MILESTONE COMPLETION REPORT
CONTRACT NUMBER: 263-C-00-99-00017-00

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Date: May 19, 2002

Task No:	7
Task Description:	Contraceptive Procurement and Logistics Management System Fully Funded by the GOE with Pricing Rationalized
Milestone No:	7.4
Milestone Description:	Contraceptive procurement and financing options presented to policy makers
Sources of Verification:	TA plans, reports and manuals
Planned End Date:	1/31/2002
Status:	Completed
Comments:	This milestone submission describes the process used and the route taken to develop contraceptive procurement and financing options for the Ministry of Health and Population (MOHP) and present them to policy makers. This submission also includes the current version of these options, which combines the latest population projections developed by the MOHP and the Policy II Project between January and March 2002, with the latest work of the USAID Contraceptive Security Study (CSS) team at the time of writing in April 2002. The Population IV and Policy projects have presented preliminary projections and options to policy makers during the 2000-2002 period. The CSS team will make the next presentation to policy makers when other elements of their study are completed. Therefore, this paper describes an ongoing process and the status at the end of the Population IV project.

MILESTONE 7.4

CONTRACEPTIVE PROCUREMENT AND FINANCING OPTIONS

POPULATION/FAMILY PLANNING IV PROJECT

B

TABLE OF CONTENTS

	Page
INTRODUCTION AND OVERVIEW	i
I. THE CURRENT ENVIRONMENT	
1. THE DEMAND FOR FAMILY PLANNING SERVICES & CONTRACEPTIVES	1
A. Population Overview	
B. Married Women of Reproductive Age and Contraceptive Use	
2. THE SUPPLY OF FAMILY PLANNING SERVICES & CONTRACEPTIVES	1
A. Role of the Government of Egypt and Ministry of Health and Population	
B. Role of the Egyptian Pharmaceutical Trading Company	
3. RESOURCE ALLOCATION AND SPENDING	4
A. Family Planning Spending	
B. Spending on Contraceptives	
4. THE PROCUREMENT OF CONTRACEPTIVE COMMODITIES	7
A. Introduction	
B. Procurement and Distribution	
II. PLANNING FOR THE FUTURE	
1. VOLUME AND COST PROJECTIONS	8
A. Demand Projections	
B. Estimating Contraceptive Costs	
C. Impact of Donor Phase-out Plans	
D. Total Program Cost Projections	
2. PROCUREMENT OPTIONS	15
A. Introductions	
B. Procurement Options	
3. FINANCING OPTIONS	18
A. Introduction	
B. GOE Budget	
C. Health Insurance Organization Coverage	
D. User Fees, Waivers and Exemptions	
E. Improving the Efficiency of the Delivery of Family Planning Services	
F. Combination	
III. DETAILED PROJECTIONS	25
IV. ENDNOTES	34
V. ANNEXES	
1. Population Sector Sustainability Process	
2. Report of the Sustainability Strategy Conference	
3. Health Sector Reform Overview	

C

Acronyms

CCO	Curative Care Organization
CPR	Contraceptive Prevalence Rate
CSI	Clinical Service Improvement
CSS	Contraceptive Security Study
CYP	Couple Years of Protection
EDHS	Egypt Demographic and Health Survey
EFPA	Egypt Family Planning Association
EPTC	Egyptian Pharmaceutical Trading Company
FP	Family Planning
GDP	Gross Domestic Product
GOE	Government of Egypt
HIO	Health Insurance Organization
ICB	International Competitive Bidding
IEC	Information Education Communication
LE	Egyptian Pound
LIB	Limited International Bidding
MOHP	Ministry of Health and Population
MWRA	Married Women of Reproductive Age
NGO	Non-government Organizations
PVO	Private Voluntary Organization
RCT	Regional Center for Training at Ain Shams University
TFR	Total Fertility Rate
THO	Teaching Hospital Organization
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development

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FINANCING ALTERNATIVES FOR CONTRACEPTIVES

INTRODUCTION AND OVERVIEW

1. Introduction

This milestone submission describes the process used and the route taken to develop contraceptive procurement and financing options for the Ministry of Health and Population (MOHP) and present them to policy makers. This submission also includes the current version of these options, which combines the latest population projections developed by the MOHP and the Policy II (Policy) Project between January and March 2002, with the latest work of the USAID Contraceptive Security Study (CSS) team at the time of writing in April 2002. The Population IV (Pop IV) and Policy projects have presented preliminary projections and options to policy makers during the 2000-2002 period. The CSS team will make the next presentation to policy makers when other elements of their study are completed. Therefore, this paper describes an ongoing process and the status at the end of the Pop IV project.

2. Summary of Process

The following elements have formed the structure of the contraceptive projections and financing options work during Pop IV:

- Initial contraceptive commodity projections for Egypt 2001-2010 developed in March 2001
- Population sector sustainability process implemented February - May 2001
- Contraceptive procurement and financing alternatives paper developed based on the sustainability process discussions
- Revised population projections based on new assumptions developed by the MOHP with assistance from the Policy and Pop IV projects
- Scenarios developed by the CSS team based on the new MOHP/Policy population projections
- Revised contraceptive procurement and financing options paper developed

3. Initial Contraceptive Commodity Projections

Initial contraceptive commodity projections were developed and described in the paper "Contraceptive Commodity Projections for Egypt 2001-2010" by Scott Moreland and Robert Burn. This report provided a set of base-line commodity projections using the 2000 Egypt Demographic and Health Survey (EDHS). The report was presented at the March 2001 sustainability meeting (See below). In addition, a summary of the projections was included in the background analysis paper for the Sustainability Strategy Conference held on May 15, 2001.

4. Population Sector Sustainability Process

The Population Sector Sustainability Process was designed to assist the leaders of the National Population Program to develop a preliminary sustainability strategy to help it reach replacement level fertility in 2017. This process included the procurement and financing of contraceptives. This seven-stage process included the following elements:

- An Executive Course in Finance, Economics, & Sustainability (February 7, 8 & 9, 2001)
- A presentation on USAID's "phase-out" experience in Turkey (February 18, 2001)
- The development of 13 subject area papers which synthesized the research on population and sustainability issues in Egypt (January - March, 2001)
- The presentation and discussion of the 13 subject area papers with population program stakeholders - the "March Meetings" (March 22 & 27, 2001)
- The production of a synthesis paper, "Issues and Strategies for Sustainability of Family Planning Services in Egypt" which summarized the key issues of the "March Meetings" and provided the agenda for a sustainability conference
- The staging of a sustainability strategy conference, sponsored by HE Minister of Health and Population, to develop a first draft of a sustainability strategy for the National Population Program (May 3 & 4, 2001)
- Production of the sustainability strategy conference report, subtitled "Sustainability Issues, Proposed Strategies and Policy Dialogue Outcomes", which serves as the foundation for a strategic plan for sustaining the National Population Program (May 15, 2001)

The process is described in Annex 1, and the Report of the Sustainability Strategy Conference is included as Annex 2.

5. Contraceptive Procurement and Financing Alternatives Paper

The first draft of a contraceptive procurement and financing alternatives paper was developed based on the sustainability process discussions.

6. Revised Population Projections Based on New Assumptions Developed

The Policy project with the support of the Pop IV project then developed and agreed on revised assumptions and population projections with the MOHP Population Sector. The revised assumptions covered total fertility rate (TFR), contraceptive prevalence rate (CPR), couple years of protection (CYP) for each method, method mix and source mix.

7. Scenarios developed b the USAID Contraceptive Security Study

Based on the new population projections, the CSS team identified 19 planning scenarios, which consist of permutations of six categories of variables: population growth, method mix, MOHP import costs, subsidies to commercial sector, sector shares, and domestic manufacturing.

8. Contraceptive Procurement and Financing Options Paper

This paper describes the current family planning (FP) environment in Egypt, projects the future growth of the public sector FP services and the contraceptives needed, the contraceptive procurement options available to the MOHP, and financing options the MOHP can consider.

As the CSS team is currently refining their scenarios, we have taken their base case as the scenario on which to base this edition of the contraceptive procurement and financing options paper. The relevant assumptions of this base case are as follows

Population Growth:	Replacement TFR of 2.1 by 2017
Method Mix:	Unchanged from current mix
MOHP Import Costs:	Same as current USAID costs
Subsidies to Commercial Sector:	Continue at current rate
Sector Shares:	Unchanged from current levels
Domestic Manufacturing:	Unchanged from current levels
Donor Support of Contraceptives	Complete withdrawal in 2008

Based on these assumptions, the number MWRA that the public sector will serve will increase from 3.04m in 2000 to 5.48m in 2017. This will require an increase in Government of Egypt contraceptive expenditure from LE 1.14m in 2000, when most contraceptives were donated, to LE 35.31m in 2017 at current exchange rates and current purchasing values.

I. THE CURRENT ENVIRONMENT

1. THE DEMAND FOR FAMILY PLANNING SERVICES & CONTRACEPTIVES

A. Population Overview

The population of Egypt was estimated to be 66 million at the beginning of 2001 and growing at an annual rate of 2.1 percent. Urban populations are growing at 1.85% annually, compared to 2.26% in rural areas. The total population is projected to reach 78.14 million by 2010, and 86.43 million by 2017 based on the goal of reaching replacement level fertility by 2017. The urban population is about 43% of the total population according to the 1996 census. [1]

The 2000 Egypt Demographic and Health Survey (EDHS) shows that in the past two decades, fertility has declined from a total fertility rate (TFR) of 5.3 births per woman in 1980 to 3.5 in 2000, again with significant urban/rural differences (3.1 urban, 3.9 rural). Urban governorates have the lowest fertility rates, averaging 2.9, while rural rates vary from 3.3 in Lower Egypt to 4.7 in Upper Egypt, compared with a replacement level TFR of about 2.1. There is still considerable progress to be made toward reducing TFR in order to reach replacement level fertility by 2017.

B. Married Women of Reproductive Age and Contraceptive Use

In 2000, married women of reproductive age (MWRA) consisted of 11.15 million women, of which 56.1% (6.25m) were using a family planning (FP) method. In order to reach replacement level TFR by 2017, the number of FP users will need to grow to 7.63m by 2005 (a 22% increase over 2000), to 9.03m by 2010 (a 44% increase), and to 11.25m by 2017 (an 80% increase). By 2017 about half of the increase will be a result of the absolute growth in size of the current proportion of MWRA using FP, assuming that it remains at 56.1% of MWRA, and half due to the addition of new users needed to increase the contraceptive prevalence rate (CPR) from 56.1% in order to reach a replacement fertility level. The CPR will need to expand to 61.1% by 2005, 66.1% by 2010, and more than 73.1% by 2017. [2]

Recent trends highlighted in the 2000 EDHS include:

- Decrease in the unmet need for FP services amongst MWRA from 16% in 1995 to 12.4% in 2000.
- Increased discontinuation rates from 29.8% in 1995 to 30.5% in 2000.
- Increased desired fertility rate from 2.6 children per woman in 1995 to 2.9 in 2000. [3]

The decline of unmet need shows a positive trend. But the increases in discontinuation rates and desired fertility show reversal of previous successes and these are critical issues that need to be addressed if the aim of replacement fertility by 2017 is to be achieved.

2. THE SUPPLY OF FAMILY PLANNING SERVICES & CONTRACEPTIVES

A. Role of the Government of Egypt and Ministry of Health and Population

The Ministry of Health and Population (MOHP) has been the leading agency providing FP services for the Egyptian population. This has resulted in a large and widespread service

delivery network (see Table 1), where FP services are provided at MOHP fixed clinics, which are operated and managed through a network of 27 governorate and 242 district health teams. According the 2000 EDHS, there are fixed MOHP clinics providing FP services for every 2,310 MWRA. In addition, the MOHP operates a significant mobile clinic program that also provides FP services, in theory to Egyptians who live in poor communities or who are located far from the services of a fixed clinic.

TABLE 1: MOHP SERVICE DELIVERY	
MOHP Service Delivery Units	
Hospital	236
Maternal & Child Health Center	216
Urban Health Center	246
Urban Health Unit	352
Rural Health Unit	3,176
Mobile Clinic	323
Total	**4,549**

Other Government of Egypt (GOE) agencies that offer FP services include the Health Insurance Organization (HIO), the Teaching Hospital Organization (THO), and the Curative Care Organization (CCO). The 2000 EDHS estimates that the public sector serves 48.6% of current users. Private hospitals, clinics, doctors, and pharmacies serve another 43.7%; while non-government organizations (NGOs) such as the Egypt Family Planning Association (EFPA), the Clinical Service Improvement (CSI) project of the United States Agency for International Development (USAID), mosque and church health units account for 7.3% of the market.

The public sector's market share has recently increased at the expense of the private sector. Between 1995 and 2000, the public sector's share rose from 35.7% to 48.6%, while the private sector's share declined from 50.7% to 43.7%, and the NGO sector's dropped from 9.4% to 7.3%. This trend is mainly attributed to quality improvements in MOHP clinics as a result of the USAID-funded Gold Star program, which provides quality of care and free services, with only a small nominal charge for contraceptives. Table 2 shows the market share of the public and private sectors.

