EGYPT
HEALTH POLICY SUPPORT PROGRAM (HPSP)
ASSESSMENT

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ACRONYMS AND FOREIGN TERMS

BBP	Basic Benefits Package
BTS	Budget Tracking System
CCIG	Curative Care Improvement Group
CCO	Cairo Curative Organization
CEED	Combating Endemic and Emerging Diseases
CS	Child Survival
EC	European Commission
ECTAT	European Commission Technical Assistance Team
EIS	Executive Information System
EOPS	End of Project Status
EU	European Union
FH	Family Health
FHF	Family Health Fund
FHU/C	Family Health Unit/Family Health Center
FM	Family Medicine
FP	Family Planning
GIS	Geographical Information System
GOE	Government of Egypt
HIO	Health Insurance Organization
HM/HC	Healthy Mother/Healthy Child
HMIS	Hospital Management Information System
HPSP	Health Policy Support Program
IEC	Information, Education and Communication
IS/IT	Information Systems/Information Technology
MCH	Maternal and Child Health
MEDS	Monitoring, Evaluation and Design Support
MIS	Management Information System
MOF	Ministry of Finance
MOHP	Ministry of Health and Population
MOU	Memorandum of Understanding
NGO	Nongovernmental organization
NHA	National Health Accounts
NICHP	National Information Center for Health and Population
PBS	Patient Based System
PH	Population and Health
PHC	Primary Health Care
PHR	Partnership for Health Reform
PM	Preventive Medicine
QI	Quality Improvement
RH	Reproductive Health
ROI	Return on Investment
SIO	Social Insurance Organization
SOW	Scope of Work
TA	Technical Assistance
TSO	Technical Support Office
TST	Technical Support Team
USAID	United States Agency for International Development
WB	World Bank

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EXECUTIVE SUMMARY

Through the Monitoring, Evaluation and Design Support (MEDS) project, the U.S. Agency for International Development (USAID) in Egypt contracted for an assessment of the Health Policy Support Program (HPSP), a 5-year (1997–2001) health sector reform project. Two consulting teams (Health Policy Team and MIS Team) carried out the field assessment from April 13 to May 6, 2001. This report was prepared by the Health Policy Team.

In implementing two major health projects, HPSP has demonstrated the capacity for reform of the Egyptian health sector through the joint efforts of the government of Egypt, USAID, and other donors. In the first project, the pilot Primary Health Care (PHC) and Preventive Medicine (PM) Model in Alexandria, Egypt's Ministry of Health and Population (MOHP) worked closely with the World Bank (WB), the European Commission Technical Assistance Team (ECTAT), and USAID and the Partnership for Health Reform (PHR) to improve the quality of health services delivery. The pilot is demonstrating that PHC programs delivered by Family Medicine (FM) physicians in a Family Health Center/Family Health Unit (FHC/U) environment can be a cost-effective way of improving quality and the health status of the population.

In the second health project, HPSP has successfully demonstrated at 40 MOHP hospitals that the quality of management as well as hospital services can be improved through a hospital management improvement program.

Another HPSP effort that has proven to be highly effective is the Cash Transfer Support Program. In this development support program, the MOHP receives up to $15 million per year by meeting specific benchmarks and can use the funds without restriction for MOHP priorities. However, due to a cumbersome and time-consuming administrative and verification process, this program faced some implementation challenges. This process needs to be revised in the next program design.

Donor coordination is essential for program success. While such coordination has been taking place through regular monthly meetings, greater efforts are needed. In particular, more discussion and pre-agreements are needed on the donor master plan, framework, goals, and objectives. This assessment recommends the following:

1. The MOHP, with donor assistance, should continue developing and implementing effective PHC/PM systems with family health services as the main component and care delivered in FHC/FHUs. The Alexandria Pilot and the Family Health Fund (FHF) Pilot design and implementation should be completed, especially work on the information, actuarial, financial, and costing systems. A thorough evaluation of the Alexandria pilots should be

completed before consideration is given to rolling out the pilot FM model concept to the rest of the country.

2. In the integration of parallel existing Maternal and Child Health (MCH) services, family planning, reproductive health programs, and services into a standardized family health approach, the MOHP and donors should seek to maintain and expand progressive service elements, quality standards, and patient access to reproductive health services that have been developed through large donor investments. Of particular importance is ensuring continuity of services and access through a responsive FH/FM referral system.

3. The MOHP, with donor assistance, should continue to rationalize and improve the quality of management and service delivery at the secondary and tertiary curative care levels. The decentralization process, including the full implementation of the Board of Trustees concept in all MOHP/Health Insurance Organization (HIO)/Cairo Curative Organization (CCO) hospitals, should become a major implementation intervention in the new program design.

4. If the new health insurance legislation is enacted, financing options should be explored and implemented with donor assistance to ensure that purchaser and provider are truly separate, that the new organization is autonomous, and that real competition in the delivery of health care services results.

5. The verification process in the Development Support Program (Cash Transfer) needs to become less time consuming and paperwork-intenstive. Fewer benchmarks should be considered with fewer verification items. One way to make them less burdesome would be to make the benchmarks multiyear as well as covering the entire program time frame.

6. USAID should seize the leadership opportunity to improve donor coordination, with development of a Donor Master Plan and Framework, with increased levels of communication and understanding of each other's agenda, resources, goals, and objectives.

7. The balance between long-term global policy and short-term implementation-related policy incentives should favor the latter. USAID should take the opportunity to initiate joint donor policy initiatives for interministerial policy areas.

I. INTRODUCTION

A. BACKGROUND AND PURPOSE

The U.S. Agency for International Development (USAID) Mission in Egypt is in the process of assessing the Health Policy Support Program (HPSP). HPSP is a USAID/government of Egypt (GOE) collaborative effort to advance a health sector policy agenda as well as to enhance indigenous capacity to carry out significant health sector policy reforms during a 5-year period from 1997 through 2001. This program began as part of the USAID/Egypt Strategic Objective 5 (SO 5), "Sustainable Improvements in the Health of Women and Children," Intermediate Result 5.3 (IR 5.3), "Improved Environment to Plan, Manage, and Finance Sustained Maternal and Child Health Systems." The overall indicator for this component (IR 5.3) is "Percent of Ministry of Health and Population (MOHP) funding allocated for primary and preventive services." The European Community and the World Bank have also been closely involved in the health reform program.

USAID/Egypt's recently approved Strategic Plan (2000–2009) calls for a final 10-year phase of assistance to the Population and Health (PH) sector. The plan brings together into one objective — "SO 20, Healthier, Planned Families" — what was previously two distinct PH strategic objectives and combines it with three complementary intermediate results: 1) increased use of family planning, reproductive health, and maternal and child health services by target population; 2) healthy behaviors adopted; and 3) sustainability of basic health services promoted. Over the ensuing months, a transition plan for the 2000–2009 strategy period will be developed and will define program parameters, technical content, funding, and management arrangements for this final phase of assistance.

The purpose of the assessment is to provide the USAID Mission with an overview of major policy and technical assistance issues that were part of the HPSP results package and implementation process. Part of the SO 20 design approach is to conduct technical assessments of major existing results package activities to determine the "bridging" activities and mechanisms that will align them within the new strategic objective. The team was tasked with assessing the HPSP results package and providing USAID with information that would inform the design of the new program and transition plan. The Scope of Work (SOW) for this assessment is included as annex A at the end of this report.

B. METHODOLOGY

Two teams worked simultaneously on the HPSP Assessment: a Health Policy Team and an MIS Team. The assessment process and methodology followed the traditional method of reviewing relevant documents, interviewing key counterparts, and visiting pilot sites to assess progress and identify major policy and technical assistance issues. Interviews were conducted with more than 40 individuals and groups of individuals, and more than 60 documents were reviewed. Due to the limited time for carrying out the assessment and the unavailability of some key counterparts spearheading health policy and the sector reform agenda in Egypt, critical policy elements, such as the status and issues surrounding the new insurance law, could not be explored. Similarly, it was not possible to do an in-depth review and assessment of the individual benchmarks, technical assistance outputs, and verification process; consequently, this assessment is limited in its scope to review of existing documents, interviews with counterparts, and impressions from visiting pilot sites and MOHP facilities.

The Health Policy Team worked in close coordination with the MIS Assessment Team working on similar issues, but with a slightly different SOW. A list of major questions was developed relating to successes, failures, and other key issues of concern to the HPSP. Every attempt was made to fully answer each question listed in the SOW. A preliminary results meeting was conducted with USAID personnel, as well as a final assessment report meeting. Finally, an assessment report was submitted including findings, lessons learned, future options, possible next steps, and recommendations.

The report presents a concise discussion of most of the relevant issues in the HPSP Assessment SOW. Key exhibits that consolidate a variety of data and information into more readable and understandable format are presented in annexes at the end of this report.

II. CONTEXT: EGYPTIAN HEALTH REFORM

Egypt has experimented over time with a variety of efforts supported by USAID and other donors to improve the responsiveness and efficiency of its health system. In the mid-1990s, Egypt initiated with donor assistance a sweeping long-term program to reform the health sector. Partly in response to public pressure for improved services on the one hand, and to growing financial pressures on the public sector on the other, the first five years of the reform were focused on providing universal access to integrated primary health care and to reform of the Health Insurance Organization (HIO) to create new mechanisms for offering and financing services. After years of discussion, a new insurance law that provides the legal and financial basis for the reform is now reported to be in the final stages of signing. USAID, the World Bank, and the European Union are the principal donors directly supporting the reform. Additionally, other donors are supporting health sector reform and systems support through smaller efforts.

Within the central Ministry of Health and Population (MOHP), a special Technical Support Office (TSO) has been established to coordinate donor support with the government's implementation of the program. Model reform governorates, such as Alexandria, link to the TSO through a local Technical Support Team (TST). Staffed with the best and brightest of the health leadership, the TSO reports directly to the Minister of Health and serves as the counterpart-implementing vehicle for donor reform programs.

