THREE YEARS AND OLDER	ONLY FOR PERSONS ATTENDING SCHOOL IN PAST OR CURRENTLY		ONLY FOR PERSONS NEVER ATTENDING SCHOOL OR NOT COMPLETING PRIMARY
013	014	015	016	017	018	019
How old was (NAME) at his/her last birthday?	What is (NAME)'s current marital status? 1 MARRIED 2 WIDOWED 3 DIVORCED 4 SIGNED CONTRACT BUT NOT YET CONSUMMATED FIRST MARRIAGE 5 NEVER MARRIED	CIRCLE LINE NUMBER FOR WOMEN ELIGIBLE FOR INTERVIEW, I.E., MARRIED, WIDOWED OR DIVORCED WOMEN 15-49 YEARS OLD PRESENT IN THE HOUSEHOLD LAST NIGHT	Has (NAME) attended school in the past or is he/she currently going to school? 1 YES, IN PAST 2 YES, CURRENTLY 3 NO, NEVER ATTENDED	What was the highest LEVEL that he/she was admitted to? 1 NURSERY 2 PRIMARY 3 PREPARATORY 4 SECONDARY 5 UPPER INTERMEDIATE 6 UNIVERSITY 7 MORE THAN UNIVERSITY	What was the highest GRADE that he/she successfully completed at that level?	Can (NAME) read a newspaper or a letter, for example?
IN YEARS				LEVEL	GRADE	YES NO
<input type="text"/>	<input type="checkbox"/>	01	1 2 3	<input type="checkbox"/>	<input type="checkbox"/>	1 2
<input type="text"/>	<input type="checkbox"/>	02	1 2 3	<input type="checkbox"/>	<input type="checkbox"/>	1 2
<input type="text"/>	<input type="checkbox"/>	03	1 2 3	<input type="checkbox"/>	<input type="checkbox"/>	1 2
<input type="text"/>	<input type="checkbox"/>	04	1 2 3	<input type="checkbox"/>	<input type="checkbox"/>	1 2
<input type="text"/>	<input type="checkbox"/>	05	1 2 3	<input type="checkbox"/>	<input type="checkbox"/>	1 2
<input type="text"/>	<input type="checkbox"/>	06	1 2 3	<input type="checkbox"/>	<input type="checkbox"/>	1 2
<input type="text"/>	<input type="checkbox"/>	07	1 2 3	<input type="checkbox"/>	<input type="checkbox"/>	1 2
<input type="text"/>	<input type="checkbox"/>	08	1 2 3	<input type="checkbox"/>	<input type="checkbox"/>	1 2
<input type="text"/>	<input type="checkbox"/>	09	1 2 3	<input type="checkbox"/>	<input type="checkbox"/>	1 2
<input type="text"/>	<input type="checkbox"/>	10	1 2 3	<input type="checkbox"/>	<input type="checkbox"/>	1 2
TOTAL NUMBER ELIGIBLE WOMEN <input type="text"/>		024 COUNT THE NUMBER OF ELIGIBLE WOMEN FOR WHOM LINE NUMBERS ARE CIRCLED IN 015. ENTER THE TOTAL IN THE BOXES AT THE BOTTOM OF THE COLUMN IN 015. THEN GO TO 025.				

OCCUPATION		WORK STATUS	
ONLY FOR PERSONS TWELVE YEARS AND OLDER		ONLY FOR PERSONS 12 YEARS AND OLDER WHO WORK	
020	021	022	023
What is the main work that (NAME) does?	OCCUPATIONAL GROUP	Did (NAME) work during the last month?	Is (NAME) usually paid in cash or in kind for the work he/she does? 1 CASH 2 KIND 3 BOTH 4 NOT PAID
	FOR CODER		
	<input type="checkbox"/> <input type="checkbox"/>	YES NO 1 2	1 2 3 4
	<input type="checkbox"/> <input type="checkbox"/>	1 2	1 2 3 4
	<input type="checkbox"/> <input type="checkbox"/>	1 2	1 2 3 4
	<input type="checkbox"/> <input type="checkbox"/>	1 2	1 2 3 4
	<input type="checkbox"/> <input type="checkbox"/>	1 2	1 2 3 4
	<input type="checkbox"/> <input type="checkbox"/>	1 2	1 2 3 4
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	<input type="checkbox"/> <input type="checkbox"/>	1 2	1 2 3 4
	<input type="checkbox"/> <input type="checkbox"/>	1 2	1 2 3 4
	<input type="checkbox"/> <input type="checkbox"/>	1 2	1 2 3 4

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO
034	What type of dwelling unit does your household live in?	APARTMENT.....01 FREE STANDING HOUSE.....02 OTHER _____ .03 (SPECIFY)	
035	Is your dwelling owned by your household or not?	OWNED.....01 OWNED JOINTLY.....02 RENTED.....03 OTHER _____ .04 (SPECIFY)	
036	MAIN MATERIAL OF THE FLOOR.	PARQUET OR POLISHED WOOD.....1 TILE (CERAMIC, CEMENT, ETC)....2 WOOD AND TILE.....3 CEMENT.....4 EARTH/SAND.....5 OTHER _____ .6 (SPECIFY)	
037	How many rooms are there in your dwelling (excluding bathroom(s), kitchen, and stairway areas)?	NUMBER OF ROOMS..... <input type="text"/>	
038	Is there a special room used only for cooking inside or outside your dwelling?	YES, INSIDE DWELLING.....1 YES, OUTSIDE DWELLING.....2 NO.....3	
039	Is the place used for cooking shared with other households?	YES.....1 NO.....2	
040	Does the dwelling unit have electrical connections in all or only part of the dwelling unit?	YES, IN ALL.....1 YES, IN PART.....2 HAS NO ELECTRICAL CONNECTIONS...3	
041	What is the major source of drinking water for members of your household?	TAP.....01 WELL WITH PUMP.....02 WELL WITHOUT PUMP.....03 TANKER TRUCK/OTHER VENDOR.....04 NILE/CANALS.....05 OTHER _____ .06 (SPECIFY)	
042	Where is the major source of the water that you use for drinking located?	WITHIN DWELLING ITSELF.....1 OUTSIDE DWELLING WITHIN SAME BUILDING.....2 IN COURTYARD.....3 ELSEWHERE _____ .4 (SPECIFY)	
043	Do you buy your drinking water from the government or from a private source?	GOVERNMENT.....1 PRIVATE SOURCE.....2 OBTAIN FREE.....3	
044	How long does it take you to go to the source, get water and come back?	MINUTES..... <input type="text"/> ON PREMISES.....966	

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO																					
045	Do you obtain water for household use other than drinking (e.g., handwashing, cooking, etc) from the same source?	YES.....1 NO.....2	→048																					
046	What is the major source of water for household use other than drinking?	TAP.....01 WELL WITH PUMP.....02 WELL WITHOUT PUMP.....03 TANKER TRUCK/OTHER VENDOR.....04 NILE/CANALS.....05 OTHER _____06 (SPECIFY)																						
047	Where is the major source of the water that you use for household use other than drinking located?	WITHIN DWELLING ITSELF.....1 OUTSIDE DWELLING WITHIN SAME BUILDING.....2 IN COURTYARD.....3 ELSEWHERE _____4 (SPECIFY)																						
048	Does your household use water which you have stored for regular use?	YES.....1 NO.....2																						
049	What kind of toilet facilities does the household have?	MODERN.....1 TRADITIONAL WITH TANK FLUSH.....2 TRADITIONAL WITH BUCKET FLUSH...3 PIT.....4 BUCKET.....5 OTHER _____6 (SPECIFY) NO FACILITIES.....7	→051 →053																					
050	Is the toilet linked to a public sewer, a canal (river) or a pit?	PUBLIC SEWER.....1 CANAL/RIVER.....2 PIT.....3																						
051	Where are the toilet facilities located?	WITHIN DWELLING ITSELF.....1 OUTSIDE DWELLING WITHIN SAME BUILDING.....2 IN COURTYARD.....3 ELSEWHERE _____4 (SPECIFY)																						
052	Do you share the toilet facilities with any other household?	YES.....1 NO.....2																						
053	Are any of the following items found in the dwelling unit: A radio with cassette recorder? A black and white television? A color television? A video?	<table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>RADIO WITH CASSETTE.....1</td> <td>1</td> <td>2</td> </tr> <tr> <td>BLACK AND WHITE TELEVISION.1</td> <td>1</td> <td>2</td> </tr> <tr> <td>COLOR TELEVISION.....1</td> <td>1</td> <td>2</td> </tr> <tr> <td>VIDEO1</td> <td>1</td> <td>2</td> </tr> </tbody> </table>		YES	NO	RADIO WITH CASSETTE.....1	1	2	BLACK AND WHITE TELEVISION.1	1	2	COLOR TELEVISION.....1	1	2	VIDEO1	1	2							
	YES	NO																						
RADIO WITH CASSETTE.....1	1	2																						
BLACK AND WHITE TELEVISION.1	1	2																						
COLOR TELEVISION.....1	1	2																						
VIDEO1	1	2																						
054	Are any of the following appliances found in the dwelling unit: An electric fan? A sewing machine? A refrigerator? A gas/electric cooking stove? A water heater? A washing machine?	<table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>ELECTRIC FAN.....1</td> <td>1</td> <td>2</td> </tr> <tr> <td>SEWING MACHINE.....1</td> <td>1</td> <td>2</td> </tr> <tr> <td>REFRIGERATOR.....1</td> <td>1</td> <td>2</td> </tr> <tr> <td>GAS/ELECTRIC COOKING STOVE.1</td> <td>1</td> <td>2</td> </tr> <tr> <td>WATER HEATER.....1</td> <td>1</td> <td>2</td> </tr> <tr> <td>WASHING MACHINE.....1</td> <td>1</td> <td>2</td> </tr> </tbody> </table>		YES	NO	ELECTRIC FAN.....1	1	2	SEWING MACHINE.....1	1	2	REFRIGERATOR.....1	1	2	GAS/ELECTRIC COOKING STOVE.1	1	2	WATER HEATER.....1	1	2	WASHING MACHINE.....1	1	2	
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GAS/ELECTRIC COOKING STOVE.1	1	2																						
WATER HEATER.....1	1	2																						
WASHING MACHINE.....1	1	2																						