Table 5 presents source information and use rates for specific contraceptive methods. While all methods show growth in the public sector's market share, injectables have increased the most, from 55.8% to 81.4% between 1995 and 2000.

TABLE 2: SOURCE OF MODERN CONTRACEPTIVES METHODS (%) (Source: EDHS 1995, 1997, 1998 & 2000)				
Source	**1995**	**1997**	**1998**	**2000**
Total public sector	**35.7**	**40.9**	**47.9**	**48.6**
• MOHP (of total)	32.0	38.0	44.9	46.4
• HIO, THO, and others	3.7	2.9	3.0	2.2
Total Private sector	**62.7**	**58.1**	**51.9**	**51.2**
• (NGOs, private doctors, & pharmacies)	0.2	0.2	0.2	0.2
• Other/Don't know	1.4	0.8		

TABLE 3: USE RATES AND SOURCES BY METHOD (%) (Source: EDHS 1995, 1997, 1998 & 2000)				
Method Type	**1995**	**1997**	**1998**	**2000**
IUD				
• Use rate (CPR for method)	**41.7**	**34.6**	**34.3**	**35.5**
Source:				
• Public	44.5	48.7	55.5	54.0
• Private	55.1	50.6	44.5	46.0
• Other/Not sure	0.4	0.7		
Injectables				
• Use rate	**2.4**	**3.9**	**3.9**	**6.1**
Source:				
• Public	55.8	67.0	76.0	81.4
• Private	40.4	33.0	24.0	18.6
• Other/Not sure	3.8			
Pills				
• Use rate	**10.4**	**10.2**	**8.7**	**9.5**
Source:				
• Public	8.1	8.7	9.9	10.8
• Private	88.5	89.5	90.1	89.2
• Other/Not sure	3.3	1.8		
Condoms				
• Use rate			**1.1**	**1.0**
Source:				
• Public			5.4	14.2
• Private			94.6	85.8

B. Role of the Egyptian Pharmaceutical Trading Company

The Egyptian Pharmaceutical Trading Company (EPTC) is the state-owned company that imports and distributes the vast majority of pharmaceuticals, including FP commodities, for the public sector via the MOHP's 26 governorate warehouses. EPTC also supplies NGOs,

some 17-18,000 commercial pharmacies and private physicians. In this capacity, EPTC manages the distribution of all USAID donated contraceptives. Table 6 shows the proportion of commodities EPTC distributes to each market sector, while Table 7 shows the amount of contraceptives distributed to the public sector and NGO clinics.

TABLE 4: MARKET SHARE OFCONTRACEPTIVES DISTRIBUTED BY EPTC, 1999 (%)					
Provider Type	**Pills**	**IUDs**	**Condoms**	**Injectables**	**Norplant**
Public & NGO FP Clinics	**8.49%**	**98.56**	**89.49**	**93.80**	**100**
• MOHP	7.49	84.86	82.69	90.02	87.77
• EFPA	0.56	5.06	3.15	1.29	-
• CSI	0.20	6.48	2.72	1.29	-
• Others	0.24	2.16	0.93	1.20	-
Pharmacies	**91.51**	**1.44**	**10.51**	**6.20**	**-**
Percentage Total	**100**	**100**	**100**	**100**	**100**
Quantity Total	**9,510,998**	**1,330,219**	**5,410,750**	**1,929,792**	**6,821**

Source: National Population Council Report, 1999

TABLE 5: QUANTITIES AND PROPORTION OF CONTRACEPTIVES DELIVERED BY EPTC TO VARIOUS AGENCIES AND/OR ORGANIZATIONS – 1999					
	MOHP	**THO, CCO, HIO**	**NGOs**	**Religious, RCT, and Universities**	**Total**
Condoms	4,657,900 (94.6%)	42,000 (0.9%)	215,600 (4.4%)	7,500 (0.2%)	4,923,000 (100%)
IUDs	1,006,462 (88.4%)	22,249 (2.0%)	109,750 (9.6%)	50 (0.0%)	1,137,911 (100%)
Depo-provera	1,786,211 (96.1%)	19,210 (1.0%)	47,470 (2.6%)	5,900 (0.3%)	1,858,791 (100%)
Norplant	11,855 (74.8%)	1,500 (9.5%)	0	2,500 (15.8%)	15,855 (100%)

3. RESOURCE ALLOCATION AND SPENDING FOR FAMILY PLANNING SERVICES & CONTRACEPTIVES

A. Family Planning Spending

Historical data on the sources and magnitude of funds provided for FP is limited, particularly for expenditures in the private sector. Table 6 shows total FP expenditure by provider type and sources in 1995/95. It shows that:

- Total FP expenditure comprised 1.3% of total health spending
- GOE FP expenditure comprised 1.7% of total GOE health spending
- Consumer FP expenditure comprised 0.2% of total household health spending
- Donor FP expenditure comprised 16% of total donor health spending. [4]

Sources of financing for FP services vary considerably between the non-profit or for-profit (private sector) providers. The GOE provided the majority of financing for non-profit providers (58%), with donors providing an additional 34%, and client payments comprising 6%. For the for-profit providers, the GOE provided 27% of total FP financing, with donors providing 54%, and clients providing 20%. Overall in FY 1994/95, the GOE provided 55% of total financing for FP services, donors provided 36%, and clients provided about 8%.

TABLE 6: FAMILY PLANNING EXPENDITURES BY PROVIDER TYPE AND SOURCE, 1994/5

TYPE OF FP INSTITUTION	FY 1994/95 (LE '000)	(%)	FP AS % OF HEALTH
NOT-FOR-PROFIT	**85,619**	**100**	-
- GOE	50,013	58.4	-
- Client payments	5,339	6.2	-
- Sponsoring Agencies*	1,230	1.4	-
- Donors	29,037	33.9	-
FOR-PROFIT (PRIVATE SECTOR)	**9,991**	**100**	-
- GOE	2,653	26.6	-
- Client payments	1,986	19.9	-
- Sponsoring Agencies*	0	0	-
- Donors	5,352	53.6	-
TOTAL FAMILY PLANNING	**95,610**	**100**	-
- GOE	52,666	55.1	-
- Client payments	7,235	7.7	-
- Sponsoring Agencies*	1,230	1.3	-
- Donors	34,389	36.0	-
TOTAL HEALTH EXPENDITURES	7,453,000	100	1.3
- GOE	3,029,000	40.6	3.2
- Client payments	3,819,000	51.2	0.2
- Sponsoring Agencies*	390,000	5.2	0.3
- Donors	215,000	2.9	16.0

* Sponsoring agencies expenditure refers to FP subsidies from the service provider organization, which are usually in the form of cross-subsidizes from non-FP services or from donations

Sources: Geary, R. et.al. (July 1998) Five Year Trend Study, Report on the Trends of the Costs of the Family Planning Program in Egypt, FY 1994/5, Tables 1 and 2. DDM (May 1999) The Distribution of Health Care Resource in Egypt: Implication for Equity - An Analysis Using a National Health Accounts Framework, Table 1.

B. Spending on Contraceptives

Table 7 shows total contraceptive expenditures by provider type and source in 1997/8. It shows that:

- Total contraceptive expenditure comprised 11.8% of total spending on FP
- GOE contraceptive expenditure comprised 4.6% of total GOE spending on FP
- Consumer contraceptive spending comprised 23.7% of total household spending on FP
- Donor contraceptive expenditure comprised 19.5% of total donor spending on FP

TABLE 7: CONTRACEPTIVE EXPENDITURES BY PROVIDER TYPE AND SOURCE, 1997/98

TYPE OF FP INSTITUTION	FY 1997/98 (LE '000)	PERCENT (%)	AS % OF TOTAL FP
NOT-FOR-PROFIT	**13,190**	**100**	-
• GOE	770	5.8	-
• Client payments	422	3.2	-
• Sponsoring Agencies*	27	0.2	-
• Donors	11,971	90.8	-
FOR-PROFIT (PRIVATE SECTOR)	**5,480**	**100**	-
• GOE	3,049	55.6	-
• Client payments	2,432	44.4	-
• Sponsoring Agencies*	0	0	-
• Donors	0	0	-
TOTAL – CONTRACEPTIVES	**18,670**	**100**	-
• GOE	3,818	20.5	-
• Client payments	2,854	15.3	-
• Sponsoring Agencies*	27	0.1	-
• Donors	11,971	64.1	-
TOTAL - FAMILY PLANNING EXP's	**157,888**	**100**	11.8
• GOE	83,404	52.8	4.6
• Client payments	12,046	7.6	23.7
• Sponsoring Agencies*	927	0.6	2.9
• Donors	61,511	39.0	19.5

* Sponsoring agencies expenditure refers to FP subsidies from the service provider organization, which are usually in the form of cross-subsidizes from non-FP services or from donations

Source: Rowan, M., Abdelakher, O., and Abdel-Meguid, H. (April 2000), Report on the Costs of the Family Planning Program, Egypt, July 1, 1997 – June 30, 1998.

In not-for-profit organizations, donors provided over 90% of the funds for contraceptives, with the GOE providing only 5.8% and consumers 3.2%. In the private sector, clients provided 44.4% of the funds, with the GOE providing the remaining 55.6%. In total, donors funded 64% of contraceptive purchases in FY 1997/98, with the GOE providing 20.5% and clients/consumers 15.3%.

4. THE PROCUREMENT OF CONTRACEPTIVE COMMODITIES

A. Introduction

Until recently, contraceptive commodities distributed through the public sector family planning program, and including a number of NGOs, were provided by either international donors, chiefly USAID (in the case of condoms, intrauterine devices, injectables, implants and vaginal foaming tablets), or purchased from local manufacturers (in the case of oral contraceptives). Currently, USAID is the only international donor supporting the program with donated contraceptive commodities. However, they will phase out their support over the period 2001 - 2008. This process began in 1999, when the last donations of implants were received, and condom support was discontinued in 2001.

Over the last few years, the MOHP has procured supplies of contraceptives for methods no longer being provided by USAID.

Table 8 summarizes recent contraceptive procurement experience of the MOHP Population Sector.

TABLE 8: PURCHASERS OF CONTRACEPTIVE COMMODITIES FOR THE MOHP, BY YEAR

Method	1997	1998	1999	2000	2001
IUD	USAID & GOE/MOHP	USAID	USAID	USAID	USAID
Condom	USAID	USAID	USAID	USAID	USAID & GOE/MOHP
Injectable	USAID & GOE/MOHP	USAID	USAID	USAID	USAID
Implant	USAID	USAID	USAID	GOE/MOHP	GOE/MOHP
Oral	GOE/MOHP	GOE/MOHP	GOE/MOHP	GOE/MOHP	GOE/MOHP

B. Procurement and Distribution

The MOHP and EPTC have both the resources and capacities to perform their procurement and distribution functions. The MOHP now has well-trained procurement staff, and EPTC has the human, operational, and capital resources to meet the systems' distribution and warehousing needs. Both the MOHP and EPTC need to sustain their capabilities through investment in staff development and logistical management systems to suit the evolving nature of the business.

II. PLANNING FOR THE FUTURE

1. VOLUME AND COST PROJECTIONS FOR FAMILY PLANNING & CONTRACEPTIVES

A. Demand Projections

The population and contraceptive projections that follow are based on the CSS base case, which builds on the latest MOHP assumptions agreed on in March 2002. These assumptions are as follow:

- Population Growth: Replacement TFR of 2.1 reached in 2017
- Method Mix: Unchanged from current mix
- MOHP Import Costs: Same as current USAID costs
- Sector Shares: Unchanged from current levels
- Domestic Manufacturing: Unchanged from current levels
- Donor Support of Contraceptives Complete withdrawal in 2008

Table 9 and 10 show projections for MWRA, FP users, CPR and TFR

TABLE 9: PROJECTION OF MWRA AND FP USERS, 2000-2017				
	2000	**2005**	**2010**	**2017**
MWRA (millions)	11.15	12.49	13.66	15.39
% Increase (compared to 2000)		12.0%	22.5%	38.0%
Family Planning Users (millions)	6.25	7.63	9.03	11.25
% Increase (compared to 2000)		22.1%	44.5%	80.0%

TABLE 10: REACHING THE GOE GOAL FOR TOTAL FERTILITY RATE BY 2017				
	2000	**2005**	**2010**	**2017**
CPR (%)	56.1	61.1	66.1	73.1
TFR	3.5	3.09	2.68	2.10

In Table 11 we show estimates of the number of users, by method, assuming a constant method mix based on the 2000 EDHS. The very slight difference in total figures between Table 1 and 11 are a result of rounding up the number of users for each method in.

TABLE 11: PROJECTIONS OF FP USERS, BY METHOD (millions) [5]				
Method	**2000**	**2005**	**2010**	**2017**
Condom	0.11	0.14	0.17	0.21
Injectables	0.68	0.83	0.99	1.24
IUD	3.96	4.85	5.75	7.19
Sub-dermal	0.03	0.03	0.04	0.05
Pills	1.06	1.30	1.54	1.93
Other	0.40	0.49	0.58	0.73
Total	**6.24**	**7.64**	**9.07**	**11.35**

Table 12 shows projections for quantities for the four major methods, while Figures 1 & 2, provide the same projections in graphical form for condoms and pills, and IUDs and injectables.