A. GOALS AND STRATEGIC OBJECTIVES

The Health Policy Support Program (HPSP) is a USAID/government of Egypt (GOE) collaborative effort to advance a health sector policy agenda and enhance indigenous capacity to carry out significant health sector policy reforms during a 5-year period, from 1997 through 2001. This program began as part of the USAID/Egypt Strategic Objective 5 (SO 5), "Sustainable Improvements in the Health of Women and Children," Intermediate Result 5.3 (IR 5.3), "Improved Environment to Plan, Manage, and Finance Sustained Maternal and Child Health Systems." The overall indicator for this component (IR 5.3) is, "Percent of Ministry of Health and Population (MOHP) funding allocated for primary and preventive services." The European Community and the World Bank have also been closely involved in the health reform program.

USAID Support

USAID funding of the original results package 5.3 is intended to develop the critical policy environment necessary "…to plan, manage and finance sustained maternal and child health systems …" using a two-pronged strategy to help the MOHP implement its ambitious health sector reform program. The strategy is as follows:

1. A nonproject assistance cash transfer package of US $60 million over a 5-year period has been built around a key set of six strategic policy areas. Funding is allocated in four Tranches against a series of policy reforms with accompanying benchmarks to be achieved in each of the six policy areas.

2. To help the MOHP accomplish the strategic reforms achieve the annual benchmarks, USAID has included a linked technical assistance package contracted through the Partnership for Health Reform (PHR) global project.

PHR and its Role in HPSP

The Results Package (USAID/Egypt, 1996) states:

"The result to be achieved under HPSP is an improved environment to plan, manage and finance sustained maternal and child health systems." (p.2)

"Health sector policy must establish the protection of maternal and child health as a priority, assign the resources to accomplish this objective, and capably manage the processes required to ensure an impact. The results package will strengthen the capacity for strategic planning and policy development and will bring about policy reforms that ensure the financial viability of preventive and maternal and child health programs, define the role of the MOHP in health sector regulation and quality assurance, rationalize personnel policy, and develop a sound social health insurance system suitable for expansion." (pp. 2-3)

The Partnership for Health Reform Project was asked to provide technical assistance, training, and research policy analysis in support of the MOHP and HIO efforts to effect policy reform. Through HPSP, PHR works with USAID, the European Union (EU), and the World Bank to identify opportunities for donor coordination in shaping an overall GOE health sector agenda and implementation strategy.

Cash Transfer Support Program

Benchmarks for each critical policy area are reviewed and revised annually around specific policy reforms needed during the next year (see Exhibit D-3, Policy Matrix for Each of the Four Tranches). An annual Memorandum of Understanding (MOU) is developed between USAID and the MOHP, which specifies the benchmarks to be accomplished, each having a measurable indicator. Using an annual verification process of benchmark indicators, USAID determines at the end of each year the degree of completion of benchmarks and determines the amount of allocated funding that will be released. Over the past three years, the benchmarks and indicators, as well as the verification process underwent minor modifications. Though the annual benchmark-setting and verification process have continued with some modification, one key element was added to the policy agenda: the development of the Alexandria pilot family health units and the Family Health Fund (FHF). This came about as a result of the USAID merger of Results Packages 5 (health reform and maternal and child health) and 4 (family planning and reproductive health) into the new SO 20, which links ongoing project

support activities with the overall reform agenda under the existing policy areas. This package potentially adds the private sector dimension to the health reform agenda, which is developed more fully in conjunction with Tranche 4. The integration of the earlier results packages into the new SO 20 affords the opportunity to design benchmarks under major policy areas that could also facilitate the fuller integration of ongoing USAID health and population support activities on the implementation level (for discussion of benchmark accomplishments, see Section III (B)).

B. PARTNER PROJECT RELATIONSHIPS

The policy reform assistance provided through PHR complements and operates within the context of other USAID development assistance programs that build technical and managerial capacity, and promote systems development. However, PHR, physically located within the MOHP and a counterpart to the Technical Support Office, has worked primarily with the MOHP on all technical issues, and secondarily with other USAID projects and other donors. This has served to support and reinforce the ministry's developing role and leadership in its health reform agenda. For example, in the development of the Alexandria pilots, PHR worked directly with MOHP counterparts of vertical programs to incorporate quality standards for such areas as family planning and reproductive health, and child survival developed under other programs and projects. PHR also coordinated formally and informally with the Healthy Mother/Healthy Child (HM/HC) Project, the Maximus contract, a carryover from the Cost Recovery Project, and to a very limited extent, with the family planning programs and the Combating Endemic and Emerging Diseases (CEED) Project.

USAID family planning and health projects have led the development of progressive clinical services, quality improvement and various training protocols, and materials for all levels of services providers. USAID's current flagship health project is the HM/HC initiative, which is improving the quality and increasing utilization of maternal, perinatal, and child health services and is coordinating closely with the larger health reform toward the development of a family health services model. PHR and HM/HC have shared most of their service standards and facility accreditation protocols, which were considered in the development of the current basic benefits package (BBP) and referral structure. Comprehensive training on all BBP services is given through MOHP-controlled and tailored FM/Family Health[1] programs to Family Physicians. Though assisted also through other technical assistance (TA) resources, USAID programs have contributed directly to shaping training curricula, the service standards, and protocols for family medicine.

[1] Family Medicine as a medical specialty is only one aspect of a broader, more inclusive Family Health integrated primary health care approach. International health reform literature, based on Western models, tends to use Family Medicine to identify a category of training, certification and service. "Family Health" is probably the more suitable concept for Egypt in that it includes a broad range of elements and actors, including the community, nonphysician health personnel such a sanitarians and promoters, health education, and preventive action, all of which are part of the basic services units from District level down.

The (CEED) Project (Results 5.2), while supporting applied research and studies that are completely different and separate from HPSP, is also developing new approaches to combating emerging and infectious diseases. It has important implications for primary health care and the potential to strengthen related public health policy and regulatory capacity for service delivery, contributing to longer-term health sector reform agenda items. Similarly, a more immediate health sector reform challenge facing Egypt, and recognized by the ECTAT, is the need to integrate public health services into PHC and financing options in a way that will sustain the critical disease control capacity that has been developed with major USAID and other donor assistance.

From a policy perspective, the PHR experiment has taken the lead in the coordination of health and family planning programs on both the policy and the services levels. The Alexandria pilot experiment integrating basic maternal and child health and reproductive health services under "one roof" as one service of the Family Health Clinics is a major policy step toward the future, signaling a new GOE social and political emphasis that is also consonant with the USAID strategic vision underlying SO 20. One of the many policy and operational challenges of the newly combined USAID Strategic Objectives 4 and 5 is the opportunity to encourage and support the GOE mandate for integration of these services at the primary care level, and to establish a solid and responsive referral process. This will eventually decrease costly duplication of parallel services and the opportunity to select and nurture the best from what has been developed under previously competing programs.

Maximus was also a partner under the HPSP, and had a defined scope of work in the area of information services, working with the CCO hospitals. A full discussion of the Maximus relationship is presented in the MIS team report.

III. FINDINGS

A. ORIGINAL RESULTS PACKAGE AGENDA AND TRANCHES

The initial results package for the Health Policy Support Program (HPSP) from July 1996 outlines its strategic objective and anticipated intermediate results. The policy areas and original benchmarks proposed are presented in Exhibit D-2 in annex D of this report. In comparing the policy areas and benchmarks in Exhibit D-2 with the policy areas and benchmarks in the final document, changes will be noted. However, these do not appear to be major and are part of the normal process of final negotiations between the parties.

Exhibit D-3 presents the policy areas and benchmarks for the four tranche years. It appears that the original assumptions and conditions established have not changed significantly, and that most of the original policy areas have remained the same, with an additional item being added in Tranche 2 and continued in Tranche 3 and 4 (i.e., Policy Area VI, Expand social health insurance coverage coupled with adequate administrative and financing mechanisms). As expected, the benchmarks have changed each year, except for the first benchmark under Policy Area I (MOHP FY 1998/99 expenditures devoted to clearly identifiable PM and PHC services increased by at least 10% over FY 1997/98), which has stayed the same as the previous year (see Exhibit D-3).

This exception for the first benchmark under Policy Area I may be the result of an inconsistency in the documents given to the consultants; it is possible this was included in the first year as well as being part of the original results package. As expected, the benchmarks have changed significantly each year as the program progressed. The biggest changes have been in the area of PHC development. Although some preliminary work was done on PHC, it appears that this was discussed in 1998 but was not fully developed and expanded until the Alexandria pilot in 1999 and implementation in 2000–2001.

The fact that there have been some changes is normal, and it proves that policy makers can be flexible when needed. The Alexandria pilot presented an opportunity that policy makers were quick to seize, which again shows the capacity for effectiveness, flexibility, and innovation on the part of all parties.

B. ACCOMPLISHMENTS

This section outlines the overall policy issues and benchmarks of HPSP and discusses the accomplishments as well as the successes and possible failures that resulted over the 5-year period (1997–2001).

Overall Accomplishments

The End of Project of PHR/Egypt Workshop Report (p. 12–15) outlines the key contributions for each year and by each policy area for each partner. Exhibit D-4 in annex D outlines the accomplishments of each party. In reviewing this list, it appears that each partner has accomplished a great deal and that overall the HPSP has been generally successful. While there was a slow start-up period, which is not uncommon, once under way the program began to develop and implement components as originally outlined and to take advantage of new opportunities, for example, the Alexandria Pilot Projects. The first year (1996–1997) was spent planning (see Exhibit D-4), securing passage of all necessary regulations and developing benchmarks, and lining up the parties to do the work. This is the usual progression for most projects, with the first year devoted to planning activities. The second year (1998) began to bring accomplishments with the Montazah Facility Survey, the budget tracking system, costing of the BBP, and the selection of 25 hospitals to be involved with the hospital improvement program. The major accomplishments were in 1999, 2000, and 2001 with the Quality Improvement (QI) Survey, the Bed Needs Model, the Work Force Survey, capital asset planning, and, implementation of the hospital management systems in 40 selected hospitals (see Exhibit D-4).