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO																																				
055	Do you or any member of your household own any of the following: Bicycle? Motorcycle? Private car? Transport equipment (truck, van, bus, etc.)? Residential buildings other than the dwelling unit? Commercial/industrial buildings (shop, factory, etc.)? Farm land? Other land? Livestock (horses, goats, sheep, etc.)? Poultry? Farm implements (tractors, etc.)?	<table border="1"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>BICYCLE.....</td> <td>1</td> <td>2</td> </tr> <tr> <td>MOTORCYCLE.....</td> <td>1</td> <td>2</td> </tr> <tr> <td>PRIVATE CAR.....</td> <td>1</td> <td>2</td> </tr> <tr> <td>TRANSPORT EQUIPMENT.....</td> <td>1</td> <td>2</td> </tr> <tr> <td>OTHER RESIDENTIAL UNITS....</td> <td>1</td> <td>2</td> </tr> <tr> <td>COMMERCIAL/INDUST BLDNGS...</td> <td>1</td> <td>2</td> </tr> <tr> <td>FARM LAND.....</td> <td>1</td> <td>2</td> </tr> <tr> <td>NONFARM LAND.....</td> <td>1</td> <td>2</td> </tr> <tr> <td>LIVESTOCK.....</td> <td>1</td> <td>2</td> </tr> <tr> <td>POULTRY.....</td> <td>1</td> <td>2</td> </tr> <tr> <td>FARM IMPLEMENTS.....</td> <td>1</td> <td>2</td> </tr> </tbody> </table>		YES	NO	BICYCLE.....	1	2	MOTORCYCLE.....	1	2	PRIVATE CAR.....	1	2	TRANSPORT EQUIPMENT.....	1	2	OTHER RESIDENTIAL UNITS....	1	2	COMMERCIAL/INDUST BLDNGS...	1	2	FARM LAND.....	1	2	NONFARM LAND.....	1	2	LIVESTOCK.....	1	2	POULTRY.....	1	2	FARM IMPLEMENTS.....	1	2	
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FARM IMPLEMENTS.....	1	2																																					

OBSERVATIONS

THANK THE RESPONDENT FOR PARTICIPATING IN THE SURVEY. FILL IN THE APPROPRIATE RESPONSES IN QUESTIONS 056-057. BE SURE TO REVIEW THE QUESTIONNAIRE FOR COMPLETENESS BEFORE LEAVING THE HOUSEHOLD.

056	RECORD THE LINE NUMBER OF THE RESPONDENT FOR THE HOUSEHOLD INTERVIEW.	LINE NUMBER..... <input type="text"/> <input type="text"/>
057	DEGREE OF COOPERATION.	POOR.....1 FAIR.....2 GOOD.....3 VERY GOOD.....4
058	INTERVIEWER'S COMMENTS: _____	
059	FIELD EDITOR'S COMMENTS: _____	
060	SUPERVISOR'S COMMENTS: _____	
061	OFFICE EDITOR'S COMMENTS: _____	

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NO.	QUESTIONS AND FILTERS	CODING CATEGORIES	SKIP TO																					
334	<p>At any time in the past month, did you fail to take a pill for even one day because of the problems that you mentioned or for any other reason:</p> <p>IF YES: What was the main reason you stopped taking the pill?</p>	<p>SIDE EFFECTS/ILLNESS.....01 SPOTTING/BLEEDING.....02 PERIOD DID NOT COME.....03 RAN OUT OF PILLS.....04 FORGOT TO TAKE/MISPLACED.....05 HUSBAND AWAY.....06 OTHER.....07 (SPECIFY) NEVER STOPPED TAKING PILL.....97</p>																						
335	<p>How many days ago did you take the last pill?</p> <p>IF RESPONSE IS TODAY, ENTER '00' DAYS AGO.</p>	<p>NUMBER DAYS AGO..... <input type="text"/> <input type="text"/> MORE THAN 30 DAYS AGO.....97 NOT SURE/DON'T KNOW.....98</p>	→338																					
336	<p>CHECK 335: MORE THAN <input type="checkbox"/> 2 DAYS AGO OR LESS <input type="checkbox"/></p>		→338																					
337	<p>Why haven't you taken the pills in the last few days?</p>	<p>WAITING TO START NEXT CYCLE....01 DOESN'T HAVE CYCLE.....02 TAKE ONLY AS NEEDED.....03 FORGOT TO TAKE04 RESTING FROM PILL.....05 HUSBAND AWAY/ILL.....06 OTHER.....07 (SPECIFY)</p>																						
338	<p>After you finished your last pill cycle (packet), when did (will) you start the next cycle (packet)?</p> <p>WRITE RESPONSE EXACTLY AS GIVEN BELOW AND THEN CIRCLE THE APPROPRIATE CODE.</p>	<p>DAY AFTER PERIOD ENDED.....01 FIVE DAYS AFTER PERIOD BEGAN...02 DAY AFTER FINISHING 1ST PACKET.03 SEVEN DAYS AFTER FINISHING 1ST PACKET.....04 OTHER.....05 (SPECIFY)</p>																						
339	<p>Just about everyone misses taking the pill sometime. What do you do when you forget to take one pill?</p>	<p>TOOK ONE PILL THE NEXT DAY.....01 TOOK TWO PILLS THE NEXT DAY.....02 USED ANOTHER METHOD.....03 OTHER.....04 (SPECIFY) NEVER FORGOT.....97 NOT SURE/DON'T KNOW.....98</p>																						
340	<p>During the past twelve months whenever you obtained the pill, have you always gotten the same brand or have you sometimes obtained another brand?</p>	<p>ALWAYS SAME BRAND.....1 SOMETIMES DIFFERENT BRAND.....2 OTHER.....3 (SPECIFY) NOT SURE/DON'T KNOW.....8</p>																						
341	<p>How many cycles (packets) of the pill do you usually get when you obtain the pill?</p>	<p>NUMBER OF CYCLES..... <input type="text"/> <input type="text"/> NOT SURE/DON'T KNOW.....98</p>																						
342	<p>How much does one cycle of pills usually cost you?</p>	<p>COST (IN PIASTRES)..... <input type="text"/> <input type="text"/> <input type="text"/> NOT SURE/DON'T KNOW.....998</p>																						
343	<p>Would you buy a cycle of pills if it cost: (IF YES, CONTINUE WITH NEXT AMOUNT. IF NO, SKIP TO 351 FOR AMOUNT 'MORE THAN 2 POUNDS', SKIP TO 351 IF YES OR NO).</p> <p>25 piastres per cycle? 50 piastres per cycle? 75 piastres per cycle? 1 pound per cycle? 2 pounds per cycle? More than 2 pounds per cycle?</p>	<table border="0"> <thead> <tr> <th></th> <th>YES</th> <th>NO</th> </tr> </thead> <tbody> <tr> <td>25 PIASTRES.....</td> <td>1</td> <td>2</td> </tr> <tr> <td>50 PIASTRES.....</td> <td>1</td> <td>2</td> </tr> <tr> <td>75 PIASTRES.....</td> <td>1</td> <td>2</td> </tr> <tr> <td>1 POUND.....</td> <td>1</td> <td>2</td> </tr> <tr> <td>2 POUNDS.....</td> <td>1</td> <td>2</td> </tr> <tr> <td>>2 POUNDS.....</td> <td>1</td> <td>2</td> </tr> </tbody> </table>		YES	NO	25 PIASTRES.....	1	2	50 PIASTRES.....	1	2	75 PIASTRES.....	1	2	1 POUND.....	1	2	2 POUNDS.....	1	2	>2 POUNDS.....	1	2	<p>→351 →351</p>
	YES	NO																						
25 PIASTRES.....	1	2																						
50 PIASTRES.....	1	2																						
75 PIASTRES.....	1	2																						
1 POUND.....	1	2																						
2 POUNDS.....	1	2																						
>2 POUNDS.....	1	2																						

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**TABULATION OF ANSWERS TO
"EGYPT DEMOGRAPHIC AND HEALTH SURVEY 1988" QUESTION 343
(CONTINUED)**

**FREQUENCY TQ343D
VARIABLE 1 pound per cycle**

	FREQUENCY	CUM. FREQ.	PERCENT	CUM. PCT.	NET PCT.	CUM. NET %
0	0	0	0.00	0.00	0.00	0.00
Yes	1064	1064	11.70	11.70	82.10	82.10
No	230	1294	2.53	14.23	17.75	99.85
MISSING	2	1296	0.02	14.25	0.15	100.00
DEFAULT NOTAPPL	0 7799	1296 9095	0.00 85.75	14.25 100.00	- -	- -
TOTAL	9095	9095	100.00	100.00	-	-

