SPECIFIC TERMS OF REFERENCE

HEALTH SECTOR POLICY SUPPORT PROGRAMME II

Second Tranche Compliance Assessment

FWC BENEFICIARIES 2013 - LOT 08: Health care and health financing
EuropeAid/132633/C/SER/multi
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1. BACKGROUND

Almost two decades ago, the Government of the Arab Republic of Egypt has endorsed a long term Health Sector Reform Programme with the objective of providing to the overall Egyptian population universal access to quality health care services. In this framework, the Government considers the reform of the Primary Health Care (updating of the clinics according to a National Standard called Family Health Model) as the backbone of its overall Health Reform Programme towards the setup of a Universal Health Insurance scheme. The reform of Primary Health Care aims at providing universal access to high quality basic health services (curative, preventative and promotional) to the whole Egyptian population irrespective of income or location. In October 2010, the EU launched the budget support Health Sector Policy Support Programme II (HSPSP-II) to provide further assistance for the implementation of this Primary Health Care Reform Programme. The Programme addresses the core goals of the ongoing reform: (1) equal access of the population to quality Primary Health services (integration of basic curative health care including some chronic diseases with health promotion & preventative health programmes), (2) fiscal sustainability of the Primary Health Care model and (3) staff retention policy and measures.

It is worth highlighting that all the Reform Benchmarks of the HSPSP-II were carefully formulated by the Egyptian authorities (Primary Health Care deputy Minister and his team) with the support of the EU as facilitator only.

➢ HSPSP main features

Budget

The contribution from the European Commission to this programme is set at a maximum of EUR 110 million. The table below shows the breakdown of the budget as per addendum No. 2 (which re-allocated the 2 million unspent TA budget to the budget support).

	Amount
Tranche I (fixed)	20,700,000
Tranche II (variable)	29,000,000
Tranche III (variable)	29,000,000
Tranche IV (variable)	31,000,000
Total budget support	**109,700,000**
Monitoring/Evaluation/Visibility/Audit	300,000
Total	**110,000,000**

Financing modality: untargeted, direct sector budget support, with four variable tranches and respective specific conditions for disbursement.

Objectives

The overall objective of the Programme is to support the Government of the Arab Republic of Egypt in implementing its Health Sector Reform Programme by improving access to quality Primary Health Care.

The specific objectives are to improve the quality of the health services provided by the public PHC Provider Network; improve client satisfaction and utilisation rates of the upgraded public PHC Provider Network facilities; and strengthen the systemic, social and financial sustainability of the Family Health Model.

The specific objectives of the HSPSP-II do not only entail quantitative and qualitative improvement of PHC services through the national roll-out of the Family Health Model, but also address the utilisation and universal access of these services by beneficiaries.

Expected results and main activities

The HSPSP-II aims to achieve three main results through the four phase gradual implementation of activities.

Result 1: Around one thousand Family Health Units[1] or Centres will be physically reconditioned, personnel will be trained to reach Family Health Model standards, in order to be accredited according to nationally approved quality standards.

An upgrade of the PHC Provider Network will be carried-out in accordance with the Primary Health Care National Investment Plan (based on geographical mapping). Around 1,000 primary health care units (representing about 18% of the total of public primary health care facilities) will be upgraded following the guidelines of the Family Health Model, thereby improving the geographical access of the Egyptian population to quality PHC services. The approach will entail the following:

- A standardised model for building and equipping facilities will be used for the infrastructure development of the PHC Provider Network, thereby improving investment effectiveness.
- Training needs assessments will be carried-out in all the physically reconditioned and re-equipped primary health care Family Health Units/Centres. The key staff of these units will be trained in technical and managerial skills targeted to official standards. The training programme embraces several themes such as: staff pattern and job-description, operational systems, clinical guidelines, essential drugs management, family folders, communicable disease surveillance, chronic disease management and the health information system.
- Once facilities are physically upgraded and re-equipped and the staff trained, the primary health care Family Health Units/Centres will take steps towards accreditation by the MoH Quality Department in conformity with nationally approved standards of quality.
- Stability in the staffing levels of qualified key staff (in particular family health doctors and nurses) will be monitored and strengthened by the programme. Recommendations will be developed and measures will be taken to promote staff retention, which is a core issue in the area of human resource management. Emphasis will be placed on retention of 1) family physicians, and 2) nurses (using the minimum staffing norms established for PHC units in Upper Egypt).
- The availability of a set of essential medicines (based on the current approved Essential medicines List) will be improved at reformed or accredited PHC facility level (the measurement will be based on a random sample of 100 accredited facilities.