The two biggest successes were: a) the Alexandria pilots, which operated with four distinct organization models (MOHP, NGO, HIO, and private), and the hospital management improvement program, which resulted in full implementation in 9 of the 40 hospitals identified; and b) the real location of PHC and FM funds that supported the implementation of an integrated basic services delivery model. Other areas were not as successful. For example, little appears to have been accomplished in the personnel policy area, with the exception of the manpower planning for PHC, and the Egyptian Board for Family Practice, which is a significant accomplishment.

Technical Assistance

Technical assistance to the Ministry of Health and Population (MOHP) and the Health Insurance Organization (HIO) under the HPSP has been provided principally by PHR and its specialized subcontractors. TA was provided partly to help meet benchmarks, but mainly to conduct operational studies and designs to develop the pilot model in service delivery and financing. TA has been concentrated in three areas to develop the Alexandria pilots: a) development of strategic information systems (see companion report on MIS); b) development of a comprehensive QI program, with an MOHP Quality Improvement Unit, facility accreditation program, clinical practice protocols, QI monitoring system, training, and operational research in QI; and c) design and

implementation assistance for developing a family health pilot primary care benefit package, with financing and insurance options.

PHR appears to have successfully met its objectives, with the exception of a slow start-up process and coming up short in completion of the information systems, costing, and financing aspects of the pilots, including the testing of financing options developed by PHR. There was also limited progress on expansion of social insurance. At least two factors appear to have contributed to this shortfall, and to some extent both lay outside of the direct control of the TA contractor. Difficulties establishing the requisite fully operational information systems played a major role and are discussed fully in the companion MIS Report.

On the whole, PHR produced studies that were responsive, timely, and of good quality. By all accounts, PHR's involvement with the studies and the discussion and dissemination workshops informed the design process and were excellent vehicles for building capacity among stakeholders. This TA approach has resonated well with counterparts and resulted in the intended learning and technology transfer. PHR's most lauded TA accomplishment is the QI development and transfer to a considerable number of institutions and individuals who have truly internalized and taken ownership of the QI perspective and approach. Indeed, the role of TA in HPSP has been somewhat akin to "the little Red Engine" that helped to motivate and drive the cars along — benchmarks, pilots, the TSO, the TST, other local organizations, and stakeholders. The stakeholders have taken ownership of the critical elements introduced through the TA process.

PHR technical assistance has also played a key role in technical donor coordination through close collaboration with the TSO. Some complaints were made that not enough TA was provided, and that there was insufficient level of effort available for TA. TA can only be effective if recipients have the time and capacity to absorb the assistance. An impression taken from interviews is that the TA mandate, like the benchmarks, were somewhat overambitious for the time frame, the limited human resources capacity in the MOHP, and the likely and competing need for more in-depth development of critical skills, such as Family Health Fund administrative management capacities. There clearly is a strong need and mandate for continuing assistance. However, future TA should take into account absorptive capacity and be more effectively adapted to recipient needs rather than to predetermined deliverables. On balance, the TA has been by far the most effective contribution under HPSP.

C. DONOR COORDINATION

One assessment question is: "Describe the nature and extent of the coordination between donors: World Bank, European Union, and USAID. Was this coordination effective? Why or why not?"

The short answer is that coordination among the "Big Three" (WB, EU, and USAID) and with the MOHP has been uneven and evolving. It has also been operating on distinct levels and seemingly in distinct cycles of cooperation and mutual understanding.

However, judging from the current status of the reform program, the overall sense is that coordination has been surprisingly effective around the HPSP policy reform issues, and for the PHR development of the basic Alexandria FHU model with the BBP and the FHF. Perhaps the key lessons learned thus far is that unlike in past eras, donor coordination is no longer an issue of donors working in tandem, but rather in tandem with the MOHP. As the TSO at the national level with its governorate-level TST has become the key mechanism for orchestrating health sector reform, it has become increasingly assertive in bringing together donors on both the policy and operational issues. Over the past four years, each donor has had to align its strategies to the evolving plan of the MOHP, and redefine its relationships with other donors in a fluid and changeable context.

Several factors and structures have affected the nature of donor coordination over the past several years. To draw guidance for future strategies, consideration of the following observations is useful:

- On the macro level, the absence of a *common conceptual framework* is hindering improved coordination. This framework must reflect the MOHP's strategy, but be more selective and operational. The European Commission (EC) attempted to provide a logframe for donor coordination.

- *Internal donor coordination* of projects into one coherent program that fits the MOHP thrust will make coordination with the MOHP and other donors easier. While USAID has made progress here, and it could strengthen its internal coordination.

- Since 1997 USAID and other key donors have participated at different levels through *executive and technical donor groups:* e.g., the donor forum, a donor consortium, sector task forces, and monthly meetings with MOHP. These mechanisms have had varied effectiveness depending on leadership, and participation and agenda issues at the time.

- Under the HPSP, USAID's *technical assistance contractors* on the operational level and the ECTAT have been effective mechanisms for continuous and consistent operational coordination. PHR is recognized almost unanimously for this role on behalf of USAID.

- Each key donor has experienced *internal administrative challenges,* some measure of organizational and/or modification of program strategy or lengthy approval process that has impeded its ability to make timely commitments or obtain approvals necessary for effective coordination. When the donor has gone "on hold," the coordination process has been interrupted. These challenges appear to be one reason for the coordination "cycles."

Though key donors have largely complementary areas of interest and division of labor, there is some overlap. WB's credit program, though flexible and open to opportunity, concentrates principally on infrastructure development, while the EC of the European

Union (EU) focuses more on human resources development. Yet there are also lesser areas of distinct overlap that necessitate increasingly closer cooperation. For example, WB and EC are both developing plans for the replication and expansion of the USAID-developed Alexandria pilots. EC and WB are now waiting and watching for the completion of the PHR Alexandria model, while they are planning next steps in the development, expansion, and adaptation of this Alexandria model, including to other governorates. EC and WB focus on Menoufiya and Sohag, sharing Alexandria governorate activities with USAID. It appears that the issue is less one of coordination to avoid duplication of effort, but rather of strengthening coordination for speedier and more effective resolution of blockages, for example, MIS issues (see companion MIS Report).

Given the complexity of the many next steps in the development of the FHF and the insurance mechanisms for the integrated FH primary health care model, it is critical that mechanisms to enhance coordination among donors and MOHP are put in place. For example, currently all three donors are engaged in designs or extension of future health reform assistance packages. Yet, it is unclear who will develop and capitalize the related governorate health funds. It may become advisable to have joint MOU agreements among donors and MOHP on strategy, policy, and divisions of labor on specific activities. Though USAID's relationship with Egypt is based on bilateral agreements, in a time of shrinking resources and phase-down planning, USAID has an opportunity to find the means to lead a new generation of interdonor agreements in critical multisector policy and financing areas. This increased communication and information flow would be helpful.

D. EXISTING POLICY MANDATE AND AGENDA

To discuss each question, we refer to the policy matrix for each of the four Tranches (see Exhibit D-3 in annex D). The five original areas are listed below and the sixth added in year 2 are all discussed under each of the policy issues.

1. Strengthen the role of the MOHP in providing and financing Preventive Medicine (PM) and Primary Health Care (PHC)

This policy area remains the international leader for most health sector reform projects. Beginning with the Alma Ata Conference in 1978, PHC and an inclusive FM approach remain the "reform of choice" for most developing countries. As globally recognized in professional circles and validated by numerous studies, such as the World Bank's famous 1993 World Development Report "Investing in Health," the cost-effectiveness potential of PHC and FM (including FP and preventive measures) has proven to be the most effective and sustainable intervention that most developing countries can afford. Egypt's health sector reform strategy is informed and solid: PHC/FM is the best possible health investment for Egypt over the long term. There has been significant progress in this area, especially in the development and implementation of the Alexandria Pilots, the FHF, and the relatively large MOF additional allocation for the FHF. There appears to be also documented increases in spending for PHC/FM. In the Egyptian context, the most important issue remains the reallocation of resources from secondary care to primary care

and preventive activities and programs. This appears to be happening. The implementing organizations (MOHP, the TSO/TST) appear to have developed mechanisms to coordinate effective reform and now are including more of the MOHP organizational units and line departments, and in Alexandria have limited NGO and private clinic participation.

2. Rationalize the role of the MOHP in providing and financing curative care

This policy area remains the second most important intervention internationally for health sector reform. The continuing high cost of secondary and tertiary care services and financing continues to be the major drain on the health budgets of almost all developing countries. Egypt's very limited health resources, like many other countries, are not allocated cost effectively. Egypt still sustains too much hospital infrastructure and bed capacity and supports too many physicians, to the exclusion of well-trained nurses and other key health personnel. It also relies excessively on costly hospital-based curative care, which, even when appropriate, serves a relatively small proportion of the population. This area of health sector reform continues as the key policy area for targeted reform interventions over the long term. From the material reviewed, it is clear that the benchmark targets have been verified, and that the construction of new hospitals has been constrained. As highlighted above, in the Egyptian context, it is important that the reallocation of resources from secondary care should remain a long-term strategy. There have been successes in the decentralization and the quality improvement process for hospitals and this should continue to be an element of continuing reform. The MOHP and the TSO/TST appear to have coordinated the necessary mechanisms to implement reform in the selected pilot hospitals.