**FREQUENCY TQ 343E
VARIABLE 2 pounds per cycle**

	FREQUENCY	CUM. FREQ.	PERCENT	CUM. PCT.	NET PCT.	CUM. NET %
0	0	0	0.00	0.00	0.00	0.00
Yes	862	862	9.48	9.48	66.51	66.51
No	432	1294	4.75	14.23	33.33	99.85
MISSING	2	1296	0.02	14.25	0.15	100.00
DEFAULT NOTAPPL	0 7799	1296 9095	0.00 85.75	14.25 100.00	- -	- -
TOTAL	9095	9095	100.00	100.00	-	-

**FREQUENCY TQ343F
VARIABLE More than 2 pounds per cycle**

	FREQUENCY	CUM. FREQ.	PERCENT	CUM. PCT.	NET PCT.	CUM. NET %
0	0	0	0.00	0.00	0.00	0.00
Yes	728	728	8.00	8.00	56.17	56.17
No	563	1291	6.19	14.19	43.44	99.61
MISSING	5	1296	0.05	14.25	0.39	100.00
DEFAULT NOTAPPL	0 7799	1296 9095	0.00 85.75	14.25 100.00	- -	- -
TOTAL	9095	9095	100.00	100.00	-	-

**TABULATION OF ANSWERS TO
"EGYPT DEMOGRAPHIC AND HEALTH SURVEY 1988" QUESTION 343**

FREQUENCY TQ343A
JVARIABLE 25 piastres per cycle

	FREQUENCY	CUM. FREQ.	PERCENT	CUM. PCT.	NET PCT.	CUM. NET %
0	0	0	0.00	0.00	0.00	0.00
Yes	1270	1270	13.96	13.96	97.99	97.99
No	13	1283	0.14	14.11	1.00	99.00
MISSING	13	1296	0.14	14.25	1.00	100.00
DEFAULT	0	1296	0.00	14.25	-	-
NOTAPPL	7799	9095	85.75	100.00	-	-
TOTAL	9095	9095	100.00	100.00	-	-

FREQUENCY TQ343B
VARIABLE 50 piastres per cycle

	FREQUENCY	CUM. FREQ.	PERCENT	CUM. PCT.	NET PCT.	CUM. NET %
0	0	0	0.00	0.00	0.00	0.00
Yes	1227	1227	13.49	13.49	94.68	94.68
No	67	1294	0.74	14.23	5.17	99.85
MISSING	2	1296	0.02	14.25	0.15	100.00
DEFAULT	0	1296	0.00	14.25	-	-
NOTAPPL	7799	9095	85.75	100.00	-	-
TOTAL	9095	9095	100.00	100.00	-	-

FREQUENCY TQ343C
VARIABLE 75 piastres per cycle

	FREQUENCY	CUM. FREQ.	PERCENT	CUM. PCT.	NET PCT.	CUM. NET %
0	0	0	0.00	0.00	0.00	0.00
Yes	1141	1141	12.55	12.55	88.04	88.04
No	153	1294	1.69	14.23	11.81	99.85
MISSING	2	1296	0.02	14.25	0.15	100.00
DEFAULT	0	1296	0.00	14.25	-	-
NOTAPPL	7799	9095	85.75	100.00	-	-
TOTAL	9095	9095	100.00	100.00	-	-

APPENDIX E

Eg 74 copy

MEMORANDUM

TO : IDP Director
EGYPTIAN FAMILY PLANNING PROJECT DIRECTOR

FROM : Elizabeth G. Heilman
SIGNATURE OF CONSULTANT

SUBJECT : **REPORT ON CONSULTANCY TO EGYPT**

- I. **NAME :** Elizabeth G. Heilman
- II. **COOPERATING AGENCY :** E. Petrich and Associates, Inc.
- III. **PROJECT(S) :** NPC/IDP
- IV. **DATES OF VISIT:** August 19 - September 6, 1991
- V. **PRINCIPAL EGYPTIAN COUNTERPART:** Directors of projects at MOH, FOF, CHO, Organon, Shering, Drug Organization.
- VI. **ITINERARY:** Family Planning/Population Agencies in Cairo.
- VII. **PRINCIPAL CONTACTS :** Dr. Carol Carpenter-Yaman (USAID); Mrs. Amani Selim (USAID); Dr. Waleed Alkhateeb (EP&A).
- VIII. **RESULTS :**

A. SCOPE OF WORK FOR VISIT (AS MODIFIED, IF APPLICABLE):

To review the 1988/89 Family Planning cost study and the 1989/90 Family Planning cost with USAID and the NPC and make requested changes. Since during this trip, the director of IDP at the NPC had just resigned, the FP cost study review work was carried out with USAID and the resident advisor for IDP.

To review the separate analysis of the 1989/90 FP cost study showing how much funding would be needed to cover the basic costs of Egypt's FP program.

To initiate design of study on pricing of FP goods and services. Identify and review relevant research and work undertaken by FP agencies and manufacturing companies providing contraceptive commodities. Focus on two particular aspects: Examples of the effect of price changes on demand and the target population of the various agencies and companies.

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B. PRINCIPAL FINDINGS, OUTCOMES AND PROBLEMS ADDRESSED DURING VISIT AND WHICH NEED TO BE ADDRESSED IN THE FUTURE:

It was agreed to revise both years of the FP cost study to focus on the local costs to be supported to keep the program operational. This revision necessitates changes in the agency worksheets (Volume two) to remove foreign technical assistance and US-based training. Changes will also need to be made in the text and summary tables (Volume one) for each year.

Work will be undertaken on the third year's FP cost study after the first two years are revised.

Concerning the pricing study it was agreed to undertake a secondary analysis of the data obtained by the 1988 demographic and health survey (DHS) for Egypt to obtain more information on the economic profiles of FP clients and their willingness - to - pay for contraceptive commodities results of the secondary analysis will be determine the need to formulate additional questions for inclusion in the next DHS to be undertaken in 1992.

In addition, similar questions will be developed for inclusion in FOF's proposed marketing survey.

C. FURTHER ACTIONS NEEDED:

<u>ACTIONS</u>	<u>PERSON RESPONSIBLE</u>	<u>EST. COMPLETION DATE</u>
1. Revise 1989/90 FP cost study	Elizabeth G. Heilman	Sept.27,1991
2. Revise 1988/89 FP cost study	Elizabeth G. Heilman	October 11,1991
3. Prepare report on findings of pricing study research	Elizabeth G. Heilman	October 11,1991
4. Begin 1990/91 FP cost study; update GOE contributions study; continue work on pricing study	Elizabeth G. Heilman	Late November, 1991

cc. USAID Project Officer
Egyptian Implementing Agency Foreign Technical Assistance
Coordinator

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Consultant:

Dr. Elizabeth G. Heilman, Senior Associate

Trip Dates:

November 3 - 22, 1991

Scope Of Work:

To assist with efforts to study and analyze the sustainability of Family Planning programs in Egypt by addressing various factors:

- A. Undertake the 1990/91 Family Planning cost study by collecting financial and distribution data from agencies participating in the National Family Planning program.
- B. Continue work on contraceptive commodity pricing study by developing questions on consumer willingness - to - pay for inclusion both in the next demographic and health survey in early 1992 as well as in FOF's proposed marketing survey. Continue analysis of DHS 1988 data.
- C. Update the GOE contributions study.

Approved by:

Amani Selim

Amani Selim
USAID Project Officer

Date: 10/07/91

✓

TABLE (4)
 PERCENTAGE DISTRIBUTION OF SAMPLED NEW CLIENTS
 BY SOCIO-ECONOMIC CHARACTERISTICS
 BY TYPE OF CLINICS, TYPE OF SERVICE
 AND BY REGION

SOCIO-ECONOMIC CHARACTERISTICS	TOTAL	BY TYPE OF CLINIC		BY TYPE OF SERVICE		R E G I O N	
		OLD	NEW	FP	NON FP	UPPER	LOWER
TOTAL SAMPLE	1200	520	680	641	559	562	638
Percentage by Age							
Less than 20	3.8	2.9	4.4	3.0	4.7	4.4	3.1
20-24	22.6	20.0	24.6	18.3	27.5	22.1	23.0
25-29	26.6	27.3	26.0	27.5	25.6	26.5	26.6
30-34	21.1	21.7	20.6	23.4	18.4	21.2	21.0
35-39	16.8	16.3	17.1	18.6	14.7	13.9	19.3
40-44	5.5	6.5	4.7	6.1	4.8	6.2	4.9
45 & more	2.3	1.7	2.6	1.6	3.0	2.7	1.9
Missing	1.5	3.5	0	1.7	1.3	3.0	0.2
- Average Age	29.4	29.6	29.2	29.8	28.9	29.2	29.5
Percentage By No. of Living Children							
No children	13.4	14.8	12.4	1.1	27.5	14.1	12.9
1-2 child	34.9	32.4	36.9	36.2	31.2	29.2	40.0
3-4 child	31.6	31.1	31.9	37.5	24.9	30.4	32.6
5-6 child	11.3	10.9	11.4	13.4	8.8	14.4	8.5
7 & more child	4.8	6.2	3.7	6.3	3.3	7.6	2.4
Missing	4.0	4.6	3.5	3.6	4.5	4.3	3.8
- Average No.	2.7	2.8	2.7	3.3	2.1	3.0	2.5
Percentage By Educational Level							
Illiterate	39.7	44.6	35.9	40.7	38.5	49.5	31.0
Read & Write	13.2	9.4	16.0	12.9	13.4	11.4	14.7
Less than Intermediate	7.2	7.3	7.1	6.6	7.9	8.4	6.1
Intermediate and above Certificate	27.9	26.5	29.0	26.7	29.3	21.9	33.2
High Education	11.2	12.1	10.4	12.2	10.0	8.9	13.2
Missing	0.9	0	1.6	0.9	0.9	-	1.7

(TABLE 4 CONT.)

