ASSESSMENT OF FAMILY PLANNING PROGRAM

June 2012

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ACRONYMS

EDHS	Egyptian Demographic Health Survey
EGP	Egyptian Pound
ETS	Expenditure Tracking Study
FHM	Family Health Model
FM	Family Medicine
FP	Family Planning
HEU	Health Economics Unit
IEC	Information, Education and Communication
IL	Implementation Letter
IUD	Intrauterine Device
M&E	Monitoring and Evaluation
MIS	Management Information Systems
MOE	Ministry of Education
MOF	Ministry of Finance
MOHP	Ministry of Health and Population
NGO	Nongovernmental Organization
PHC	Primary Health Care
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund

EXECUTIVE SUMMARY

Preventive health care, which includes maternal and child health (MCH) services (prenatal care, child health care, and immunization), family planning (FP), and reproductive health continues to be among the priorities of the Ministry of Health and Population (MOHP) in Egypt. Recent reforms have restructured the delivery of preventive services from separate vertical programs to integrated services delivered through the Family Health Model. Reforms also have changed the manner in which the services are contracted and paid for, and made the social insurance system more sustainable. Nevertheless, the programs still rely on donor assistance, and diminished assistance could affect program performance in a detrimental way. It is within this context that the Preventive Sector Assessment study was undertaken. The purpose of this current assessment was to evaluate the performance of the FP program to provide feedback and recommendations for improvement. The study used a combination of qualitative and quantitative data collection, in addition to reviewing key literature about Egypt's FP sector.

The national FP program in Egypt has made significant strides over the past three decades. The results of the 2008 Egyptian Demographic Health Survey (EDHS) show that the contraceptive prevalence rate doubled during the between 1980 and 1991, from 24 to 48 percent. This was associated with a decline in total fertility rate (TFR) from 5.3 births per woman in 1980 to 3.0 births per woman in 2008. The number of FP clinics has also increased, from 2,255 in 1996 to 5,034 in 2008.

Despite the progress, this assessment shows that there are still gaps in the FP program that should be addressed to improve quality of services, ensure program sustainability, and achieve the MOHP goal of reducing the TFR to 2.1 births per woman by 2017. Among priority areas for intervention is the need to establish an operational financing system that can provide information about government spending on FP, broken down by level, activity, and function, and ensure the availability of financial resources for all aspects of the program. The lack of such a financing system curtails the MOHP ability to secure the availability of major commodities and equipment according to need. The study found a fair amount of variation across governorates in regard to shortages in FP supplies, as well as in clients' perception of the need to improve availability of different FP methods. Furthermore, there is a need to strengthen Information, Education, and Counseling (IEC) programs. The 2008 EDHS found that only 67 percent of currently married women age 15–49 had heard or seen a FP message during the six months prior to the survey, compared to 91 percent in 2005 EDHS. Results of this assessment highlight this problem further and show a high level of missed opportunities for IEC within the clinics. For example, 98 percent of respondents in this study indicated that they did not see or hear any FP messages in the clinic's waiting room. Leveraging the role of private providers and nongovernmental organizations is critical to sustain demand. Improving training and supervision, especially in the face of diminishing donor assistance, is critical for improving quality of services.

1. INTRODUCTION

Egypt has a strong government-led national family planning (FP) program that has produced remarkable results over the past three decades. The 2008 Egyptian Demographic Health Survey (EDHS) found that the contraceptive prevalence rate, which doubled (from 24 to 48 percent) during the 11-year period between 1980 and 1991 (El-Zanaty and Way 2009: xxii) had continued to rise, to 60 percent in 2003. This percentage was sustained from 2003 to 2008. Research has shown this is largely attributable to an increased number of service delivery outlets (El-Zanaty and Way 2009: xxiv) – the number of FP clinics increased from 2,255 in 1996 to 5,034 in 2008 (El-Zanaty and Associates 2011). In addition, the total fertility rate (TFR) declined, from 5.3 births per woman in 1980 to 3.0 births per woman in 2008 (El-Zanaty and Way 2009: 51). The overall goal of the FP program is to reduce the TFR to 2.4 children per woman by 2012 and to 2.1 by 2017.

As part of a major health sector reform program, the Ministry of Health and Population (MOHP) has undertaken a series of steps to transform and strengthen the financing and delivery of health care services. Some of these changes include moving from independent vertical programs to an integrated Family Health Model (FHM), changing the manner in which services are contracted and paid for, and making the social insurance system more sustainable. At the same time, there is diminished donor assistance to Egypt, which could affect program performance. It is within this context that this Preventive Sector Assessment study was undertaken. In consultation with the MOHP, three major programs (FP, Maternal and Child Health [MCH], and Infection Control [IC]) were selected for study. The purpose of the current assessment is to evaluate the performance of the FP program to provide feedback and recommendations for improving the impact, effectiveness, efficiency, equity, and sustainability of that program. Therefore, the study aims to understand how well the program structures and processes have worked to achieve program objectives, and to assess program needs going forward.

2. METHODOLOGY

The study methodology used a combination of qualitative and quantitative data collection, in addition to literature review. The qualitative portion of the research consisted of interviews with 32 respondents from all three programs (MCH, FP, IC). The first four in-depth interviews were with key stakeholders at the central MOHP level. These interviews served as the basis for semi-structured interviews that were carried out with 17 stakeholders from the three preventive health programs in the governorates of Alexandria, Ben Suef, Dhakalia, Qaliobia, Qena, and the Red Sea. Fifteen of the respondents in the six governorates were senior program (FP, MCH, IC) officials. The remaining two were mid-level officials working in these programs. In addition, 11 FP program staff – health educators, nurses, and media and public relations specialists – from two governorates took part in focus group discussions. Nearly all the interviews took place at the MOHP governorate headquarters "Moderiat El Seha" in each governorate; Qena was one exception.

Most of the participants interviewed preferred not to be identified by name or official position in the report. Therefore, the report refers to participants as "stakeholder 1," "stakeholder 8," etc. Even though the MOHP is striving to build an environment of trust and transparency, the reluctance of most participants to be identified by name indicates that a lot of work remains to be done in order to build such environment in the ministry.

The qualitative data were collected using semi-structured interviews, which included open-ended questions that allowed the participants to express themselves freely and to present the program situation as they perceive it. Questions included "How is the program doing before and after the implementation Family Health Program?"; "Do you face any barriers or obstacles in doing your work?"; "Did you notice any difference in your work after the Implementation Letter has ended? Has it affected your work in any way?" Following the inductive analysis, the themes revealed were examined and incorporated in the study report.

The quantitative component of the study consisted of conducting exit interviews at public health facilities in all six governorates. A total of 1,738 for FP seeking care at the health facility were conducted, in addition to a total of 337 interviews with providers at each of these facilities. The public health facilities that were included in the sampling framework were identified by using a random selection process.

Finally, a desk review was conducted to review program documents, working papers, and research conducted about the MCH program in Egypt.

2.1 POLICY ENVIRONMENT

Addressing Egypt's population problem is a priority of the country's government, and the FP program has strong support from both the government and religious leaders. The National Population Policy Plan for 2002–2017, developed at the central level in coordination with local officials, addresses the problem of high fertility and endorses FP as an important step. The plan clearly identifies and provides a strategy for removing important policy obstacles, and assigns responsibility for policy development activities. The MOHP has developed a strategic plan for expanding the national FP program, and recently the MOHP began assessing key barriers to program success at the governorate level. Policy planners have integrated demographic data into development planning, and current program objectives address the needs of the poor.

The FP program calls for a social dialogue regarding legal proceedings to create a supportive environment for the population policy (addressing issues including age of marriage, premarital counseling, child labor, and school drop-out rates). Due to this effort, the Egyptian government has enacted family laws that support FP goals. For instance, in June 2008 a presidential decree regarding

the child law framework was issued that increased the minimum age of marriage for males and females to 18 years old and also established premarital testing and counseling as a precondition to issue a marriage certificate (UNFPA 2010a). It appears that this decree has been effective, as average age at first marriage has increased (e.g., among women aged 45–49, 12 percent had married by age 15; however, among younger cohorts of women (age 20–24), only 2 percent had married by age 15). It is likely that the TFR has decreased partially as a result of this decree, as "trends in age at first marriage can help explain changes in fertility levels in Egypt" (El-Zanaty and Way 2009).

Despite these strengths, there are a few areas in which FP policy planning could be improved.

The first regards the lack of sound financial planning. The strategic plan does not include projections of the resources (material, human, and financial) required to implement the strategy, or a plan to secure them. Additionally, attempts by the MOHP to conduct an Expenditure Tracking Study (ETS) in 2010–2011 highlights that there is no system to track the flow and use of financial resources at the national, governorate, district, and local levels. The department reports against line items but has no ability to know what proportions of funds are spent at different levels, the activities on which these funds are spent, or what functions account for spending. In the absence of this financial information there is a misalignment between needs and financial resources, and, equally importantly, between implementation responsibilities and financial resources. Furthermore, there is concern that the budgets at the governorate level do not reflect the activities set forth in the National Population Policy Plan, and governorate officials have criticized the plan[1] as being "too ambitious" for the budgets in place.

Secondly, the lack of government coordination with other stakeholders in policy formulation, especially with private sector stakeholders, is a point for improvement. Although an estimated 40 percent of women prefer private providers over public ones for FP services (El-Zanaty and Way 2009), private sector involvement in policy formulation and coordination with the FP program has historically been weak. Earlier studies have shown that the MOHP seldom encouraged NGO efforts through adequate funding or participation in planning (Khalifa et al. 2001: 21). In 2010-2011, Health Systems 20/20 conducted a review of seven health sector reform benchmarks that were agreed to by the MOHP and USAID. One of the benchmarks focuses on MOHP ability to establish an operational financing system that supports FP, including a protected line item for contraceptive procurement. Means for verifying this benchmark included a thorough review of the FP program organization and management systems. Results from this review show that the MOHP is coordinating with the private sector and NGOs in some aspects, mainly in forecasting activities but also to lesser extent in policy dialogue. Insufficient cooperation and dialogue among NGOs and private and public entities may lead to inefficiencies, with the three parties' efforts potentially overlapping in some areas while neglecting others as they service the same goals.