3. Reform the MOHP Personnel Policy

The cost of personnel remains the single biggest cost in health care service delivery, often making up 60–80 percent of total costs. Hospitals are personnel intensive. The civil service policies and the centralization of most activities are a serious burden to improving personnel productivity and performance. The MOHP has made some progress in this area with the development and implementation of the performance incentive program, work force standards, staffing norms and planning criteria, as well as the FM specialty board designation. Personnel productivity and personnel systems reform in the MOHP has and should remain a high priority. It is difficult for the MOHP to make progress in this area as long as their control is limited, due to the wider interministerial issues. Consequently, it is possible that given wider coordination among the key donors, some type of interministerial incentives might be developed to bring about real change in staff planning and human resources management. It appears that the MOHP has coordinated implementation in the pilot areas.

4. Develop the MOHP role in regulation and accreditation and its capacity for national health strategic planning, policy analysis, and management

This area of policy reform has the potential to take Egypt from a developing to a developed country in health care quality improvement systems. Improving management activities has been a priority under HPSP, and some progress has been made in a number of areas, including Information Systems (IS), and EIS (see MIS report), as well as the development of regulations and new policies and procedures in this area (see Exhibit D-3). The Master Plans at the District and Governorate level are a major step in this area. The introduction of accreditation into hospitals and PHC is a developed-country intervention and shows the tremendous progress Egypt has made in this quality improvement area. The key element is the effective and efficient management process of producing a return on the investment in PHC as it relates to reducing curative care expenses. This should remain an important area and should be included in future planning for health sector reform in Egypt. It appears that the MOHP through TSO/TST has worked to begin implementation of these interventions in the pilot governorates and districts.

5. Ensure the viability of the HIO as the instrument for social insurance expansion

Development of the HIO to establish its new role under health reform is a multilevel and complex undertaking leading to the full transformation of the existing organization into a contracting and payment institution integrated with the FHF. Separation of purchaser from provider is a critical next step for Egypt and the pilot experiment should continue as a long-term policy reform area. The assistance to the HIO has been a priority under HPSP and the development of the Alexandria model and the FHF (with separation of provider and purchaser) is a good example of the progress that has been made. PHR's Year 2000 Activity Plan for this benchmark addressed strengthening FHF operational systems and management to establish performance-based contracting with FH providers. Information system development has also been a priority and much has been implemented, but the job is not completed and needs additional modifications (see MIS report). HIO MIS has been expanded to Upper Egypt; policies, procedures, and support systems for performance-based contracting have been implemented with the Alexandria pilot. Options and recommendations for financing the services of an urban pilot model, using preliminary cost and utilization data, were developed under PHR but have not been tested. One issue with respect to the options has been the use of estimates in place of actual data. For example, interviews suggested a considerable range of estimates for the actual cost of a patient visit in the pilot. Until actual costing becomes possible, testing options may not be efficient. The highest priority next steps in the pilot are the finalization of the information system necessary to develop the costing, actuarial, and financial systems by the FHF. Continued strengthening of the fund's technical and managerial resources is equally important, as the FHF is seriously stretched at this time, in part due to loss of trained accounting and other technical staff. Perhaps an early integration of HIO expertise into the fund would be prudent. After an evaluation and a critical review of the BBP, its affordability in Alexandria governorate and nationally should be studied. Similarly, strengthening and evaluation of the FHF model are priority

steps for planned replication of the FHF. The new insurance legislation, if adopted (and the change of HIO to provider status), will have a significant impact in this area and could play a major role in future reform efforts. Under the past and present environment, this reform area has been and is still a high priority. It appears that the HIO has worked effectively to implement the model and coordinated with the respective institutions in the pilot area.

6. *Expand social health insurance coverage coupled with adequate administrative and financing mechanisms*

In part of the original Results Package, this policy area is intended to expand the social health insurance to cover more target groups in underserved areas and the most needy groups through additional available models to deliver integrated family care. Significant efforts have gone into this, first with the development of a new BBP under the Alexandria model and second with the addition of models for contracting NGO and private services providers. These new provider contract models had been scheduled for performance evaluation in PHR's year 2000 work plan, but they are behind schedule. Because recruitment of an NGO and a suitable private provider to participate with the government took the TSO longer than anticipated, the contracts were in their early infancy at the time of the assessment. The challenge will be to make the pilot FHCs economically viable, combining financial resources in a manner that will permit coverage for currently noninsured, nonpoor, and poor populations. PHR has proposed short-term and long-term financing options with provisional set estimated cost distributions for all the models based on Seuf Center. Proposed financing seeks to capture and combine revenues from MOHP, HIO, household contributions, and a variety of MOHP subsidies and resources for school health, pensioners, and various laws. Experience and data from the NGO and private models will help refine basic services costing and financing models. Whether the favored options among the groupings selected by expert TA are suitable could not be judged by this assessment and provides an additional rationale in favor of an evaluation of the Alexandria Pilot.

This should remain a priority health sector reform area. The new insurance law may present the framework for success in this area. The MOHP, through the TSO/TST and the HIO, appears to be coordinating action in the various pilot facilities and institutions.

IV. KEY OPERATIONAL ISSUES

A. INSTITUTIONALIZATION AND CAPACITY BUILDING

Looking back over two decades, the single greatest change observed by consultants working in Egypt on the Health Policy Support Program (HPSP) has been the transition among counterparts to the language of "management," and by all appearances, to practicing and institutionalizing management concepts. During visits to the four Primary Health Care (PHC)/Family Medicine (FM) units and centers and the two hospitals, Egyptian executives and managers were observed talking about "management" as one would hear it in many developed countries. Counterparts are using management terms such as staffing standards, stakeholders, IEC, transparency, community involvement, management by objectives, action plans, policies and procedures, vision, gatekeeper, teamwork, quality improvement, and income.

Today, supervisors and managers in the pilot hospitals and Family Health Units (FHU)/ Family Health Centers (FHCs) use these terms and discuss planning, organizing, staffing, directing, and controlling on a day-to-day basis. And if they are discussing management, they must be practicing the capacity building and initiating and managing change that management embodies. This was obvious from observations at all the pilot sites, and there was clear evidence these concepts have been institutionalized. The continued focus on management development and human resources management should remain a high priority in all future program design.

It is difficult to say which institutions have made the most progress from observations over a 3-week period. However, looking at the FHC/FHU's pilot sites, it is apparent that the PHC institutions have made much progress in this area over the life of the project. Family Medicine and Preventive Medicine, and the vision of PHC, are accepted and institutionalized in the pilots. The two brief hospital visits also showed that the hospitals appear to believe in and support FM/PM/PHC concepts and methods. Although it cannot be stated that each specialist believes in "general" or "family medicine," it is clear that the hospital leadership is expressing support for the vision of PHC and Family Health.

USAID has long history of support to hospitals in Egypt. Under the Cost Recovery Project and with HPSP, Egyptian hospitals have had resources over the last 10 years to improve management and facilities at some hospitals. Most other countries have neglected the hospital sector since the Alma Ata Conference in 1978 and during the era of PHC implementation. It is refreshing to see that Egypt has not made that mistake, and that selected hospitals have improved over the last 10–20 years. During the consultants' visit to two pilot facilities (one general hospital and one Centre of Excellence), hospitals were observed practicing management principles and demonstrating that decentralization is a living, breathing, successful development and implementation intervention in

Egyptian hospitals. As in other countries, Egypt is validating the concept of having a Board of Trustees, a quality improvement change that even five years ago was not very evident. The 40 or so pilot facilities, with programs fully implemented in only 9, appear to be making much progress in institutionalizing management, capacity building, and initiating and managing change.

In spite of the achievements in both the PHC and the hospital sectors with capacity building and initiating change, much remains to be done, especially in bringing more hospitals into the improvement process. Egypt has 700 hospitals, with 262 hospitals having more than 300 beds and 226 being general hospitals. With only 9 hospitals fully implemented over the 5-year program period, it will take many decades to expand the hospital improvement process to all of the hospitals in Egypt. The work of decentralization must become more of a reality, especially at the district level.

B. REPLICATION AND SUSTAINABILITY OF EXISTING PROGRAMS: THE PILOTS

The issue of replication and sustainability of existing programs is a difficult one. The international experience and history of sustainability of pilot activities once they move into the real world is not a good one. Once funding is reduced or eliminated, many pilot projects fall back to their original condition, and many fail altogether. This is due to a number of factors, including the tendency to "over-design" pilots, bring in the best people, work in the best facilities, and put in too many resources including over-building information systems, benefit packages, and equipping and renovating facilities to standards that cannot be sustained once funding is reduced. This does not mean that all pilot activities are negative, but only that it is important to realize that pilots are not the real world. Consequently, projects must prepare for the difficulties of "rolling out," or trying to apply all of the model concepts in a varying economic environment.

The political reality of universal coverage and expanding the pilot model to larger areas of the country will be challenging. Large quantities of TA will be needed to help counterparts in the continuing process of implementing quality improvements along with cost-effective delivery. It is essential that the pilot model be adapted; indeed, there are and will be many efficacious models developed. There is no one best model, and variations will need to be developed to meet local needs. This is the essence of decentralization.

PHC is meant to be a cost-effective solution to improving health status, and it must be kept low cost/high quality if it is to be an effective intervention. The subsections below review the sustainability issues for both the PHC and the hospital sectors.

Family Medicine/Family Health Units/Family Health Fund

The Alexandria Pilot includes the establishment of PHC services provided by a Family Medicine physician in an FHC/FHU environment, and funded by a Family Health Fund (FHF). This pilot is innovative and well designed. The concept of PHC and Family

Medicine/Family Health are well established in many countries. HPSP has made great strides in getting FM accepted and established as an Egyptian medical specialty with its own board. The FHF is also an innovative program, and separates purchaser from provider, which is a critical element in design of effective payment systems for primary care. The implementation of the one model in four different organizational environments — (Ministry of Health and Population [MOHP], Health Insurance Organization [HIO], nongovernmental organization [NGO], and private) — is an excellent intervention assisted with HPSP resources. All parties involved should be commended for the development and implementation of this innovative program.