TABLE (4)
PERCENTAGE DISTRIBUTION OF SAMPLED NEW CLIENTS
BY SOCIO-ECONOMIC CHARACTERISTICS
BY TYPE OF CLINICS & TYPE OF SERVICE

SOCIO-ECONOMIC CHARACTERISTICS	TOTAL	BY TYPE OF CLINIC		BY TYPE OF SERVICE		BY REGION	
		OLD	NEW	FP	NON FP	UPPER	LOWER
TOTAL SAMPLE	1200	520	680	559	562	638	

Percentage by Working Status							

Working	22.1	23.8	20.7	22.9	21.1	18.0	25.7
Not Working	77.8	76.2	79.0	77.1	78.5	82.0	74.0
Missing	0.2	0	0.3	0	0.4	-	0.3
Percentage by Contraceptive Method Use							

Current Users	31.0	26.2	34.7	32.6	29.2	26.5	35.0
Ever Users	32.5	34.2	31.2	38.8	25.2	33.6	31.5
Never Users	36.1	39.2	33.7	28.1	45.3	39.3	33.2
Missing	0.4	0.4	0.4	0.5	0.4	0.5	0.3

APPENDIX F

**Central Agency of Public Mobilization
and Statistics**

10/20

1

Assessment of Quality of Family Planning Service
Delivery in Egypt:
Brief Notes on Methodology, Major Activities and
Selected Preliminary Findings

1. Background/Importance of the Study

Studies pertaining to quality of family planning service delivery are increasingly gaining importance and support. It is perceived that family planning providers and researchers should give due attention to developing measures of programme performance that include quality of services. Although quantity indicators are necessary, they are not sufficient to measure quality aspects of the services. This is because quality affects health human rights and demographic outcomes.

2. The Framework

Judice Bruce's framework on assessing the quality of family planning services was adopted in this study. Quality is defined in terms of the way individuals and couples are treated by the system providing family planning services. It would ensure that clients are treated with dignity and care, that they are adequately informed of various options available to meet their needs, and that they are helped in selecting contraceptive care that is most likely to continue without health risks to realize their reproductive goals.

Elements of Quality

Six elements of quality were developed by Bruce:

1. Choice of methods.
2. Information given to clients.
3. Technical competence.

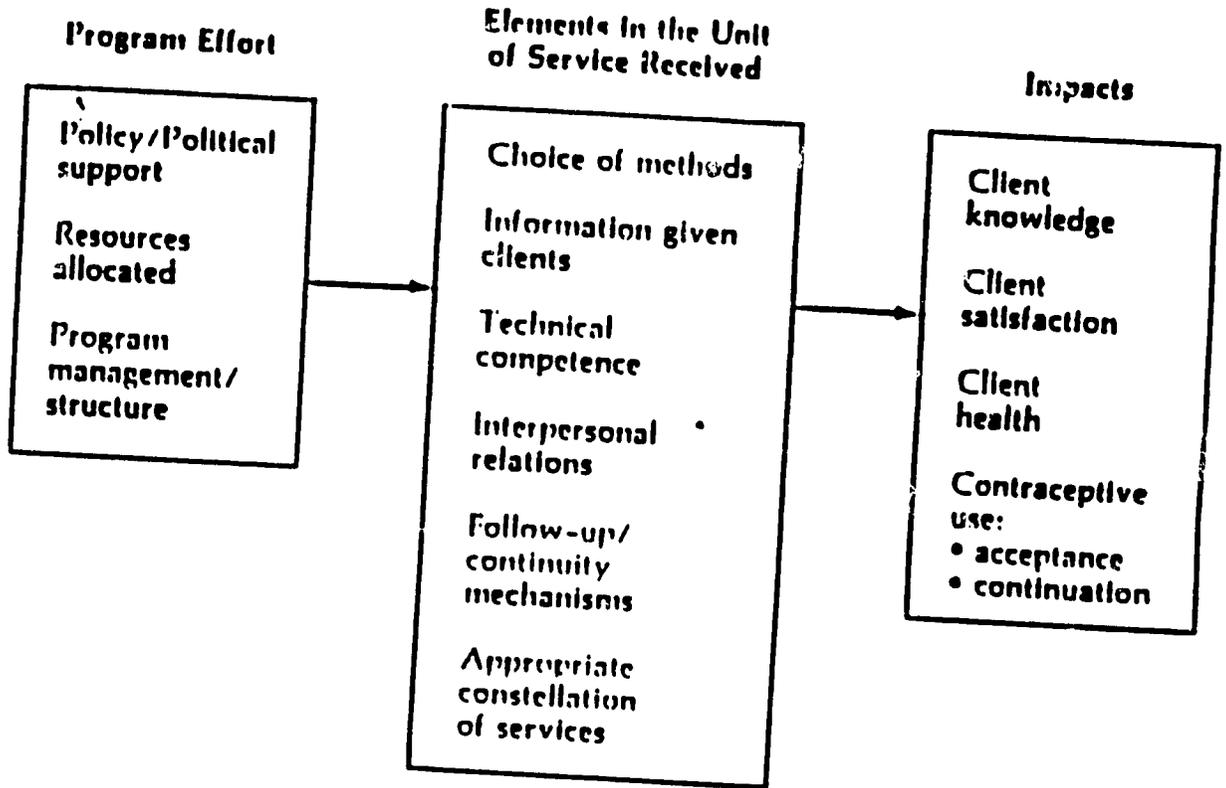
4. Interpersonal relations.
5. Follow-up/continuity mechanisms.
6. Appropriate constellation of services.

For each of these elements, indicators were developed as well as items included in each indicator.

3. Scope of the Study

Family planning centers/units that follow both Ministry of Health (MOH) and Egypt Family Planning Association (EFPA) were included in the study. These centers (especially the former type) constitute major network of centers spread throughout the whole country. Within EFPA, a limited number of centers of the Clinical Service Improvement Project was also included (CSI).

The quality of the service experience—its origins and impacts



Judice Bruce's Framework

at

4. Questionnaires Used

Three questionnaires were designed for this study.

The first questionnaire sought information on the structure of family planning centers/units. It included questions among others on type/general information about the center, working days and hours, staffing pattern, qualifications and training of staff, management, IE & C activities, supplies available, activities pertaining to home visits, follow-up and counselling, target set for the center, medical equipment available and problems faced and suggestions to promote performance of the center.

The second questionnaire was designed to be administered to the center's clients (at the exit point). It included questions on client's background and actual and desired fertility. In addition, a separate section was devoted to collect information on last visit (the process of receiving the service). In doing that, clients were stratified according to reason of last visit. Thus, they were accordingly classified into new acceptors, IUD follow-up, complaining from side effects, getting supplies, switcher and IUD insertions. Two more sections were designed on client's views about quality of services received and satisfaction with it, and husband's background.

The third questionnaire was addressed to a sample of non users of MOH, EFPA and CSI centres who are residing in the area served by the center surveyed. Those women could be users of services of private doctors/hospitals/pharmacies, or non users at the time of the survey. The former group were asked among others, about reasons for preferring private source, and the latter was

asked about past experience (if any) with the type of centers surveyed; those with no experience were asked about their perception about quality of service offered at these units.

For each center, one questionnaire of the first type was completed, 10 of the second type and 12 of the third type. Activities pertaining to questionnaires design were completed in late 1989.

5. The Sample

A sample of 120 centers was regarded as reasonable to adequately serve the research purposes (about 7% of all centers). This was also seen as reasonable with regard to resources available and work load expected. Contacts with resource persons in the field indicated that it might be better to select the centers intended to be surveyed in relatively limited rather than big number of governorates, but should cover Lower and Upper Egypt as well as metropolitan areas. Both initial and upgraded units were included in the assessment. Cairo, Alexandria, Dakhalia, Gharbia, Behera, Beni Suef, Quena, Aswan and New Valley governorates were finally selected in the sample. This selection has been made taking into consideration two criteria, balanced geographical distribution and level of contraceptive prevalence as indicated by Egypt demographic health survey (1988) findings. These two criteria worked well together in a coherent way.

A complete frame of units/centers offering family planning services was obtained from the National Population Council (NPC) to help select final units (see Table A). Number of centers surveyed in each governorate that follow MOH and EFPA was determined as to be roughly proportional to initial size. The final selection was made as follows:

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<u>Type</u>	<u>No. of Centers</u>
MOH	90
EFPA	25
CSI	5
<u>Total</u>	<u>120</u>

In selecting the ultimate family planning centers in the nine governorates, the project staff were advised to accomplish this phase through visits to respective governorates. The purpose was to get relevant information on a number of important issues including the socio-economic level of the population served by the centres, whether or not upgraded, working days and hours, ...etc. Three senior staff travelled to the nine governorates selected and completed this activity during February 1990.