Result 2: Within the catchment area the utilisation rate, of the upgraded PHC Provider Network, by the population and especially by the poor will be increased (including for reproductive health services and family planning). The level of satisfaction of the population in using these facilities is expected to increase.

[1] The figure of 1000 might need to be adjusted in the course of the programme due to mergers and relocations of FHUs.

The better coverage of the Egyptian population with quality integrated PHC services[2] will be translated into higher consumption of quality health services and a higher degree of client satisfaction and will be measured as follows:

- The utilisation rate of the accredited facilities will be monitored using the routine data of the National Health Information Centre (to be compared with the results of periodic Household Utilisation Surveys).
- Household surveys and exit-polls will be designed to measure the utilisation rate of the PHC Provider Network by the catchment area population and the poor. The surveys will give an overview of the performance of PHC facilities, they will account for the basic health needs of the catchment area population, and they will determine how these needs are being met (including for chronic diseases). They will explore and provide relevant and accurate information "from the field" concerning:
- PHC facilities infrastructure, equipment, and essential non-medical and medical supplies (availability of essential medicines including for chronic diseases such as Arterial Hypertension (AHT), diabetes…);
- enrolment and re-enrolment of uninsured catchment area population;
- The official service charges and the out-of-pocket expenditures will be measured for monitoring purposes only;
- awareness level of catchment area population about exemption policies for the poor in reformed facilities;
- overall utilisation rates in the catchment area, including for the poor;
- satisfaction rate of the catchment area population in reformed facilities.

Result 3: The proportion of the catchment area population enrolled in the Family Health Fund will increase and the number of FHU/Cs establishing a contractual relation with the Family Health Fund (or a similar health public purchaser) will increase. As a consequence, in the long term, the out-of pocket money paid by visit and by the enrolled population is expected to decrease.

The social and fiscal sustainability of the PHC Provider Network will be strengthened by an increase in enrolment of catchment area populations covered by reformed facilities which reflects a higher quality PHC services provision, increased confidence of the population in the quality of care provided and implementation of a streamlined performance-based incentive policy. This approach will entail the following:

- The established contractual relationship between the accredited Family Health Units/Centres and the Family Health Fund (or any similar new public health purchaser) will be promoted and monitored (as an indicator reflecting the effectiveness of the overall PHC model);
- The enrolment of the population in the catchments areas of contracted facilities will be promoted and monitored (measuring the confidence and the willingness of the population to subscribe to and participate in the reformed PHC system);
- In the governorates where the new social health insurance is established (or where the New Payor/Purchaser is in place), the enrolment of the poor previously identified by the Ministry of Social Solidarity will be targeted by the MoH;
- The financial stance of the existing PHC public purchasing entities (FHF, New PHC Payor) will be monitored and strengthened (assessed on an annual basis).
- The PHC staff retention policy will be streamlined. The legislation defining the parameters for staff incentive payments will be updated and applied to all PHC Units.

The household surveys will be developed by the MoHP and will include: household questionnaires, facility questionnaires, in-depth interviews and focus group discussions with providers and beneficiaries. They could be conducted with the support of institutions such as the Central Agency for

[2]Once reformed the integrated primary health care Basic Benefits Package provided by the accredited health facilities is expected to cover 70-80% of the health needs of the population. They will be provided with appropriate services to deal with the high existing communicable disease burden and increasing non-communicable disease resulting from a health status transition in Egypt.

Public Mobilization and Statistics (CAPMAS) or the Social Research Centre (SRC) of the American University of Cairo.

Duration

The initial execution period of the Agreement was 60 months. This period comprised 2 phases under the conditions of article 4.1 of the General Conditions (Annex I of the present Agreement): an (1) operational implementation phase that started from the entry into force of the financing agreement and will have an initial duration of 36 months and (2) a closure phase which will have a duration of 24 months starting from the expiry date of the operational implementation phase.