Third, the FP program faces socioeconomic challenges, especially in regard to child labor. As long as children are viewed as a source of income the population growth rate will remain high. From the perspective of some Egyptian families, the prospect of additional household income serves as an incentive to have more than two children. It is very difficult to change the behavior of families; however, with the support of laws, the behaviors may be forced to change. The amended child law has prohibited and criminalized child labor, although more efforts are needed to ensure the law is being implemented, and more social programs are needed in order to reintegrate children into the education system.

Another policy obstacle to improving FP and reducing fertility is the recent decision by the Ministry of Education (MOE), announced last year, to eliminate sex education and any information pertaining to reproductive health or physiology in all school levels (Abdel Salam 2010). This decision came despite the fact that the Minister of Health has publicly stressed the importance of correcting family size misconceptions among youths "who still do not seem to grasp the problem of having three,

[1] Source: interviews conducted with officials at the governorate level.

four, or five children" (Agence France Presse 2008). The MOE's decision replaces formal lessons with dialogues between teachers and students without the use of textbooks (Abdel Salam 2010).

Lastly, although the FP program should operate horizontally (due to the implementation of the integrated Family Health Program), the system is still quite centralized. Most of the planning activities take place at the central level and the governorate and district staff function mostly as implementers. Also, policy analyses and supporting documents are only available at the central level.

2.2 TRACKING EXPENDITURES ON FAMILY PLANNING AT THE CENTRAL AND GOVERNORATE LEVELS

The current FP program has no system in place to collect financial data, nor has there been any effort to train managers in the use of financing information (both resources and expenditures) to improve and sustain program performance. The simple question of how much the government spends on FP cannot be answered, let alone how much is spent broken down by level, activity, and function.

To this end, as part of this FP assessment, an ETS was designed by the Health Systems 20/20 project and implemented by the MOHP. The purpose of the exercise was to break down spending by level (national, governorate, district, and facilities), by program activities, and by program functions to help understand how much is being spent on FP, where this money comes from, and what it is used for.

The implementation of the ETS at the governorate level faced several problems during the course of this study. Pilot governorates suffered from both incompleteness and poor data quality and required more skills and time for data validation. The core MOHP and governorate teams, although trained, still lacked the technical capacity and expertise to oversee this activity. This problem raised several questions about the lack of capacity for financial planning within the MOHP, not only for the FP program, but for the entire health sector. Later discussions within the MOHP related to this problem led to an agreement to establish a Health Economics Unit (HEU), staffed with people with enough expertise to serve as a policy shop responsible for creating and maintaining a database of information that can be used to produce analyses in support of MOHP policy development. The development of this unit will enable the ETS to be implemented more successfully.

At the time of writing this report, the only reliable information available for analysis was at the national level and for the Suez governorate for the period 2008–2009. Information was gathered from Sohag and Giza governorates but its quality was not as good. Luxor was dropped from the analysis due to the difficulty in obtaining information. In general, the ETS highlights the multiplicity of means by which individuals receive wages, including base salary and benefits, remuneration related to training activities, and salary supplements through government decrees. It is not uncommon for people to get multiples of their base salary in incentives and salary supplements. No one really knows how large these supplements are or whether the incentives are generating the performance improvements for which they are intended. The information from the ETS needs to be interpreted with caution because of data quality issues and the fact that this was the first time such an exercise has been conducted in Egypt.

The analysis from the national level and the three governorates revealed the following:

- Total spending on FP at the national level was EGP126,542,901.
    - Of this, 25.6 percent was spent on salaries, 17.4 percent on incentives, 30.3 percent on methods, 9.0 percent on materials used for methods, and 13.1 percent on nonmedical supplies. Additionally, 4.7 percent was donor support for training and supervision.
    - Of the total national-level FP spending, 16.4 percent was spent on activities conducted at the national level, 1.4 percent at the governorate level, 6.6 percent at the district level, and 75.7 percent at the facility level. Therefore the majority of the expenditures under national-level control are transferred to subnational levels to support the

implementation of the FP program. These transferred resources are used to pay salaries, incentives, the cost of methods, and training and supervision payments.

  - Of the 16.4 percent retained at the national level, 4.8 percent is spent on salaries, 5.6 percent on incentives, 79.8 percent on nonmedical supplies, and 9.6 percent on supervision and training supported by donor assistance.

- Expenditure per female in the reproductive age group:
  - On average, EGP6.30 was spent per female in the reproductive age group.
  - Average spending was EGP5.30 in Giza, EGP13.20 in Suez, and EGP14.30 in Sohag.
  - This variation in spending needs to be looked into to ensure that resource allocation meets program needs.
- Total expenditures across governorates:
  - Sohag spent a total of EGP13,753,907, Giza spent EGP4,236,167, and Suez spent EGP2,514,816.
  - Significant variations in spending by level were observed across governorates: Suez spent 11 percent at the governorate level, 21 percent at the district level, and 68 percent at the facility level; Sohag spent 4 percent at the governorate level, 7 percent at the district level, and 89 percent at the facility level; and Giza spent 3 percent at the governorate level, 15 percent at the district level, and 82 percent at the facility level. The vast majority of governorate spending went to the facility level.
- Expenditure by input:
  - Overall, 59.8 percent of all FP spending was spent on salaries and incentives, 21 percent on methods, 16 percent on recurrent expenditures, and 3.2 percent on medical supplies.
  - Variations were observed across governorates: Suez spent 69.1 percent on salaries and incentives, 12.3 percent on methods, 16.9 percent on recurrent expenditures, and 1.7 percent on medical supplies; Sohag spent 52.3 percent on salaries and incentives, 25.3 percent on methods, 18.6 percent on recurrent expenditures, and 3.8 percent on medical supplies; and Giza spent 78.7 percent on salaries and incentives, 12.5 percent on methods, 6.7 percent on recurrent spending, and 2.1 percent on medical supplies. It was not possible to ascertain the reason for these variations.
- Expenditure by function:
  - Functions were classified as management, supervision, general administration, and technical work. The distribution of all FP expenditures by function was as follows: 60 percent on technical work, 32 percent on management, 4 percent on supervision, and 3 percent on general administration. An interesting finding was the fact that management accounted for over 30 percent of the spending while supervising how the work was actually carried out accounted for just 4 percent.
  - Variations were observed across governorates in the distribution of spending by function. In Suez 53 percent was spent on technical work, 30 percent on management, 11 percent on supervision, and 5 percent on general administration; in Sohag 59 percent was spent on technical work, 35 percent on management, 3 percent on supervision, and 3 percent on general administration; and in Giza 68 percent was spent on technical work, 25 percent on management, 4 percent on supervision, and 3 percent on general administration.
- Expenditure by activity:
  - At the outset of this assessment, a detailed list of activities was drawn up. These included strategic planning and coordination, monitoring and evaluation (M&E),

Information, Education and Communication (IEC), training, methods distribution, information systems, mobile clinics, outreach, NGO support, advocacy, medical service delivery, and Women's Club.

- The analysis showed that five activities accounted for over 90 percent of all FP expenditures. These activities were medical service delivery at 46.2 percent, M&E at 16.4 percent, IEC at 10.6 percent, information systems at 8.8 percent, and Women's Club at 8.2 percent. The remaining activities accounted for less than 10 percent of FP spending: strategic planning and coordination accounted for 0.6 percent, training for 1.9 percent, methods distribution for 1.1 percent, mobile clinics for 0.7 percent, advocacy for 0.6 percent, and NGO support for 0.4 percent.
- As in the other areas of analysis, variations were observed across governorates. Spending on the top five activities was as follows: Suez spent 35.9 percent on medical service delivery, 20.2 percent on M&E, 12.7 percent on IEC, 11.3 percent on information systems, and 8.5 percent on Women's Club; Sohag spent 50.5 percent on medical service delivery, 15.8 percent on M&E, 10.2 percent on IEC, 8.2 percent on information systems, and 8.2 percent on Women's Club; and Giza spent 38.4 percent on medical service delivery, 16.2 percent on M&E, 10.6 percent on IEC, 9.3 percent on information systems, and 8.0 percent on Women's Club.

2.3 COMMODITIES AND LOGISTICS SYSTEM

As stated earlier, between 2010 and 2011, a comprehensive external review to assess several MOHP benchmarks was conducted. One of the benchmarks is the establishment of an operational financing system that supports FP, including a protected line item for contraceptive procurement. Several methods were used to assess this benchmark including extensive interviews with stakeholders and a documentation review. Verification of the benchmark was based on nine elements all of which were achieved according to the assessment, except for one relating to the establishment of a separate budget line item for FP commodities. Results of the assessment showed the following:

- At the organizational level, the FP program established a High Committee for Contraceptive Security under the chairmanship of the General Director for Contraceptive Commodity-Family Planning Sector. The committee is responsible for securing contraceptives at the national level and overseeing the process of procurement and distribution at all levels, including the Egyptian Pharmaceutical Trading Company.
- The program continues to successfully secure the availability of methods, due to its making the necessary funds available for method purchasing and its use of a robust logistics system. However, the results of this study show that there is room for improvement with around 25 percent of providers reporting unavailability of some FP methods.
- A five-year Investment Plan has been developed by the MOHP. This plan includes a line item called procurement of "Raw Material," in which the FP sector assesses its need for raw materials. However, the Contraceptive Security Strategy prepared by the FP sector calls for the creation of a separate line item for the procurement of contraceptives, instead of the existing raw material line item. MOHP officials indicated that they have discussed this issue with the Ministry of Finance (MOF); however, MOF sources indicated that a separate line item for procurement of contraceptives has not been included in the 2011/2012 budget.
- A management information system (MIS) to monitor the contraceptive movement in the FP sector is currently in place. Interviews with MOHP officials indicated that attempts were made to build the capacity of staff in the MIS. This included training of statisticians and storekeepers at the governorate and district levels to use the database and generate monthly reports, to enable decision makers at to manage the contraceptive inventory. Continued capacity building at all levels is needed to ensure proper implementation of the system.

- The FP program also developed an automated forecasting system to estimate contraceptive needs by type. The information is included in the five-year Strategic Plan as well as the Annual Plan. Contraceptive forecasting activities performed through the General Directorate for Contraceptive Commodity-Family Planning Sector include assessments of needs for the three sectors (public, private, and NGO). The assessment of future needs for pharmacies is incorporated in the forecasting activities, especially those related to combined oral contraception pills. Of the two national warehouses, one is fully computerized while the other is still using a paper-based system.