The projections provided here include the following Couple Years of Protection (CYP) assumptions:

Method	**CYP**
• Condom	100 per year
• Injectable	4 per year
• IUD	3 years
• Pill	13 cycles per year
• Sub-dermal	3 years

Assuming the current method mix continues through 2017, the Egyptian FP program will need approximately 9 million more condoms, 2.18 million more injectable doses, 860,000 more IUDs, and 11.3 million more pill cycles in 2017 than it required in 2000. (See Table 12)

TABLE 12: PROJECTIONS OF CONTRACEPTIVES REQUIRED, BY METHOD (million) [6]				
Method	**2000**	**2005**	**2010**	**2017**
Condom (pieces)	11.17	13.63	16.13	20.1
Injectables (doses)	2.72	3.33	3.93	4.9
IUD (devices)	1.8	2.04	2.27	2.66
Pills (cycles)	13.79	16.83	19.91	24.82
Sub-dermal (sets)	0.01	0.01	0.01	0.01

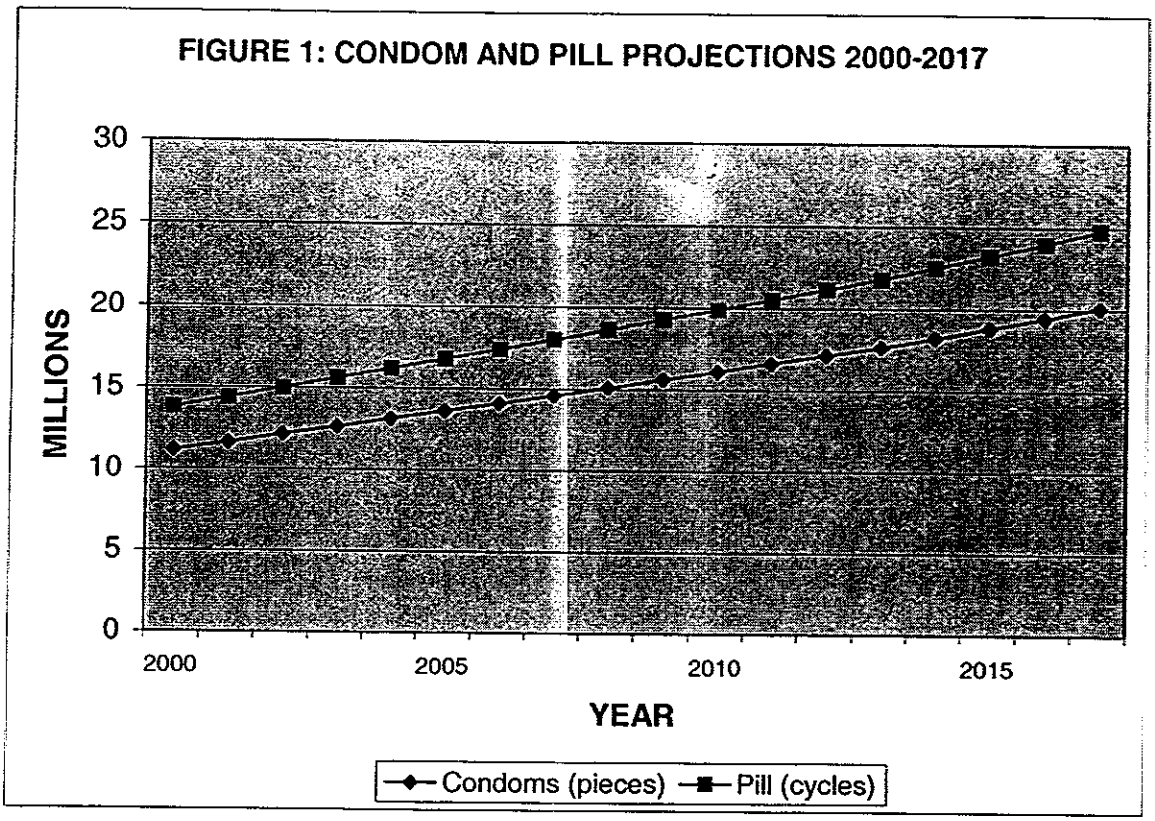


FIGURE 1: CONDOM AND PILL PROJECTIONS 2000-2017
30
25
20
15
10
5
0
MILLIONS
2000
2005
2010
2015
YEAR
Condoms (pieces)
Pill (cycles)

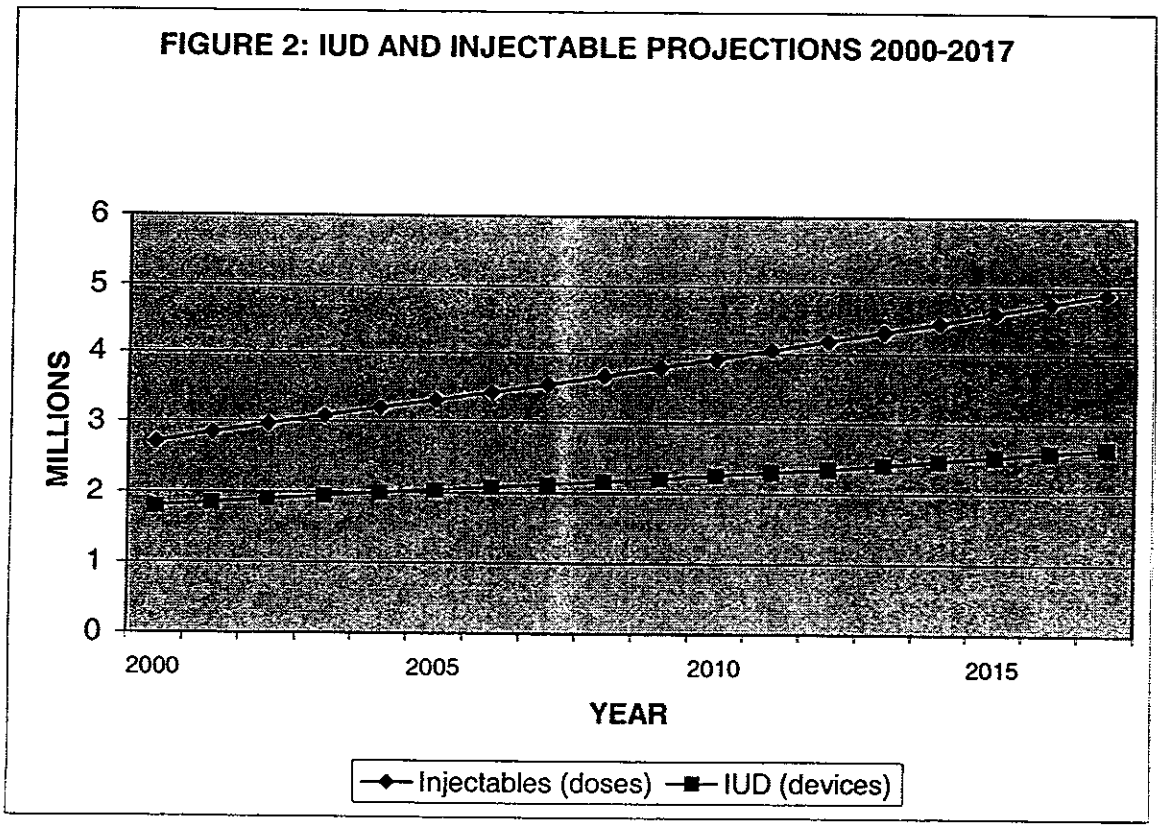


FIGURE 2: IUD AND INJECTABLE PROJECTIONS 2000-2017
6
5
4
3
2
1
0
MILLIONS
2000
2005
2010
2015
YEAR
Injectables (doses)
IUD (devices)

Table 13 provides projections for the MOHP contraceptive supply needs. Included in these projections are the quantities of contraceptives that the GOE/MOHP supplies to several NGOs, teaching hospitals, and religious organizations. These projections assume that the public sector's share will remain constant at the 2000 EDHS levels: condoms at 14.2%; injectables at 81.4%; IUDs at 54.0%; and pills at 10.8%. They also assume that the NGO's share of the market remains at 2000 EDHS levels.

TABLE 13: PROJECTIONS OF CONTRACEPTIVES REQUIRED BY THE GOE/MOHP, BY METHOD, USING DATA FROM 2000 EDHS (millions)

	2000	2005	2010	2017
Condom	1.59	1.94	2.29	2.85
Injectables	2.21	2.71	3.20	3.99
IUD	0.97	1.10	1.23	1.44
Sub-dermal	0.01	0.01	0.01	0.01
Pills	1.49	1.82	2.15	2.68

B. Estimating Contraceptive Costs

Currently, most contraceptives are purchased through the USAID procurement system, rather than by the GOE/MOHP. Moreland and Burn suggest [7] that the MOHP will find it difficult to obtain prices as low as current USAID prices due to differences in procurement experience and to the volume of the purchases. However, for the purpose of their projections, they used USAID prices, while noting, "These estimates should therefore be regarded as indicative of the level of resources required. Actual costs would almost certainly be higher." Their projections also included freight charges [1], but do not make adjustments for inflation. The same assumptions are used for the projections shown in Tables 14 and 15, although freight is included as a separate line item, rather than being incorporated into the unit price. These assumptions are also used in the CSS base case. The full year-by-year costs are shown in Section III.

[1] Freight estimates vary from 5% for pills to 10% for injectables and implants, 12% for IUDs, and 15% for condoms and vaginal tabs.

TABLE 14: CONTRACEPTIVE COST PROJECTIONS FOR THE GOE/MOHP, BY METHOD, USING DATA FROM 2000 EDHS (in US $ millions) [2]					
Method	Unit Prices (US$)	2000	2005	2010	2017
Condom	0.0657	0.10	0.13	0.15	0.19
Injectables	0.9700	2.15	2.63	3.10	3.87
IUD	1.4505	1.41	1.60	1.78	2.08
Sub-dermal	23.8000	0.24	0.24	0.24	0.24
Pills	0.2166	0.32	0.39	0.47	0.58
Freight		0.44	0.52	0.59	0.72
TOTAL US $	--	4.66	5.51	6.33	7.68

TABLE 15: CONTRACEPTIVE COST PROJECTIONS FOR THE GOE/MOHP, BY METHOD, USING DATA FROM 2000 EDHS (in LE. millions) [3]					
Method	Unit Prices (LE)	2000**	2005*	2010*	2017*
Condom	0.30	0.34	0.59	0.69	0.86
Injectables	4.46	7.31	12.10	14.27	17.80
IUD	6.67	4.79	7.35	8.18	9.58
Sub-dermal	109.48	0.82	1.10	1.10	1.10
Pills	1.00	1.09	1.81	2.14	2.67
Freight		1.50	2.38	2.73	3.30
TOTAL LE.	--	15.85	25.33	29.11	35.31

LE Unit prices derived from US$ unit prices at exchange rate of LE 4.60/US$1
** Calculated with exchange rate of LE 3.40/US$1
* Calculated with exchange rate of LE 4.60/US$1

C. Impact of Donor Phase-out Plans

A CSS assumption is that USAID will continue providing the public sector's IUD and injectable commodity needs through donated products until 2007, with the MOHP completely taking over the financing and procurement of these commodities in 2008. Table 16 shows estimates of the allocation of procurement costs between the MOHP and USAID under this assumption.

[2] Table figures rounded up from the detailed projections shown in Section III
[3] Ditto

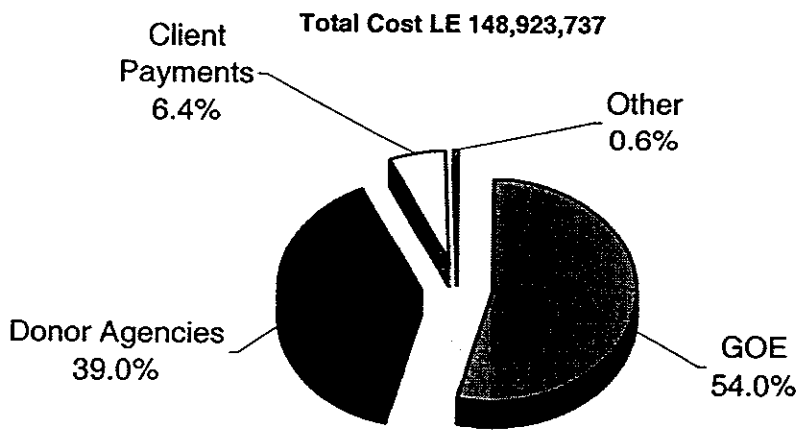
TABLE 16: IMPACT OF DONOR PHASE-OUT PLANS ON GOE's CONTRACEPTIVE PROCUREMENT COSTS (LE millions)												
Method	2000**		2005*		2007*		2008*		2010*		2017*	
	GOE	Donor	GOE	Donor	GOE	Donor	GOE	Donor	GOE	Donor	GOE	Donor
Condom	0	0.34	0.59	0	0.63	0	0.65	0	0.69	0	0.86	0
Injectables	0	7.31	0	12.10	0	12.97	13.40	0	14.27	0	17.80	0
IUD	0	4.79	0	7.35	0	7.67	7.85	0	8.18	0	9.58	0
Sub-dermal	0	0.82	1.10	0	1.10	0	1.10	0	1.10	0	1.10	0
Pills	1.09	0	1.81	0	1.94	0	2.01	0	2.14	0	2.67	0
Freight	0.05	1.45	0.29	2.09	0.30	2.22	2.59	0	2.73	0	3.30	0
Total LE.	1.14	14.71	3.79	21.54	3.97	22.86	27.60	0	29.11	0	35.31	0

** Calculated with exchange rate of LE 3.40/US$1
* Calculated with exchange rate of LE 4.60/US$1

D. Total Program Cost Projections

The June 2000 report by Rowan, Abdelakher, and Abdel-Megaid, "Report on the Cost of the Family Planning Program in Egypt, July 1, 1997 – June 30, 1998", provides the most recent information on the full costs of providing public sector FP services. They estimate total costs of FP agencies in the not-for-profit sector to be LE 148.92 million during FY 1997-1998. Figure 3 shows the major funding sources for this expenditure.

