

# **How Much Will It Cost to Achieve Egypt's Population Goals?**

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## **Executive Summary**

In 1997–1998, the government of Egypt financed approximately 53 percent of the costs of family planning among service provider organizations that receive public funding (Rowan et al., 2000). Future donor assistance, which will pay the other 47 percent, is uncertain, especially since USAID, which is the largest family planning donor in Egypt, is currently designing a strategy that will greatly reduce its assistance during the next decade.

This study uses data from the 1998 Egypt Demographic and Health Survey (EDHS) and 1998 family planning cost data to project public sector costs of achieving the family planning goals established by Egypt. If Egypt is to reach its goal of two children per family by 2015, the number of family planning users will have to increase from 5.1 million in 1998 to more than 9.5 million. Using unit costs based on the 1998 cost study and the projection of users, this study estimates that overall public sector costs will increase nearly 86 percent from 1998–2015. Total annual public costs will increase from £E153 million to £E286 million by 2015, an average increase of nearly £E8 million annually.

To explore the implications of reduced donor financing of family planning for the government of Egypt, a reduced funding projection was made assuming that by 2015 only 10 percent of family planning would be donor financed in contrast to the current 47 percent. Under these conditions, it is expected that government of Egypt funding requirements would increase more than two and one-half times by 2015. Further scenarios and policy options to reduce the financing burden will be explored in a follow-on study.



# How Much Will It Cost to Achieve Egypt's Population Goals?

## I. Background

In Egypt, there were approximately 10 million married women of reproductive age (MWRA) in 1998, of which a little more than 50 percent (approximately 5.12 million) were using a family planning method. Egypt's long-term national goal of achieving two children per family by 2015 means that a larger percentage of couples will have to practice family planning. This, combined with an expected increase in the number of women entering their reproductive years, means that an unprecedented increase in resources will need to be mobilized in order to meet the expected demands.

In 1997–1998, the government of Egypt financed approximately 53 percent of family planning costs among service provider organizations that receive public funding (Rowan et al., 2000). Future donor assistance, which pays the other 47 percent, is uncertain, especially since USAID, which is the largest family planning donor in Egypt, is currently designing a strategy that will greatly reduce its assistance during the next decade. While the private, commercial, and nongovernmental organization (NGO) sectors, which indirectly benefit from public subsidies, currently serve approximately 52 percent of family planning users (1998 EDHS), this percentage has been declining over time.

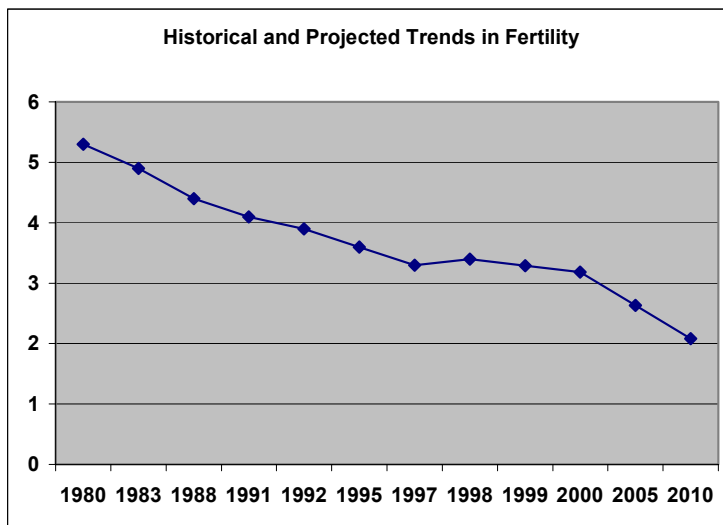
The long-term sustainability of Egypt's family planning program is therefore of concern. This study looks at the resource requirements that will be needed to meet Egypt's goals, projecting the public family planning costs through 2015 and presenting scenarios for financing these requirements. In addition, several alternative strategies for the reallocation of resources and for efficiency gains to the system are discussed with a view toward further analysis in a follow-on report.

## II. Egypt's National Goal

### *Fertility*

In 1980, Egypt's total fertility rate (TFR) stood at 5.3 children per woman. By 1998, this rate had declined to 3.4 (1998 EDHS) (see Figure 1). If this trend in fertility decline continues, TFR will reach replacement level by 2010. In fact, Egypt's stated national goal is to achieve replacement level fertility (2.1) by 2015; thus, judging from past

Figure 1



trends, it appears that this goal is possible.

**Family Planning Use**

The decline in fertility has been accompanied by an increase in the use of contraception, reflected in the contraceptive prevalence rate (CPR, see Figure 2). While other factors such as increases in the marriage age have affected and can continue to affect fertility, it is unlikely that further future reductions in fertility can be achieved unless there are also accompanying changes in contraceptive use. The 1998 CPR of 52 percent will therefore need to increase accordingly.

