



## POLICY BRIEF

# The Private Sector as a Provider of Family Planning Services in Egypt:

## Challenges and Opportunities

The recent increase in Egypt's fertility rate, following decades of progress in lowering fertility levels, highlights the need for renewed attention to the country's family planning program. The Ministry of Health is currently the largest provider of family planning in Egypt, serving a diverse population of women, many of whom may not need the free public service. Expanding the role of the private sector in the provision of family planning services and supplies holds great potential to more effectively meet the current and future family planning needs of millions of Egyptian women.



## GROWING POPULATION AND UNMET NEED

Since the inception of the National Population Program in the mid-60s, Egypt has made significant strides in lowering fertility levels, from a total fertility rate (TFR) of 5.3 in 1980 to 3.0 in 2008 (Ministry of Health and Population, El-Zanaty and Associates, and ICF International 2015). However, the TFR has since risen to 3.5 in 2014. This recent increase, along with a persistently high contraceptive discontinuation rate of around 30 percent, has raised the alarm that current family planning (FP) programming in Egypt is losing momentum and must be reinvigorated. If the current annual population growth rate of 2.5 percent continues, Egypt's population will hit 120 million in 2030.

Currently, more than 16 million women in Egypt have a demand for FP – they are either currently using contraception (13.2 million) or want to delay or stop childbearing but are not using contraception (2.8 million). Although the Ministry of Health and Population (MOHP) is the largest provider of FP services, it may not be able to meet the current needs of Egyptian women or the future needs of the growing cohorts of women who are entering into reproductive age, some of whom may not prefer or need the free public service. Thus, options to expand FP access through the private sector (including for-profit and not-for-profit) should be explored.

### More than 16 million women in Egypt have demand for family planning.

In 2014, 43 percent of married women using a modern FP method obtained their method at a private facility (private clinic or hospital, NGO clinic, or pharmacy). This percentage has decreased significantly since 1995, when 64 percent of married women using a modern FP method relied on private sector sources (Ministry of Health and Population, El-Zanaty and Associates and ICF International, 2015) (see Figure 1). Use of private physicians declined from 27.9 percent in 1995 to a low of 21.7 percent in 2014. Pharmacists' contribution declined from 23 percent in 1995 to 20.5 percent in 2014.

However, the most remarkable change has been in the contribution of NGO clinics: In 1995, about 10 percent of contraceptive users obtained their method at an NGO facility, while only 0.6 percent did so in 2014.

### The percentage of women using contraception who relied on the private sector declined from 64 percent in 1995 to 43 percent in 2014.

This brief examines the role of the private sector in providing FP services and identifies challenges that are hindering the private sector from playing a more effective role in FP service delivery. In addition, this brief offers recommendations on how to strengthen the role of the private sector in providing FP to meet the needs of 16 million women with a demand for family planning.

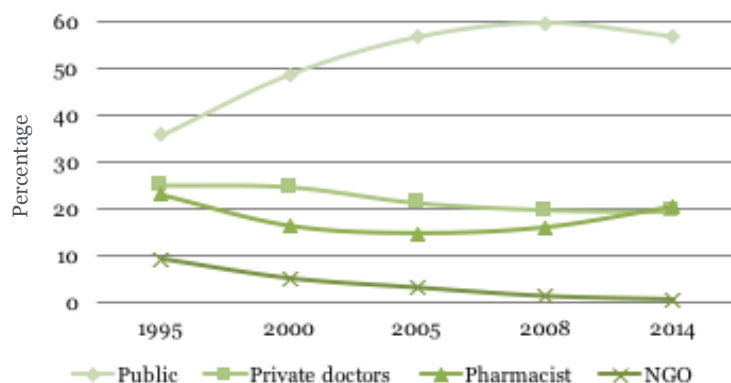
## METHODOLOGY LEADING TO EVIDENCE-BASED SOLUTIONS

The results and recommendations presented in this brief are based on: (1) a desk review of published and gray literature (2000-2015) on the role of the private sector in providing FP services in Egypt and related aspects of the policy environment that may influence functioning of the private sector; (2) secondary analysis of Egypt Demographic and Health Surveys (EDHS), including a market segmentation analysis to identify socio-demographic and economic characteristics of women who could be targeted by the private sector; and (3) a qualitative component which included in-depth interviews (IDIs) with key informants from public and private sectors and development agencies, IDIs with private sector providers, and focus group discussions (FGDs) with married women of reproductive age (18-40 years old) who had ever used FP methods from the public or private sector. Participants for the study were recruited from Cairo, Assiut, and Gharbeya governorates. This work was conducted under the Evidence Project, a USAID-funded project led by the Population Council.