FIGURE 3: TOTAL COSTS OF FP AGENCIES IN THE NOT-FOR-PROFIT SECTOR 1997-98



Donors plan to reduce, rather than expand, their assistance to Egypt's FP program in the coming years. In 1997/8 contraceptive costs were calculated as 8.9% of the total costs of the non-for profit sector. Currently, most of this expense is borne by donors. As donors reduce this support and other support for IEC, training, supervision and capital equipment, the GOE will need to take up the slack. Moreover, contraceptive costs as a proportion of total FP

program cost are likely to increase because of the falling value of the Egyptian pound. Since the GOE began floating the LE on currency markets in 2001, it has lost over 35% of its value against the US dollar. The LE will probably to continue to loose value. However, because of the uncertainties associated with the foreign currency rates and inflation rates we have made all projections in this paper with the current US dollar/LE rate of LE 4.60 to US $1. These projections estimate that the GOE's financial contribution to the procurement of contraceptives will rise from LE 1.14m in 2000 to LE 35.31m in 2017.

2. PROCUREMENT OPTIONS

A. Introduction

During the 2001-2008 period USAID will gradually withdrawal its financial support for the Egyptian Population Program. As a result, the GOE/MOHP will be required to take responsibility for procuring and financing contraceptives.

For contraceptives, as for other pharmaceutical and medical products, good quality is critical and takes precedence over price and delivery, although both these issues are important too. The lowest priced offer is usually accepted only after quality and delivery requirements have been met by the supplier.

The GOE/MOHP has limited experience in contraceptive procurement especially in the international marketplace. However, Pop IV has provided much assistance to build the GOE/MOHP capacity to procure contraceptives. This has included the development of contraceptive procurement guidelines and projection and procurement software, and the training of staff to use the systems. In addition, the trained staff have begun procuring commodities on their own.

There are essentially the following four main procurement options available to the MOHP:

B. Procurement Options

1). The MOHP's Procurement Department procures internationally and/or locally following GOE regulations and other best procurement practices for pharmaceuticals.
2). The MOHP contracts with a suitably experienced and qualified procurement agent, selecting the agency through a tendering process.
3). The MOHP contracts with the United Nations Population Fund (UNFPA) to obtain the required contraceptives.
4). The MOHP seeks and finds donor(s) who purchase (and donate) contraceptives to the national program on their behalf.

The advantages and disadvantages of these options are described in Table 17.

TABLE 17: PROCUREMENT OPTIONS			
Advantages	**Disadvantages**	**Other Issues**	**Comments**
OPTION 1: MOHP PROCURES DIRECTLY			
• No intermediary's fees • Direct oversight of procurement activity • Should obtain low unit costs (if competitive procurement methods are used transparently and efficiently) • Utilizes existing in-house pharmaceutical and medical supply procurement expertise • MOHP may be able to enter into cost-saving multiple-year contracts • May be able to enter into direct negotiations for particular requirements	• Increased work load for Procurement Department • Highest level of effort by MOHP • Requires expertise in International Competitive Bidding (ICB) • Requires knowledge of the international contraceptive market • Most time-consuming and complex option • Places responsibility for quality assurance directly with MOHP	• Registration of contraceptive products—all products procured must be registered • Prompt payment to suppliers (manufacturers or agents) is required	Should a decision be reached to use this strategy, the procurement method (e.g. competitive bidding, direct negotiation, etc.) used will be influenced by the nature of the international marketplace for each contraceptive method (and its formulation, where appropriate). In general, the number of competent manufacturers of a product has a major influence on the choice of procurement method. Some contraceptive methods or formulations are only produced by a single manufacturer. **OPTIMAL PROCUREMENT METHOD, BY COMMODITY** ***Method:*** International Competitive Bidding (ICB) - Condoms, orals ***Method:*** Limited International Bidding (LIB) - IUDs, injectables ***Method:*** Direct Negotiation – Implant, orals NB. Orals could be procured by ICB if purchased generically.

TABLE 17: PROCUREMENT OPTIONS			
Advantages	**Disadvantages**	**Other Issues**	**Comments**
OPTION 2: MOHP CONTRACTS WITH PROCUREMENT AGENT			
• May result in lower unit costs (if agent can combine MOHP requirements with other clients' needs to increase purchase volume) compared to Option 1 • Less work load (than Option 1) for MOHP Procurement Department	• Procurement agent's fee (possibly between 5-15% of value of procurement • Need to rely upon agent to verify quality • May require pre-payment • In-house contraceptive procurement capability is not developed • Limited number of "experienced and qualified agents"	• Prompt payment to suppliers (manufacturers or agents) is required	This option aims to compensate for the MOHP's limited expertise in contraceptive procurement, through utilizing an organization with extensive experience in this area. The MOHP would be required to follow GOE regulations on the contracting of services, be able to draft a suitable contractual arrangement, which ensures quality and service, and have the ability to monitor the contractor's performance and manage the relationship.
OPTION 3: MOHP CONTRACTS WITH UNFPA			
• Very low unit costs result from UNFPA bulk purchases • Quality assured • Lower effort by MOHP • UNFPA very knowledgeable about the contraceptive market	• UNFPA fee (6% of value of procurement) • Requires payment in advance • In-house procurement capability may not be developed	• Prompt payment to suppliers (manufacturers or agents) is required	The use of UNFPA would be appropriate under circumstances where the MOHP is concerned about its lack of expertise and experience in international procurement of contraceptives, and wished to be certain of obtaining quality products during a period when in-house expertise is strengthened.
OPTION 4: CONTRACEPTIVES PROCURED BY DONOR(S)			
• Minimal/no cost	• Not a long term solution • Probably "politically" unacceptable (to USAID) • Possibility of discontinuity in products provided to clients of MOHP health facilities • No strengthening of capacity within the MOHP	• Reaction of the private sector • Establishment of new donor relationship • Quality assurance • Prompt payment to suppliers (manufacturers or agents) is required	As USAID reduces and eventually ceases its in-kind contribution of contraceptive commodities, GOE/MOHP can approach other donors for support.

3. FINANCING OPTIONS

A. Introduction

Assuming the GOE/MOHP cannot find new donor funds, there are five plausible financing options available to the GOE/MOHP:

1) Funding from the national GOE budget on a long-term basis,
2) Expanding the Health Insurance Organization's (HIO) benefit package to include family planning and contraceptives and broadening it's membership to include families, or at minimum, spouses
3) Increasing user fees while strengthening mechanisms for ensuring access to the poor through fee waivers and/or exemptions
4) Improving service delivery efficiency, through active and coherent support of private providers of family planning services and commodities (better market segmentation) and targeting for public sector services
5) Using a combination of some or all of these approaches.

Table 18 describes these options.

TABLE 18 - FINANCING OPTIONS SUMMARY					
	GOE BUDGET Option 1	**HIO COVERAGE** Option 2	**USER FEES AND WAIVERS** Option 3	**SERVICE DELIVERY EFFICIENCY** Option 4	**COMBINATION OF OPTIONS 1 - 4** Option 5
OVERALL REQUIREMENTS	• New resource allocation decisions at GOE level so that necessary funds are obtained from national budget indefinitely	• Expansion of HIO benefit package to include FP services and contraceptives • Broadening of membership to include spouses and family members	• Substantial increase in user fees and better mechanisms for ensuring access by poor and disadvantaged	• Active and coherent program to support private providers of family planning and FP commodities	• MOHP takes active role in "lobbying" for increased GOE support to FP and for inclusion of FP in HIO benefit package and membership expansion. • MOHP increases user fees for FP services and commodities, develops and implements targeting, improves protection mechanisms, and develops program to support private sector role in FP.

19.

TABLE 18 - FINANCING OPTIONS SUMMARY					
	GOE BUDGET Option 1	**HIO COVERAGE** Option 2	**USER FEES AND WAIVERS** Option 3	**SERVICE DELIVERY EFFICIENCY** Option 4	**COMBINATION OF OPTIONS 1 - 4** Option 5
PLUSES	• Can happen quickly if decisions are made. • Easy to understand and is familiar to MOHP staff. • Lets others make difficult resource allocation decisions on FP.	• Great potential if political will is there to support the inclusion of FP as a benefit. • Member contributions defray the total cost to the GOE (assuming the GOE will contribute a substantial portion of the HIO's budget well into the future).	• Revenue generation is controlled within MOHP and rules allow flexibility regarding the use of these funds. • Local control of revenues which are generated. • Families who can afford to pay are using MOHP FP services. - More revenue can be collected. • Current cost recovery of 6% can be significantly increased without harming access (with formal waiver system in place).	• Formal program can improve quality in private sector, ensure adequate supplies, and clarify target markets for public and private sectors respectively. • Private sector involvement in FP reduces reliance on public sector while ensuring that services are provided. • Dramatic increases in future demand require that private sector's volume increases.	• No one strategy is likely to provide the resources needed to meet the dramatic increase in demand over the next 15 years; therefore, a combined strategy is practical. • Some strategies can be implemented more rapidly than others; immediate action is required but a combined strategy allows for short-term and long-term contributions from the different alternatives. • MOHP can move on several fronts at the same time, not placing "all its eggs in one basket".

TABLE 18 - FINANCING OPTIONS SUMMARY					
	GOE BUDGET Option 1	**HIO COVERAGE** Option 2	**USER FEES AND WAIVERS** Option 3	**SERVICE DELIVERY EFFICIENCY** Option 4	**COMBINATION OF OPTIONS 1 - 4** Option 5
RISKS	• Dramatic increases in demand will require large increases in funding. • MOHP asked to reduce other services to obtain FP money (trade-offs). • GOE priorities change over time, and FP funds disappear. • Funds are not adequate, resulting in shortages and poor quality services.	• Requires significant changes in benefits, membership, and providers. FP may not have enough political support to create these changes. • Likely to take several years due to changes required. • Even with these changes, total HIO coverage will still be small in comparison to total FP demand. • No precedent; HIO only supports 0.7% of FP services and commodities currently.	• Policies and price controls would need to be changed, potentially creating public reaction. • Fees might keep people at the margin from obtaining FP services and/or commodities, an outcome contrary to the primary goal of the FP program. • Poor implementation of fee waiver system could negatively affect some consumers. • Fees at MOHP facilities could make some clients move to private sector.	• Hard to ensure quality when there is such a wide range of independent providers. Requires adequate regulatory (licensing, inspection, etc.) mechanisms and personnel. • Personal and/or organizational views of private providers can inhibit FP choices being offered. • Requires MOHP to improve in area where they have little experience (regulation). • Likely to be considerable regional variation in private sector services.	• Requires adequate staff and coordination to move in several directions at same time and do them well. • Will require purposeful lobbying and ongoing promotion of the program requirements of family planning to lawmakers and others. • Requires continuing positive interaction with HIO leadership and GOE decision-makers. • Directions may be dramatically changed by health sector reform initiatives. MOHP leadership must take active role in this process to protect FP interests.

B. GOE Budget

The resources that would be required if the GOE/MOHP were to handle the total financial burden directly, were highlighted in Section II.1. This financial outlay, while perhaps feasible, would likely have a major impact on other health and population services, as budget monies inevitably require tradeoffs of one program against others. With historical budget support for health and population at relatively low levels (1.7% of GDP in FY 1994-95), it should not be expected that budget support for health and FP could increase sufficiently to meet the increases in demand, loss of donor support, and inflation. Other sources for the FP program will be required.