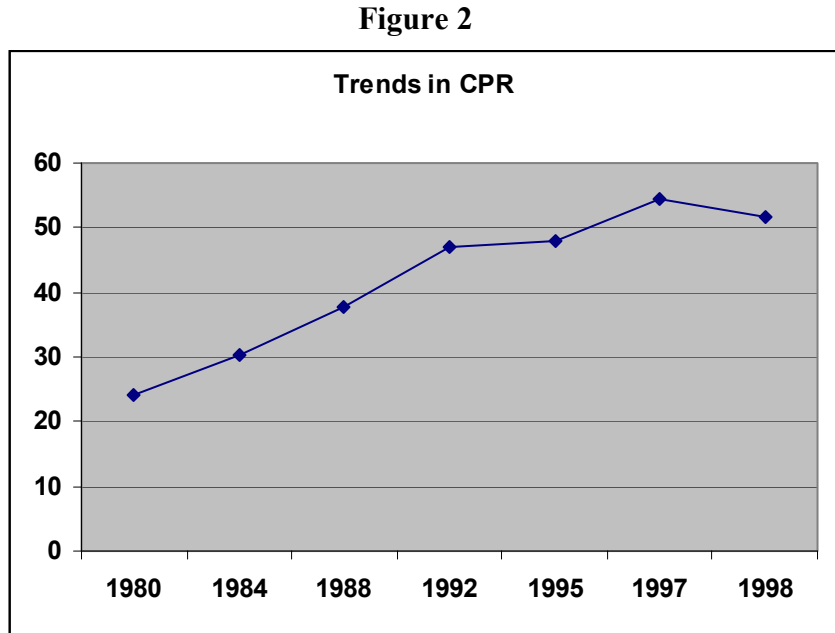


Table 1 shows the projection of CPR that would be necessary to achieve a TFR of 2.1 by 2016. This projection assumes that there are no changes in method mix and other factors that can affect fertility, such as marriage age, postpartum insusceptibility, or sterility.

**Table 1**  
**CPR Required to Achieve Fertility Reductions**

Year	TFR	CPR
1998	3.4	51.8
2000	3.3	53.8
2005	2.9	58.6
2010	2.6	63.4
2016	2.1	69.1

**III. Service Requirements**

**Total Number of Users**

The expected decline in fertility will lead to a decrease in the natural rate of population growth. Because of past high rates of population growth, there is a tendency for certain population age groups to continue to grow. From 1998–2015, the growth rate



of the total population will decline from 2.2 to 1.28 percent. However, the growth rate of the population aged 15–49 will continue to grow at 1.98 percent (see Table 2).

**Table 2**  
**Growth Rates of Population**

<b>Year</b>	<b>Total Population</b>	<b>Population Aged 15–49</b>
1998	2.20	3.09
2000	2.16	2.88
2005	1.98	2.09
2010	1.66	1.64
2015	1.28	1.91

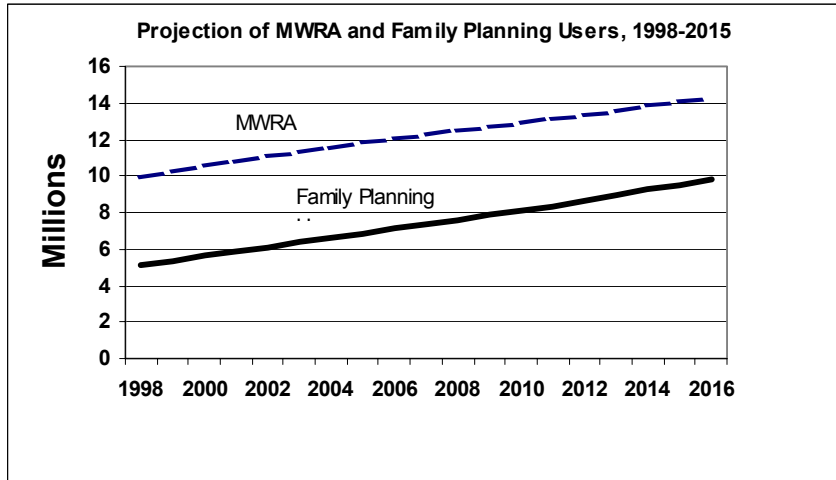
The number of women of reproductive age who seek services will affect future service delivery requirements for family planning. The number of MWRA represents the relevant population that will seek family planning services in Egypt. Table 3 and Figure 3 show the projections of the MWRA as well as the overall required number of users from 1998–2015.

Our estimates show that while the number of MWRA is expected to increase by approximately 42 percent from 1998–2015, the percentage increase in family planning users will be more than double that at 86 percent. Thus, roughly one-half the growth in family planning users is due to the growth in population, while the other one-half is a result of the expected increased tendency to use family planning. Table 3 shows that the number of MWRA that will seek family planning services will increase from 5.12 million in 1998 to over 9.5 million by 2015.

**Table 3**  
**Projection of MWRA and Family Planning Users, 1998–2015 (millions)**

<b>Year</b>	<b>MWRA</b>	<b>Family Planning Users</b>
1998	9.93	5.12
2000	10.51	5.63
2005	11.80	6.88
2010	12.89	8.12
2015	14.08	9.54

**Figure 3**



***Users by Method***

Table 4 shows the 1998 percentage distribution of users by method from the 1998 EDHS. Projections of the number of users by method are also shown in Table 5. The predominant method remained the IUD in 1998, used by two out of every three women using a method. Injectables continued to gain in popularity (7.5 percent of users), while use of the pill continued to decline.

**Table 4**  
**Percentage Distribution of Users by Method, 1998**

<b>Method</b>	<b>Percentage of Users</b>
Condom	2.1
Female Sterilization	2.5
Injectable	7.5
IUD	66.2
Pill	16.8
Other	4.8

Source: 1998 EDHS

Projections in Table 5 are based on maintaining the distribution figures from Table 4 constant. Although this is not likely to be the case in reality, it is difficult to predict with certainty what the future trajectory will be. Hence, as a base scenario, percentage distribution is kept constant; however, alternative scenarios based on a different percentage distribution are presented later.