## WHO PROVIDES FAMILY PLANNING SERVICES IN EGYPT?

Family planning services are provided through a wide network of public (governmental) and private (nongovernmental) facilities. Public facilities are mostly run by the MOHP and include primary health care facilities and hospitals, while private facilities include for-profit (private doctors, private pharmacies, and private hospi-

**FIGURE 1: TRENDS IN LOCATIONS OF WOMEN OBTAINING MODERN FAMILY PLANNING METHODS**





## About one third of women who obtained their FP method at the public sector can afford to obtain services at the private sector.

tals) and not-for-profit organizations (nongovernmental organizations that provide health services, including private voluntary organizations (PVOs), community development associations (CDAs), and clinics affiliated with mosques or churches).

The public sector, namely MOHP, is the largest provider of FP services in Egypt, used by 57 percent of FP users (Ministry of Health and Population, El-Zanaty and Associates and ICF International, 2015). There are nearly 5,000 FP clinics affiliated with MOHP (National Population Council, 2015), including rural health units, urban health centers, Family Health Units, clinics at general service hospitals, and mobile units. MOHP facilities offer FP services at nominal fees (ranging from EGP 0.65 for oral pills to EGP 5.0 for subdermal implants) from 8 AM to 2 PM, six days a week. MOHP facilities offer combined oral contraceptives (COCs), progestin-only pills (POPs), three-month injectables, Copper T IUDs, and condoms. Some facilities also carry one-month injectables, while subdermal implants (Implanon) are offered in selected urban facilities that have a trained Ob/Gyn specialist or Reproductive Health specialist. Three-month injectables and subdermal implants are imported exclusively for MOHP; three-month injectables may be offered at NGO clinics, but are not supposed to be sold in pharmacies or offered by private clinics, and subdermal implants are only offered in public facilities. Although MOHP facilities cater to poor women who cannot afford private services, EDHS 2014 data indicate that 34 percent of women who obtained their FP method at the public sector belong to the highest two wealth quintiles.

According to EDHS 2014, 21.7 percent of FP users obtained their method at a private clinic or hospital. There are more than 30,000 private clinics across Egypt (CAPMAS, 2014), mostly concentrated in urban areas, especially Cairo and other large urban centers (Nakhimovsky, 2011). Physicians who work in public facilities are permitted to work in the private sector after work hours, and almost three quarters of private sector physicians also have a government job (Cairo Demographic Center, 2002). The cost of FP services offered by private physicians varies widely, depending on the physician's level of seniority, academic degrees, and clinic location. Most private clinics do not offer FP methods and instead refer clients to pharmacies to buy oral pills, an IUD, or an injectable. However, some private doctors carry IUDs in their clinics, while others carry three-month injectables or subdermal implants, which are occasionally obtained unofficially from the public sector. Private doctors who offer FP services are most likely to be general practitioners (GPs) or Obstetricians / Gynecologists (OB/Gyn specialists). For example, the cost of IUD insertion at a private clinic ranges from EGP 30-100 in poor neighborhoods to EGP 150-200 in middle-income neighborhoods and EGP 300-350 in high-income neighborhoods.

<sup>1</sup> US\$= 8.83 EGP.

<sup>2</sup> Implanon costs EGP 5.0 at public facilities.

One in five FP users in Egypt visit pharmacies to obtain their FP method. There are more than 60,000 private pharmacies across the country (CAPMAS, 2014), in both rural and urban areas, though concentrated in urban areas. Most private pharmacies offer COCs, mini pills, one-month injectables, and condoms. Emergency contraceptive pills (ECPs) are available on an irregular basis, while IUDs are more likely to be found in pharmacies located near Ob/Gyn doctors, to ensure they will be purchased by clients. Prices of FP methods are fixed by the government at all pharmacies, with profit margins ranging from 5 to 10 percent. Prices of FP methods sold at pharmacies vary widely, according to which company produced the method. For example, one brand of IUD costs EGP 15.0, while another costs EGP 700. Pharmacies obtain their contraceptive commodities from manufacturing or importing pharmaceutical companies, via distributing companies.