The long-term replication and sustainability of the model in different environments is a complex issue. The program has had large inputs of excellent Technical Assistance (TA) from a number of sources. The staff is highly motivated, believes in the vision of the reform, and feels strong ownership of the program. While it is still early in the implementation process and the NGO and private clinics are just getting started, it is clear that the pilots will be successful. However, as noted above, pilots are not the real world, and this pilot has some of the characteristics of other pilots in other countries.

Following are the sustainability issues that should be reviewed in light of a possible roll out to the entire country:

- A thorough evaluation of the entire pilot has not been performed and needs to be done once the pilot is fully operational.
- The costing, actuarial probabilities, and financial viability of the FHF needs to be evaluated.
- The BBP is a "rich" one in that it covers almost all categories for everything, which may make it unsustainable in the real world.
- The Information System design is excellent but resource intensive and may not be able to be reproduced cost effectively.
- The renovated facilities and excellent equipment are expensive and may not be able to be reproduced in other resource-poor areas of the country, especially rural areas.
- The issue of reduced referral to secondary care needs to be rigorously evaluated to validate the economic model of more cost-effective PHC reducing expensive secondary care.

While the PHC pilot project in Alexandria is a good start, it is fragile and some of the systems, in particular in information systems/information technology (IS/IT), are unfinished and need to be completed in the next stage. The pilot, including the FHF model and design need to be evaluated thoroughly before proceeding to the next stage or to consideration of a roll out. The FHF is still in its infancy, is under capitalized, and

financial and information systems are not well developed. The actuarial probabilities need to be completed, including a full costing of the entire project. Because the BBP appears "over designed" and expensive (relative to other countries, in the consultants' opinions), it remains unclear whether the economics of cost-effective PHC can be justified (see following paragraph).

The start of a new program provides a unique opportunity to institute a formal evaluation process. The concept of cost-effective PHC is well known but not well documented in experience. The economics of PHC are predicated on the reduction of unnecessary referrals to the curative-care secondary and tertiary levels. This means that resources spent on PHC/PM have a return on investment (ROI) at the curative-care level. To the consultants' knowledge, this ROI has never been well documented. The new program, with continuing assistance to the Alexandria pilots, is an excellent opportunity to put in place a formal evaluation process. This might include a reliable database of pre and post change behavior (costs, referrals, incentives, etc.), which may be able to document the cost effectiveness of PHC, the changes in referral patterns, the reduction in curative care costs, as well as other indicators of the pilot's success or failure. This formal evaluation could also include or exclude the FHF economics behavior, and the PHC-hospital relationship at the first referral level. Incorporating this into the new program would help validate the PHC concept, provide a valuable contribution to the literature, and position Egypt as a leader in verifying the economics of health reform interventions.

Hospital Sector

The hospital pilots appear to be well designed and implemented thus far. The general hospital (Abu Qir) visited by the consultants was well managed, decentralized, improving facilities and services, and has demonstrated quality improvement success, especially in infection control. The vision appears institutionalized and sustainable in the pilot facilities. However, the pilots have only begun to scratch the surface. Egypt has 700 hospitals, with 262 facilities above 300 beds, yet only 9 pilot hospitals of 40 selected have been fully implemented in 5 years. The pilot improvement programs are excellent and need to be expanded to as many hospitals as possible in the future.

The relationship between hospitals and PHC will need ongoing attention, along with the design of effective referral systems. PHC will be cost effective only if the number unnecessary referrals is reduced and the problem of self-referral is eliminated. This area will need TA to ensure that effective systems, incentives, and disincentives are developed and implemented.

The National Level: MOHP, HIO, TSO, TST

The relationships among the staff visited and their effectiveness in carrying out their missions appeared to be excellent. The Technical Support Office (TSO) and Technical Support Team (TST), and HIO facilities and organizations visited by the consultants were staffed by hard-working, effective management groups that support change and give advice and guidance to the line MOHP facilities. Given the few short visits conducted to these facilities, it is not possible to accurately predict whether the pilots can be sustained

or whether they can be fully integrated into the whole MOHP and among stakeholders. However, in both the hospitals and PHC/FHUs, all parties were working together effectively and the HPSP-designed interventions were being effectively communicated and institutionalized.

The District Level

The Health Sector Policy Team had the opportunity to visit one district-level general hospital participating in the reform, but has not been able to form a full perspective on the range of organizational, clinical, technical, and managerial challenges that come together at this level in the PHC services, and in the interface between PHC and the first and second levels of referral. Given that the district level is the anchor for the implementation of all ongoing health activities in Egypt, critical integration of related but vertical program structures and systems is effected here. Egypt is committed to this concept and steps are being taken to improve this area.

The element of decentralization is not well developed in Egypt and will need significant TA inputs to get it right. The integration of family planning and maternal and child health is perhaps the biggest challenge because of duplication of distinct services programs with reproductive health services. To integrate services in line with FH protocols, standards, and staffing patterns, some staffing and functions will need to be reallocated. Other areas will require discussion and consensus, including effective integration of other vertical health programs, public health services, critical management systems at this level, and the issue of referral systems.

Given the importance of the district-level health system, as documented in such World Health Organization publications as *PHC and Hospitals at the First Referral Level (1987*), its development into an effective health system is an important priority.

V. POLICY ISSUES AND RECOMMENDATIONS

A. CONTINUING POLICY AGENDA

The objective of this assessment was to review and document past activities under the Health Policy Support Program (HPSP). The consultants were instructed not to spend much time on future possibilities because USAID has a group working on the new design. Therefore, the section that follows is limited in scope. A review of the Health Policy Reform Agenda under HPSP is presented under findings in section III (D) of this report and need not be repeated here. In line with these findings, the two major policy reform areas — Primary Health Care (PHC) and hospitals — should remain a top priority for future programs.

HPSP has demonstrated a relatively successful approach to modification and development of policies conducive to sector reform measures. Given the government of Egypt's (GOE) strong commitment to improving equity in access to basic health services through a rapid expansion of the PHC model**,** it is important that policy incentives in the short-term should assist and facilitate this mandate.

At the same time, USAID and other donors should maintain a view to the more complex, long-term macro policy issues. These issues comprise a long-term health sector policy agenda that will require interministerial collaborations and consensus development at the highest levels. For example, the human resources matter of physicians includes production and training, but must also become part of a larger health sector human resource rationalization and development plan.

Issues such as production of physicians and nursing cadres, modification of their basic training, qualification and licensing issues, and redistribution all reach far beyond the authority of the Ministry of Health and Population (MOHP). They pertain principally to the Ministry of Higher Education but also involve the Personnel/Civil Service Administration as well as possibly the Ministries of Planning and Finance and other powerful stakeholder groups such as the Medical Syndicate. First steps toward long-term rationalization of the production of physicians have already been taken through the requirements for Primary Health Care (PHC) and Family Practice/Medicine. Interim policy assistance should encourage incremental personnel changes and upgrades, especially nurses and district administrative personnel. These may go far in paving the way for later and more comprehensive human resources development changes.

For the foreseeable future, MOHP and donor partners will continue to raise national policy issues that are also crossministerial, including the following:

1. National Health Accounts (NHA) must include such ministries as Interior and Armed Forces and cannot be obtained from the MOHP, but most likely would involve the Cabinet.

2. Social health insurance for personal health services care, and financing of public health care (e.g., water and sanitation, disease surveillance, environmental modification, food, etc.) and pharmaceuticals are major long-term global policy issues that involve other ministries, powerful constituencies, and direct stakeholder groups. It is not advisable to turn them into MOHP cash transfer "deliverables."

3. Privatization issues also pose complex and far-reaching societal debates beyond the MOHP, yet dispensations for small experimental programs such as work with NGOs can pave the way for later national privatization policy exceptions.

4. Successful demonstrations of expansion, financing, and payments through the FHF and parallel intermediaries in other governorates can help prepare for the national approaches.

5. Decentralization and devolution issues.

6. Economic rationalization of the health sector by levels of care are policy areas that will eventually flow from the expansion of PHC and are best addressed incrementally at the current stage of sector reform.

Based on these examples, the assessment suggests that USAID assistance should be focused on interim policy issues that would support implementation of modest but important reforms, such as the demonstrated replication of a completed Alexandria PHC/Family Health (FH) model. A gradual approach, arising through successful demonstrations of PHC expansion, is likely to achieve greater success.

B. OTHER ISSUES AND THE D-4 DOCUMENT

Egypt, like many countries, is courageously but slowly charting its own path toward health reform. This road is always painful and requires sacrifice. However, it is worth reviewing health reform issues and experiences from other developing countries to see what can be learned.

Exhibit D-1 in annex D presents a list of components and subcomponents of health system strengthening in developing countries. This exhibit was developed for another USAID project and presents many interventions that have proven successful in other developing or transitional economies (former Soviet Union countries). In reviewing this list in the Egyptian context, and using the D-4 document (Egypt Health Sector Reform Program, December 1997), the following components or subcomponents stand out as questions to be reconsidered in developing the new program.

<u>Health Sector Reform Strategy</u>

Are the vision and goals of health reform institutionalized, or are they known only to the minister, the Technical Support Office (TSO), and other selected groups?

Devolution

The D-4 document makes no mention of this intervention strategy. Is the continued centralization of most policy and management functions an effective strategy for Egypt in the long term? Why is devolution not discussed as a possible intervention?