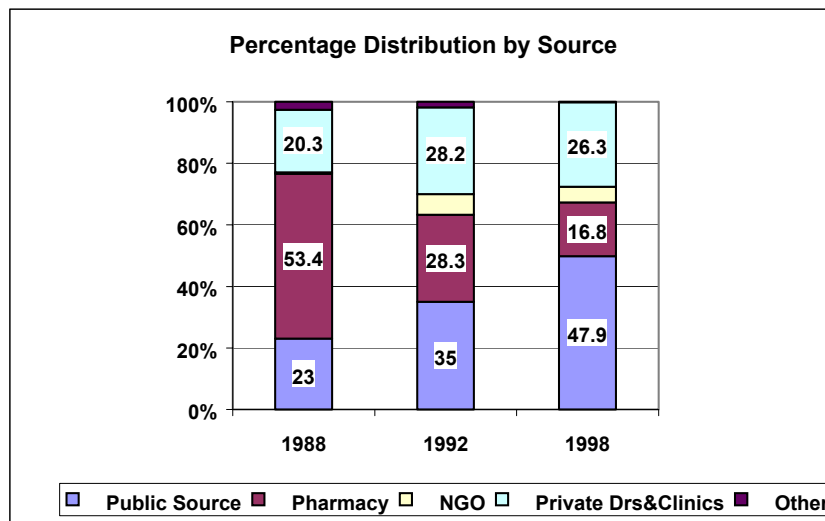
**Table 5**  
**Projection of Users by Method with Fixed Method Mix (thousands)**

Year	Condom	Female Sterilization	Injectable	IUD	Pill	Other	Total
1998	110	130	380	3,390	860	250	5,120
2000	120	140	420	3,730	950	280	5,630
2005	140	170	520	4,550	1,160	340	6,880
2010	170	200	610	5,380	1,360	400	8,120
2015	200	240	720	6,320	1,600	470	9,540

*Users by Source of Service*

The projection of where users obtain their services is also of interest, especially since there are significant differences in the costs of family planning by source of service. Figure 4 shows that in the last 10 years the public sector has increased its share significantly relative to other sources. In 1988, the public sector served 23 percent of users, whereas in 1998 this percentage doubled to nearly 48 percent. Meanwhile, pharmacies were the largest losers of market share with a decline from 53 percent to less than 17 percent. This decline was due mainly to the switch in methods from the pill to more clinically based methods, namely the IUD.

**Figure 4**



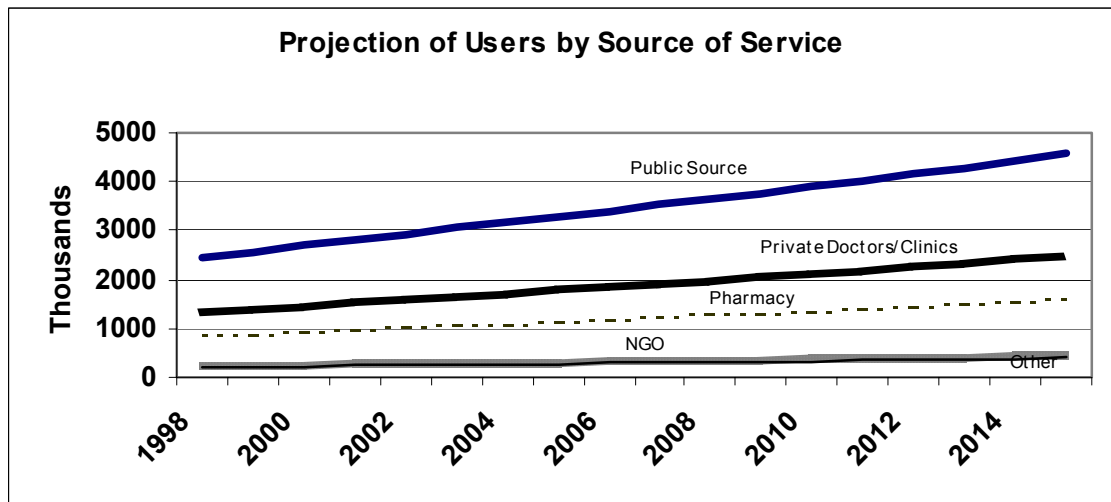
**Table 6**  
**Percentage Distribution of Users by Method and Source, 1998**

Source	Condom	Female Sterilization	Injectable	IUD	Pill	Other
Public	4.5	51.8	76	55.5	9.9	47.9
Pharmacy	80.6	0	3.8	0	81	16.8
NGO	0.5	1.2	7.1	10.9	1.6	8.8
Private Doctors and Clinics	0	47	11.1	33.6	7.4	26.3
Other	14.4	0	2	0	0	0.2
<b>Total</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>99.9</b>	<b>100</b>

Source: 1998 EDHS

On the basis of a constant share for each source, Figure 5 shows the expected increases in the number of users. (As with the assumption of constant method share, this is a simplifying assumption only.) The number of public sector users will increase from just under 2.5 million in 1998 to more than 4.5 million by 2015, an increase of 2 million. Of course, if past trends continue and the public sector gains market share, the number of public sector users can be expected to increase more. An increase in the number of clients seeking service from private doctors and clinics is also expected with a little more than one million additional clients by 2015 compared with 1998. Pharmacy clients are expected to increase to 1.6 million by 2015, nearly double the 860,000 estimated clients in 1998.