C. Health Insurance Organization Coverage

The HIO, because of government commitment to its expansion as a national health insurer, could become a significant source of funding for FP. Three elements would be required initially:

1) Inclusion of FP services and contraceptives as member benefits
2) Inclusion of family members (at minimum, the spouses of eligible workers) as covered members
3) Provider qualification/certification program. Over the long-term, further expansion of the HIO's total membership would also be necessary in order to increase the number of eligible female members and thus FP users

Data from FY 1994/95 show that the HIO had a considerable role in health services nationally, using 12.5% of total health expenditures, or LE 993m [8]. Firms, private insurance, and syndicates provided an additional 5.4% of overall health expenditure (LE 406m). Overall, however, the degree of risk pooling and cost sharing in Egypt is still limited, although both HIO and private payers have increased their market share in recent years.[9]

Currently, the HIO's role in family planning is considerably less than their contribution to overall health. According to the 2000 EDHS, the combined efforts of the HIO and the CCO provided only 0.7% of the total FP services/commodities provided nationally.[10] This is because FP services are not a part of the designated benefit package, except at HIO clinics, and because spouses of HIO members are not generally included as HIO beneficiaries.

HIO has the potential to provide substantial funds to FP in the long-term if the benefits package is broadened and membership is increased to include families, or at minimum, spouses. These changes are consistent with national leaders' goals for the HIO and its future role.

D. User Fees, Waivers and Exemptions

Since 1997, GOE regulations have allowed MOHP providers to charge all FP clients a method, or commodity, fee. These fees are set by the MOHP and vary according to method.

Also allowed by the legislation covering the commodity fee is the retention of collected revenue by the MOHP clinic, and its use for staff financial incentives and other purposes. Governors of individual governorates were also authorized to establish fees for FP sessions, as appropriate for their region, although few, if any, have actually done so.

If a person is considered too poor to pay the commodity fee, it is suggested that the fee should be waived, although there are no formal guidelines for this decision, and there is considerable variation depending on location and the individual clinic/provider. The MOHP also operates an active mobile clinic program, and services at these clinics are free. The mobile clinics are generally used to target (provide services) low use areas and to serve low use populations, thus serving as a "mode of delivery" waiver mechanism.

MOHP doctors are also allowed to use the MOHP clinics in the afternoon for their private work, as an incentive. The doctor will charge the same price for the contraceptive but will probably charge a service fee too.

NGO and private sector providers are required to offer FP contraceptives at the same fixed prices as the MOHP, but are allowed to have higher service/consult fees. The service fee is one element that differentiates NGO clinics, such as those of EFPA and CSI, from the FP clinics of the MOHP. Method prices actually vary slightly by provider, even though according to GOE/MOHP regulations, they should be the same. Service fees are moderate in NGOs and higher in private physician offices. Commodity prices are also controlled for private pharmacies.

In 1998, the average cost to a client (the average of all methods) for a clinic visit in the MOHP was LE 4, at EFPA LE 8, and at CSI LE 16. The highest cost element of each visit is the FP commodity (method), which ranges from 89% of total cost in MOHP clinics to 70% of total cost in both EFPA and CSI clinics.

In 1998, user fees recovered LE 6,640,159, or about 6% of the estimated total cost of the public sector's program. Of this amount, 23% was generated by public sector providers, 44% by NGOs, and 33% in pharmacies and EPTC. Public sector FP clinics generated less than LE 398,489 in comparison to estimated total expenditures of more than LE 109.3m and direct FP expenditures of more than LE 67.6m.

Long-term sustainability of the national FP program will require re-evaluation of the current GOE/MOHP user fees. At present, there is no explicitly stated cost-sharing policy. The program's anticipated growth and resource constraints require a more revenue-oriented perspective.

E. Improving the Efficiency of the Delivery of Family Planning Services

The private sector provides about 50% of Egypt's family planning services. This includes private physicians, pharmacies, mosque and church-sponsored clinics, and NGOs such as the EFPA and the CSI. Consumers tend to rely on the private sector (including NGOs) for the purchase of specific methods, in particular, condoms and pills (81% and 83% respectively), but are more likely to obtain IUDs and injectables at public sector clinics (56% and 76% respectively).[11] Female sterilization is fairly equally divided between public and private providers.

In general, the private sector provides these services and commodities to those both able to and willing to pay. Both the market and the regulatory environments should support the private sector's contribution to ensure that it is able to play a flourishing long-term role. Without a developed market environment, private sector providers may abandon offering FP services or selling FP commodities, leaving the government with additional service delivery

and financial burdens. This could seriously affect the GOE's ability to reach their national population goals.

To reduce the GOE's financial burden, the public sector could define specific target populations which have the most need, and organize their services to meet these needs. Target populations may be defined according to income, geographic location, specific needs (such as clients who have achieved their desired family size), or other user characteristics (such as young, newly married couples, geographic location or specific services).

This strategy would allow the MOHP to realistically provide family planning services to those who otherwise could not obtain them, either due to access or affordability. It also provides the MOHP with a better chance to have programmatic goals matched to resource availability. This strategy would support the active role of the private sector through the removal of FP subsidies to those who could afford to pay. These clients would then seek FP services in the private sector.[12]

F. Combination

The GOE could combine the resources of the public clinics, the HIO, user-fees, and the private sector to meet the challenges of future population growth. This would require commitment to a sustainability strategy that incorporates these various approaches. A key component of this plan, especially in the short-term, would be an active lobbying strategy - at the national level for budget funds and HIO expansion, and within the HIO for support of the relevant benefit and membership changes. Internally, the MOHP would need to address user fee and waiver/exemption issues, improve the market environment for the private sector, improve targeting and protection mechanisms, and carefully monitor trends and patterns within the FP program.

The health sector reform initiatives currently under way in Egypt will, if implemented, have major consequences on all of the Ministry's programs (see Annex 3). Their principles include integrated primary health care, national health insurance, and competitive bidding for service providers. FP program leaders should be fully involved in the planning activities of health sector reform so they can fully represent the needs and priorities of the national FP program and the goal of replacement level growth by 2017.

III. DETAILED PROJECTIONS

ESTIMATED COSTS OF CONTRACEPTIVE COMMODITIES FOR THE PUBLIC SECTOR (IN US$)

METHOD	Unit costs US$	2000	2001	2002	2003	2004	2005	2006	2007	2008
Condom	0.0657	104,209	108,781	113,352	117,924	122,588	127,160	131,731	136,396	141,061
Female Sterilization	0.0000	0	0	0	0	0	0	0	0	0
Injectables	0.9700	2,147,658	2,250,303	2,345,053	2,439,802	2,534,552	2,629,301	2,724,051	2,818,801	2,913,550
IUDs	1.4505	1,409,886	1,449,050	1,488,213	1,527,377	1,566,540	1,597,871	1,637,034	1,668,365	1,707,529
Pills	0.2166	322,587	336,856	351,126	365,396	379,431	393,701	407,970	422,474	436,744
Sub-dermal	23.8000	238,000	238,000	238,000	238,000	238,000	238,000	238,000	238,000	238,000
Freight	--	439,513	455,876	471,450	487,024	502,600	517,234	532,807	547,467	563,055
	TOTAL	4,661,853	4,838,866	5,007,194	5,175,522	5,343,711	5,503,266	5,671,594	5,831,502	5,999,938

METHOD	Unit costs US$	2009	2010	2011	2012	2013	2014	2015	2016	2017
Condom	0.0657	145,725	150,483	155,241	160,093	165,037	170,262	175,766	181,550	187,521
Female Sterilization	0.0000	0	0	0	0	0	0	0	0	0
Injectables	0.9700	3,008,300	3,103,049	3,205,695	3,308,340	3,410,986	3,513,631	3,632,068	3,750,505	3,868,942
IUDs	1.4505	1,738,859	1,778,023	1,817,186	1,848,517	1,895,513	1,942,510	1,989,506	2,036,502	2,083,498
Pills	0.2166	451,247	465,751	480,722	495,693	511,133	527,274	544,117	562,129	580,609
Sub-dermal	23.8000	238,000	238,000	238,000	238,000	238,000	238,000	238,000	238,000	238,000
Freight	--	577,714	593,328	609,754	625,255	642,672	660,167	679,318	698,570	717,873
	TOTAL	6,159,846	6,328,634	6,506,599	6,675,898	6,863,341	7,051,843	7,258,774	7,467,256	7,676,443

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ESTIMATED COSTS OF CONTRACEPTIVE COMMODITIES FOR THE PUBLIC SECTOR (IN EGYPTIAN POUNDS)

METHOD	Unit costs LE	2000	2001	2002	2003	2004	2005	2006	2007	2008
Condom	0.30	479,363	500,392	521,420	542,449	563,906	584,935	605,963	627,421	648,878
Female Sterilization	0.00	0	0	0	0	0	0	0	0	0
Injectables	4.46	9,879,225	10,351,394	10,787,242	11,223,090	11,658,938	12,094,786	12,530,635	12,966,483	13,402,331
IUDs	6.67	6,485,476	6,665,628	6,845,780	7,025,932	7,206,084	7,350,206	7,530,358	7,674,479	7,854,632
Pills	1.00	1,483,899	1,549,539	1,615,179	1,680,819	1,745,384	1,811,024	1,876,664	1,943,380	2,009,020
Sub-dermal	109.48	1,094,800	1,094,800	1,094,800	1,094,800	1,094,800	1,094,800	1,094,800	1,094,800	1,094,800
Freight	--	2,021,759	2,097,030	2,168,670	2,240,309	2,311,959	2,379,275	2,450,914	2,518,348	2,590,052
	TOTAL	21,444,522	22,258,783	23,033,091	23,807,399	24,581,071	25,315,025	26,089,334	26,824,911	27,599,713

METHOD	Unit costs LE	2009	2010	2011	2012	2013	2014	2015	2016	2017
Condom	0.30	670,336	692,223	714,110	736,426	759,171	783,203	808,523	835,131	862,596
Female Sterilization	0.00	0	0	0	0	0	0	0	0	0
Injectables	4.46	13,838,179	14,274,027	14,746,196	15,218,365	15,690,534	16,162,703	16,707,513	17,252,323	17,797,133
IUDs	6.67	7,998,753	8,178,905	8,359,057	8,503,179	8,719,362	8,935,544	9,151,727	9,367,909	9,584,092
Pills	1.00	2,075,737	2,142,453	2,211,321	2,280,190	2,351,210	2,425,459	2,502,936	2,585,793	2,670,803
Sub-dermal	109.48	1,094,800	1,094,800	1,094,800	1,094,800	1,094,800	1,094,800	1,094,800	1,094,800	1,094,800
Freight	--	2,657,486	2,729,307	2,804,869	2,876,171	2,956,293	3,036,769	3,124,864	3,213,421	3,302,214
	TOTAL	28,335,291	29,111,716	29,930,354	30,709,131	31,571,369	32,438,478	33,390,362	34,349,377	35,311,638

TOTAL NUMBER OF USERS (MILLIONS) (From Spectrum File from POLICY PROJECT adjusted to constant method mix)							
	Condoms	Injectables	IUDs	Implants	Pills	Other	Total
2000	0.11	0.68	3.96	0.03	1.06	0.40	6.24
2001	0.12	0.71	4.14	0.03	1.11	0.42	6.53
2002	0.12	0.74	4.32	0.03	1.16	0.44	6.81
2003	0.13	0.77	4.50	0.03	1.21	0.46	7.10
2004	0.13	0.80	4.67	0.03	1.25	0.47	7.35
2005	0.14	0.83	4.85	0.03	1.30	0.49	7.64
2006	0.14	0.86	5.03	0.03	1.35	0.51	7.92
2007	0.15	0.90	5.21	0.04	1.40	0.53	8.23
2008	0.16	0.93	5.39	0.04	1.45	0.55	8.52
2009	0.16	0.96	5.57	0.04	1.49	0.57	8.79
2010	0.17	0.99	5.75	0.04	1.54	0.58	9.07
2011	0.17	1.02	5.94	0.04	1.59	0.60	9.36
2012	0.18	1.05	6.13	0.04	1.64	0.62	9.66
2013	0.18	1.09	6.32	0.04	1.69	0.64	9.96
2014	0.19	1.12	6.52	0.04	1.75	0.66	10.28
2015	0.19	1.16	6.73	0.05	1.81	0.68	10.62
2016	0.20	1.20	6.96	0.05	1.87	0.71	10.99
2017	0.21	1.24	7.19	0.05	1.93	0.73	11.35

METHOD MIX (From POLICY PROJECT Draft Projections Low version)					
	Condoms	Injectables	IUDs	Implants	Pills
2000	1.80	10.90	63.40	0.40	17.00
2001	1.80	10.90	63.40	0.40	17.00
2002	1.80	10.90	63.40	0.40	17.00
2003	1.80	10.90	63.40	0.40	17.00
2004	1.80	10.90	63.40	0.40	17.00
2005	1.80	10.90	63.40	0.40	17.00
2006	1.80	10.90	63.40	0.40	17.00
2007	1.80	10.90	63.40	0.40	17.00
2008	1.80	10.90	63.40	0.40	17.00
2009	1.80	10.90	63.40	0.40	17.00
2010	1.80	10.90	63.40	0.40	17.00
2011	1.80	10.90	63.40	0.40	17.00
2012	1.80	10.90	63.40	0.40	17.00
2013	1.80	10.90	63.40	0.40	17.00
2014	1.80	10.90	63.40	0.40	17.00
2015	1.80	10.90	63.40	0.40	17.00
2016	1.80	10.90	63.40	0.40	17.00
2017	1.80	10.90	63.40	0.40	17.00