Health Sector Human Resources/Health Services Delivery

There is only one mention of decentralization in the D-4 document, at page 147 under Health Service Delivery. We are told the minister has informally stated that this will be a reality at the governorate level in 5 years and the district level in the next 10 years. If so, why is this strategy not formalized with respective action plans, deadlines, and follow-up activities?

PHC/Basic Health Care Services

A major goal is the provision of an affordable and cost-effective package of health services based on PHC. If this is the goal, is the population being educated about the importance and efficacy of PM and PHC?

Family Health Approach

It is clearly stated that organization of public and private service delivery is centered around holistic family medicine; however, is it possible to educate and clinically train a large quantity of FM physicians over 5–10 years with existing education and clinical training programs?

Cost-Effective Basic Benefits Package And Out-Of-Pocket Expenditures

Is the pilot BBP affordable on a national level, and is the FHF actuarially sound with its present design? Are copayments and out-of-pocket fees increasing to discourage over utilization of services (as in other countries)? Is the new health law, as written, truly designed to separate purchaser and provider and develop real competition in health care delivery?

Information Systems

There appears to be no mention of Information Systems/Information Technology (IS/IT) in the D-4 document. Is the necessary interministerial cooperation available to implement the needed national interventions (e.g., National Health Accounts [NHA])? Are all the various MIS/IS/IT systems being used for management and decision-making?

Rationalization

Is the continued overproduction/oversupply of physicians really a problem that cannot be solved or addressed by donors? While it is mentioned as an intervention strategy in the D-4, there appears to be no formal plan to coordinate activities between the various ministries to try to make this a reality.

Privatization

The D-4 does not specifically mention privatization as an intervention strategy, but does discuss competition on page 152. Is the privatization (or denationalization) of some government health facilities or health-related institutions not a viable reform strategy in the long term? Can the HIO and CCOs only compete with the MOHP if they become truly autonomous of the government of Egypt (GOE)? Has the pharmaceutical system been privatized fully or is it still partially a GOE institution?

NGO Development

The D-4 document does not appear to discuss the role of NGOs either as providers or as professional organizations. If NGO involvement in the health sector has been effective in other countries (e.g., services, education, certification, policy input), could it not become an effective intervention in Egypt?

These are only a few of many questions that might be considered in discussing possible issues and interventions in the new program, and are for discussion purposes only and not recommendations.

C. RECOMMENDATIONS

Given that the objectives of this assessment were to review prior accomplishments, successes, and failures, our recommendations in this section grow out of the retrospective analysis documented in this report.

1. The MOHP, with donor assistance, should continue developing and implementing effective PHC/PM systems with family health services as the main component and care delivered in FHC/FHUs. The Alexandria Pilot and the Family Health Fund (FHF) Pilot design and implementation should be completed, especially work on the information, actuarial, financial, and costing systems. A thorough evaluation of the Alexandria pilots should be completed before consideration is given to rolling out the pilot FM model concept to the rest of the country.

2. In the integration of parallel existing Maternal and Child Health (MCH) services, family planning, reproductive health programs, and services into a standardized family health approach, the MOHP and donors should seek to maintain and expand progressive service elements, quality standards, and patient access to reproductive health services that have been developed through large donor

investments. Of particular importance is ensuring continuity of services and access through a responsive FH/FM referral system.

3. The MOHP, with donor assistance, should continue to rationalize and improve the quality of management and service delivery at the secondary and tertiary curative care levels. The decentralization process, including the full implementation of the Board of Trustees concept in all MOHP/Health Insurance Organization (HIO)/Cairo Curative Organization (CCO) hospitals, should become a major implementation intervention in the new program design.

4. If the new health insurance legislation is enacted, financing options should be explored and implemented with donor assistance to ensure that purchaser and provider are truly separate, that the new organization is autonomous, and that real competition in the delivery of health care services results.

5. The verification process in the Development Support Program (Cash Transfer) needs to become less time consuming and paperwork-intensive. Fewer benchmarks should be considered with fewer verification items. One way to make them less burdensome would be to make the benchmarks multiyear as well as covering the entire program time frame.

6. USAID should seize the leadership opportunity to improve donor coordination, with development of a Donor Master Plan and Framework, with increased levels of communication and understanding of each other's agenda, resources, goals, and objectives.

7. The balance between long-term national policy and short-term implementation-related policy incentives should favor the latter. USAID should take the opportunity to initiate joint donor policy initiatives for interministerial policy areas.

ANNEXES

ANNEX A

SCOPE OF WORK

Health Policy Assessment Statement of Work

BACKGROUND

The Health Policy Sector Program (HPSP) is a USAID/government of Egypt collaborative effort designed to advance a health sector policy agenda as well as to enhance indigenous capacity to carry out significant health sector policy reforms during a five year period from 1997-2001. This Program began as part of the USAID/Egypt strategic objective 5 (SO5) "Sustainable Improvements in the Health of Women and Children", Intermediate Result 5.3 (IR 5.3) "Improved Environment to Plan, Manage, and Finance Sustained Maternal and Child Health Systems." The overall indicator for this component (IR 5.3) is "Percent of Ministry of Health and Population (MOHP) funding allocated for primary and preventive services."

The European Community and the World Bank have also been closely involved in the health reform program.

USAID/Egypt's recently approved Strategic Plan (2000-2009) calls for a final ten-year phase of assistance to the Population and Health (PH) sector. The Plan brings together in one objective what was previously two distinct PH strategic objectives - "Strategic Objective 20", Healthier, Planned Families" - with three complimentary Intermediate Results: (1) increased use of family planning, reproductive health and maternal and child health services by target population; (2) healthy behaviors adopted; and (3) sustainability of basic health services promoted. A Transition Plan for the 1999-2009 strategy period to be developed over the ensuing months will define the program parameters, technical content, funding, and management arrangements for this final phase of assistance.

Part of Strategic Objective 20 strategy is to conduct technical assessments of its major existing results package activities to determine the "bridging" activities and mechanisms that will align them with the new strategic objective. HPSP is one of the results packages to be assessed. The team shall assess the HPSP results package.

DOCUMENTS TO REVIEW

Prior to arrival to Cairo, the team shall review the following list of documents:

1. Tranche II Progress Report
2. HPSP Results Package
3. USAID/Egypt R4 for year 2000
4. Strategic Objective 20
5. Strategic Objectives 4 & 5
6. MAXIMUS statement of work
7. PHR/Abt Associates, Inc. statement of work
8. PHR Country Activity Plans
9. Policy Matrix and End of Project Status (EOPS)

10. Barents Reports on Private Health Insurance
11. PHR Special Reports
12. Sustainability Options for USAID/Egypt's Health and Population Program, Knowles, et al

KEY QUESTIONS TO BE ANSWERED

The Results Package (USAID/Egypt, 1996) states:

"The result to be achieved under HPSP is an improved environment to plan, manage and finance sustained maternal and child health systems". (P.2)

"Health sector policy must establish the protection of maternal and child health as a priority, assign the resources to accomplish this objective, and capably manage the processes required to ensure an impact. The results package will strengthen the capacity for strategic planning and policy development and will bring about policy reforms that ensure the financial viability of preventive and maternal and child health programs, define the role of the MOHP in health sector regulation and quality assurance, rationalize personnel policy, and develop a sound social health insurance system suitable for expansion (pp. 2-3)."

The assessment team shall provide answers to the following key questions:

Against this ambitious agenda, how much did the MOHP and its partners under the Results Package actually accomplish? What were the major policy successes, failures? Lessons learned from failures? What can be improved?

Is the policy agenda developed under the HPSP still valid today and if so, what elements remain the appropriate focus of donor (USAID) assistance?

According to reports from the PHR/Abt contractors, top-down and bottom-up approaches were utilized in carrying out health sector reform activities. For example, the Development Support Program (DSP) cash transfer program of USAID rewards the government of Egypt (GOE) for, among other actions, the adoption of laws, decrees and directives expanding national health insurance coverage for women and children, establishing guiding committees and so on – all characteristic of change from the top. On the other hand, a great deal of contractor effort and USAID resources went into development of pilot centers – providing family based care (at Abu Qir and Seuf) or automated patient billing and record keeping (Health Insurance Organization [HIO]) to cite several examples. These were also part of the DSP cash transfer program. Has the effectiveness of either top-down or bottom up been better? Are both approaches still valid and recommended for any follow-on activities?

Are there broad policy issues and areas for further investigation that were not given sufficient emphasis under the HPSP and which should now be considered by USAID and the GOE in the development of a new policy reform program?

Analyze the current status of the HPSP goals, planned achievements and activities as stated in the SO5, HPSP Results Package under the technical support contracts of:

- PHR/Abt Associates, Inc.
- MAXIMUS

- Determine whether the implementing agencies and technical assistance contractors met the planned goals and objectives. Assess whether the planned goals and objectives were realistic in the given environment.

- Broad scoped health sector reform is a complex task, has the MOHP and its implementing organizations developed effective mechanisms to coordinate action needed for effective reform?

- How have the original assumptions and conditions established in the HPSP Results Package changed? How have these changes affected achievement of the original planned goals and objectives? What, if any, further adjustments are recommended?

- Assess the policy reforms achieved under the HPSP.

- Assess the mechanisms to institutionalize the interventions carried out through HPSP plans; for example, assess the integration of HPSP activities into MOHP and its affiliated organizations to attain sustainability and support for reform among various stakeholders.

- Has HPSP been successful in strengthening institutional capacity to initiate and manage change? Which institutions have made the most progress? What precluded the other institutions from achieving progress? Can these obstacles be removed?

- Describe the nature and extent of the coordination between donors: World Bank, European Union and USAID. Was this coordination effective? Why or why not?

OUTPUT

The team shall look at the objectives and planned outputs at various levels (results package, contract, work plan) for each component, the approach adopted, and the results obtained to date. A comparison shall be made between those activities originally planned for, and those activities actually carried out to date.