**Figure 5**



**Contraceptive Commodities**

To meet growing needs, an essential family planning service program input is the contraceptives themselves. It is important to know what these requirements are, especially as donors are less likely to donate them to Egypt’s family planning program in

the future. This section presents the results of estimating future commodity requirements on the basis of the method-mix assumptions outlined above.

Commodity requirements per user for IUDs, pills, and injectables are based on USAID/Washington consumption per couple year of protection (CYP) assumptions. For these purposes, the assumptions were 120 condoms per year, 4 injections per year, 15 cycles of pills per year, and an average duration of IUD insertion of 3.5 years.<sup>1</sup> Table 7 shows that, if the current method mix continues, by 2015 Egypt can expect to need almost 10 million more condoms, 1.3 million more injectable doses, 1.5 million more IUDs, and 9.6 million more pill cycles per year.

**Table 7**  
**Projected Commodity Requirements (millions of units)**

<b>Year</b>	<b>Condom</b>	<b>Injectable</b>	<b>IUD</b>	<b>Pill</b>
1998	10.75	1.54	1.92	11.18
2000	11.82	1.69	2.08	12.29
2005	14.44	2.06	2.49	15.02
2010	17.06	2.44	2.9	17.74
2015	20.04	2.86	3.43	20.84

#### **IV. Projecting the Cost of Family Planning Services**

The additional service requirements presented in the previous section will require additional resources. In this section, we use existing information to estimate the cost of meeting those requirements. The first step in making these projections was to estimate the cost per user of family planning services. On the basis of this average cost calculation, the SPECTRUM system of models was used to project future costs using the projected numbers of users.

##### ***Calculation of Costs per User***

Projection of the costs of family planning requires estimates of the costs of providing services to users. For the purposes of this study, we project only costs for those types of agencies that receive public sector funding, namely public organizations, NGOs, and pharmacies. Since we are interested only in the public costs of family planning, costs of private physicians and private clinics that offer family planning services are not considered. Pharmacy costs included here are those attributable only to the EPTC, the government-owned pharmaceutical distribution company, and not to the operational costs of the private pharmacies themselves.

The model used for these projections employs a “cost per user” parameter. This parameter can be broken down by source of service and method. To estimate this parameter, data from the 1995 EDHS and the Population Project Consortium’s (PPC’s) *Report on the Costs of the Family Planning Program in Egypt, 1995–1996*, were used.

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<sup>1</sup> These numbers are based on various Egyptian sources.

The PPC study contains data on the costs of family planning services that received funding from the public sector. As defined in the study, public sector funding includes both government of Egypt (GOE) and donor funds. The study thus attempts to identify all costs that the GOE would have to pay if it were to cover public sector costs. Some of the family planning activities were financed with nonpublic sector money, such as client payments and contributions by sponsoring agencies. Total costs as reported, therefore, include all costs identified by each agency, including public as well as nonpublic sector costs.

Agency information is classified into two broad categories: those working in the not-for-profit sector and those serving the for-profit sector. Moreover, agencies are further broken down into service providers and support agencies.

Although the PPC study is detailed and contains a wealth of data, it is impossible to break out the costs by method and source, since the data were not collected at the clinics. The study attempts to allocate total costs into contraceptive commodity and noncommodity costs; however, there are insufficient data to make a reliable estimate.<sup>2</sup> Thus, the data presented here and used for the projections is not disaggregated by method.

Table 8 shows the data on public costs by type of service delivery agency and support agency. For the for-profit sector, a significant part (3 million out of nearly 8 million) was paid for by the contraceptive social marketing program (CSMP), a program which no longer exists. For this reason, in subsequent analysis, we drop this component of costs assumed to have been absorbed by the private sector.

**Table 8**  
**Public Costs of Family Planning by Type of Agency, 1997–1998**

Service Providers	Total Costs (£E)
Ministry of Health (MOH)	63,794,936
Curative Care Organization (CCO)	12,438
Teaching Hospital Organization (THO)	3,060,975
Health Insurance Organization (HIO)	805,030
<b>Total Public</b>	<b>67,673,379</b>
Egyptian Family Planning Association (EFPA)	7,886,650
Clinical Services Improvement (CSI)	10171,583
Coptic Evangelical Organization for Social Services (CEOSS)	1,267,305
BPESS	322,919
AlAzhar	193,383
<b>Total NGO</b>	<b>19,841,840</b>
Pharmacies (EPTC)	5,611,489
Private Sector Initiative (PSI)	3,353,171
<b>Total For-Profit</b>	<b>8,964,660</b>

<sup>2</sup> The PPC study does provide estimates for commodity costs; however, the information is incomplete.