For a comprehensive evaluation of Egypt's current commodities and logistics systems, see UNFPA/Egypt's "Assessment of the Logistics System for Contraceptives, Ministry of Health, Egypt" (UNFPA 2010b).

2.4 ORGANIZATION AND DELIVERY OF FAMILY PLANNING SERVICES: PROVIDER PERSPECTIVES

For this study, 420 providers were interviewed voluntarily, in 52 clinics across six governorates (Alexandria, Dakahlia, Qalyubia, Qena, Beni Seuf, and Red Sea). Providers were asked a series of questions about their work, training, and satisfaction, their perceptions on the functioning of the clinic, and the availability of medical supplies. This section reports on those findings.

2.4.1 HUMAN RESOURCES AND WORKFORCE

On average, providers reported working on FP-related care for some amount of time on about 4.9 days per week. On each of these days, providers reported working an average of 2.8 hours per day on FP-related care. This means that providers are spending an average of 14 hours per week on FP. There was some variation in time spent on FP by governorate, with Qena and Qalyubia reporting the most days spent, and the Red Sea governorate reporting the most hours per day spent on FP.

TABLE 1: DAYS PER WEEK WITH TIME SPENT ON FAMILY PLANNING

Governorate	Average
Alexandria	4.9
Dakhalia	3.8
Qalyubia	5.6
Qena	5.7
Beni Suef	5.1
Red Sea	5.2
Total	4.9

TABLE 2: HOURS PER DAY SPENT ON FAMILY PLANNING

Governorate	Average
Alexandria	2.6
Dakhalia	3.2
Qalyubia	3.1
Qena	2.5
Beni Suef	2.5
Red Sea	4.4
Total	2.8

2.4.2 SHORTAGE OF STAFF

Sixty-three percent of providers said the number of physicians was adequate, 3 percent said they were overstaffed, and 33 percent said they were understaffed. The governorate with the percentage of providers reporting inadequate staffing was Dakahlia with 48 percent, followed by 44 percent in Bani Suef, 42 percent in Qena, 26 percent in Alexandria, 23 percent in Red Sea, and 12 percent in Qalyubia.

Regarding nurses, 68 percent of providers said staffing was adequate, 5 percent said there was overstaffing, and 27 percent said there was a shortage of nurses. The shortage of nurses was highest in Qena (48 percent), followed by Dakahlia (42 percent), Alexandria (36 percent), Red Sea (27 percent), Bani Suef (19 percent), and Qalyubia (6 percent).

An area of significant shortage is cleaning staff. Seventy percent of providers said there was a significant shortage of cleaning staff. This was highest in Bani Suef and Dakahlia (both 86 percent), followed by Qena (68 percent), Alexandria (61 percent), Red Sea (50 percent) and Qalyubia (46 percent).

2.4.3 SUPERVISION

Supervisory visits to clinics are an important aspect of the primary health care (PHC) system and especially the FP program. Providers were asked about the occurrence and effectiveness of these visits (see Tables 3 and 4). There was almost unanimous (99 percent) consent that the visits took place on a regular basis (i.e., within the last three months) and that they were effective (96 percent). The only areas of concern are that in Qena 9.5 percent of respondents said these visits did not occur on a regular basis, while in Alexandria and Qalyubia some respondents reported that these visits were not as effective as they should be (13 percent and 5 percent, respectively). These three areas of concern may indicate a need for more, or more effective, supervisors in these governorates.

> Similarly, while the IL was in effect, there were allowances for supervisory visits, which now are not available. Most of the program vehicles are quite old (1992) and function poorly, which affects supervision activities because supervisory teams struggle to reach health facilities and are not always able to achieve their goals. This leads to the facilities in the most remote areas being neglected from monitoring and supervision.

TABLE 3: ANYONE FROM FAMILY PLANNING DISTRICT OFFICE VISITED THE PROVIDER IN THE LAST THREE MONTHS (PERCENT OF PROVIDERS)

Governorate	Yes	No
Alexandria	98.0%	2.0%
Dakahlia	100.0%	0.0%
Qalyubia	100.0%	0.0%
Qena	90.5%	9.5%
Beni Seuf	100.0%	0.0%
Red Sea	100.0%	0.0%
Total	98.6%	1.4%

TABLE 4: PROVIDER BENEFITED FROM THE SUPERVISORY VISIT

Governorate	Yes	No	Sometimes
Alexandria	87.2%	2.1%	10.6%
Dakahlia	100.0%	0.0%	0.0%
Qalyubia	95.0%	0.0%	5.0%
Qena	100.0%	0.0%	0.0%
Beni Seuf	100.0%	0.0%	0.0%
Red Sea	100.0%	0.0%	0.0%
Total	96.1%	0.5%	3.4%

2.4.4 TRAINING

Training in FP is important for ensuring that clients receive the best care possible, and that providers stay abreast of developments in FP medicine. Of the 420 providers interviewed, 167 recalled having received at least one training in FP over the course of their career. Providers reported when they last received FP training; this ranged from 1983 to 2010, with 92 percent of providers having received training within the last 10 years. Of the 167 who reported training, 95 percent stated that the training and education topics were relevant to their professional needs, and 97 percent stated that the training courses and education materials were accessible. As seen in Table 7, the majority of providers were also satisfied with the training space (87 percent), the trainer (93 percent), and the training materials (92 percent); only a small percentage of providers were not satisfied with these aspects of the training program(s).

TABLE 5: TRAINING AND EDUCATION TOPICS ARE RELEVANT TO PROFESSIONAL NEEDS (AMONG PROVIDERS THAT REPORTED TRAINING)

Response	Percent of Providers
Relevant	95.2%
Mostly Relevant	4.8%
Not Relevant	0.0%

TABLE 6: TRAINING COURSES AND EDUCATION MATERIALS ARE ACCESSIBLE

Response	Percent of Providers
Yes	97.0%
Sometimes	1.8%
No	1.2%

TABLE 7: SATISFACTION WITH ASPECTS OF TRAINING PROGRAMS (PERCENT OF PROVIDERS)

Response	Training Space	Trainer	Training Materials
Satisfied	86.8%	93.4%	91.5%
Moderately Satisfied	10.2%	6.0%	7.9%
Not Satisfied	3.0%	0.6%	0.6%

2.4.5 AVAILABILITY OF MEDICAL SUPPLIES

As shown in Table 8, more than half (60 percent) of surveyed clinics indicated that, in general, medical supplies are available, with 36 percent indicating that supplies are somewhat available. Beni Seuf clinics were the most likely to report that supplies are not available, with 8 percent providing this answer. When clinics were asked to specify which supply was the most constantly unavailable,[2] 59 percent reported that gloves were unavailable, followed by medical instruments (12 percent) and registration forms (14 percent) (see Table 9). Further analysis is needed to determine the management and/or logistical reasons for such shortages.

The fact that 40 percent of surveyed clinics do not have all needed medical supplies (even gloves, a basic item) demonstrates serious weaknesses in Egypt's medical supply logistics system. This is not surprising given the UNFPA report's findings that many improvements are needed in the commodities and logistics systems (UNFPA 2010b). It appears that the system functions (supplies are mostly available), but does not function very well (supplies are not always available, even gloves).

TABLE 8: AVAILABILITY AND ADEQUACY OF NEEDED MEDICAL SUPPLIES

Governorate	Available	Somewhat Available	Not Available	Don't Know
Alexandria	58.3%	41.7%	0.0%	0.0%
Dakahlia	77.5%	22.5%	0.0%	0.0%
Qalyubia	62.5%	35.0%	2.5%	0.0%
Qena	47.6%	47.6%	4.8%	0.0%
Beni Seuf	52.1%	37.5%	8.3%	2.1%
Red Sea	62.5%	37.5%	0.0%	0.0%
Total (n=205)	60.5%	36.1%	2.9%	0.5%

[2] This question was asked only of those clinics that indicated that supplies were "somewhat available," "not available," or "don't know."

TABLE 9: AMONG CLINICS WHERE SUPPLIES ARE NOT ALWAYS AVAILABLE, WHAT MEDICAL SUPPLIES ARE CONSTANTLY UNAVAILABLE?

Governorate	Gloves	Registration Forms	Cotton	Medical Instruments	Syringes	Detergents
Alexandria	60.0%	10.0%	15.0%	15.0%	0.0%	0.0%
Dakahlia	40.0%	10.0%	0.0%	20.0%	10.0%	20.0%
Qalyubia	50.0%	16.7%	0.0%	25.0%	8.3%	0.0%
Qena	63.6%	9.1%	18.2%	9.1%	0.0%	0.0%
Beni Suef	63.6%	22.7%	0.0%	4.5%	9.1%	0.0%
Red Sea	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	59.0%	14.1%	6.4%	12.8%	5.1%	2.6%

2.4.6 AVAILABILITY OF FAMILY PLANNING METHODS

Tables 10 and 11 display provider responses regarding the availability of FP methods at their clinic. Three-quarters of providers indicated that the FP methods they need to do their work were available and adequate, with 25 percent saying they were available on an intermittent basis. Among that 25 percent, the specific methods not available were Implanon (56 percent of providers who indicated limited method availability stated that Implanon was not available), followed by Levenor (35 percent), Microsept (6 percent), and Depo-Provera (4 percent). There was a fair amount of variation across governorates in regard to shortages of FP supplies. In Alexandria 80 percent said there was a shortage of Levenor; in Dakahlia 75 percent said there was a shortage of Implanon and 25 percent said there was a shortage of Levenor; in Qalyubia 46 percent said there was a shortage of Implanon and 31 percent indicated a shortage of Levenor; in Beni Suef shortages were only reported for Implanon; and in Red Sea Depo-Provera and Implanon shared the shortage burden at 50 percent each. This variation indicates that commodity and logistics systems are not standardized across the country and create varying supply problems depending upon clinic location.