The expected outcome shall be a written report including a comprehensive analysis on the progress of the Health Sector Support Program (HPSP) and response to key questions and issues noted above. It shall also include concise and clear findings (as well as any recommendations (if any) to USAID) on how to improve results in the policy area. The report shall be final and complete when it is deemed acceptable to USAID/Egypt.

PLANNED SITE VISITS AND INTERVIEWS

The team shall travel to pilot sites in the Alexandria governorate and facilities in Cairo to observe and assess the activities of PHR.

Team Health's expected site visits are:

- Seuf Family Health Clinic
- Abu Qir Health Clinic
- Family Health Fund (FHF)/HIO
- Abu Qir General Hospital
- MOHP/Directorate of Planning

The team shall conduct interviews with:

- PHR Chief of Party/staff
- Key Technical Support Office personnel
- Technical Support Team Director at Alexandria
- Ministry Officials
- Directors of Seuf and Abu Qir Health Clinics
- Director General of Abu Qir General Hospital
- MOHP/Directorate of Planning Director General
- Director of HIO Alexandria branch and Director of the FHF
- Director of HIO MIS

TIME FRAME

The HPSP assessments will start in Cairo as soon as possible. Prior to convening in Egypt, the assessment team shall review key documents and reports provided in advance of travel to Cairo.

In conjunction with USAID/Egypt and PHR, the team shall develop an assessment schedule that includes a list of individuals to be interviewed and sites to be visited, meet with relevant partners in Cairo and be briefed by PHR.

One team of two persons will be contracted, for the HPSP assessments. A six-day workweek will be authorized for the two contractors while in Egypt. One of the contractors will work for an additional 5 days in the U.S. to finalize the two reports.

QUALIFICATIONS REQUIRED

The Health Policy Assessment Candidate will have the following qualifications:

The candidate shall:

- Have a minimum 10 years of experience in the design, implementation and evaluation of health policy programs.

- Proven track record of strong analytical and conceptual skills.
- Clear, strong, concise writing skills.
- Minimum 2-5 years international experience.
- Graduate degree in health policy or associated health.

It is desired that the candidate:

- Prior significant experience in health policy reform – in developing countries, particularly in the Middle East.
- Past experience and knowledge of USAID health policy activities (Egypt in particular).

Knowledge/experience with non-project assistance or cash transfer for policy change programs.

ANNEX B

PERSONS CONTACTED

Persons Contacted

Chris McDermott, Chief, Office of Population & Health, USAID/Egypt
Cheryl Robinson, Health Policy Advisor
Milly Howard, Senior Health Officer and Team Leader
Nancy Pielemeier, PHR Project Director, Abt Associates
Mary Patterson, Former COP, PHR-Egypt
Mellen Tanamly, former USAID Health Officer
Dr. Sameh E. El Gayar, USAID Senior Health Policy Advisor
Dr. Bassyouni Zaki, Executive Director
Dr. Emad Ezzat, Technical Coordinator
Dr. Adbel Aziz El Shoubary, Qir Unit, TSO
Eng. Sami Gad, CCIG, TSO
Dr. Alaa Ghanaam, HIO, TSO
Dr. Magdi Bakr, MIS, TSO
Dr. Badr El Masri, M&E, TSO
Dr. Esmat Mansour, Undersecretary for Basic Health Care
Dr. Leila Soliman, Director General, Rural Health Directorate and Family Medicine
Dr. Azza El Husseiny, undersecretary for Training and Human Resources Development
Dr. Maher Abdel Gawad, Undersecretary for Curative Care
Dr. Ibrahim Sahleh, Director General, Directorate of Planning
Dr. Mahdeya Aly, TSO Directorate in Alexandria
Dr. Hanem El Abbassy, Health Clinics Director of Seuf
Dr. Ali Abou El Nasr, Director of Abu Qir Clinic (HIO)
Dr. Mahmoud El Damati, DG of Abu Qir General Hospital
Dr. Hazem Helmy, Director of HIO Alexandria
Dr. Salwa El Siwy, Director of HIO MIS
Dr. Sami Shehab, HIO Family Health Fund
Dr. Reginald Gipson, COP, JSI
Ian Pett, Team Leader, ECTAT
Jane Coury, DHHS Project on Healthy Egyptians
Karin Fredrikzon, Secondary Secretary, Economic Affairs, European Union
Alaa Hamed, Senior Health Specialists, The World Bank
Lily Kak, Senior Technical Advisor, Population Leadership Program, USAID
Maureen H. Norton, Senior Technical Advisor, TAACS, USAID
Peter Connell, Development Business Associates

ANNEX C

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- PHC Accreditation Program: Policies and Procedures Manual.
- Accreditation Standards Assessment Monitoring System Tutorial.
- Tutorial: Beds Needs Model.
- Policy Simulation of Inpatient Bed Needs.
- Capitals Project Clearinghouse: a tool for tracking and prioritizing the flow of candidate projects.
- Accreditation Program Support Tool.
- PHR Egypt Consultant Trip Reports.
- Family Planning Personnel Management System.

ANNEX D

EXHIBITS

Exhibit D-1. Key Components And Subcomponents Of Health Sector Strengthening In Developing Countries

Components And Subcomponents
1. Vision ▪ National health care plan (written) document ▪ Health systems model ideal outlined and disseminated ▪ Institutionalized at all levels
2. Devolution ▪ Power, authority, and responsibility transferred to the regions ▪ Assets, liabilities, finances, and personnel transferred to the regions
3. Decentralization ▪ Centralization and command/control systems are reduced ▪ Responsibility and authority transferred to lower levels ▪ Personnel management and spending transferred to lower levels ▪ Process implemented in all regions and at all levels
4. Restructuring Health System For Primary Care ▪ Prevention and promotion including environment health (air, water, waste) programs become priority ▪ Population education on new PHC system is implemented ▪ Secondary and tertiary care are restructured and downsized
5. Family Medicine Development ▪ Family practice becomes a specialty and clinical and residency programs in FM begin ▪ Urban and rural models are developed for family medicine practice ▪ Facilities are renovated and Instrument and equipment are procured for family medicine ▪ Pharmaceuticals and ancillary services for PHC are improved ▪ Quality improvement programs are implemented ▪ Information systems for family health information established ▪ Family health nursing and other support personnel programs are initiated ▪ Business practices for FM are developed ▪ Vertical program integration into PHC begins ▪ Open enrollment/choice of doctor and competition among FM is implemented ▪ Patient and community satisfaction surveys are introduced
6. Alternative Payment Systems ▪ Basic benefits package defined and implemented ▪ Separation of purchaser from provider of services established ▪ Mandatory health Insurance programs are established or expanded and improved ▪ Capitation systems for primary care services are implemented ▪ Case-based systems with diagnostic groups for secondary /tertiary care are implemented ▪ Contacts between providers and patients/families implemented ▪ Fee for service/out-of-pocket/copayments at all levels introduced ▪ Salary incentives or bonuses for FM are introduced ▪ Punishments for self-referrals to specialists/hospitals established ▪ Independent health facility accreditation programs established

7. Information Systems
- Health information systems developed and Implemented
- Clinical/quality information systems developed and Implemented
- Accounting/financial information systems developed/implemented
- National health accounts implemented
- Accurate and timely reporting is implemented
- Education in the use of information systems implemented
- Data and Information utilized for decision-making

8. Rationalization/Optimization
- Pharmaceutical system is rationalized
- Group purchasing introduced at regional level
- Reduce beds and length of stays, one day surgery, day beds are implemented in hospitals
- Secondary and tertiary normatives are reviewed and revised
- Reductions, mergers and consolidations of facilities
- Reallocations of secondary/tertiary resources to primary care
- Retraining of hospital and narrow specialists to primary care
- Re-employment of excess medical personnel into other industries
- Reductions in graduates from medical schools in all specialties
- Licensing of professionals implemented
- Licensing of health facilities implemented

9. Privatization
- Private practice legislation implemented
- Pharmacy and drug retail outlets privatized
- Dental clinics and private dental practice privatized
- Legislation on privatization of health facilities implemented
- Rural facilities sold to physicians
- Individual and group practice develops
- Business training for private physicians is introduced

10. NGO Development
- Professional organizations of physicians and of nurses develop
- Health and medical organizations to assist with specific illnesses develop
- Organizations begin to develop education programs for professionals
- Organizations begin to assists with licensure requirements and professional standards
- Organizations begin to input into policy and planning process
- Organizations begin to develop education programs for population

Exhibit D-2. HPSP Results Package (Draft 8/4/96)

Reform Agenda	Reform Strategies	Expected Benchmarks Tranche 1 (97/98)
1.0 Rationalize the role of the MOHP in financing curative care	1.1 Stop the construction of unnecessary hospitals and set strict guideline to the completion of facilities under construction	▪ Freeze new hospital construction until criteria and guidelines are developed ▪ Completed a study on hospital assessment establishing criteria and guidelines for constructing new hospitals ▪ Mandate that all newly constructed hospitals operate under cost recovery
	1.2 Transfer existing hospitals to other parastatal organizations	▪ Establish two new DHOs in additional governorates ▪ Transfer MOHP hospitals to CHO in two governorates ▪ Transfer one MOHP hospital in each governance with CHO
	1.3 Expand cost recovery in government facilities	▪ Issue # decrees to convert # MOHP General Hospitals to Cost Recovery ▪ Allow private practitioners to use the MOHP facilities ▪ Examine the introduction of fee-for-service at the PHC level
	1.4 Support hospitals based on efficiency/equity indicators	▪ Tranche 2
2.0 Strengthen the role of the MOHP in the provision of and increased share of financing Preventive Medicine and Primary Health Care	2.1 Use cost effectiveness analysis to identify a package of PM and PHC services to be supported by MOHP to which every Egyptian is entitled	▪ Tranche 2
	2.2 Increase funding of MCH programs	▪ Include full cost of vaccines and cold chain maintenance in BAB II MoHP budget for FY 97/98
	2.3 Provide incentive for the health care providers to specialize in PM, PHC and Family Medicine and to serve in underserved and remote areas	▪ Tranche 2
3.0 Reform the MOHP Personnel policy	3.1 Eliminate Guaranteed employment 3.2 Develop guideline for MOHP personnel needed and apply to redistribute the personnel	
4.0 Develop the MOHP role in regulation and accreditation; and its capacity for national health strategic planning and policy analysis	4.1 Develop and adopt National Health Standards of Practice and health facility accreditation 4.2 Establish a policy of continued physician certification and CME 4.3 Adapt the national health information systems including GIS for planning and policy decision making	