**Table 8 (continued)**

<b>Support Agencies</b>	
Donor Agencies	4,312,264
National Population Council (NPC)	9,708,087
State Information Service (SIS)	35,045,749
Regional Centers for Training (RCT)	4,079,687
Ministry of Health and Population (MOHP)	5,246,319
ITRFP	1,673,364
EPTC	427,263
Pop.Ed. Inst.	71,322
<b>Total Support Agencies</b>	<b>60,564,055</b>

Source: Rowan et al. (2000)

Table 9 shows the estimate of the total public costs of the public, NGO, and pharmacies sectors that can be attributed to the direct service costs and to those of the support agencies. In Table 9, the costs of the support agencies are allocated across the public, NGO, and pharmacy agencies according to the share of those agencies' clients (excluding private sector doctors.). Pharmacies are assumed to benefit from the service support agencies in as much as the SIS contribution through mass media campaigns, especially on television, can generate sales for subsidized products.<sup>3</sup>

**Table 9**  
**Total Public Costs by Category of Agency**

<b>Category</b>	<b>Costs (£E)</b>
Public	109,354,675
NGO	24,105,689
Pharmacies (EPTC)	20,230,399
<b>Total</b>	<b>153,690,763</b>

Table 10 presents the calculation of the average cost per user during a one-year period, obtained by simply dividing the total costs by type of agency from Table 9 by the estimated number of source users in 1998. The first column of Table 10 shows the estimated number of users by the three sources. This repeats the information shown on family planning users in Table 3, column 2.

**Table 10**  
**Estimated Public Costs per User by Source, 1997/1998**

<b>Source</b>	<b>Estimated Users</b>	<b>Total Cost (£E)</b>	<b>Average Cost per User (£E)</b>
Public	2,452,480	109,354,675	44.59
NGO	250,880	24,105,689	96.08
Pharmacy	860,160	20,230,399	23.52
<b>Total</b>	<b>3,563,520</b>	<b>153,690,763</b>	<b>43.13</b>

<sup>3</sup> The costs attributed to the SIS as a support agency are considerable and nearly equal to the MOH (see Table 1).

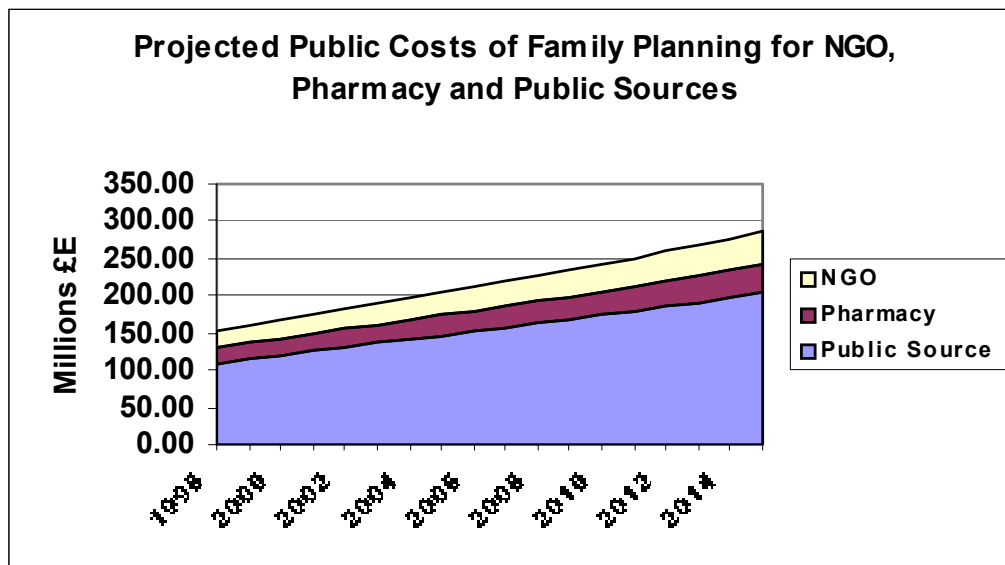
Table 10 shows that the overall average public cost per user in 1997–1998 was £E43, which represents a significant increase from a 1991–1992 estimate (Moreland et al., 1996) in which costs per user for all sources was estimated to be £E17. Note also that the pharmacy sector has the lowest public cost per user compared with the public and NGO sectors, which had estimated public cost per user of £E44.59 and £E96, respectively. In making these comparisons, however, it should be repeated that these are not the full costs of providing these services, but rather the public costs incurred, including those of support agencies that have been allocated to the service providers.

Cost estimates in Table 10 fall within the range of other international estimates. According to the UNFPA, average user costs in 1995 were estimated at \$15.13 in North Africa/West Asia, \$12.14 in East Asia, \$8.76 in Southeast Asia, and \$14.86 in Latin America (UNFPA, 1994). Converting the estimates in Table 10 to U.S. dollars provides a range of \$28 per user in NGOs, \$6.92 in pharmacies, and \$13.11 in public facilities, with an overall average of \$12.68.

***Projection of Costs***

The above calculated user costs and the growth in users were used to project public costs. Figure 6 and Table 11 show the expected growth in the public costs of family planning that would be required to meet the expected increases in services until 2015. The growth here is proportional to that of the expected increases in women who are using contraceptives during this period. Thus, overall public costs will increase nearly 86 percent between 1998 and 2015. Total annual public costs will increase from £E153 million to £E286 million by 2015, an average increase of nearly £E8 million annually.

**Figure 6**





In terms of the costs by source of service, public sector agencies (MOHP, THO, HIO) will, of course, require the largest share. Public sector agency costs can be expected to increase costs from £E109 million in 1998 to more than £E203 million in 2015. Public costs in support of NGOs will increase from £E24 million to nearly £E45 million, whereas pharmacy costs will rise from £E20 million to almost £E38 million by 2015.