Finally, NGOs are a source of FP for just 0.6 percent of FP users in Egypt. There are nearly 2,000 registered NGOs that supposedly provide FP services in Egypt, but only 274 NGOs reported on their FP activities in 2015, suggesting that some NGOs have frozen their FP activities or closed down altogether (National Population Council, 2015). In general, large NGO clinics that provide FP services are located in urban areas, while those run by Community Development Associations (CDAs) are usually located in rural or slum areas. NGO clinics cater to lower-middle-class women as well as women in communities without public services (e.g. slum areas). NGOs receive subsidized FP commodities, namely oral pills, condoms and three-month injectables, from the government and sell them at the same price as MOHP facilities. However, they are allowed to charge higher consultation fees, ranging from EGP 10.0 to EGP 45.0.

## CHALLENGES AND OPPORTUNITIES FOR FP PROVISION THROUGH THE PRIVATE SECTOR

### 1. COMPETITION BY THE PUBLIC SECTOR

The public sector is a strong competitor for the private sector. With MOHP's highly subsidized rates, widespread coverage in most governorates, and relatively good quality of services, many women do not have a strong reason to go to the private sector for FP services. Restricting provision of certain FP methods (i.e. three-month injectables and subdermal implants) to public facilities limits the private sector's ability to play a role. These restrictions on private sector providers limit the availability of specific contraceptives to women who do not want or need to use public services.

Insufficient cooperation and dialog among private and public sector entities may lead to duplication of efforts in some areas and neglect in others (Health Systems 20/20 Project, 2012). The fact that

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*“I used to pay EGP 12 to get an injection at a private doctor’s, then I found it for EGP 3.5 at the NGO center and for EGP 1.0 at the government, so I decided to get it at the NGO center.”*

*– An interviewed woman*

34 percent of women who obtained their FP method at a public facility belong to the richest two wealth quintiles is a good example of inefficient targeting and poses a burden on meager government resources. This is despite the fact that many women are willing to pay for FP services: The majority of women who participated in our FGDs expressed willingness to pay EGP 20-30 in return for good quality FP services, while a few said they were willing to pay up to EGP 50.

### RECOMMENDATION 1

#### Adopt a total market approach

Egypt's FP program should consider adopting a total market approach whereby all sectors are integrated within one “market” that is segmented by willingness to pay (Pollard, 2007; Brady et al., 2016). MOHP should target those who live in remote rural and low-income urban areas; NGO clinics should target lower-middle-class women; private doctors should target middle- and upper-class women, while pharmacists should target all groups of women and possibly husbands.

### RECOMMENDATION 2

#### Foster public-private partnerships

The relationship between the private and public sectors needs to be more complementary than competitive. MOHP should make all FP methods available to the private sector (including three-month injectables and subdermal implants) in return for provision of adequate statistics and good quality services. Moreover, pharmaceutical companies could take advantage of privileges offered to MOHP on national TV and jointly sponsor media campaigns with MOHP on public TV and satellite channels to promote specific FP methods.

## 2. BUREAUCRATIC PROCEDURES AND RESTRICTIVE POLICIES LIMIT CONTRACEPTIVE OPTIONS

Pharmaceutical companies complained about long and complex procedures that must be followed for registration of a new FP commodity. The registration process is supposed to be completed in six months, but often takes up to two years, and some commodities failed to receive registration approval, without valid justification. Study participants believe that the fact that drug approvals are issued by MOHP and not an independent entity like the Food and Drug Administration in the United States makes the process liable to frequent change of policies and procedures with the change of ministers.

Current pricing policies discourage pharmaceutical companies from manufacturing or importing contraceptives. In many cases, the price set by the MOHP Committee does not allow for a sufficient margin of profit to the importer or manufacturer, who may then decide not to import or manufacture a contraceptive that is not bringing in enough profit (e.g. Copper T IUD and ECP). Moreover, importation policies may be responsible for method stock-outs as the Central Agency for Pharmaceutical Affairs performs routine inspection of every shipment and sends samples to be analyzed by the National Organization for Drug Control and Research, a process which could take up to several months.

At the policy level, there are positive and encouraging messages from senior government officials: The recently released “Sustainable Development Strategy: Egypt’s Vision for the Year 2030,” by the Egyptian Government focuses on expanding the role of the private sector in the country’s economic development and simplifying registration procedures that deter foreign investors from starting businesses in Egypt.