TABLE 10: AVAILABILITY AND ADEQUACY OF FAMILY PLANNING METHODS

Governorate	Available	Somewhat Available	Not Available	Don't Know
Alexandria	71.4%	28.6%	0.0%	0.0%
Dakahlia	69.2%	30.8%	0.0%	0.0%
Qalyuabia	72.5%	27.5%	0.0%	0.0%
Qena	95.2%	4.8%	0.0%	0.0%
Beni Seuf	77.8%	22.2%	0.0%	0.0%
Red Sea	75.0%	25.0%	0.0%	0.0%
Total	75.4%	24.6%	0.0%	0.0%

TABLE 11: AMONG CLINICS WHERE FAMILY PLANNING METHODS ARE NOT ALWAYS AVAILABLE, WHICH FAMILY PLANNING METHODS ARE NOT AVAILABLE?

Governorate	Hormonal Contraception (Microsept)	Hormone (Levenor)	Depo-Provera Contraceptive Injection (Every 3 Months)	Subdermal Capsule (Implanon)
Alexandria	6.7%	80.0%	0.0%	13.3%
Dakahlia	0.0%	25.0%	0.0%	75.0%
Qalyubia	7.7%	30.8%	15.4%	46.2%
Qena	0.0%	0.0%	0.0%	100.0%
Beni Seuf	0.0%	0.0%	0.0%	100.0%
Red Sea	50.0%	0.0%	0.0%	50.0%
Total	5.6%	35.2%	3.7%	55.6%

2.4.7 PRIVATE PRACTICE AT CLINICS, TARGETS, BONUSES, AND PENALTIES

The survey asked a number of questions about doing private practice at the clinic, the presence or absence of targets, and either penalties or bonuses for meeting targets. The responses showed a significant variation among the governorates in the understanding of providers about these issues.

When asked about doing private practice at the clinic 40.9 percent of respondents answered in the affirmative, 52.7 percent said they did not, 6.1 percent said this was not applicable to them, and 0.2 percent said they sometimes engaged in private practice. The variation across governorates is marked.

TABLE 12: DO YOU PRACTICE PRIVATE MEDICAL WORK AT THE CLINIC AFTER WORKING HOURS?

	Yes	No	N/A	Sometimes	Total
Alexandria	52.9%	44.8%	1.1%	1.1%	100.0%
Dakahlia	43.8%	53.8%	2.5%	0.0%	100.0%
Qalyubia	33.0%	53.4%	13.6%	0.0%	100.0%
Qena	32.1%	60.7%	7.1%	0.0%	100.0%
Beni Seuf	39.8%	53.1%	7.1%	0.0%	100.0%
Red Sea	25.0%	75.0%	0.0%	0.0%	100.0%
Total	40.9%	52.7%	6.1%	0.2%	100.0%

When asked if there were FP targets at the facility level, 63.2 percent of respondents answered yes and 36.8 percent answered no. There was a fair amount of variation across governorates. In Alexandria 51 percent answered in the affirmative, in Dakahlia it was 56 percent, in Qalyubia 92 percent, in Qena 38 percent, in Bani Suef 70 percent, and in Red Sea 43 percent.

TABLE 13: DO YOU HAVE TARGETS REGARDING FAMILY PLANNING IN THE HEALTH UNIT?

	Yes	No	Total
Alexandria	25 (51.0%)	24 (49.0%)	49 (100.0%)
Dakahlia	22 (56.4%)	17 (43.6%)	39 (100.0%)
Qalyubia	37 (92.5%)	3 (7.5%)	40 (100.0%)
Qena	8 (38.1%)	13 (61.9%)	21 (100.0%)
Beni Seuf	39 (69.6%)	17 (30.4%)	56 100.0%
Red Sea	3 (42.9%0	4 (57.1%)	7 (100.0%)
Total	134 (63.2%)	78 (36.8%)	212 (100.0%)

Among clinics that have FP targets, some providers in all sample governorates indicated that they receive bonuses if the unit reaches its targets. The highest percentage was found in Qalyubia, where 66.7 percent of respondents indicated that they receive bonuses, followed by Red Sea (40.0 percent) and Qena (37.5 percent).

TABLE 14: DOES THE STAFF GET A BONUS IF THE UNIT REACHES ITS TARGETS?

	Yes	No	Don't Know	Total
Alexandria	7.7%	88.5%	3.8%	100.0%
Dakahlia	29.2%	70.8%	0.0%	100.0%
Qalyubia	66.7%	33.3%	0.0%	100.0%
Qena	37.5%	62.5%	0.0%	100.0%
Beni Seuf	12.8%	87.2%	0.0%	100.0%
Red Sea	40.0%	60.0%	0.0%	100.0%
Total	31.2%	68.1%	0.7%	100.0%

A surprising finding is that 72 percent of providers said there was a penalty if the facility-level targets were not achieved. This was highest in Qalyubia (91 percent), followed by Bani Suef (90 percent), Qena (57 percent), Alexandria (54 percent), Dakahlia (40 percent), and Red Sea (33 percent).

TABLE 15: IS THERE A PENALTY IF THE TARGETS ARE NOT REACHED?

	Yes	No	Sometimes	Total
Alexandria	53.8%	42.3%	3.8%	100.0%
Dakahlia	40.0%	60.0%	0.0%	100.0%
Qalyubia	90.9%	9.1%	0.0%	100.0%
Qena	57.1%	42.9%	0.0%	100.0%
Beni Seuf	89.7%	10.3%	0.0%	100.0%
Red Sea	33.3%	66.7%	0.0%	100.0%
Total	71.9%	27.3%	0.8%	100.0%

2.5 FAMILY PLANNING SERVICES ACCESS AND UTILIZATION: CLIENT PERSPECTIVES

For this study, clients were interviewed, voluntarily, at the conclusion of their FP service visit. Overall, 1,747 clients completed interviews regarding the FP services that they had just received. Table 16 provides a breakdown of the number of clients interviewed in each governorate. The results of the client interviews are presented below.

TABLE 16: BREAKDOWN OF SAMPLE BY GOVERNORATE

Governorate	Percent of Sample (Number)
Alexandria	22.8% (399)
Beni Suef	19.8% (345)
Dhakalia	20.7% (362)
Qalyubia	9.2% (161)
Qena	18.9% (330)
Red Sea	8.6% (150)
Total	100% (1,747)

2.5.1 PROFILE OF CLIENTS USING FAMILY PLANNING SERVICES

As displayed in Table 17, in every governorate the majority of clients using FP services were in the age group 20–34. Overall, 4 percent reported they were in the age group 15–19, 72 percent were in the age group 20–34, 20 percent were in the age group 35–44, and about 4 percent were over the age of 45. These age distributions were similar across the governorates, with some minor exceptions. For example, clinics in Red Sea had fewer young clients (ages 15–19) and fewer older clients (over 45) than the other governorates. Additionally, the split between clients ages 20–34 and 25–44 was more evenly distributed in Qena than in the other governorates.

TABLE 17: AGE OF CLIENT SAMPLE (PERCENT OF CLIENTS)

Governorate	15–19	20–34	35–44	45–49	50 and Older
Alexandria	3.5%	76.1%	16.6%	2.8%	1.0%
Beni Suef	5.6%	66.7%	22.8%	4.6%	0.3%
Dhakalia	3.2%	76.5%	15.7%	4.6%	0.0%
Qalyubia	3.9%	71.5%	19.9%	4.4%	0.3%
Qena	3.1%	55.9%	36.0%	5.0%	0.0%
Red Sea	1.3%	85.2%	12.8%	0.7%	0.0%
Total	3.7%	72.4%	19.7%	3.9%	0.3%

Overall, the majority (59 percent) of women surveyed had completed high school-level education, demonstrating that the majority of FP clients are educated. Only 3 percent overall had attended illiteracy classes. When broken down by governorate, Beni Suef and Alexandria had the highest proportions of illiterate clients (9.6 percent and 5.1 percent, respectively), and Red Sea had the highest proportion of university-educated clients.

TABLE 18: EDUCATION LEVEL OF CLIENT SAMPLE (PERCENT OF CLIENTS)

Governorate	Attended Illiteracy Classes	Primary	Preparatory	Secondary/ Vocational High School	University	Don't Know
Alexandria	5.1%	12.3%	25.7%	46.4%	10.5%	0.0%
Beni Suef	9.6%	8.7%	6.1%	69.6%	6.1%	0.0%
Dhakalia	1.2%	9.3%	11.6%	67.6%	10.4%	0.0%
Qalyubia	1.4%	12.1%	10.6%	61.7%	12.1%	2.1%
Qena	2.3%	12.6%	26.4%	50.6%	6.9%	1.1%
Red Sea	0.8%	3.3%	17.1%	61.8%	17.1%	0.0%
Total	3.1%	10.2%	15.9%	59.3%	10.9%	0.6%

Based on the client interview responses regarding preferred family size, it appears that Egypt has effectively implemented many of its FP programs, resulting in changed attitudes towards family size. Overall, almost three-quarters of respondents said that they would prefer to have no more than three children. In fact, in Alexandria, Beni Suef, Dhakalia, and Red Sea, about 75 percent (or more) of clients felt this way. However, in Qena and Qalyubia the percentages were lower. In Qena, 61 percent of women wanted three or fewer children, with the remaining 39 percent wanting four or more. And, most distinctly, in Qalyubia only 37 percent of women said they wanted three or fewer children, with 63 percent desiring four or more. Therefore, FP programming should focus on these two governorates (especially in Qalyubia) to reduce the preferred family size.

TABLE 19: PREFERRED FAMILY SIZE (PERCENT OF CLIENTS)

Governorate	3 or Fewer Children Desired	4 or More Children Desired
Alexandria	81.6%	18.4%
Beni Suef	91.7%	8.3%
Dhakalia	73.4%	26.6%
Qalyubia	36.9%	63.1%
Qena	60.9%	39.1%
Red Sea	79.9%	20.1%
Total	73.6%	26.4%

An important determinant of the use of FP services can be the sex of the physician. The client interview assessed the views of the respondents about this issue. As expected, overall 79 percent of respondents said that they preferred a female doctor. About 17 percent said they had no particular preference and 3 percent said they preferred a male doctor. There is significant and sometimes surprising variation among the governorates in responses to this question. For example, 39 percent of respondents in Qena said they did not really care about the sex of the physician, followed by 24 percent in Dakahlia and 22 percent in Bani Suef. On the other hand, 94 percent of clients in Alexandria preferred a female doctor, and Alexandria also had the lowest proportion of clients that did not have a preference (5 percent).