**Table 11**  
**Projected Public Costs by Source of Service (millions £E)**

<b>Year</b>	<b>Public</b>	<b>Pharmacy</b>	<b>NGO</b>	<b>Total</b>
1998	109.35	20.23	24.11	153.69
2000	120.25	22.25	26.51	169.00
2005	146.95	27.18	32.39	206.52
2010	173.43	32.08	38.23	243.74
2015	203.76	37.69	44.92	286.37

### *Commodity Costs*

The cost of contraceptives is a small but significant part of the costs of family planning. Contraceptives are an essential element in family planning service provision, along with direct service provision, clinic-level costs, such as provider salaries and clinical facility costs. Given the information currently available, however, it is only possible to estimate the overall contraceptive costs by source of service. Apart from contraceptive costs within the public sector, we are unable to break down costs for NGOs and pharmacies. Undoubtedly, these agencies benefit from public sector expenditures of contraceptives, but it is not known by how much. Accordingly, we present the overall contraceptive commodity costs for each source.

To estimate the contraceptive costs of family planning, we used international unit cost estimates of contraceptives. Since contraceptives are an internationally traded commodity, such an assumption is reasonable. Table 12 shows the unit cost assumptions that were used for these calculations.

**Table 12**  
**Unit Cost Assumptions for Contraceptives**

<b>Method</b>	<b>Cost in US\$</b>	<b>Cost (£E)</b>
Condom	0.495	0.168
Injectable	0.93	3.162
IUD	1.46	4.964
Pill	0.2066	0.7024

Exchange rate: £E3.4 = \$1

Table 13 shows the commodity cost calculations based on the unit costs in Table 12. For public sector agencies (second column), the costs of all contraceptives is expected to increase from £E8.6 million to £E17.7 million from 1998–2015. With the

current method mix, these contraceptive costs represent between 8 and 9 percent of the total family planning costs for the public sector.

**Table 13**  
**Projected Cost of Contraceptives by Source and Method, 1998 (millions £E)**

	<b>Public Source</b>	<b>Pharmacy</b>	<b>NGO</b>	<b>Private Doctors and Clinics</b>	<b>Other</b>	<b>Total</b>
<b>Condom</b>						
1998	0.081	1.458	0.009	0.000	0.261	1.809
2000	0.090	1.603	0.010	0.000	0.286	1.989
2005	0.109	1.959	0.012	0.000	0.350	2.430
2010	0.129	2.314	0.014	0.000	0.413	2.871
2015	0.152	2.718	0.017	0.000	0.486	3.373
<b>Injectable</b>						
1998	2.451	0.123	0.229	0.358	0.065	3.225
2000	3.869	0.193	0.361	0.565	0.102	5.091
2005	4.782	0.239	0.447	0.698	0.126	6.292
2010	5.671	0.284	0.530	0.828	0.149	7.462
2015	6.657	0.333	0.622	0.972	0.175	8.759
<b>IUD</b>						
1998	5.290	0.000	1.039	3.202	0.000	9.531
2000	5.730	0.000	1.125	3.469	0.000	10.325
2005	6.860	0.000	1.347	4.153	0.000	12.360
2010	7.990	0.000	1.569	4.837	0.000	14.396
2015	9.450	0.000	1.856	5.721	0.000	17.027
<b>Pill</b>						
1998	0.777	6.369	0.126	0.581	0.000	7.853
2000	0.855	7.001	0.138	0.639	0.000	8.633
2005	1.045	8.557	0.169	0.781	0.000	10.551
2010	1.234	10.106	0.199	0.922	0.000	12.461
2015	1.449	11.872	0.234	1.083	0.000	14.639
<b>All Methods</b>						
1998	8.600	7.950	1.403	4.142	0.325	22.419
2000	10.544	8.798	1.635	4.673	0.388	26.038
2005	12.796	10.754	1.975	5.632	0.476	31.634
2010	15.024	12.704	2.313	6.587	0.563	37.190
2015	17.707	14.923	2.729	7.776	0.661	43.797

## V. Funding of Family Planning

### *Current Funding Sources*

Family planning costs, like other health costs, are financed from several sources. These include the GOE, donor agencies, client payments, and, especially in the case of NGOs, contributions by the service agencies themselves. Figure 7 shows the distribution of funding for the three categories of provider agencies by sources of funding as reported in the PPC cost studies. The GOE is the largest contributor for public sector funding of family planning, with 55 percent. Next largest are donor agencies that fund 36 percent. Client payments make up 8 percent.