### RECOMMENDATION 3

#### Ensure method availability and expand method choice

**Current registration procedures and importation pricing policies for FP methods should be revisited by MOHP. To help women prevent unintended pregnancies, emergency contraceptive pills, woman-controlled barrier methods, and long-acting, reversible methods should be made available to both public and private sectors.**

## 3. INADEQUATE PROVIDER KNOWLEDGE AND SKILLS IN THE PRIVATE SECTOR

Pharmacists who participated in the qualitative study generally indicated that they did not receive any training in FP, although some of the older pharmacists said that they received training several years back through the ‘Ask – Consult’ project (active from 1994 to 2008).

Shortage of international funding and political transitions over the last five years have led to the discontinuation of training programs for physicians, which has contributed to limited knowledge. Those affiliated with MOHP mentioned that the Ministry used to provide training, but not in the last five years. The quality of private sector FP services is further undermined by the absence of standard operating procedures for private providers, combined with lack of supervision and training.



*“What I cannot understand is people who just got married and want to use FP ... this is wrong because she may not be able to get pregnant afterwards.”*

*- A private physician*

Reports by women and providers who participated in the qualitative study suggest serious knowledge gaps and misconceptions among private sector providers in relation to FP. For example, FGD participants mentioned that their private doctors advised them against using subdermal implants because they could cause infertility, water retention or “they could melt inside a woman’s body if she is exposed to heat of the oven,” none of which is true. Other doctors said they believed female sterilization and ECP were ‘haram’ to use.

It is noteworthy that coverage of FP methods in medical and pharmacy schools is very limited, with no opportunities for continuing medical education (CME). Doctors rely on medical representatives from pharmaceutical companies as their main source of information. Inadequate physician knowledge and misconceptions about some methods limit contraceptive options for women, and indirectly affect pharmacists and the pharmaceutical industry, as doctors are unlikely to prescribe certain methods, contributing to low sales remain and eventual discontinuation by importation companies.

#### RECOMMENDATION 4

### Educate physicians & pharmacists about new FP methods

Pharmaceutical companies should increase awareness of new brands of FP methods among physicians and pharmacists through brochures, newsletters, and medical representatives as well as conferences and training workshops.

#### RECOMMENDATION 5

### Integrate FP and contraceptive technology into medical and pharmacy school curricula

Training for undergraduates should include expanded information on FP, while programs for house officers and OB/GYN residents should include practical training in FP counseling, and IUD and implant insertion and removal.

Only 53 percent of women aged 15-49 know the male condom and less than one in eight men and women know about Emergency Contraceptive Pills (ECPs).

-EHIS, 2015

Antenatal care (ANC), postnatal care (PNC), and child health care visits are a few of the missed opportunities for raising client awareness about FP. Eighty-eight percent of women with demand for FP received ANC at a private facility, and more than one-third delivered at a private facility. Furthermore, slightly more than half (52 percent) of children who had acute respiratory infection symptoms were taken to a private physician (Ministry of Health and Population, El-Zanaty and Associates and the ICF International, 2015), which offers an opportunity to bring up FP with mothers.

#### RECOMMENDATION 6

### Capitalize on other opportunities to offer FP counseling

Private doctors should capitalize on all opportunities to counsel women and their husbands about FP, including during ANC, PNC and child health care visits.

The private sector should also work to make its services more attractive to clients and to justify its higher prices. NGOs need to enforce the use of service delivery guidelines to ensure minimum standards of quality, while doctors and pharmacists must more proactively seek new information about FP methods and enhancement of their own skills. Private physicians and NGO clinics could also consider offering extended hours and additional services to attract more clients (e.g. breast or cervical cancer screening).

#### RECOMMENDATION 7

### Create demand for private FP services

The private sector should create social marketing campaigns that specifically target young couples, those in the upper two wealth quintiles and those who live in urban areas. Campaigns should also target youth at universities, youth centers, and factories as a strategy to “prepare the market” before they get married. Innovative communication channels such as social media and mobile technology should be explored.

## 4. REDUCED DEMAND FOR PRIVATE FP SERVICES

Between 1985 and 2000, several USAID-funded projects supported the private sector, namely Family of the Future (1981-1990), Clinical Services Improvement Projects (CSI) (1988-2003), the Doctor's Project (1990-1992), and Ask-Consult (1994-2008). Efforts aiming at improved service delivery and expanding method choice were coupled with intensive demand creation activities, such as media campaigns while the Gold Star program improved quality of services in the public sector. Concerted service strengthening and demand creation efforts, along with strong political support, resulted in a fertility decline from 4.4 in 1988 to 3.5 in 2000. (Robinson and El-Zanaty, 2006).