Reform Agenda	Reform Strategies	Expected Benchmarks Tranche 1 (97/98)
	4.4 Develop a nuclear unit for economic and policy analysis	
5.0 Ensure the viability of the HIO	5.1 Do not add any new groups of beneficiaries to HIO 5.2 Eliminate the current HIO deficit 5.3 Reduce the proportion of the pharmaceutical costs 5.4 Unify the existing Health Insurance laws into one law 5.5 Change the HIO legal and legislative framework to ensure its autonomy 5.6 Develop premiums based on actual costs using co-payments and deductibles 5.7 Identify and adopt an affordable health benefit package	▪ Do not add any new group of beneficiaries to HIO until it is financially viable ▪ Adopt a phased plan to reduce the HIO deficit
6.0 Expand social health insurance coverage coupled with adequate administrative and financing mechanism	6.1 Transform the HIO into a financing or a service organization 6.2 Design and develop a plan for expanding national health insurance coverage 6.3 Develop a well defined minimum package of benefits under the national health insurance	▪ Tranche 2 ▪ Tranche 2 ▪ Tranche 2

Exhibit D-3
Policy Matrix For Each Of The Four Tranches

Tranche 1: 1998		
	Policy Areas	**Benchmarks**
I.	Strengthen the role of the MOHP in providing and financing Preventive Medicine (PM) and Primary Health Care (PHC)	▪ A district-based PHC strategy developed and officially endorsed by the MOHP ▪ A pilot project designed to test the feasibility of the PHC strategy implementation completed ▪ Full Cost of vaccines covered by the GOE beginning in FY 97/98 ▪ Percent of MOHP expenditures for identifiable PM and PHC increased by 10% for FY 97/98
II.	Rationalize the role of the MOHP in providing and financing curative care	▪ A plan developed to rationalize the MOHP hospital construction ▪ A plan developed and officially endorsed by the MOHP for the development of the economic section in the MOHP hospitals
III.	Reform the MOHP Personnel Policy	▪ Official body established to develop licensure and relicensure standards and procedures for nursing practice
IV.	Develop the MOHP role in regulation and accreditation and its capacity for national health strategic planning, policy analysis, and management	▪ An overall MIS plan for the health sector developed and officially endorsed ▪ MOHP Quality Improvement (QI) unit established and staffed ▪ A comprehensive longer-term national health sector reform agenda developed
V.	Ensure the viability of the HIO as the instrument for social insurance expansion	▪ HIO expenditure on pharmaceuticals increased only by 10% ▪ Adequate funding for MIS operating costs is allocated by HIO
VI.	VI. Expand social health insurance coverage coupled with adequate administrative and financing mechanisms Unclear if this was in first year as documents provided were inconsistent	▪ Not clear what was proposed for this year as documents are inconsistent

Tranche 2: 1999		
	Policy Areas	**Benchmarks**
I.	Same as previous year	▪ MOHP FY 1998/99 expenditures devoted to clearly identifiable PM and PHC services increased by at least 10% over FY 1997/98
II.	Same as previous year	▪ Systems adopted to improve operational efficiency and effectiveness in hospitals
III.	Same as previous year	▪ Health work force practice standards, staffing norms, and planning criteria adopted
IV.	Same as previous year	▪ Access to and utilization of information for planning and decision making increased at the MOHP Executive Level ▪ Health Facility accreditation standards, systems and procedures developed
V.	Same as previous year	▪ HIO Management Information Systems expanded to Upper Egypt
VI.	Expand social health insurance coverage coupled with adequate administrative and financing mechanisms	▪ A "Financing Entity" developed and pilot-tested in one Governorate to provide a basic-benefit package for all citizens who are not currently covered by the HIO ▪ Procedures authorized to contract with MOHP facilities and professional staff; and revised proc. developed for the HIO to contract service for HIO benef. in the pilot areas from non-HIO providers
Tranche 3: 2000		
	Policy Areas	**Benchmarks**
I.	Same as previous year	Same as previous year
II.	Same as previous year	Same as previous year
III.	Same as previous year	▪ Systems implemented to identify, recruit and retain selected FM physicians and other health workers in MOHP FH facilities
IV.	Same as previous year	▪ A unified facility and service accreditation system is institutionalized within MOHP in public, HIO, private, and NGO family health units and centers ▪ MOHP EIS is expanded
V.	Same as previous year	▪ Procedures, policies, and systems that support performance based contracting with MOHP, HIO, NGO and private sector providers are implemented
VI.	Expand mechanism for family health coverage	▪ Systems that assure universal access to the service provided in health care reform are developed. These systems support the participation of all interested primary care providers in the reform

Tranche 4: 2001		
Policy Areas		**Benchmarks**
I.	Same as previous year	▪ MOHP FY 2000/2001 expenditures devoted to clearly identifiable PM and PHC services increased by at least 40% over the GOE FY 1995/96
II.	Same as previous year	▪ MOHP establishes policies and procedures to implement the Economic Section Model in selected MOHP hospitals
III.	Same as previous year	▪ MOHP policy and procedures to convert MOHP primary care clinics to FHU and FHCs ▪ Procedures for administration and fiscal management of MPHP FHU and FHC developed and approved
IV.	Same as previous year	▪ MOHP defines and implements a basic hospital accreditation instrument with a special emphasis on the BBP of services ▪ NICHP establishes a GIS data Management policy and procedures based on the existing GIS data provided through the Master Planning Project
V.	Same as previous year	▪ Policy and procedures for performance-based contracting by the Family Health Fund with the private sector and NGO's for Basic Benefit services are established
VI.	Same as previous year	▪ MOHP mechanisms for family health coverage are defined through adoption of policies and procedures to identify the vulnerable and underserved populations nationwide.

Exhibit D-4
PHR and Partner Contributions by Policy Area and by Year

PHR/WORLD BANK/USAID/MOHP/ECTAT

Policy Areas: **I. Primary Health Care Development** **II. Rationalize the Role of MOHP in Providing and Financing Curative Care**	
Year	**PHR And Partner Contributions**
1996	▪ PHC Strategy
1997	▪ Contributed to D–4 Report ▪ EOPS design ▪ Development of policy areas
1998	▪ Montazah facility survey ▪ BBP developed and costed ▪ Budget Tracking System implemented in pilot governorates ▪ Hospital selection ▪ CCIG assembled ▪ Framework developed ▪ Economic model adapted
1999	▪ QI Survey ▪ Bed needs model ▪ Work force standards ▪ Capital asset planning ▪ HIS piloted ▪ District health plan for Montazah ▪ 25 Hospital Implementation ▪ Management modules ▪ Establishment of economic section in MOHP hospitals ▪ Centers of excellence included: • HMIS in CCO hospitals • Performance-based incentive system • Declaration of Egyptian Society of FM • Master planning CIS units at MOHP • Reorganizing for MMIS
1999-2000	▪ GIS Map ▪ Technical advice on HMIS strategy

2000	Medical & Eng. Survey ▪ Governorate health plan – Alexandria ▪ Governorate standards and guidelines ▪ Applying FM practice model ▪ Rise of PHC and PM expenditures by 40 percent since 1997 "BTS NHA" ▪ Integration of vertical programs ▪ Establish PBS ▪ Upgrade MR ▪ Expanding coverage ▪ New polyclinic/hospitals ▪ Training FHU staff ▪ MIS evaluation
2001	▪ End-of-project conference and CD with articles produced
Policy Area III: Personnel Policy	
Year	**PHR And Partner Contributions**
1999-2000	▪ Standards and guidelines for staffing patterns at all levels
2000	▪ HR rationalization plan ▪ Min decree on regulating nursing practice ▪ Egyptian Board of FP input ▪ Manpower planning for PHC
Policy Area IV: Regulatory, Accreditation, and HIS	
Year	**PHR And Partner Contributions**
1996	▪ Contributed to QI/NICIP decrees ▪ Contributed to QI strategy ▪ Quality directorate ministerial decree and capacity building
1998	▪ NICHP remodeled ▪ Quality tools used to improve PHC, FP model
2000	▪ Development of accreditation standards as contracting tool with FHF ▪ Accreditation system implementation
2001	▪ Vertical integration for QI surveillance system
Policy Area V: HIO	
Year	**PHR And Partner Contributions**
1997	▪ Expansion of coverage for the newly born
1998	▪ Development of HIO MIS
1999	▪ Pilot implementation in Abu Qir Clinic ▪ FHC and FHU Abu Qir
2000	▪ MIS at Abu Qir ▪ FHF ▪ FHF MIS. INTL

Policy Area VI: Family Health Fund	
Year	**PHR And Partner Contributions**
1998	▪ Models explored and presented to HE
1999	▪ Preparation studies for establishment of FHF ▪ Ministerial Decree
2000	▪ Contracting options for s/m/long-term assessment tools: •Focus groups •Medical records •Performance assessment •Establishment of FHF training •Contract with 4 pilots •First payment for performance
2001	▪ NGO and private sector contract signed ▪ Allocating start-up fund