TOTAL PROGRAM COMMODITY REQUIREMENTS (MILLIONS) (From POLICY PROJECT Draft Projections Low version)					
CYP	Condoms 100	Injectable 4	IUD 0.33'	Sub-dermal 0.33'	Pill 13
	Condoms (pieces)	Injectables (doses)	IUD (devices)	Sub-dermal (sets)	Pill (cycles)
2000	11.17	2.72	1.80	0.01	13.79
2001	11.66	2.85	1.85	0.01	14.40
2002	12.15	2.97	1.90	0.01	15.01
2003	12.64	3.09	1.95	0.01	15.62
2004	13.14	3.21	2.00	0.01	16.22
2005	13.63	3.33	2.04	0.01	16.83
2006	14.12	3.45	2.09	0.01	17.44
2007	14.62	3.57	2.13	0.01	18.06
2008	15.12	3.69	2.18	0.01	18.67
2009	15.62	3.81	2.22	0.01	19.29
2010	16.13	3.93	2.27	0.01	19.91
2011	16.64	4.06	2.32	0.01	20.55
2012	17.16	4.19	2.36	0.01	21.19
2013	17.69	4.32	2.42	0.01	21.85
2014	18.25	4.45	2.48	0.01	22.54
2015	18.84	4.60	2.54	0.01	23.26
2016	19.46	4.75	2.60	0.01	24.03
2017	20.10	4.90	2.66	0.01	24.82

Public Sector requirements (quantities - millions) (From POLICY PROJECT Draft Projections Low version)					
	Condoms (pieces)	Injectables (doses)	IUD (devices)	Sub-dermal (sets)	Pill (cycles)
Share of total market	**14.20%**	**81.40%**	**54.00%**	**100.00%**	**10.80%**
2000	1.59	2.21	0.97	0.01	1.49
2001	1.66	2.32	1.00	0.01	1.56
2002	1.73	2.42	1.03	0.01	1.62
2003	1.79	2.52	1.05	0.01	1.69
2004	1.87	2.61	1.08	0.01	1.75
2005	1.94	2.71	1.10	0.01	1.82
2006	2.01	2.81	1.13	0.01	1.88
2007	2.08	2.91	1.15	0.01	1.95
2008	2.15	3.00	1.18	0.01	2.02
2009	2.22	3.10	1.20	0.01	2.08
2010	2.29	3.20	1.23	0.01	2.15
2011	2.36	3.30	1.25	0.01	2.22
2012	2.44	3.41	1.27	0.01	2.29
2013	2.51	3.52	1.31	0.01	2.36
2014	2.59	3.62	1.34	0.01	2.43
2015	2.68	3.74	1.37	0.01	2.51
2016	2.76	3.87	1.40	0.01	2.60
2017	2.85	3.99	1.44	0.01	2.68

PUBLIC SECTOR REQUIREMENTS (COSTS)						
A. EXCLUDING FREIGHT						
Source: Unit costs at 2002 prices to USAID and MOHP						
In US$	*0.0657*	*0.9700*	*1.4505*	*23.8000*	*0.2166*	
	Condoms	**Injectable**	**IUD**	**Sub-dermal**	**Pill**	**TOTAL**
2000	104,209	2,147,658	1,409,886	238,000	322,587	4,222,340
2001	108,781	2,250,303	1,449,050	238,000	336,856	4,382,990
2002	113,352	2,345,053	1,488,213	238,000	351,126	4,535,744
2003	117,924	2,439,802	1,527,377	238,000	365,396	4,688,498
2004	122,588	2,534,552	1,566,540	238,000	379,431	4,841,111
2005	127,160	2,629,301	1,597,871	238,000	393,701	4,986,033
2006	131,731	2,724,051	1,637,034	238,000	407,970	5,138,787
2007	136,396	2,818,801	1,668,365	238,000	422,474	5,284,035
2008	141,061	2,913,550	1,707,529	238,000	436,744	5,436,883
2009	145,725	3,008,300	1,738,859	238,000	451,247	5,582,132
2010	150,483	3,103,049	1,778,023	238,000	465,751	5,735,306
2011	155,241	3,205,695	1,817,186	238,000	480,722	5,896,844
2012	160,093	3,308,340	1,848,517	238,000	495,693	6,050,643
2013	165,037	3,410,986	1,895,513	238,000	511,133	6,220,669
2014	170,262	3,513,631	1,942,510	238,000	527,274	6,391,676
2015	175,766	3,632,068	1,989,506	238,000	544,117	6,579,456
2016	181,550	3,750,505	2,036,502	238,000	562,129	6,768,686
2017	187,521	3,868,942	2,083,498	238,000	580,609	6,958,570
In Egyptian Pounds @ Exchange Rate of LE 4.60 to US$ 1						
2000	479,363	9,879,225	6,485,476	1,094,800	1,483,899	19,422,763
2001	500,392	10,351,394	6,665,628	1,094,800	1,549,539	20,161,752
2002	521,420	10,787,242	6,845,780	1,094,800	1,615,179	20,864,421
2003	542,449	11,223,090	7,025,932	1,094,800	1,680,819	21,567,090
2004	563,906	11,658,938	7,206,084	1,094,800	1,745,384	22,269,112
2005	584,935	12,094,786	7,350,206	1,094,800	1,811,024	22,935,751
2006	605,963	12,530,635	7,530,358	1,094,800	1,876,664	23,638,420
2007	627,421	12,966,483	7,674,479	1,094,800	1,943,380	24,306,563
2008	648,878	13,402,331	7,854,632	1,094,800	2,009,020	25,009,661
2009	670,336	13,838,179	7,998,753	1,094,800	2,075,737	25,677,805
2010	692,223	14,274,027	8,178,905	1,094,800	2,142,453	26,382,408
2011	714,110	14,746,196	8,359,057	1,094,800	2,211,321	27,125,484
2012	736,426	15,218,365	8,503,179	1,094,800	2,280,190	27,832,959
2013	759,171	15,690,534	8,719,362	1,094,800	2,351,210	28,615,076
2014	783,203	16,162,703	8,935,544	1,094,800	2,425,459	29,401,709
2015	808,523	16,707,513	9,151,727	1,094,800	2,502,936	30,265,499
2016	835,131	17,252,323	9,367,909	1,094,800	2,585,793	31,135,956
2017	862,596	17,797,133	9,584,092	1,094,800	2,670,803	32,009,424

PUBLIC SECTOR REQUIREMENTS (COSTS)						
B. FREIGHT (ONLY)						
Source: Unit costs at 2002 prices to USAID and MOHP						
(Freight %)	*15.0%*	*10.0%*	*12.0%*	*10.0%*	*5.0%*	
	Condoms	**Injectable**	**IUD**	**Sub-dermal**	**Pill**	**TOTAL**
US$						
2000	15,631	214,766	169,186	23,800	16,129	439,513
2001	16,317	225,030	173,886	23,800	16,843	455,876
2002	17,003	234,505	178,586	23,800	17,556	471,450
2003	17,689	243,980	183,285	23,800	18,270	487,024
2004	18,388	253,455	187,985	23,800	18,972	502,600
2005	19,074	262,930	191,744	23,800	19,685	517,234
2006	19,760	272,405	196,444	23,800	20,399	532,807
2007	20,459	281,880	200,204	23,800	21,124	547,467
2008	21,159	291,355	204,903	23,800	21,837	563,055
2009	21,859	300,830	208,663	23,800	22,562	577,714
2010	22,572	310,305	213,363	23,800	23,288	593,328
2011	23,286	320,569	218,062	23,800	24,036	609,754
2012	24,014	330,834	221,822	23,800	24,785	625,255
2013	24,756	341,099	227,462	23,800	25,557	642,672
2014	25,539	351,363	233,101	23,800	26,364	660,167
2015	26,365	363,207	238,741	23,800	27,206	679,318
2016	27,233	375,051	244,380	23,800	28,106	698,570
2017	28,128	386,894	250,020	23,800	29,030	717,873
In Egyptian Pounds @ Exchange Rate of LE 4.60 to US$ 1						
2000	71,904	987,922	778,257	109,480	74,195	2,021,759
2001	75,059	1,035,139	799,875	109,480	77,477	2,097,030
2002	78,213	1,078,724	821,494	109,480	80,759	2,168,670
2003	81,367	1,122,309	843,112	109,480	84,041	2,240,309
2004	84,586	1,165,894	864,730	109,480	87,269	2,311,959
2005	87,740	1,209,479	882,025	109,480	90,551	2,379,275
2006	90,894	1,253,063	903,643	109,480	93,833	2,450,914
2007	94,113	1,296,648	920,938	109,480	97,169	2,518,348
2008	97,332	1,340,233	942,556	109,480	100,451	2,590,052
2009	100,550	1,383,818	959,850	109,480	103,787	2,657,486
2010	103,833	1,427,403	981,469	109,480	107,123	2,729,307
2011	107,116	1,474,620	1,003,087	109,480	110,566	2,804,869
2012	110,464	1,521,836	1,020,381	109,480	114,009	2,876,171
2013	113,876	1,569,053	1,046,323	109,480	117,561	2,956,293
2014	117,480	1,616,270	1,072,265	109,480	121,273	3,036,769
2015	121,278	1,670,751	1,098,207	109,480	125,147	3,124,864
2016	125,270	1,725,232	1,124,149	109,480	129,290	3,213,421
2017	129,389	1,779,713	1,150,091	109,480	133,540	3,302,214

IV. ENDNOTES

[1] Paper # 3 - Population Sector Sustainability Process, Mona Khalifa, Utilization and Demand for Family Planning Services, March 2001.

[2] Draft Population Projections 2000-2017, "Low" Projection, The Policy Project, March 2002.

[3] Paper # 2 - Population Sector Sustainability Process, Dr. Mediha Said, Private Sector / NGO Provision of Family Planning Services, March 2001.

[4] Paper # 4 - Population Sector Sustainability Process, Dayl Donaldson, Overview of Health and Family Planning Financing in Egypt, March 2001.

[5] Draft Population Projections 2000-2017, "Low" Projection, The Policy Project, March 2002.

[6] Presentation of Paper # 3 - Population Sector Sustainability Process, Dr. Mona Khalifa, Utilization and Demand for Family Planning Services, The Policy Project, March 2001.

[7] Moreland, Scott and Burn, Robert, Contraceptive Commodity Projections for Egypt, 2001-2010, Revised, March 2001.

[8] Paper # 4 - Population Sector Sustainability Process, Dayl Donaldson, Overview of Health and Family Planning Financing in Egypt, March 2001.

[9] In the late 1990s, the school health program was added to the overall HIO program. While it added substantial numbers to the HIO's membership pool, this group would not be impacted by, or have an impact on, the types of benefit and membership expansions which are needed for family planning coverage.

[10] Paper # 10 - Population Sector Sustainability Process, Steve Reimann, Planning, Management, and Human Resources, Table 1, March 2001, and El Zanaty and Associates, and Macro International, Inc., Egyptian Demographic Health Surveys, 1988, 1992, 1995, 1997, 1998 & 2000.

[11] Presentation of Paper # 3 - Population Sector Sustainability Process, Dr. Mona Khalifa, Utilization and Demand for Family Planning Services, The Policy Project, March 2001.

[12] While this is perhaps not an ideal approach for a government that desires to offer a comprehensive set of social and health services to its population, it is an appropriate strategy when resources are limited and compromises are required.

ANNEX 1

THE SUSTAINABILITY PROCESS: DEVELOPING A SUSTAINABILITY STRATEGY FOR POPULATION AND FAMILY PLANNING SERVICES IN EGYPT

7 December, 2000

Sustainability "...the ability of host country entities (community, public and/or private) to assume responsibility for programs and/or outcomes without adversely affecting the ability to maintain or continue program objectives or outcomes." [1]

The sustainability strategy for population and family planning in Egypt will be a document that outlines the principles and strategies that may act as a guide for the Ministry of Health and Population in setting policies, procedures, laws, rules and regulations for family planning programs in Egypt in the future. Chosen strategies should accurately reflect the needs of the people of Egypt, be constrained by what is feasible given available resources. Strategies must also be within the ability of host country entities (community, public and/or private) to assume responsibility for programs and/or outcomes without adversely affecting the ability to maintain or continue program objectives or outcomes.

I. Objectives

The objective of this exercise is to develop a national strategy for sustaining population and family planning (FP) activities in Egypt over the coming years. In order to do so, it is the sub-objective of this activity to develop a common definition and understanding of what "sustainability" means in the Egyptian context. With a common definition and strategy all parties can work together to make sure that the positive results of the FP program can be maintained, if not expanded, into the future.