TABLE 20: PREFERENCE REGARDING SEX OF DOCTOR (PERCENT OF CLIENTS)

Governorate	Prefers Female Doctor	Prefers Male Doctor	No Preference
Alexandria	94.2%	1.0%	4.8%
Dhakalia	66.4%	9.3%	24.3%
Qalyubia	86.7%	2.2%	11.0%
Qena	58.4%	2.5%	39.1%
Beni Suef	75.9%	2.4%	21.6%
Red Sea	81.1%	1.4%	17.6%
Total	79.3%	3.3%	17.4%

2.5.2 HOME VISIT BY HEALTH CARE WORKER

A key aspect of the FP program in Egypt is home visits by the Raedat Rifeat. The survey findings show that this aspect of the program is not working well, as only 38 percent of women overall reported having been visited in the last six months, 6 percent saying that they did not know if there was a visit, and the remaining 56 percent reporting no visit. Visit rates by governorate are strikingly varied, with the highest percentage (74 percent) of women reporting visits in Beni Suef, and the lowest percentage (16 percent) in Qalyubia.

TABLE 21: CLIENTS RECEIVED VISITS OR CALLS FROM FACILITY HEALTH CARE WORKER IN THE PAST SIX MONTHS (PERCENT OF CLIENTS)

Governorate	Yes	No	Does Not Remember
Alexandria	23.6%	64.4%	12.0%
Dhakalia	39.9%	53.4%	6.7%
Qalyubia	16.4%	81.7%	1.9%
Qena	54.0%	34.8%	11.2%
Beni Suef	74.2%	23.9%	1.8%
Red Sea	28.0%	70.6%	1.4%
Total	38.1%	55.9%	6.0%

Those who reported having been visited were also asked about the subject(s) discussed during the Raedat visit. The majority (87 percent) of respondents reported that they discussed FP methods with the Raedat. The bird flu was discussed among 21 percent of respondents, followed by vaccinations (reported by 8 percent). It is clear that important issues such as breastfeeding, H1N1, and female circumcision were not adequately covered during the Raedat visits.

TABLE 22: TOPICS DISCUSSED DURING HEALTH CARE WORKER VISIT/CALL MADE IN THE PAST SIX MONTHS

Topic	Percent of Visited Clients Reporting Having Discussed Topic
Family Planning	86.6%
Bird Flu	21.3%
Vaccinations	7.9%
Breastfeeding	2.1%
General and Special Hygiene	6.0%
Childbed Fever	0.2%
Child Care	2.1%
Child Feeding	0.5%
Child Polio	0.2%
Swine Flu	7.0%
Illiteracy	0.2%
Female Circumcision	4.7%
Pregnant Care	1.1%
Mother Care	0.8%
Do Not Remember	1.5%

Note: categories are not mutually exclusive, among those that reported a Raedat visit

2.5.3 SOURCES FOR OBTAINING FAMILY PLANNING INFORMATION

The government uses various methods to convey its FP message, including Raedat Rifeat, radio, television, newspapers, posters, and pamphlets. The answers from the survey shed light on the sources of information to which clients tend to be receptive, as displayed in Table 23. Note that respondents could select more than one information source. Across Egypt, the three highest reported information sources are friends/relatives/neighbors (52 percent), television (41 percent), and Raedat Rifeat (40 percent). Given that only 38 percent of women reported having received a visit by a Raedat, the low percentage reported in this question is not surprising, although it does point to failures in this program.

Women tended not to report having received FP information from religious leaders (<1 percent), the newspaper (1 percent), pamphlets/brochures (1 percent), or radio (1 percent). Health care providers and posters seemed to have some effectiveness (14 percent and 10 percent, respectively). The overall low numbers of women reporting having received FP information from their health care provider is a cause for concern and suggests that health care providers need more training in conveying FP information to their patients.

It is interesting to note that sources of information varied considerably by governorate. Friends/relatives/neighbors seemed to be a particularly large information source in Qalyubia (83 percent) and Alexandria (68 percent), a modest information source in Red Sea, Dakahlia, and Beni Suef (each at about 38 percent), and a small information source in Qena (17 percent). The reach of the Raedat Rifeat also varies considerably by governorate: three-quarters of women reported receiving FP information from Raedat in Qena and Beni Suef, about half identified them as a source

of information in Dakahlia, and one-quarter or less identified them as a source of information in Red Sea (25 percent), Alexandria (17 percent), and Qalyubia (16 percent). It appears that the Raedat Rifeat program needs improvements in these governorates.

TABLE 23: SOURCES OF FAMILY PLANNING INFORMATION (PERCENT OF CLIENTS)

Governorate	Radio	Television	Newspaper	Friend/ Relative/ Neighbor	Poster	Pamphlet/ Brochure	Raedat Rifeat	Health Care Provider	Religious Leaders	Other
Alexandria	3.0%	42.9%	1.5%	68.4%	13.3%	1.0%	16.8%	10.8%	0.0%	2.8%
Dakahlia	0.0%	44.6%	1.5%	38.0%	4.4%	1.5%	46.7%	6.7%	0.3%	2.6%
Qalyubia	2.8%	30.1%	0.6%	82.9%	7.7%	0.3%	15.8%	16.0%	0.6%	0.8%
Qena	0.6%	52.2%	0.0%	17.4%	1.2%	2.5%	76.4%	23.0%	0.6%	1.2%
Beni Suef	0.0%	23.0%	0.0%	37.6%	2.7%	0.0%	75.8%	26.4%	0.9%	2.4%
Red Sea	0.7%	78.7%	0.0%	38.7%	43.3%	0.7%	24.7%	2.7%	0.0%	0.0%
Total	1.4%	40.8%	0.7%	52.3%	9.9%	0.9%	39.8%	14.4%	0.4%	1.9%

Note: source categories are not mutually exclusive

2.5.4 REASON FOR CHOOSING FACILITY

Access to FP services tends to be good in Egypt. Proximity to place of residence, availability of needed services, presence of female providers, cost of services, confidence in provider, and quality of services were the primary reasons for choosing to come to a particular facility. Twenty-nine percent of clients interviewed cited closeness to their place of residence as the reason for coming to the facility. This was followed by availability of needed services (22 percent), presence of female provider (11 percent), cost of services (11 percent), confidence in provider (8 percent), quality of care (7 percent), and recommendation by Raedat Rifeat (5 percent), with other reasons making up the rest. There are intergovernorate variations, with the presence of a female provider being the predominant reason in the Red Sea, proximity to residence the primary reason in Qena, and the provision of needed services was the main determining factor in Qalyubia.

TABLE 24: REASON FOR CHOOSING FACILITY:

	Alexandria	Beni Suef	Dhakalia	Qalyubia	Qena	Red Sea	Total
Close to My House	36.2%	20.5%	29.2%	33.6%	37.7%	16.2%	28.6%
Provides Needed Services	18.1%	16.9%	24.8%	33.1%	19.2%	22.3%	22.3%
Confidence in Provider	6.6%	10.5%	11.4%	3.3%	2.7%	8.3%	7.6%
Presence of Female Provider	11.6%	8.2%	2.9%	15.5%	3.1%	36.7%	11.4%
Quality of Care	3.0%	11.4%	7.0%	2.6%	4.8%	11.2%	6.7%
Cost of Services	18.6%	10.4%	6.0%	8.2%	18.5%	2.2%	10.9%
Recommended by Raddeh	1.1%	9.3%	8.5%	0.8%	8.2%	2.9%	5.2%
Recommended by Friend/Family	3.7%	4.9%	4.4%	2.0%	4.8%	0.4%	3.6%
Other: Only Unit in the Village	1.1%	8.0%	5.8%	0.9%	1.0%	0.0%	3.7%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

2.5.5 TYPES OF SERVICES USED

Facilities offer a wide variety of FP services. The survey showed that a few of these services accounted for the vast majority of visits. Overall, 45 percent of clients came to the clinic primarily to obtain a contraceptive method. Twenty-two percent came for a follow-up on their contraceptive method, and 16 percent came for a gynecological exam. Note that Table 25 presents the primary reason for the client's visit to the clinic, and clients may have received more than one service during their visit.

TABLE 25: PRIMARY REASON FOR COMING TO FACILITY, BY GOVERNORATE (PERCENT OF CLIENTS)

Reason	Alexandria	Beni Suef	Dhakalia	Qalyubia	Qena	Red Sea	Total
Contraceptive Method	41.1%	42.3%	26.5%	62.5%	54.4%	52.0%	45.3%
Contraceptive Follow-Up	21.9%	36.9%	41.9%	20.3%	41.4%	14.0%	29.6%
Method Switch	9.1%	3.6%	2.8%	3.0%	1.2%	13.3%	5.1%
IUD Removal	2.7%	2.1%	6.4%	4.0%	0.0%	4.0%	3.4%
Treatment of Side Effects	0.7%	3.6%	1.1%	0.2%	0.0%	0.7%	1.2%
Infertility Consultation	0.0%	0.0%	0.0%	0.0%	0.0%	0.7%	0.1%
STDs and Infection	2.2%	3.3%	2.0%	0.5%	1.2%	2.7%	2.0%
Contraceptive Counseling	4.9%	0.8%	2.2%	1.2%	1.8%	1.3%	2.2%
Gynecological Exam	15.8%	5.9%	14.8%	7.2%	0.0%	10.7%	9.9%
Ultrasonography	0.5%	1.3%	0.0%	0.0%	0.0%	0.0%	0.4%
Pregnancy Test	0.0%	0.3%	0.3%	0.0%	0.0%	0.0%	0.1%
Pregnancy Follow-Up	1.0%	0.0%	1.1%	0.0%	0.0%	0.7%	0.5%
Premarital Exam	0.0%	0.0%	0.0%	1.0%	0.0%	0.0%	0.2%
Lab Analysis	0.0%	0.0%	0.8%	0.0%	0.0%	0.0%	0.2%

Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

2.5.6 PREFERRED METHOD

Table 26 provides details on the FP methods that women reported using. Overall, 42 percent of the sample reported using Depo-Provera injections, followed by Copper IUD (24 percent), the hormonal contraception Microsept (14 percent), the low-hormone pill Levenor for use while breastfeeding (13 percent), and the subdermal capsule Implanon (0.5 percent). Only 1 percent of the sample reported using condoms.