6. Interviewers, Recruitments and Training

Research assistants, males and females with prior experience in field work, were selected among Population Studies and Research Center staff. A two-week training program was planned and implemented during March 1990. This included explaining the project objectives and the contents of the three questionnaires, the responsibilities in the field, and the selection of eligible women for completing the third questionnaire.

7. Pretest and Printing of Questionnaires

After completion of interviewers training, some family planning centres that follow both MOH and EFPA were selected in Giza governorate (not included in the final sample) for pretest activities in late March 1990. Based on the results of the pretest, minor changes have been introduced in the three questionnaires. All the

survey materials, including the final version of the questionnaires were printed in late April.

8. Field Activities

Field activities started in mid May 1990. For each family planning center selected in the sample, a team consisting of three persons (one of them acting as the head of the team) was assigned to complete interviews relating to that center. At least one female interviewer was included in each team. By the end of September 1990, all of the 120 centres were surveyed. For each center, the following questionnaires were expected to be completed:

Type	No.	Expected Total Number
First (Family Planning Center's doctor/director).	1	120
Second (The Center's clients).	10	1200
Third (Non users of MOH or EFPA units).	12	1440

However, due to minor problems in securing the required number of respondents of the second questionnaire, the actual number completed was 1188 questionnaires. As for the first and third questionnaires, planned number were successfully completed.

9. Design of Tabulation Plan

The project senior staff designed the tabulation plan for analysing the survey data. This was done with due consideration to Bruce's framework. This activity was done during October 1990.

10. Office Editing and Coding Activities

In mid August, activities pertaining office editing and coding started simultaneously with completion of field activities. Three teams were assigned each to one type of questionnaires. Data processing activities started early September and lasted to mid October at the Micro Computer Department at CAPMAS.

Table (A) Distribution of Family Planning units selected
in the Project Sample by Governorates

Governorate	Ministry of Health *MOH			Egyptian Family Planning Association EFPA			Clinical Services Improvement CSI			Total		
	U	R	Total	U	R	Total	U	R	Total	U	R	Total
	Cairo	8	-	8	4	-	4	-	-	-	12	--
Alexandria	6	-	6	2	-	2	1	-	1	9	--	9
Gharbia	3	9	12	2	1	3	1	-	1	6	10	16
Dakahlia	6	12	18	3	2	5	1	-	1	10	14	24
Behera	4	12	16	2	-	2	-	-	-	6	12	18
Beni-Suef	3	6	9	1	2	3	1	-	1	5	8	13
Qena	3	9	12	1	-	1	1	-	1	5	9	14
Aswan	2	5	7	3	1	4	-	-	-	5	6	11
New-Valley	-	2	2	1	-	1	-	-	-	1	2	3
Total	35	55	90	19	6	25	5	-	5	59	61	120

* MOH centers include:

- Hospitals
- Health offices
- MCH Centers
- Health Compound
- Rural Health Unit

Table (16): Percent Distribution Of Clients According to Method Currently Used and Reasons for use.

Why Do They Use This Method:	Type of Method						Total	
	Pill	160 Tablets	FOAMS	CONDOM	INJECTION	CREAM & Jelly	%	NO.
The doctor advised me to use this method	40.9	53.1	73.3	63.6	57.1	0.0	49.0	567
Heard from T.V & Radio	4.5	4.3	0.0	0.0	0.0	0.0	4.2	49
More used among my relatives	18.9	13.6	0.0	18.2	0.0	0.0	15.3	177
The method was available	6.4	0.0	13.3	9.1	14.3	0.0	2.7	31
Suitable cost of method	4.5	0.4	6.7	9.1	0.0	0.0	2.1	24
Efficient Method	20.5	27.4	0.0	0.0	28.6	0.0	24.3	281
Convenience of use	2.4	1.0	6.7	0.0	0.0	100.0	1.5	19
Other	1.9	0.1	0.0	0.0	0.0	0.0	0.8	9
Not stated	0.0	0.1	0.0	0.0	0.0	0.0	0.1	1
	%	100.0	100.0	100.0	100.0	100.0	100.0	
Total	No.	423	701	15	11	7	1	1158

* Confined to those who are currently using any method

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APPENDIX G

**Central Agency of Public
Mobilization and Statistics**

TABLE 1

PSCAPTB

**PERCENT DISTRIBUTION OF CLIENTS
ACCORDING TO TYPE OF UNITS AND
WHAT THEY THINK OF THE FAMILY PLANNING METHOD COST**

What They Think of the Family Planning Method Cost	Type of Units			Total	
	MOH	EFPA	CSI	%	No.
Cheap	51.4	66.1	14.3	52.1	237
Expensive	4.4	—	—	3.7	17
Suitable	44.2	33.9	85.7	44.2	201
TOTAL					
%	100	100	100	100	
No.	385	56	14		455

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TABLE 2

Distribution of Family Planning Units According to Socio-Economic Levels of the People Served by those Units.

Socio-economic Levels	MOH	EFPA	CSI	Total	
				%	NO.
LOW	23.3	16.0	0.0	20.8	25
MEDIUM	75.6	80.0	100.0	77.5	93
HIGH	1.1	4.0	0.0	1.7	2
Total	%	100.0	100.0	100.0	
	NO.	90	25	5	120

TABLE 3

Percent Distribution of F.P Units According to Type
And the Educational levels of the Clients of the Units.

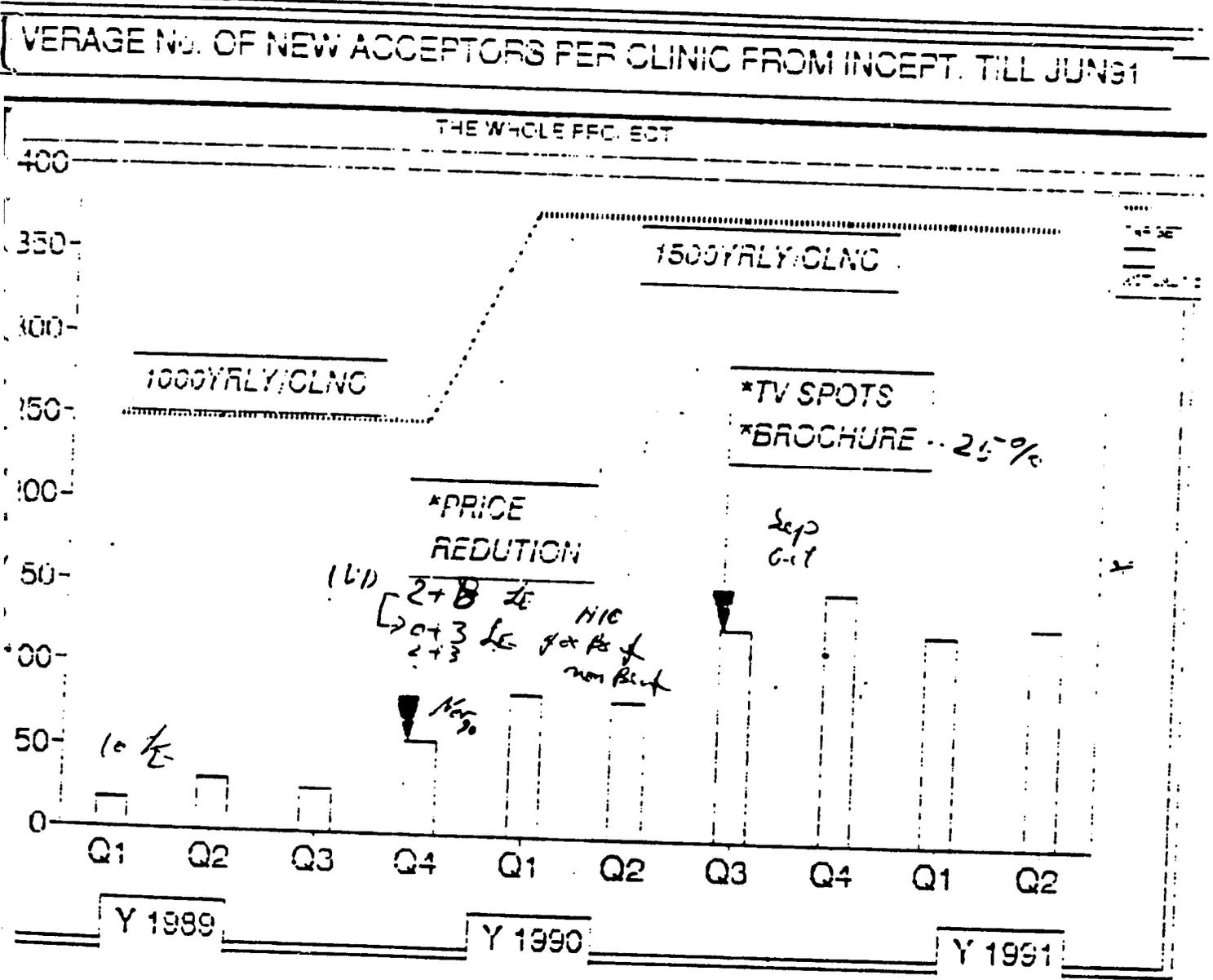
Educational levels of the clients of the units	Type of the units				
	MOH	EFPA	CSI	Total No.	%
1-The majority are illiterate.	56.7	36.0	20.0	61	50.9
2-The majority can read and write.	8.9	20.0	—	13	10.8
3-Approximately 50% illiterates and 50% can read and write.	21.1	20.0	—	24	20.0
4-The majority are poorly educated but some of them have better education.	8.9	8.0	—	10	8.3
5-The educational level is generally medium level.	4.4	16.0	80.0	12	10.0
Total		100.0	100.0	100.0	100.0
	%				
	NO.	90	25	5	120