II. Overview of the process

The process leading to a sustainability strategy involves several steps. First there needs to be a common understanding of what the word "sustainability" means with emphasis on the principles and methods that underly financial sustainability. Second, analysis of existing information needs to be carried out summarizing the implications of the existing state of affairs on sustainability. This will involve the collection and synthesis of available literature. Third, improvement of our understanding of sustainability options can be enhanced by learning from other countries' experiences as they have addressed family planning sustainability issues. At least one seminar will be held to learn of experiences in Turkey and possibly other countries. Finally, there needs to be a discussion, debate and formulation of consensus on the strategies,

[1] USAID Africa Bureau's Office of Sustainable Development's (AFR/SD) Health and Human Resources Analysis for Africa (HHRAA), *A Working Document of Health and Family Planning Indicators: A Tool for Results Frameworks*, p. 11.

policies, procedures, rules, regulations and financing practices that need to be put in place to assure the program's long term sustainability.

2.1 Principles of financing, economics and sustainability

One of the initial steps in the process will be to hold a 3-day conference on this subject. Days 1-2 will cover the principles and definitions of finance and economics as they relate to the financial sustainability of the Egyptian Pop/FP program.

2.2 Common definition of "sustainability"

Day three of the above conference will focus on creating a consensus definition of "sustainability" for Egypt. This definition should be specific enough to guide policy and program action in such a way that it enhances opportunities for and the potential for sustainability.

2.3 Learning from the Turkey country case

A 1-day meeting will be sponsored by the Policy II Project to learn from the experience of the Government of Turkey as it addressed the sustainability of its family planning program. Jeff Sine of The Futures Group will come to Egypt to present this case study and discuss its implications for Egpyt with Egyptian policy makers.

2.4 Synthesis of existing reports and publications

Although there are many research activities related to Pop/FP ongoing in Egypt, there are also literally hundreds of research papers and documents available that have information relevant to this work. As input into deliberations on sustainability of Pop/FP in Egypt, available literative will be examined for information pertinent to the sustainability debate. In order to make the process manageable, this examination will be broken down into eleven topic areas. Within each topic area all available documents will be reviewed and synthesized in order to summarize the implications for sustainability. Findings and implications from analysis of this information will be used as input into the sustainability debate.

2.4.1. Production of synthesis papers

Twelve (12) synthesis papers will be prepared as inputs into the development/refinement of a sustainability strategy for family planning (FP) in Egypt. These papers will require a minimal amount of new data collection - instead, the writers will rely on existing papers, studies and written materials that have been produced in Egypt and in other countries. The papers should each be no longer than 10 pages in length and each should address specific questions. Examples of questions that might be considered are found below.

The proposed topics will cover all aspects of program policy, financing and service provision. After the papers are completed, each is to be presented to, and discussed with, a group of selected stakeholders with emphasis on the implications of each paper's findings and conclusions on FP sustainability in Egypt. These smaller

meetings are proposed for early March 2001. Synthesis paper meetings may also define issues which need to be studied further in preparation for the final sustainability strategy conference.

After these initial educational/informational meetings, a team will be tasked with combining the findings.resulting in a final summary paper which looks at the relationships between the individual topics, develops a summary of the important FP sustainability issues, and outlines proposed sustainability policies for the long term.

The final summary paper as well as summaries of the findings and conclusions of the individual papers will be presented to a larger audience in a formal meeting proposed for April 2001. The primary purpose of this meeting will be to reach consensus on the most important findings, agree on conclusions and the policy implications of the findings and conclusions, establish a general direction for the sustainability of FP services in Egypt, and set the stage for specific follow-on actions by the key providers and financiers within the Egyptian FP sector.

2.4.2. Subject area groups and papers

The following subject areas and papers will be the focus of analysis:

Subject 1:	Supply (provision) and demand for Pop/FP services
Synthesis paper 1:	Public Sector Provision of Health Services
Synthesis paper 2:	Private / NGO Provision of Health Services
Synthesis paper 3:	Utilization and demand for FP services
Subject area 2:	Financial sustainability
Synthesis paper 4:	Global sources and destinations (uses) of population and FP resources in Egypt
Synthesis paper 5:	Equity in the distribution of FP resources
Synthesis paper 6:	Efficiency in the production of FP Services
Synthesis paper 7:	Resource mobilization and protection mechanisms in Government, NGO, and private facilities
Subject area 3:	Institutional capacity and enabling enviroment
Synthesis paper 8:	Policy Process
Synthesis paper 9:	Legal/Regulatory Environment
Synthesis paper 10:	Planning, management, and human resources
Synthesis paper 11:	Information systems, logistics and supply of commodities
Subject area 4:	Egypt's health sector reform
Synthesis paper 12:	Egypt's current and future health system reform activities and sustainability of the population and FP program

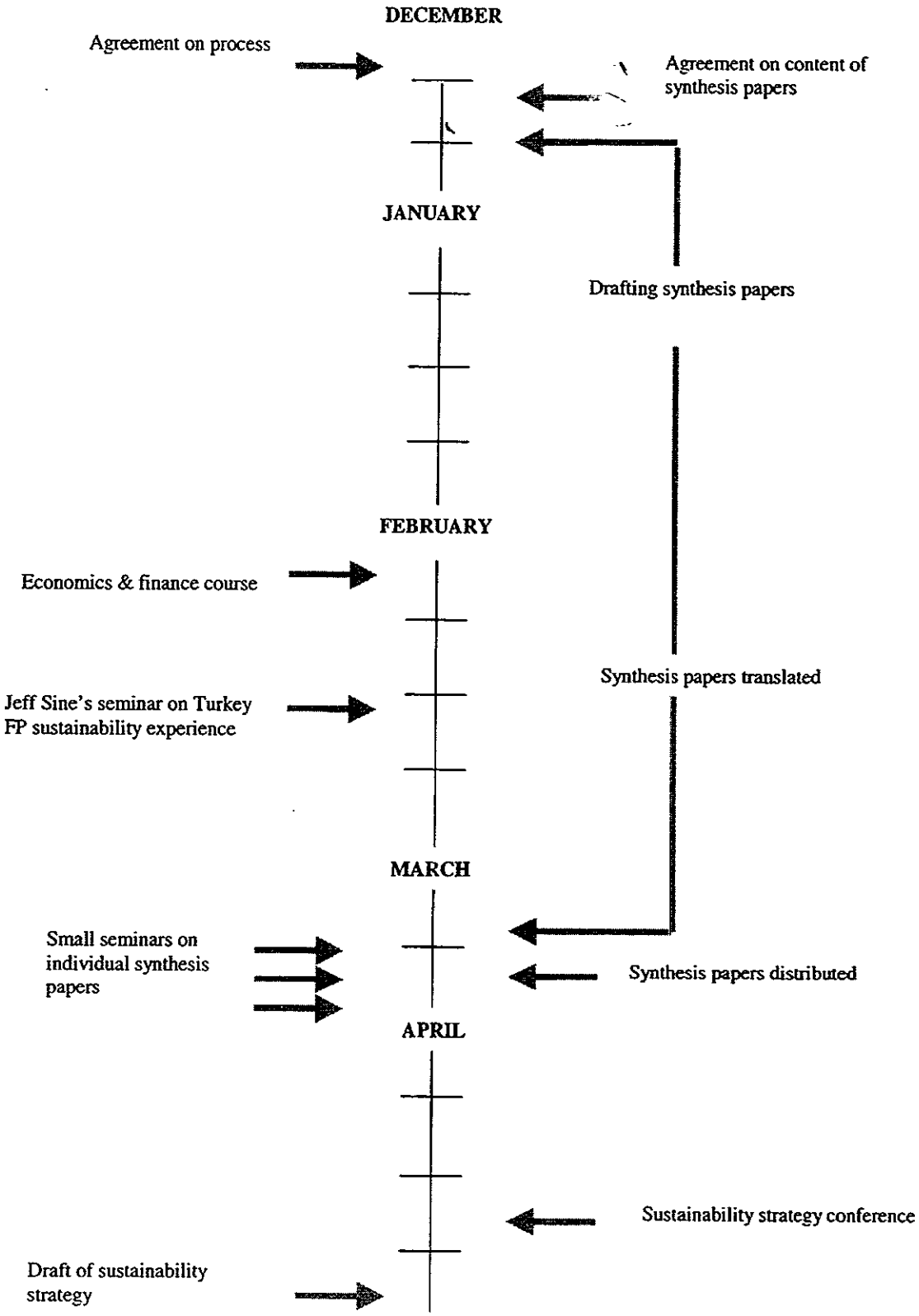
2.5 Sustainability strategy conference

After all synthesis papers have been written, discussed in individual meetings and a final summary synthesis developed, a sustainability strategy conference will be held. This conference will have as its purpose to define and debate key Pop/FP sustainability issues and strategies that will later be combined into a formal sustainability strategy document for Egypt.

III. Developing Egypt's Pop/FP sustainability strategy

Based on the above process and the outcomes of the sustainability strategy conference a select group of people will draft the populatoin and family planning sustainability strategy. This draft will be distributed for review and comment and later modified accordingly and adopted for approval by the Government of Egypt.

Appendix 1: **Outline of the Process by Week**



Appendix 2

Executive Course in Health Economics and Finance

Objective: To inform policy makers on the most important economic and finance issues related to the sustainability of Egypt's population and family planning program.

Outcomes: At the end of the course particants will have developed a common definition of the term "sustainability". Basic health economics and financing terms and issues will be understood as they relate to Egypt and the stage will be set for the development and review of synthesis papers which will outline sustainability issues for Egypt.

Length: The course will last 3 days. Days 1-2 will focus on key finance and sustainability issues while day 3 will focus on a discussion and consensus on a working definition of sustainability.

Invitees: A maximum of 20 people will be invited to attend this course. These people will be invited from those institutions that have considerable influence over the current or future coures of the population/family planning program. Specific individuals will be invited from the following organizations:

- Ministry of Health and Population's family planning sector, MCH program, health sector reform program.
- CSI
- RCT
- Egyptian Family Planning Association (EFPA)
- National Population Council (NDP)
- Egyptian Pharmaceutical Trading Company (EPTC)
- USAID
- Population Council

Course Content: The course will be limited to 2 days so only the most important concepts will be covered. This will include basic economic and finance definitions and concepts and certain elements of financial management, budgeting and accounting.

Appendix 3

List of Papers and Relevant Questions

Subject 1: Supply (provision) and demand for Pop/FP services

Synthesis paper 1: Public sector provision of health services

- What services are provided by the government? National? Regional? Local? By what providers?
- What is the extent of the FP public sector, and who uses its services?
- Utilization of public services: Determinants, costs and trends
- What factors are likely to affect public sector growth?
- What is the role of government in the financing of FP services?
- What are the legal and regulatory issues related to the public provision / production of FP services?
- What are the different market scenarios and options for FP services in the public sector?

Synthesis paper 2: Private/NGO provision of health services

- How is the "private" sector defined? (pharmacies, drug stores, private providers, etc.)
- What is the extent of the FP private sector and who uses its services?
- Utilization of private services: Determinants, costs and trends
- What factors are likely to affect private sector growth?
- To what extent to employers provide FP services?
- What is the role of NGOs, particularly CSI, NPC, RCT and others in the financing and delivery of FP services?
- What are the legal and regulatory issues related to the private provision / production of FP services in the public, NGO and pure private sector?
- What are the different market scenarios and options for FP services in the private sector?

Synthesis paper 3: Utilization and demand for FP services

- What are Egypt's demographic projections?
- What are the projections for family planning demand for contraceptives (10 year horizon)? What is the related impact on CPR and GOE's goal for a replacement level fertility rate by 2020?
- What factors affect the demand for FP services, and how do these vary around Egypt?
  - The distinction between perceived and expressed need
  - Determinants of FP utilization
- How accessible are FP services?
- How much to FP users and pay for FP services?
- Who uses which type of FP providers and why?
- What is the price elasticity of demand for FP services?

- Is there an ongoing need for proactive social marketing programs for family planning services? Is demand growing at an acceptable rate or does it need assistance? If the growth rate is adequate for now, how will it be evaluated as time progresses? Who monitors and evaluates the population's CPR and its use of FP services? How?

Subject area 2: Financial sustainability

Synthesis paper 4: Global sources and destinations (uses) of population and FP resources in Egypt

- What is the overall macro economic environment in Egypt?
- How much money from all sources is flowing in the health sector for all health services? For population and FP services? What is the trend and likely future resources for health and FP services under current conditions?
- What is the extent of non-treasury (MOHP) resource flows for health and FP services? What are the likely trends?
- How do non-Treasury (MOHP) health and FP resources flow in the system?
  - International Aid/Donors
  - Household Expenditures
  - Employers and other private sector sources
- What is the per capita expenditure on health services currently and historically? FP services?
- How does Egypt compare with other countries, and what are the prospects for growth in Government spending? Donor spending?
- Does GOE health and FP expenditures go towards GOE stated priorities?
- What is the FP use of resources by level of care within the health system?
- What are the current and historical execution rates?