However, in 2007, direct USAID funding to the national FP program ceased. As a result, most of the above mentioned projects, including social marketing campaigns, ended or decreased their activities, which has led to decreased awareness of new FP methods among both clients and providers. Women's exposure to FP messages through mass media declined from 100 percent in 1995 to 47 percent in 2014. Lack of awareness of some methods (e.g. ECP) along with negative attitudes towards other methods (e.g. condoms) reduce the likelihood of physicians prescribing those methods or clients requesting them.

## 5. FUNDING AND STAFFING CONSTRAINTS FOR NGOS

Lack of funds is the main challenge facing NGOs. To maintain their low cost of services, NGOs often rely on donations or international funds. However, laws governing the operations of NGOs have made it very difficult for them to receive external funds and hence sustain their activities. Lack of funds undermines training activities as well as the availability of equipment and supplies, and has a negative impact on the overall quality of services.

**The total number of NGOs that provided FP services went down from 669 in 1995 to 274 in 2014.**

*-National Population Council Statistics, 1995 and 2015*

Staffing is another significant challenge. NGOs used to receive female physicians seconded from MOHP, with their salary fully paid by MOHP. However, the Civil Service law (in effect from July 2015 to January 2016) required the receiving organization to pay the salary of the seconded employee. This condition made it difficult for NGOs to afford enough doctors to staff their clinics. Also, as MOHP is experiencing difficulty retaining female doctors who are willing to work in rural areas, MOHP is increasingly declining NGOs' requests for seconded doctors.

Finally, similarly to private physicians and pharmacists, NGO physicians included in this study indicated that they have not received FP training in almost ten years.

### RECOMMENDATION 8

#### Support the creation of more private sector outlets for clients

The Ministry of Social Solidarity (MOSS) should consider easing procedures and accelerating review of registration and approvals for NGOs to receive funding. Also, MOHP should continue to provide subsidized contraceptives to NGOs and should work out a mutually acceptable mechanism for secondment of physicians to NGOs. In the meantime, NGOs should seek innovative mechanisms to increase their revenues (e.g. by introducing new services) and by working in the afternoon and evenings so as not to conflict with MOHP service hours.

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*“The private sector has no syndicate or association to talk to ... there are no representatives for the private sector.”*

*- A senior MOHP official*

## 6. PRIVATE SECTOR FRAGMENTATION

The private FP sector is composed of separate entities (private clinics, NGOs, and pharmacies) and lacks a common platform that brings them together. They are seldom invited to participate in national FP committees, and as a result their voice is not heard by government officials.

### RECOMMENDATION 9

#### Create linkages among private sector providers

**A branded network that links pharmacists and private doctors (e.g. a revitalized Ask – Consult network) could serve as a platform to reach both groups of health care providers, strengthen their capacity, and ensure high quality services. The network could serve as a platform for communication with MOHP and other government agencies (e.g. MOSS, Ministry of Industry and Trade).**

## CONCLUSION

In the coming years, in the context of reduced donor assistance, the financial needs of the Egyptian FP program will increase, due to the increasing number of women entering reproductive age, and the overall need to improve access to and effective use of FP methods. Increasing access to FP services will require leveraging the roles of different service providers. This includes promoting the role of private physicians in counseling about FP, pharmacists in dispensing methods, and NGOs in reaching out to marginalized communities.

Opportunities for involvement of the private sector in family planning exist across the whole spectrum of demand, from expanding contraceptive access to the 2.8 million women with unmet need to more effectively meeting the needs of the 13.2 million women currently using contraception, including those who receive services from the public sector but who may want to switch to the private sector. A large segment of these women could be better reached by the private sector, if the private and public sectors work together to define the “market” for each sector, and if the private sector is seen as a true partner in family planning service delivery.

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The Evidence Project uses implementation science—the strategic generation, translation, and use of evidence—to strengthen and scale up family planning and reproductive health programs to reduce unintended pregnancies worldwide. The Evidence Project is led by the Population Council in partnership with INDEPTH Network, International Planned Parenthood Federation, PATH, Population Reference Bureau, and a University Research Network.

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