APPENDIX H

Health Insurance Organization



TABLE 1

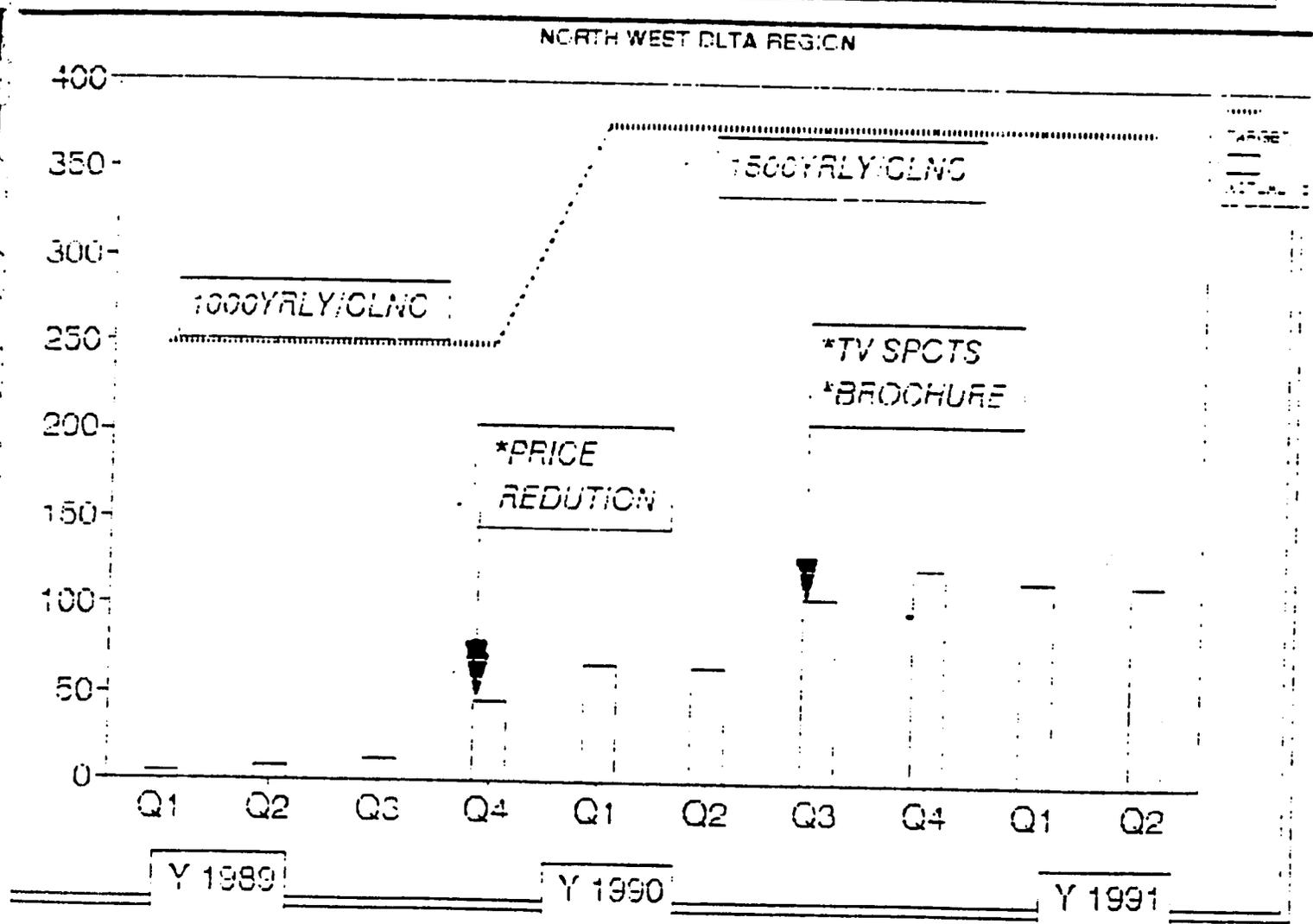


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TABLE 2

AVERAGE No. OF NEW ACCEPTORS PER CLINIC FROM INCEPT. TILL JUN 91



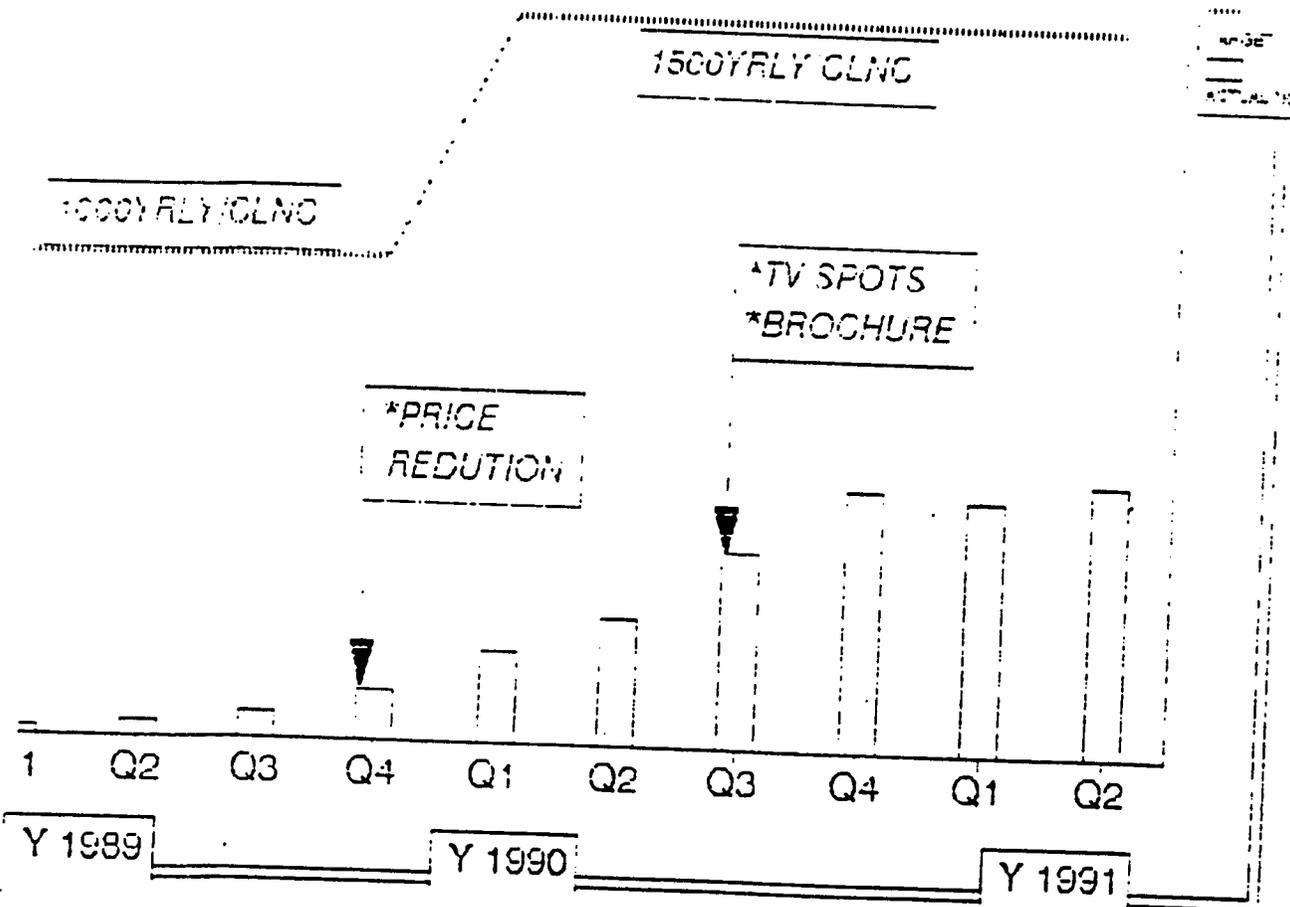
[Handwritten signature]