Synthesis paper 5: Equity in the distribution of FP resources

- How are FP resources distributed programmatically and geographically (governorate)?
- What is the distribution of resources by Urban and Rural areas?
- How are FP healthworkers distributed around the country, and how efficiently do they work?

Synthesis paper 6: Efficiency in the production of FP Services

- How efficiently are FP resources used?
- How productive are FP workers?

Synthesis paper 7: Resource mobilization and protection mechanisms in Government, NGO, and private facilities

- What is the nature of the current user fee program?
  - Antecedents
  - Objectives
  - Types of user fee systems currently in place

Current challenges

- The inequality of exemptions: Who pays for which health services
- The administrative difficulties of implementing user fees
- Are the poor being protected? How? How effective are protection mechanisms?
- How does the commodity fee system operate?
- How much revenue is being collected, official or otherwise?

Subject area 3: Analysis of institutional capacity and enabling enviroment for Pop/FP services

Synthesis paper 8: Policy process - Capacity of Government to perform analysis and create appropriate policies for family planning program/services

Synthesis paper 9: Legal/regulatory environment - Does Government properly oversee/guide the FP sector through regulation/oversight/inspection?

- How are FP services, both public and private, overseen so that quality of care is ensured?
- Are there accreditation/licensing/certification programs in place which monitor FP providers in terms of quality, minimum standards, etc.? If so, how can these programs be improved/made more effective? If not, what are the barriers to their creation? What approaches does Government use to ensure/increase quality of care?
- Are these programs reasonably funded? What are their sources of funding?

Synthesis paper 10: Planning, management, and human resources

- How are FP services planned and managed?
- How do the public and private sectors interact, cooperate, and/or coordinate?
- Do FP advocacy groups exist, and if so, what roles do they play? How can these roles be enhanced/improved/supported?
- What is the distribution of public, private, NGO FP providers?
- What is the production of providers?
- How can production be improved?
- Are FP providers appropriately trained, certified, and/or recertified?
- What are the strengths and weaknesses of the current logistics management system for FP supplies? What additional steps are required for the logistics management system to be fully sustainable by the GOE/MOHP?

Synthesis paper 11: Information systems, logistics and supply of commodities

- What information systems exist, and how do they function?
- Do information systems produce appropriate information for management decision making?
- What strengths and weaknesses exist? What efforts are currently under way to improve information systems?
- What is the level of integration among the systems that do exist? How can integration be improved?

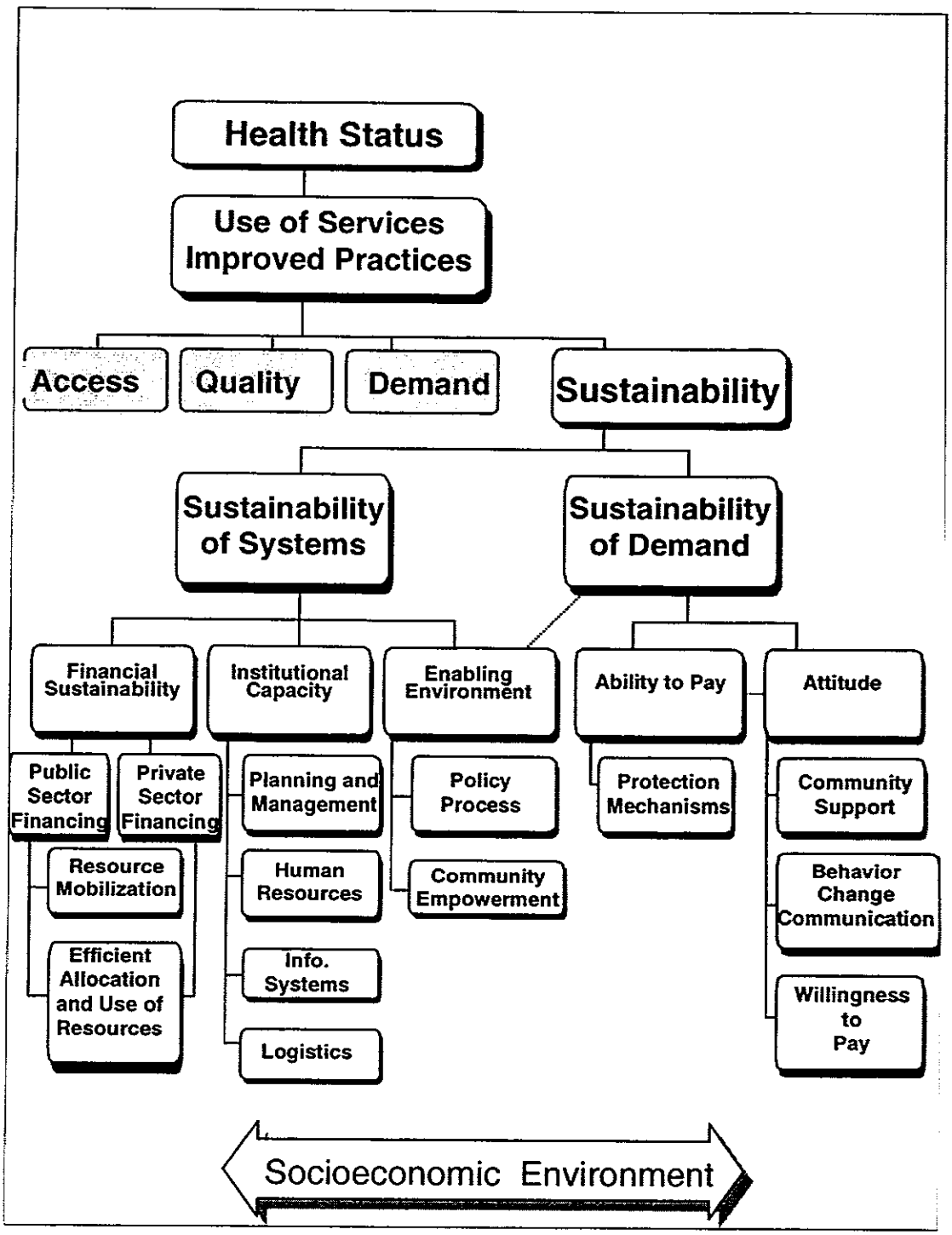
Subject area 4: Egypt's health sector reform

Synthesis paper 12: Egypt's current and future health system reform activities and sustainability of the population and FP program.

- What aspects of current reform efforts have an impact on sustainability of FP servcies?
- How do reform efforts propose to finance FP services in the public sector? Private sector? NGO sector?
- Are capitation models being proposed? If so, do they include FP as part of the basic benefit package for primary care? Is FP part of the capitation payment program?
- How are services for the poor to be financed and delivered? Are provider options other than public sector delivery points being considered? If not, why not?

Appendix 4

Graphic of FP Sustainability



ANNEX 3

HEALTH SECTOR REFORM OVERVIEW [1]

Health Sector Reform Program Strategies

The GOE has adopted as its long-term goal and its priority objective, to achieve universal coverage of basic health services, for all its citizens and in particular the most vulnerable population groups.

The Health Sector Reform Program aims at achieving the following:

- *Financial Coverage and Benefits:* Social heath insurance coverage will be expanded from one third of the population to universal coverage based on the family as a basic unit. An affordable and cost-effective package of basic health services based on the priority health needs of the population is to be provided.[2] The out-of-pocket expenditures will be reorganized to promote risk sharing and to collect contributions according to ability to pay. Sustainable financing will be ensured through Family Health Fund (FHF) to act as the sole financier of the basic benefit package
- *Family Health Approach:* Public and private service delivery will be organized into one system centered on a holistic family health approach. The MOHP health facilities' infrastructure will be consolidated into three types Family Health Unit (FHU), Family Health Center (FHC), and district hospital (OH) to provide the basic package at the district level. Provision of the package will be based upon competition and choice among the different public and private providers under the single (NHIF) using incentive-based provider payment mechanism.
- *Organizational Structures and Effective Management Systems:* These will be developed to enable competent capabilities, regulatory framework and relationships to implement the health sector reform. (MOHP) role will be strengthened in strategic planning, regulation and coordination of the health sector at all levels. The health workforce will be of the right size, place, mix and level of skills to meet the needs of the population served. MOHP will gradually phase out from the role of provider and financier of services towards a role of arbiter, policy maker, regulatory and orchestrator of the health system.
- *Affordable quality drugs:* These will be made available and ensured in rational prescribing, dispensing and consumption.
- *Integrated health programs:* Vertical health programs such as family planning will no longer be financed, managed, delivered, monitored and evaluated vertically and independently with its own staff. On the contrary, FP services will be integrated into Family Health Units (FHU) and Family Health Centers (FHC). Stand-alone FP clinics will be integrated into these delivery settings and family physicians and support staff will provide FP services.

Implementation of the HRSP Strategies

To put the HSRP strategies into operation, one has to consider that it is a comprehensive reform program, which needs to be implemented over a period of 15 to 20 years, in two or three phases.

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[1] Paper # 12, HSR Technical Support Office, Egypt's Current and Future Health System Reform Activities: Implications for Sustainability of the National Population and FP Program, Sections 3.2, 3.3, and 3.4, March 2001.

[2] The "basic package" will include three sets of cost-effective services including maternal health services, child health services, and adult and all age group services for treatment of TB and management of STIs.

The choice of options depends on the implementation capacity in Egypt. Implementation priorities will depend on the costs of implementation, the effects on improving the system, and the constraints (macroeconomic, social, political, etc.). This will require the implementation of policies that give the best value for money in terms of improved health status, equity, accessibility, quality, efficiency and laying the base for the later phases of the reform.

Many of the basic policy reforms require major pre-implementation research and development. In the current situation, phasing in universal coverage through a basic package of primary care services is a sensible first step. By focusing on primary care and public health the people benefiting most would be the most under-served (poor, rural population) and vulnerable groups (women and children).

Phasing of the Health Sector Program

The first phase of the reform started in the Governorates of Alexandria, Menoufia and Sohag. In Alexandria, the family health model has been implemented as Model Family Health centers and as a first step towards insurance through the Family Health Fund taken. Experience from Alexandria can be tested and evaluated in these Governorates before its implementation at the national level.

The phase two will deal with major curative care and manpower reforms. Annual implementation, and long-term plans of five-year duration, that will be incorporated in the coming Five Years National Health Plan define the phasing.

HSRP has already created an integrated health care delivery system centered on a family health team. The family physician is the gatekeeper capable of managing the majority of cases and able to refer the cases beyond his skills to second & tertiary care facilities levels.

As an integral part of this strategy, HSRP will support the preparation of comprehensive District and Governorate Health Plans to address the priority health care needs of the population efficiently within the envelope of available resources. These Health Plans will be used to prepare investment strategies for cost-effective and sustainable health care systems in terms of staffing and financing the targeted Governorates of Alexandria, Menoufia and Sohag.

For translating the Health Sector Reform Program into plans and implementing them in the proposed three pilot Governorates, the MOHP has established a Technical Support Office (TSO) composed of a group consultants and leading experts supported by Technical Support Teams (TSTs) in the three pilot Governorates. Their role will be to coordinate the reform activities and establish management organizational structures to facilitate program planning and implementation.

Two oversight committees have been created by ministerial decrees, namely:

Health Policy Forum Committee (HPF) - For review and approval of different phases of the reform process. It will promote policy dialogue among concerned GOE officials and stakeholders encourage transparency in policy-making, ensure continued Government commitment to the reform program and facilitate inter-sectoral coordination. The HPF will provide a forum for participation of all stakeholders in the reform. Specifically, the HPF will:

- Provide a forum for discussion of strategies and interventions developed under the HSRP;
- Facilitate/promote coordination of various actors regarding program activities and interventions

- Ensure support for HRFP from the rest of government and the general public
- Draw on the experience of organizations outside the government system
- Promote convergence with other social services
- Provide advice for planning and implementing HSRP
- Ensure feasibility of recommendations concerning wider issues
- Facilitate acceptance of HSRP interventions by concerned ministries other than health
- Provide guidance for studies which require support from ministries other than health
- Facilitate coordination among implementing agencies, Governorates and TSO.

Program Planning and Monitoring Committee (PPMC) - for monitoring the implementation of the phases. The main role of the PPMC is policy formulation, planning and monitoring of the reform outcome. The main functions of the PPMC are:

- Analyze policy alternatives and prepare relevant strategies
- Translate policy and reform measures into implementable program activities
- Provide guidelines and assistance for Governorates in plan preparation
- Review plans prepared by Governorates and implementing agencies
- Ensure that donor assistance is consistent with government policies and fit into the overall framework and objectives of the HSRP
- Ensure integration and cooperation among relevant MOHP departments and mobilize staff for the execution of HSRP; and
- Monitor overall reform progress and evaluate against target objectives and outcomes.

Governorate Program Coordination Committees (GPCC) will coordinate and monitor the health reform activities at the district and Governorate levels. The Under-secretary or the Director of Directorate of Health will establish a PCC in each pilot Governorate in order to oversee program planning and to monitor implementation at the Governorate levels, The main function of these Committees will be to help prepare the annual work plans and to ensure that health needs and priorities are properly reflected in the various reform interventions at the Governorate level.