The survey results point to a great deal of variance among governorates in the preferred FP method. While some of this variance might be due to individual preferences, it is also possible that this is due to non-uniform availability of FP methods across the governorates. Specifically, in Alexandria the two most commonly used methods were a Copper IUD (35 percent) and Depo-Provera injections (31 percent). In Dakahlia and Qalyubia, Depo-Provera injections (43 percent and 40 percent, respectively) and Copper IUD (27 percent in both governorates) were the most commonly reported, and no clients reported using Implanon. In Qena, Microsept was the most commonly used method (45 percent) followed closely by Depo-Provera injections (42 percent), and this is the only governorate in which no clients reported using Copper IUD (and none used Implanon). In Beni Suef the majority (59 percent) of clients reported using Depo-Provera injections. Finally, in Red Sea four methods had similar usage: Copper IUD (28 percent), Depo-Provera injections (24 percent), Levenor pills (23 percent), and Microsept (22 percent).

TABLE 26: FAMILY PLANNING METHOD SELECTED (PERCENT OF CLIENTS)

Governorate	Hormonal Contraception Hormone (Microsept)	Low-Hormone Pills While Breastfeeding (Levenor)	Copper IUD (coil)	Depo-Provera Injections Every 3 Months	Subdermal Capsule (Implanon)	Condom	Did Not Take a Method
Alexandria	8.6%	11.2%	34.9%	30.9%	2.3%	4.3%	7.9%
Dhakalia	9.4%	10.5%	27.2%	42.8%	0.0%	0.4%	9.8%
Qalyubia	11.4%	13.5%	26.5%	40.3%	0.0%	0.6%	7.7%
Qena	44.9%	13.5%	0.0%	41.7%	0.0%	0.0%	0.0%
Beni Suef	5.7%	11.4%	17.1%	59.0%	0.0%	0.6%	6.0%
Red Sea	22.2%	23.0%	27.8%	23.8%	0.8%	1.6%	0.8%
Total	13.6%	12.8%	23.7%	41.5%	0.5%	1.3%	6.4%

2.5.7 COUNSELING AND INTERACTION WITH PROVIDER

One of the main roles of service providers is to discuss with the client the different methods available to them and to help the client select the one that is best suited to their needs. Based on the interview results, there is clearly room for improvement in this aspect of the program's implementation. Discontinuations of FP method use are most likely linked to the lack of counseling and support. Counseling and follow-up are important to help users avoid discontinuation and to ensure that users who experience problems switch to another method instead of abandoning use.

Clients were also asked whether or not the provider taught them how to use the chosen method. Eighteen percent of the respondents reported in the negative, with the highest percentage of "no" responses in Qalyubia (29 percent), followed by Bani Suef (25 percent), Alexandria (15 percent),

Qena (14 percent), and Dakahlia (10 percent). In Red Sea over 99 percent of the respondents reported that the provider had taught them how to use the method.

While 84 percent of respondents reported that the service provider explained the selected method to them, it still leaves 16 percent of the cases where the clients responded in the negative. Negative responses were highest in Qalyubia (32 percent) followed by Alexandria (14.8 percent) and Red Sea (13.8 percent).

TABLE 27: COUNSELING ON FAMILY PLANNING METHOD (PERCENT OF CLIENTS)

Governorate	Provider Explained All Available Methods (If Client's First Visit)		Provider Taught Client How to Use the Method	
	Yes	No	Yes	No
Alexandria	85.2%	14.8%	85.1%	14.9%
Dakahlia	95.1%	4.9%	89.8%	10.2%
Qalyubia	68.0%	32.0%	71.5%	28.5%
Qena	93.0%	7.0%	86.1%	13.9%
Beni Suef	92.4%	7.6%	75.0%	25.0%
Red Sea	86.2%	13.8%	99.2%	0.8%
Total	84.2%	15.8%	82.2%	17.8%

Finally, it is critical that the provider explain to the client possible complications associated with the chosen method and how to deal with them. As reported in Table 28, 20 percent of the respondents overall said that the provider did not explain common side effects. In Bani Suef, this proportion was 31 percent of the respondents, followed by Qena (25 percent), Qalyubia (21 percent), Alexandria (19 percent) and Dakahlia (12 percent). Red Sea again seemed to have the best client consultations, with 96 percent reporting that the provider had explained common side effects to them. Of the clients who were told about common side effects, 10 percent reported that the provider did not tell them how to deal with them. This was highest in Bani Suef (23 percent) and Qena (17 percent). Finally, among clients who were told about common side effects, 91 percent reported having been instructed to return to the clinic if the problem persisted.

TABLE 28: COUNSELING ON FAMILY PLANNING METHOD SIDE EFFECTS (PERCENT OF CLIENTS)

Governorate	Provider Explained Common Side Effects of the Method		Provider Told Client How to Take Care of Side Effects Themselves		Provider Told Client to Come to the Facility if Problem Persisted	
	Yes	No	Yes	No	Yes	No
Alexandria	81.2%	18.8%	94.0%	6.0%	89.3%	10.7%
Dakahlia	88.1%	11.9%	95.6%	4.4%	92.3%	7.7%
Qalyubia	79.2%	20.8%	90.0%	10.0%	92.9%	7.1%
Qena	75.0%	25.0%	83.3%	16.7%	94.2%	5.8%
Beni Suef	69.3%	30.7%	76.7%	23.3%	86.7%	13.3%
Red Sea	96.0%	4.0%	96.7%	3.3%	90.7%	9.3%
Total	80.1%	19.9%	89.5%	10.5%	90.8%	9.2%

2.5.8 USE OF WAIT TIME TO IMPART KNOWLEDGE ABOUT FAMILY PLANNING PRACTICES

Clinics can use time that the client spends in the waiting room to provide educational materials on FP practices or other health concerns. Unfortunately, 98 percent of clients reported seeing nothing during their wait time. These responses show that clinics can make much better use of wait times to impart critical information about a variety of FP issues.

TABLE 29: INFORMATION SEEN OR HEARD WHILE WAITING TO SEE PROVIDER (PERCENT OF CLIENTS)

Governorate	Nothing	Lecture About Female Circumcision	Lecture About Contraceptives	General Lecture	Lecture About Hypertension
Alexandria	99.7%	0.0%	0.0%	0.3%	0.0%
Dhakalia	99.2%	0.0%	0.4%	0.0%	0.4%
Qalyubia	97.4%	1.5%	0.0%	1.2%	0.0%
Qena	100.0%	0.0%	0.0%	0.0%	0.0%
Beni Suef	98.5%	1.2%	0.3%	0.0%	0.0%
Red Sea	93.5%	1.5%	4.4%	0.7%	0.0%
Total	98.3%	0.7%	0.5%	0.4%	0.1%

2.5.9 PARTICIPATION IN THE DECISION-MAKING PROCESS REGARDING WHICH METHOD TO USE

The survey provides interesting insights into the decision-making process regarding which FP method to use. Overall, the survey showed active participation by clients in the decision-making process. Ninety-six percent of respondents reported that they had participated in the decision about which method to use. This ranged from 98 percent in Dakahlia, Qalyubia, Alexandria, and Red Sea, to a low of 87 percent in Qena. It is also interesting to note that overall 94 percent of women reported that their husbands were involved in the decision to use contraceptives. In Qalyubia 10 percent of the women reported that their husbands were not involved in the decision, followed by 7 percent in Red Sea, 6.5 percent in Qena, 5 percent in Bani Suef and Dakahlia, and 4 percent in Alexandria. Overall, 72 percent of women said that their husband shared in the decision of which methods to use. This was highest in Red Sea (91 percent) and Dhakalia (90 percent), and lowest in Qalyubia (44 percent) and Qena (52 percent).

TABLE 30: PARTICIPATION IN DECISION-MAKING REGARDING THE FAMILY PLANNING METHOD (PERCENT OF CLIENTS)

Governorate	Yes	No	Don't Know
Alexandria	97.5%	2.5%	0.0%
Dhakalia	98.0%	2.0%	0.0%
Qalyubia	98.3%	1.7%	0.0%
Qena	87.2%	12.8%	0.0%
Beni Suef	94.0%	5.7%	0.3%
Red Sea	97.6%	2.4%	0.0%
Total	95.9%	4.0%	0.1%

TABLE 31: PARTICIPATION OF HUSBAND IN FAMILY PLANNING DECISIONS (PERCENT OF CLIENTS)

Governorate	Husband Shared in the Decision of Whether to Use Contraceptives		Husband Shared in the Decision of Which Contraceptive to Use	
	Yes	No	Yes	No
Alexandria	96.1%	3.9%	78.0%	22.0%
Dhakalia	95.2%	4.8%	89.5%	10.5%
Qalyubia	90.1%	9.9%	43.9%	56.1%
Qena	93.5%	6.5%	51.9%	48.1%
Beni Suef	94.6%	5.4%	80.8%	19.2%
Red Sea	92.7%	7.3%	91.1%	8.9%
Total	93.8%	6.2%	71.5%	28.5%

2.5.10 QUALITY OF CARE

USE OF GLOVES AND STERILE SYRINGE

An important indicator of the quality of care is the use of gloves by providers while inserting IUDs as well as ensuring that a new syringe is used for each injection. It is concerning that some clients reported that the provider did not use gloves for IUD insertion or did not use a sterile syringe for an injection. The problems seem to lie most heavily in Red Sea, where 30 percent of clients reported that the provider did not use gloves for IUD insertion and 26 percent of clients reported that the provider did not use a sterile syringe for an injection. Use of gloves is also a problem in Alexandria, where 13 percent of clients reported no gloves, and is a small problem in Dhakalia, where 3 percent of clients reported no gloves. Additionally, Alexandria is also a problem area in regard to the use of sterile syringes, as sterile syringes were reportedly not used in 6 percent of cases.