TABLE 3

NUMBER OF NEW ACCEPTORS PER CLINIC FROM INCEPT. TILL JUNE 91

MIDDLE DELTA REGION



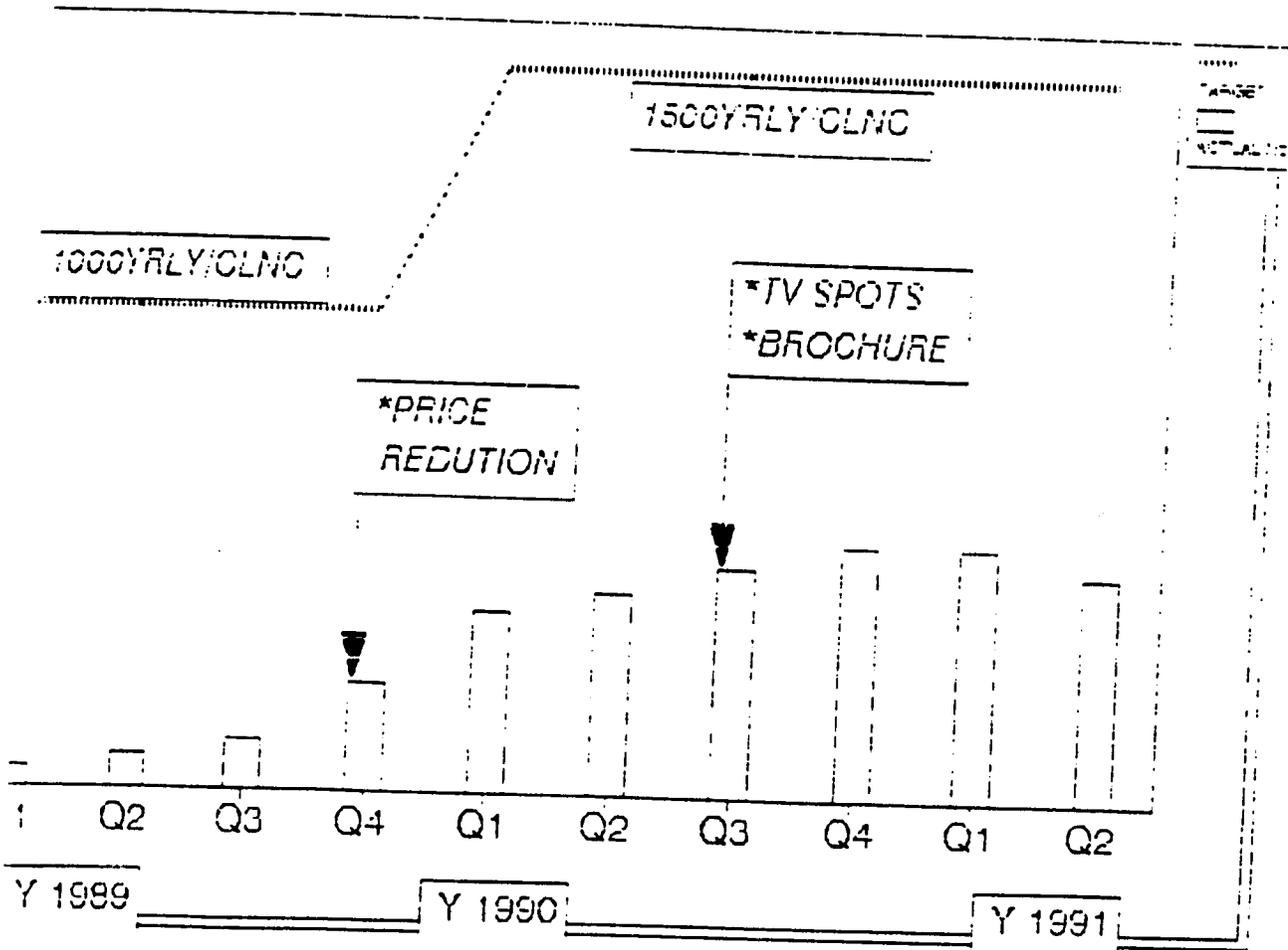
7



TABLE 4

NO. OF NEW ACCEPTORS PER CLINIC FROM INCEPT. TILL JUN 91

CANAL & EAST DELTA REGION



5

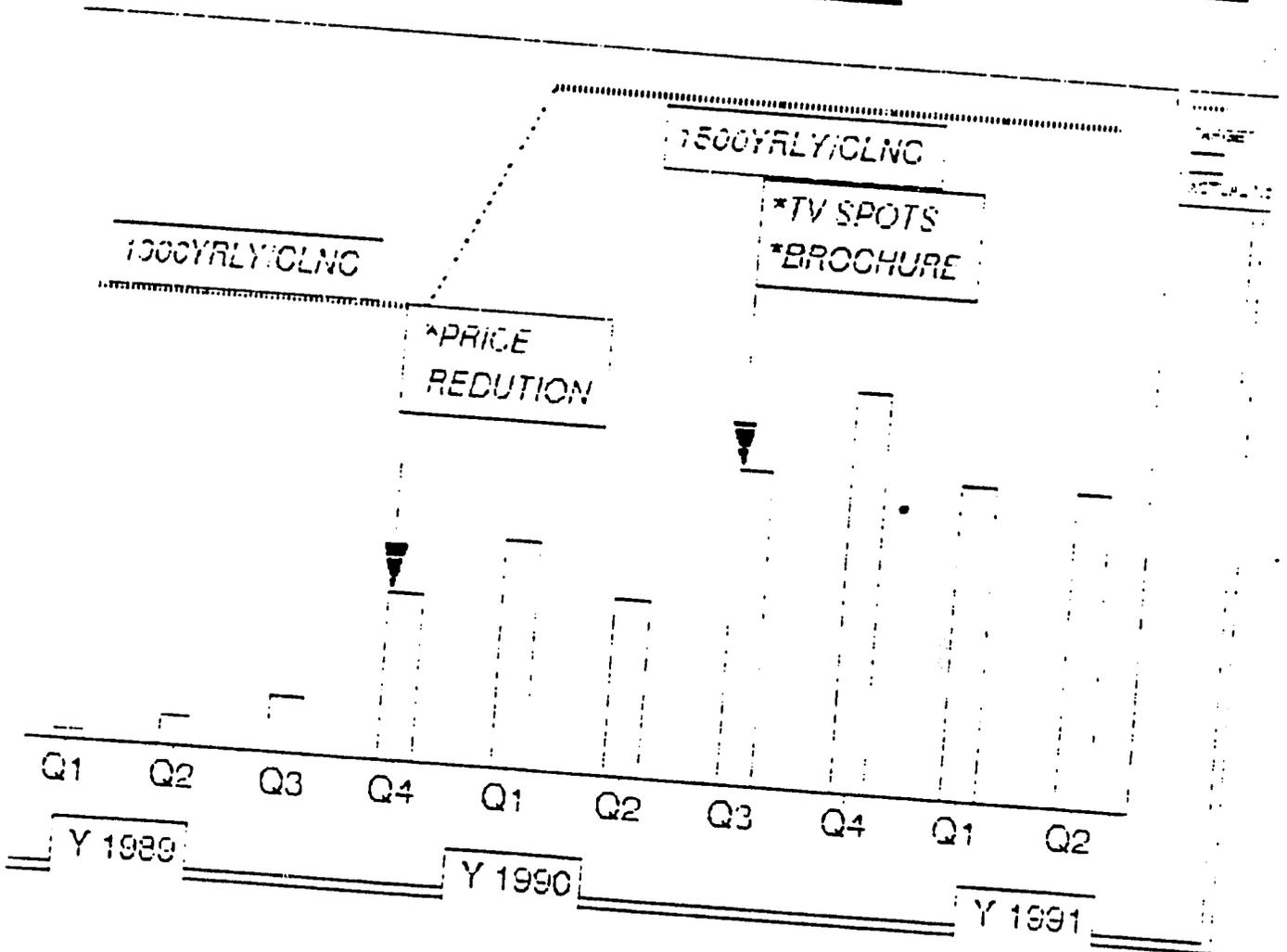
100



TABLE 5

AGE No. OF NEW ACCEPTORS PER CLINIC FROM INCEPT. TILL JUNE 1

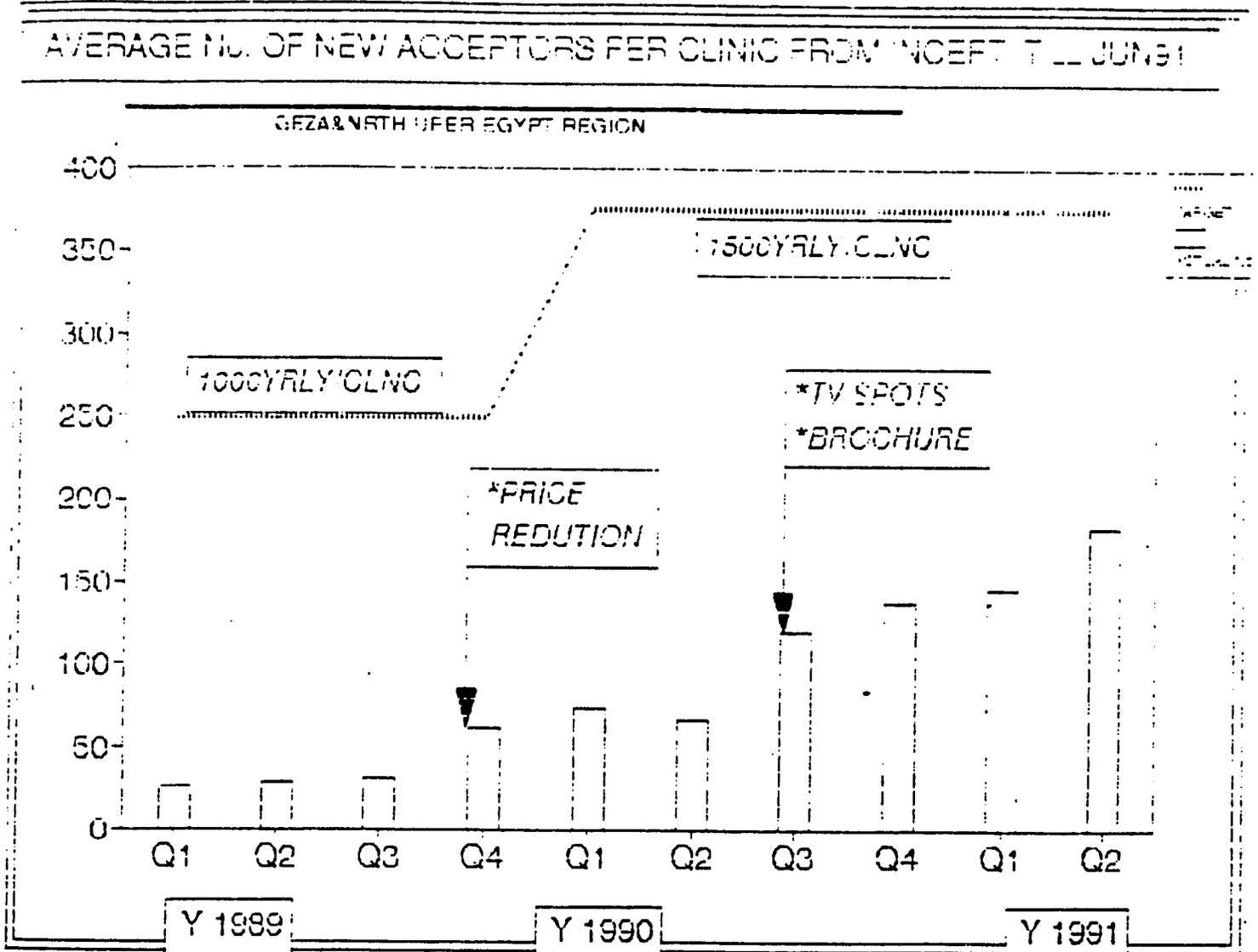
CAIRO REGION



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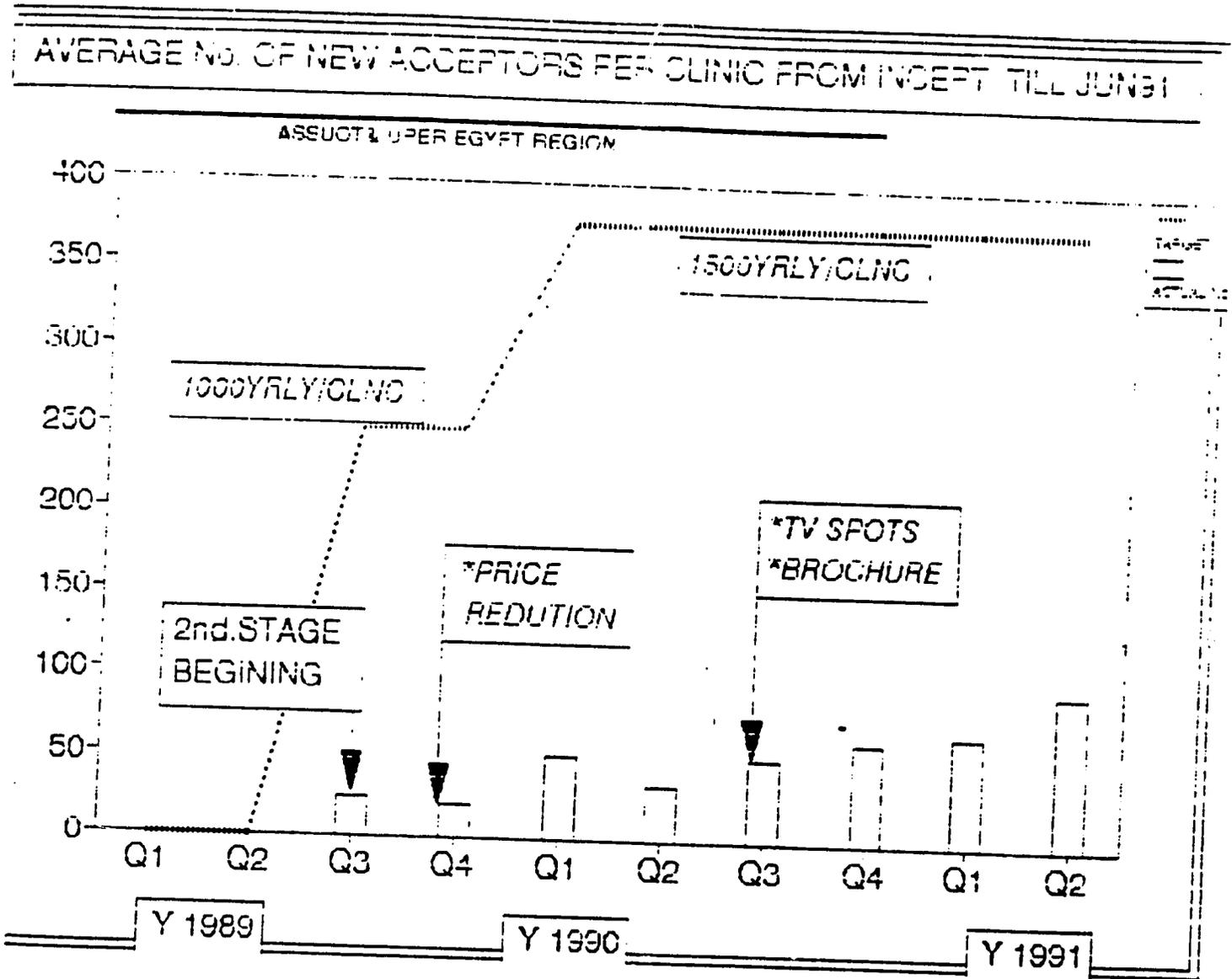
TABLE 6



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TABLE 7



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40%

APPENDIX I
Family of the Future

TABLE 1*
QUANTITY OF CONTRACEPTIVE COMMODITIES DISTRIBUTED
(I.E., NET SALES) BY FOF BETWEEN 1979 AND 1991

Year	IUDs (cuT380A NovaT & Cu7)	Condoms (Tops)	Foaming Tablets (Aman)	Oral Contraceptives (Norminest)
1979	17,625	678,431	422,750	
1980	37,871	1,385,916	725,888	
1981	71,696	1,734,071	1,721,088	
1982	125,834	3,695,492	2,073,624	
1983	137,682	4,580,433	4,331,676	
1984	168,489	6,848,504	2,052,360	1,092,920
1985	191,726	12,018,186	654,192	1,226,332