**Figure 7**

### **Percentage Distribution of Financing of Public Costs of Family Planning, 1998**

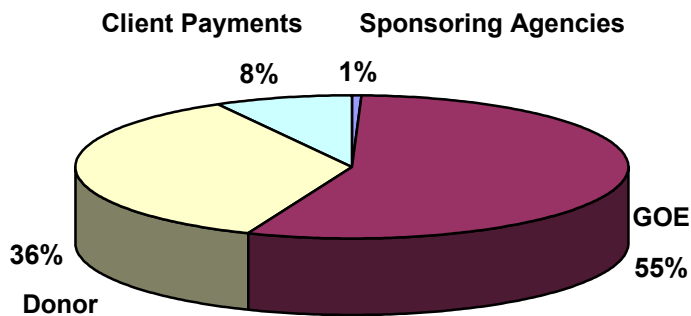
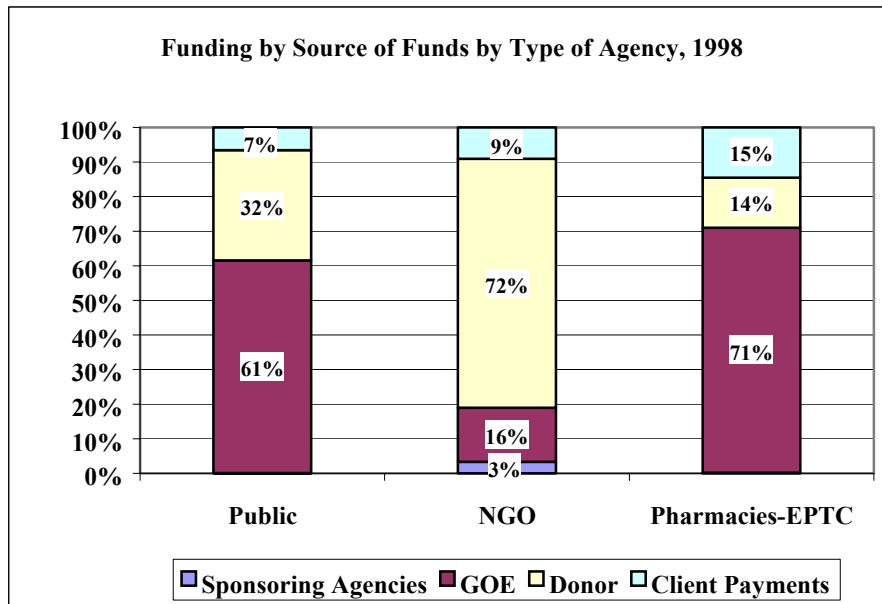
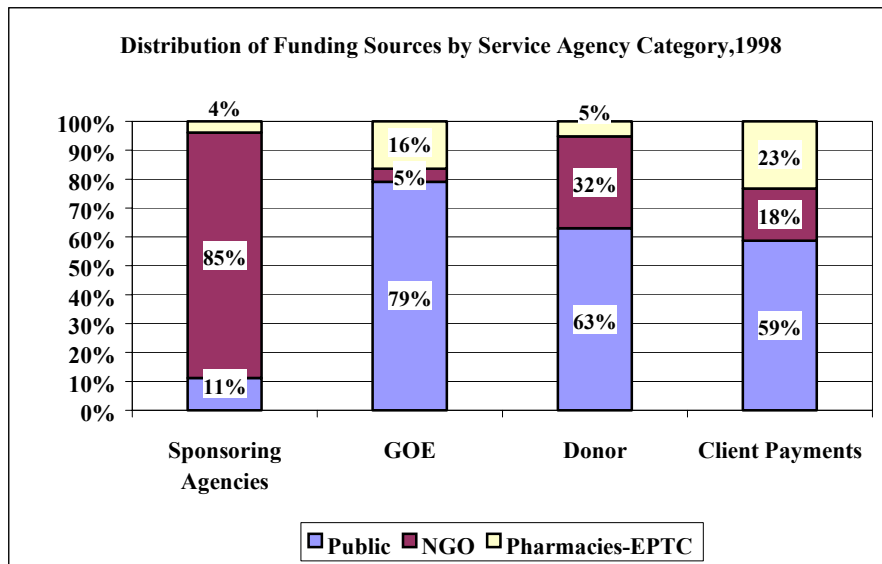


Figure 8 shows the distribution of funding by category of service agency. The GOE contributes to the highest percentages of public agency family planning costs, and to pharmacies (through the EPTC). Donors support the largest share of support for NGO agencies, but still contribute a substantial percentage (32 percent) of public agency costs. Client contributions are the largest for the NGOs.

**Figure 8**



**Figure 9**



Where the money of funding sources money goes is shown in Figure 9. The overwhelming use of sponsoring agency money is for NGOs. The bulk (79 percent) of GOE money in family planning funds public family planning agencies, with 16 percent going to pharmacy sales. Donor monies are split between public programs (63 percent), NGOs (32 percent), and pharmacies. Client payments, perhaps unexpectedly, mostly fund the public program; it is interesting to see that a relatively small share of client payments (21 percent) goes to pharmacy sales, possibly a reflection of the relatively small share of this segment.

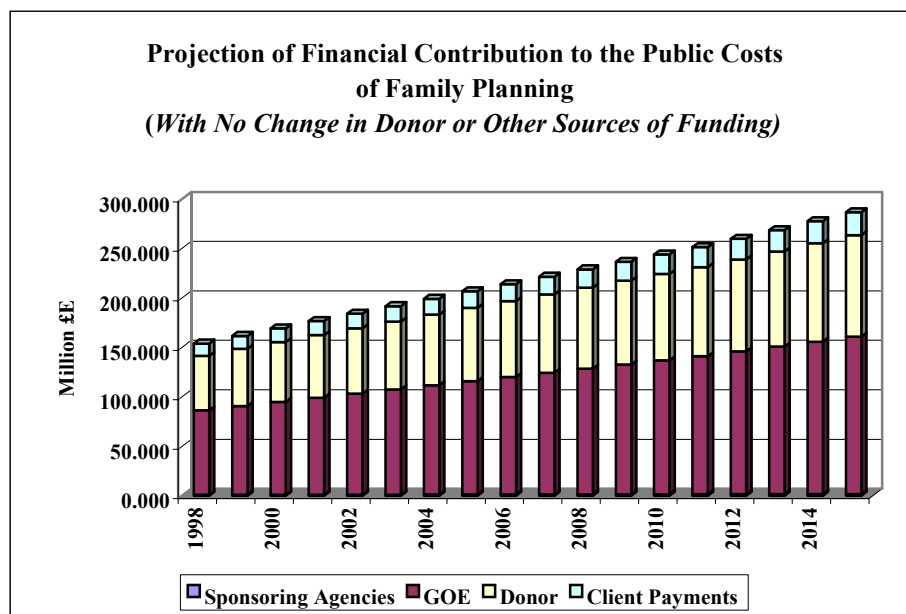
### Projections of Funding

Based on these 1997–1998 shares, we have projected the funding of the public costs of family planning that we previously saw through to 2015. This is shown in Table 14 and Figure 10.