TABLE 32: PROVIDER USE OF GLOVES AND STERILE SYRINGE (PERCENT OF CLIENTS)

Governorate	Provider Used Gloves for IUD Insertion		Provider Used Sterile Syringe for Injection	
	Yes	No	Yes	No
Alexandria	86.9%	13.1%	94.4%	5.6%
Dhakalia	97.4%	2.6%	100.0%	0.0%
Qalyubia	100.0%	0.0%	100.0%	0.0%
Qena	100.0%	0.0%	100.0%	0.0%
Beni Suef	100.0%	0.0%	100.0%	0.0%
Red Sea	70.0%	30.0%	74.4%	25.6%
Total	91.8%	8.2%	97.5%	2.5%

CONFIDENTIALITY, PRIVACY, AND DISPLAYING THE PRICE LIST

Transparency and ensuring privacy as well as confidentiality are critical elements of any health care program. This is another area where some concerns exist. Overall, 91 percent of clients surveyed said there was enough privacy during the consultation. However, 20 percent of the clients in Qalyubia, 14 percent of clients in Dakahlia, and 10 percent of clients in Red Sea said that there was not enough privacy during the consultation. Another concern is the issue of confidentiality of information shared during the visit. This is an indicator of the trust the patient has in their provider. Only 65 percent of those surveyed said they were reassured about the confidentiality of information

they shared. In Qalyubia 72 percent of respondents said they were not reassured about the confidentiality of information shared, followed by 57 percent in Bani Suef.

TABLE 33: PRIVACY AND CONFIDENTIALITY (PERCENT OF CLIENTS)

Governorate	Enough Privacy During Consultation		Reassured About the Confidentiality of Information Shared During Visit	
	Yes	No	Yes	No
Alexandria	97.2%	2.8%	90.7%	9.3%
Dhakalia	86.3%	13.7%	80.8%	19.2%
Qalyubia	80.4%	19.6%	27.6%	72.4%
Qena	93.2%	6.8%	91.9%	8.1%
Beni Seuf	97.9%	2.1%	43.1%	56.9%
Red Sea	89.8%	10.2%	71.4%	28.6%
Total	90.7%	9.3%	65.2%	34.8%

Only 56 percent of those surveyed said the price list was clearly displayed at the clinic. In Qalyubia, 36 percent of the respondents said the price list was displayed, followed by around 50 percent in Bani Suef, 56.4 percent in Dakahlia, 69 percent in Qena, 69.3 percent in Alexandria, and 69.8 percent in Red Sea.

TABLE 34: CLIENT SAW PRICE LIST CLEARLY DISPLAYED IN CLINIC

Governorate	Yes	No
Alexandria	69.3%	30.7%
Dhakalia	56.4%	43.6%
Qalyubia	36.0%	64.0%
Qena	69.3%	30.7%
Beni Suef	49.7%	50.3%
Red Sea	69.8%	30.2%
Total	55.7%	44.3%

PAYING FOR CONSULTATION

The majority (70 percent) of clients across Egypt did not pay for their FP consultation. However, contrary to expectations, about 30 percent of clients reported paying at least EGP1.00 for the visit, although the interview did not collect the specific reasons why the client paid. The average amount paid was EGP1.80, with a minimum amount among paying clients of EGP0.75 and a maximum amount of EGP59.00 reported. There seems to be a wide variation across governorates in whether people paid for FP services, as well as the amount paid. Dhakalia had a significant portion of clients (60 percent) that reported paying. Qena had the smallest portion of paying clients (8 percent).

TABLE 35: CLIENT PAID FOR FAMILY PLANNING CONSULTATION

Governorate	Yes	No	Don't Know
Alexandria	39.3%	60.7%	0.0%
Beni Suef	10.7%	89.0%	0.3%
Dhakalia	59.7%	39.4%	0.9%
Qalyubia	19.7%	79.7%	0.6%
Qena	8.1%	91.3%	0.6%
Red Sea	26.2%	72.4%	1.4%
Total	29.8%	69.6%	0.5%

When looking at each type of expense incurred, for consultation the average amount paid was EGP1.80 and ranged from EGP1.00 in Red Sea to EGP2.60 in Qalyubia. For contraceptives, the average amount paid was EGP9.20. It was EGP1.00 in Qena, EGP1.10 in Bani Suef, EGP1.30 in Red Sea, EGP6.50 in Dakahlia, EGP10.40 in Alexandria, and EGP11.20 in Qalyubia. The average amount paid for lab services was EGP4.40, and ranged from EGP1.50 in Bani Suef to EGP7.00 in Red Sea. It was EGP6.30 in Qalyubia, EGP6.20 in Alexandria, EGP3.00 in Qena, and EGP2.50 in Dakahlia. Sonar charges were closely clustered around EGP5.00.

TABLE 36: OUT-OF-POCKET SPENDING ON CARE (AMONG THOSE WHO PAID), IN EGP

	Consultation	Contraceptives	Drugs	Labs	Sonar	Transportation	Total
Alexandria	2.40	10.40	1.10	6.20	5.30	1.10	26.50
Beni-Suef	1.40	1.10	1.30	1.50	5.00	0.60	10.90
Dhakaliya	1.20	6.50	1.30	2.50	5.10	1.30	17.90
Qalyubia	2.60	11.20	1.50	6.30	5.20	1.30	28.10
Qena	2.50	1.00	3.00	3.00	5.00	2.80	17.30
Red Sea	1.00	1.30	1.00	7.00	5.00	2.10	17.40
Average	1.80	9.20	1.50	4.40	5.10	1.50	23.50

2.5.11 PERCEPTIONS ABOUT FACILITY HOURS

There is a hypothesis that keeping FP clinics open all day will increase utilization of FP services. This was not borne out by the survey. Overall, 92 percent of respondents said that they prefer to go to the clinic for FP services in the morning; 4 percent said they prefer the morning or afternoon, 1 percent said they prefer the clinic to be open 24 hours, 2 percent prefer the afternoon, and only 0.3 percent prefer the night. The responses are similar across governorates.

2.5.12 SATISFACTION WITH THE SERVICE PROVIDED

The survey asked a number of questions about the client's satisfaction with the services they received at the facility. Overall levels of satisfaction were high, with 98 percent of clients reporting that the provider listened to their questions and concerns, 98 percent reporting that they were satisfied with the length of visit, 99 percent reporting that they had been treated either very well or

well by the doctor, and 98 percent reporting that they had been treated either very well or well by the nurse. Satisfaction levels were consistent across governorates.

TABLE 37: CLIENT SATISFACTION WITH DOCTORS AND NURSES

Area of Satisfaction	Very Well	Well	Not Very Well
How Well Client Was Treated by Doctor	30.3%	68.6%	1.1%
How Well Client Was Treated by Nurse	22.3%	75.7%	2.0%

2.5.13 CLIENT RECOMMENDATIONS FOR IMPROVING QUALITY

Of those surveyed, 75 percent in Qena, 70 percent in Alexandria, 62 percent in Dakahlia, and 50 percent in Red Sea felt services could be improved. Some of the recommendations were not specific to FP but covered ways to improve overall quality of services provided at the clinics. In Alexandria the main suggestions centered on having more physicians, the need for more female doctors, and having better operating rooms. In Bani Suef the primary recommendations were once again regarding having more physicians available and increasing the number of female doctors. However, 33 percent also felt there was a need to improve the waiting area. In Qalyubia the primary recommendation was to increase the variety of FP methods, medicines, and supplies, followed by the need to have more physicians, a blood analysis lab, and better hygiene at the clinic. In Red Sea, once again, there was a request to improve availability of different FP methods, increase the number of female doctors, and improve the labs. In Qena the three key recommendations were to increase availability of FP methods, increase the number of female doctors, and improve the operating room conditions. In Dakahlia, the three main recommendations centered around improving the availability of FP methods, increasing the number of services at the clinic, and improving the communication and organization of the clinic.

2.6 IMPACT OF THE FAMILY HEALTH MODEL ON THE FAMILY PLANNING PROGRAM

Interviews with FP managers highlighted the impact of the integrated FHM on the FP and MCH programs. Many FP physicians and nurses were recruited to the Family Medicine (FM) program through the latter's better incentives; as a result, they now provide all types of services and no longer work exclusively for the FP program. This shift of human resources has created problems for the program in urban areas where FP clinics had specialist FP physicians and nurses. When the well-trained FP health professionals became FM doctors and nurses, the FP program had to train new FP physicians and nurses who are not as experienced or well-trained as their predecessors. In the words of one of the physicians working for the FP program in an urban governorate, "newly trained physicians and nurses do not provide services with the same quality as the old staff – there is a difference between training physicians and nurses for years versus weeks – the newly trained physician is usually afraid to insert an IUD so they just give pills."

The problem is further exacerbated in urban areas because FHM professionals receive performance-based incentives according to the FM program rules, while physicians and nurses working at the FP clinics receive no such incentives. This has created a situation where being a FP health care provider is the least desirable profession at the PHC clinics in urban areas. Also, as an MOHP interviewee stated: "as physicians and nurses rotate between clinics at the PHC, they give the lowest priority to the FP clinic because it is the only clinic where are there no performance-based incentives." This problem does not exist in rural areas because rural physicians and nurses have traditionally provided all types of services to clients who come to the rural health unit.

Clients who go to the FHM units must pay a one-time fee of EGP30 in order to open a file at the unit. However, the FP program noticed that clients coming in for contraceptives did not want to pay the fee, so the Head of Family Planning at the central level made a new rule that any woman coming

in for contraceptives would only pay for the contraceptives with no additional fees. Consultations at FP units are free of charge, but nearly 30 percent of client respondents in this assessment said they paid for the consultation, with the highest proportion in Dakahlia (59.7 percent). As shown earlier, there was significant inter-governorate variance regarding payment for consultation. Given that the MOHP has standard guidelines for paying for FP services, and a limited number of services accounted for the vast majority of visits, one would not have expected to see such large differentials.

As was similarly found in the Maternal and Child Health assessment in this study, the FHM is perceived by MOHP policy- and decision-makers as an effective mechanism to providing integrated, cost-effective preventive health care, but the system is not yet mature enough to fully support integration of FP services. A phased approach is recommended, where continued support for vertical programs during a limited period of time is paralleled with efforts to build integrated systems.

2.7 RECOMMENDATIONS

Based on the results of this assessment, there are several issues that call for special attention by the MOHP. This section describes these issues and recommendations for action.