1986	244,122	13,615,491	9,840	1,233,614
1987	273,422	16,201,203		1,407,422
1988	338,007	15,889,968		1,866,583
1989	396,325	15,772,558		1,783,299
1990	442,311	16,557,744		2,082,434
1991	420,308	15,276,262		2,083,594

*This is a translation of the attached Table 2 in Arabic.

1/2.

TABLE 2

FOR NET SALES FROM THROUGH TO DISCOUNT
 إدارة المبيعات
 جدول المبيعات بوضع الكميات من ربيع ١٩٧٩ حتى ١٩٩١

سنة	توبس	امان	تورمنت	المجموع $uT + Novu + u7$
١٩٧٩	٦٧١,٤٣١	٤٤٢٧٥		١٧٦٢٥
١٩٨٠	١٣٨,٥٩٦	٧٥٥٨٨		٣٧٨٧١
١٩٨١	١٧٢٤,٧١	١٧٤١,٨٨		٧١٦٩٦
١٩٨٢	٣,٦٩٥,٤٩٥	٥,٧٤٦,٥٤		١,٥٥٨,٢٤
١٩٨٣	٤٥٠,٤٢٢	٤٢٢,١٧٧		١,٢٧٦,٨٥
١٩٨٤	٦٨٤,٨٥٠	٥,٥٤٦,٥٠	١,٩٤٩,٥٠	١,٦٨٤,٨٩
١٩٨٥	١٤,١٨١,٨٦	٦٥٤,١٩٥	١,٢٦٢,٢٢	١,٩١٧,٨٦
١٩٨٦	١٢,٦١٥,٩١	٩٨٤	١,٢٢٤,٦١٤	٢,٤٤١,٢٥
١٩٨٧	١٦٢,٠١٦	—	١,٤٠٧,٤٣٥	٢,٧٢٩,٤٥
١٩٨٨	١٥,٨٨٩,٩٦	—	١,٨٦٦,٥٨٢	٢,٢٨٠,٠٧
١٩٨٩	١٥,٧٧٥,٥٥	—	١,٧٨٢,٩٩	٢,٩٦٤,٥٥
١٩٩٠	١٦,٥٥٧,٤٤	—	٥,٨٤٤,٢٤	٢,٤٢٢,١١
١٩٩١	١٥,٢٧٦,٦٤	—	٥,٨٢٥,٩٤	٤٢٠,٢٠
المجموع	١٠,٩٤٤,٤٦	١٢٧٧-١١٩٨		٢,٨٦٥,٧٨

د. محمد العبد

TABLE SHOWING THE QUANTITIES DISTRIBUTED (I.E., NET SALES) BY FOB FROM 1979 THROUGH 1991

APPENDIX J

**Cairo Demographic Center
Egypt Demographic and Health Survey 1988**