**Table 14**  
**Projection of Funding by Source of Funds (millions £E)**

Year	Sponsoring Agencies	GOE	Donor	Client Payments	Total
1998	0.942	85.312	55.061	12.375	153.691
2000	1.036	93.810	60.546	13.608	169.000
2005	1.266	114.638	73.988	16.629	206.522
2010	1.494	135.300	87.323	19.626	243.744
2015	1.756	158.961	102.594	23.059	286.369

**Figure 10**



These projections show that the GOE can expect its own funding for family planning to increase by 86 percent through 2015 from £85 million to £159 million. Donor contributions and client payments would also proportionally rise. These projections assume that there is no change in donor funding as a proportion of overall funding. This is not likely to be the case, however. First, as an overall strategy, the 1994 International Conference on Population and Development (ICPD), to which Egypt was an important signatory, has a goal of 66 percent national support, which Egypt (at 55 percent) still is behind schedule. Second, USAID, which contributes an important proportion of donor funds, announced its long-term strategy to phase out its assistance

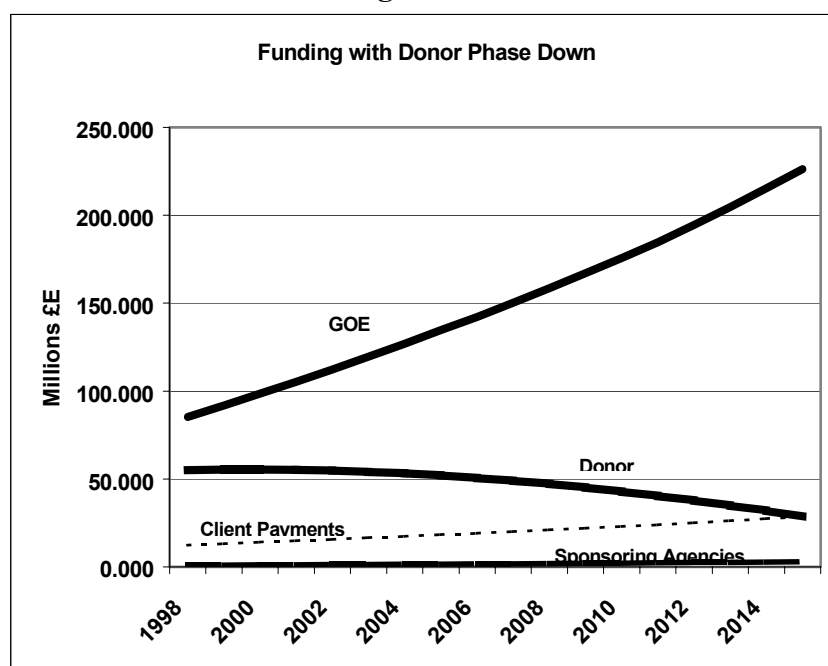
during the next decade. Thus, the future of donor funding is uncertain, and Egypt must consider relying more on its own resources.

To explore the implications of this likelihood, we projected funding requirements based on an assumption of a donor reduction from its current 36 to 10 percent by 2015. We also assumed that the GOE would be responsible for picking up the gap left by this reduction, meaning that by 2015 the GOE would increase its share to 79 percent of the public costs of family planning. Results are shown in Table 15 and Figure 11.

**Table 15**  
**Funding Requirements with Donor Phase Down (millions £E)**

Year	Sponsoring Agencies	GOE	Donor	Client Payments	Total
1998	0.942	85.312	55.061	12.375	153.691
2000	1.113	98.481	55.411	13.995	169.000
2005	1.595	134.615	52.026	18.286	206.522
2010	2.160	175.717	42.889	22.978	243.744
2015	2.864	226.232	28.637	28.637	286.369

**Figure 11**



Under this scenario, the GOE funding requirements increase more than two and one-half times from £E85 million in 1998 to £E226 million in 2015. In turn, donor contributions are cut in half.

## **VI. Options for Meeting the Future Costs of the Family Planning Program**

Public costs will have to increase if Egypt is to achieve a full demographic transition to two children per family by 2015. With less donor support likely, growth in GOE support that will be required to sustain the program. Projections made here contain various assumptions, such as the method mix, source mix, contraceptive prevalence rate, and so forth. In exploring the policy options open to the GOE, these assumptions need to be examined.

In general, there are two broad strategies that can be adopted: (1) more resources can be brought to bear on the family planning sector budget, and (2) the budget can be reduced. Within each of these two strategies are a number of options that depend on efficacy, impact on the program, and political acceptability.

Some of the policy options for increased financing include increased financing from the MOHP budget; increased role for NGOs and the private sector; increased client payments; and third-party payment mechanisms such as insurance. In terms of reducing costs, options include reallocation of resources to reduce costs; elimination of unnecessary costs; changes in the method mix to cheaper methods; increased efficiency of client's use; and reduction in avoidable switching. These options will be explored in more depth in another paper.

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