Address population and poverty issues. The size of the Egyptian population is still of major concern. The current population of Egypt is 88 million, and the population growth rate from 2005 to 2010 was 1.8 percent (United Nations 2010). Egypt has high population density, with 2,000 inhabitants in every square kilometer. FP concerns are a major priority for Egypt and it is seen as one of the most important strategies to slow population growth and reduce demographic pressure. Currently, 40 percent of the total population lives below the poverty level, while 60 percent of Cairo's inhabitants dwell in informal areas (Fischer and Kipper 2009), which may include slums and shantytowns (World Bank 2010). Studies in Jordan and Bangladesh have demonstrated the link between economic development and falling rates of fertility and mortality. Reductions in TFR lead to higher investments in children (due to smaller family size), and when this is combined with appropriate education, health, and labor policies it triggers and sustains economic growth. This process is described as a "virtuous spiral" of demographic transition, and in order for it to occur, governments must be proactive. Countries that do not take a proactive stance on this issue run the risk of large segments of their population living at or near poverty levels, which in turn slows growth, increases inequities, and fosters social unrest. As part of the FP program's goal to improve the quality of and access to FP and reproductive health services, the FP program needs to continue to address the unmet needs of squatter and deprived areas.

Strengthen coordination with NGOs and the private sector. An estimated 40 percent of women still prefer private to public providers for FP methods (El-Zanaty and Way 2009). This is despite the fact that public services are often one-third the price of private services (Khalifa1995). Even though the involvement of the private sector in service delivery is high, private sector involvement in policy formulation and coordination with the FP program is weak because the incentives for them to participate in the program are not strong. Public cooperation with NGOs is also rare, and the MOHP seldom encourages NGO efforts through adequate funding or participation (Khalifa et al. 2001: 21). The fear is that lack of cooperation and dialogue among NGOs, private, and public entities will soon lead to inefficiencies, where all three are servicing the same goals and their efforts are potentially overlapping in some areas while completely neglecting others.

Decentralize the FP program and improve data quality. The Government of Egypt is moving toward implementing decentralization. However, there is concern that major steps are needed in the future in order for the FP program to become decentralized. This study has shown that there are significant differentials across governorates, and therefore different needs and areas for improvement. The EDHS does not provide governorate-specific information, which the heads of FP programs believe would allow them to do a better job in planning activities. Without doing governorate-specific planning, it is difficult for FP mangers to address leading policy questions and to direct policymakers' attention to these issues. The program heads would also like to see more information on client feedback. Studies that demonstrate how the client feels about the services

provided are crucial for FP managers, because it allows them to see how satisfied the clients are and what areas needs improvement.

Sustain demand. Concern about demand is based on the concept of momentum, which describes the fact that as population in Egypt continues to rise, so does the demand for FP products such as commodities. Momentum "occurs when a large proportion of women are in the childbearing years"(Khalifa et al. 2000: 2); current estimates of women in the childbearing years (aged 15–49) in Egypt amount to about 48 percent of Egypt's total female population (CAPMAS 2009), which is an indication of the extent to which this issue requires utmost attention. Thus, although fertility rates have plateaued, population growth coupled with increases in momentum are causing concern regarding decreases in donor funding and the lack of response by the MOHP.

Reduce unmet need for FP. Unmet need for contraception refers to women who do not want more children or want to delay their next pregnancy but do not use contraception. There are several indications of unmet need for FP in Egypt. According to the 2008 EDHS, the unmet need for FP is 14 percent (El-Zanaty and Way 2009: xxii). Results of this study have also shown fair amounts of variation across governorates in regard to shortages in FP supplies, as well as clients' perception of the need to improve availability of different FP methods. The FP programs must reach these clinics and women who are most in need of contraceptive services. To achieve the government's goal of 2.1 children per woman in 2017, it will be necessary to increase contraceptive prevalence to 70 percent. Most of the increase can be achieved by meeting current unmet need.

Establish an operational financing system and ensure availability of financial resources for all aspects of the FP program. In the coming years financial needs will increase, not only because of the need to reach more people with FP methods but also because of cutbacks in donor assistance. Donors have worked on building institutional capacities in the form of trained health personnel, standards of practice, and clinic renovations and equipment, as well as MIS. As donor funding is decreasing, Egypt must be prepared to continue the efforts of the donors. This includes sustaining training and supervisory activities. Training activities were severely affected by the ending of the implementation letter (IL). The FP program used to have budgets for training that included realistic per diems and incentives for trainers and trainees as well as for the logistics of conducting training. Most of this training was replaced by on-the-job training, which is insufficient and therefore affects the quality of providers. Similarly, while the IL was in effect, there were allowances for supervisory visits, which now are not available. Financing is needed to update the fleet of supervisory program vehicles, to ensure that supervisors can access all health facilities, especially those in more remote areas.

In order to create a sustainable MOHP FP financial system, several activities must first be undertaken. These include:

- **Establishing a dedicated line item for FP methods:** this will ensure that availability of critical supplies and procurement methods are streamlined.
- **Institutionalizing the ETS as part of the HEU:** it will be impossible to adequately meet future challenges if policymakers, planners, and managers at the national, governorate, district, and facility levels are unaware of the amount of financial resources being used and what they are being spent on.
- **Training of staff at all levels on the use of financial information to improve program effectiveness and efficiency:** in the coming years Egypt is likely to face increased economic strain, and this will likely be reflected in a tightening of government budgets. Under these circumstances focusing merely on the sufficiency of funds will not suffice. It will be even more important to ensure greater allocative and technical efficiency in how resources are used. Explicitly developing and implementing a "value for money" culture and matrix should be a priority. This means the government will need to define what "value for money" in the Egyptian context means and use that definition to develop a performance matrix. This matrix should be used to assess effectiveness of spending.

Establish a FP workforce strategy that addresses the following:

- Continue to promote importance of mobile clinics and equip the mobile clinic with female providers.
- Increase the number of female providers and ensure their allocation in governorates with highest demand for female doctors. Results of this study showed that the majority of clients (73 percent) prefer female providers.

Leverage the role of different providers to increase access to FP services. This includes promoting the role of pharmacies in distributing methods as well as the necessary procedures that go along with the method, and increasing the role of NGOs since many of them are better equipped or able to reach out to marginalized communities. Also, the role and the pay of the Raedat should be strengthened and improved because of the major role they play in disseminating FP messages.

Secure the availability of major commodities and equipment that are critical for sustaining the program. This assessment shows that there is a need to ensure that facilities have the necessary equipment and supplies. The program should also address vehicle issues, which came up in all six governorates as a major challenge faced by the program, as well as fixing equipment. .

Improve training and supervision:

- This study clearly indicates that doctors need better training on how to counsel their patients, and highlights the importance of contact with a health provider and the opportunity for confidential discussion about FP issues. A majority of providers surveyed in six governorates reported that more training is needed. Training activities were severely affected by the ending of the IL. As described earlier, the FP program used to have budgets to conduct trainings, but these have since been replaced by on-the-job training, which is not sufficient.

Strengthen IEC programs. The 2008 EDHS found that only 67 percent of currently married women age 15–49 had heard or seen a FP message during the six months prior to the survey, which is substantially lower than the level of exposure to FP messages reported in the 2005 EDHS (91percent) (El-Zanaty and Way 2009: xxii). To a large extent, demand for FP has increased due to the media and IEC campaigns that donor projects have supported, and it is alarming how much this number has decreased. Results of this assessment show that 98 percent of respondents indicated that they did not see or hear any FP messages in the clinic's waiting room. Also, young people need more information on reproductive health and access to services before they have their first child (Beamish 2003). Ninety-eight percent of Egyptian women consider it inappropriate for a newly married couple to use contraception to delay the first pregnancy (El-Zanaty and Way 2009: xxiv). This is not only because couples are under social pressure to begin childbearing right after getting married, but also because there are misconceptions regarding FP, regardless of socioeconomic group.

- Information and education on adolescent reproductive health, specifically targeting Egypt's young adults, have been severely limited. Egypt has changed in the past 50 years, especially in the realm of media through satellite and movies, and the country should utilize the lack of taboos in media to address sexual and reproductive health education. Many young couples are entering into marriage with insufficient information on sexuality, reproduction, and FP (Beamish 2003: 13).
- The government should make it a priority to convey FP messages to people through whatever means possible and secure funding for these activities. This should include employing creative mechanisms which will facilitate transmitting information to more communities, such as:
    - Disseminating commercials on satellite channels and taking advantage of high viewer hours on public television, such as during football games or evening talk shows, to show its advertisements. By seeking out peak viewing hours according to type of program and the segment of society which views these programs, advertisements can cater to specific audiences and effectively reach men and women through clear, targeted messages.
    - Using TV to incorporate "clean" sex education messages into adolescent programs.

- Developing a website that targets young couples which allows them to privately obtain reproductive and sexual health education.
- Advertising for specific contraceptives in magazines targeted to women and clearly describing side effects. This will help eradicate myths about certain contraceptive side effects.
- Increase overall time allotted for free public services messages.
- **Provide IEC information to clients in waiting area to avoid missed opportunities.** A majority of clients in the six governorates surveyed reported that they did not see or heard any education session while waiting for FP services, with only 8 percent of respondents in Dakahlia reporting that they heard an educational session.
- **Incorporate new ideas for how Raedats can reach more people.** For example, factories or government offices that employ a high percentage of women could have a day where a Raeda visits and conducts a group information session.
- **Strengthen the role of NGOs.** Despite considerable increases in NGO activity in Egypt in general, their prevalence in FP in particular remains low, especially in service provision. Donors and international organizations continue to advocate that the government integrate and encourage the activities of NGOs, especially since they are able to take on a community-based approach in marginalized areas. NGOs could play a bigger role in designing strategies and evaluation campaigns.

Establish a research unit within the FP program. The FP program needs to take the lead in policy analysis and share results with other stakeholders. Policymaking and organization should be guided by the information available to the MOHP through studies and observed trends, especially since current information regarding FP users and financial distributions is often not effectively utilized (Beamish 2003: 13).

Address the challenges faced due to the implementation of the Family Health Model. Further evidence is needed to assess the impact of the integrated FHM on maternal and child health outcomes. A strategic plan should be developed to capitalize on the existing support for improving FP, to fully implement the transition from a vertical to an integrated service delivery model and to carefully allocate resources. Careful management is necessary to optimize the use of existing skilled health workers while future initiatives could improve the strength of skilled health workforce.

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