With Addendum No. 1 & 2, the execution period of the Agreement was extended to 96 months with an operational implementation phase of 72 months.

- **Current State of Affairs in the Primary Health Care Sector Reform**

Since the January 2011 Egyptian revolution (three months after the signature of the Financing Agreement), seven Ministers of Health and Population were successively appointed along with new governments. Also, new Deputy Ministers on Primary Health Care and on Social Health Insurance were appointed. Despite this context, the Ministry of Health and Population has always reconfirmed that both (1) the modernisation and standardisation of the Primary Health Care public service provision as well as (2) the new Social Health Insurance scheme, remain the top priorities of the Egyptian Health Sector Reform agenda.

The Egyptian Health Sector Reform is quite an ambitious programme which can solely be achieved within a long timeframe. Since the revolution, a number of key activities have been carried-out: (1) the new constitution foresees a doubling of the state budget earmarked to health, (2) a new committee appointed by Ministerial decree has prepared a new draft legislation on social health insurance, (2) the Primary Health Care reform programme is reasonably progressing, providing a quantitative and qualitative improvement of basic health services provision to the poorest segments of the population.

- **State of Play of the Health Sector Policy Support Programme II (HSPSP-II)**

Since the January 2011revolution, the implementation of various activities of the HSPSP II has been slowed down due to two principal causes: (1) Political instabilities inside the Egyptian Government and in particular within the Ministry of Health and Population, (2) a decline of the national economy causing fewer resources were allocated to the National Health Sector Reform Programme (and more specifically for the development of Primary Health Care).

In May 2012, a first HSPSP-II Steering Committee was convened by the Ministry of International Cooperation involving representatives of the Ministries of Health & Population, Finances and Social Solidarity. The Committee concluded that progresses were made on part of the requirements. However, due to the situation in the country, several reform benchmarks became very challenging, showing important delays in their implementation. Accordingly, the Ministry of International Cooperation requested a first extension of the programme's Operational Implementation Phase by one year (second tranche postponed to first quarter of 2013) in order to reach a higher level of achievement of the aforementioned activities.

At the second and third Steering Committees hold in March and September 2013, in light of the additional delays observed in achieving some reform benchmarks, the Beneficiary and the EU Delegation have agreed to postpone the compliance assessment related to the release of the second tranche by an additional twelve months to first quarter of 2014. In October 2013, the Ministry of International Cooperation officially requested the second time extension of the programme's operational implementation phase as well as the reallocation to the last tranche of the programme of

the Euro 2 million unused technical assistance budget[3] (as stipulated in chapter "2.2 Budget and calendar" of the Financing Agreement: Any unused amounts remaining from the allocation for technical assistance can be added to the last tranche payment).

In April 2014, the Ministry of International Cooperation submitted a request for the release of the second tranche (with its annexes, a compliance assessment and some means of justification).

Given the situation prevailing in Egypt since 2011 and on the basis of the noncompliance of the general conditions (at least those related to Public Finance Management and Macro-economic stability), no disbursement has been made in Budget Supports operations since 2012. Under these conditions the HSPSP-II will be maintained open and the disbursement will be allowed if and when the conditions are again in place. The Egyptian authorities were informed of the situation and are well aware that substantial efforts are still to be made for complying with the general eligibility criteria (which also implies a close and genuine dialogue with the EU Delegation).

2. DESCRIPTION OF THE ASSIGNMENT

➢ Global objective

The purpose of this assignment is to advise the EU Delegation on the release of the 2nd tranche of the HSPSP-II on the basis of complete assessment of the performance against the specific Reform Benchmarks (performance indicators and means of verification) and with regards to the General Condition towards the implementation of the Government Primary Health Care National Development Policy.

➢ Specific objectives

The specific objectives of the assignment are (with regards to the release of the 2nd tranche of the HSPSP-II): (1) to assess the progress in terms of performance indicators of the reform on Primary Health Care (Primary Health Care National Development Policy), (2) to evaluate the degree of completion of each Reform Benchmark (3) to collect and verify the appropriateness of all the means of verification specified in the Financing Agreement, (4) to advise the EU Delegation on the release of the tranche, (5) to guide the beneficiaries and the EU Delegation in structuring their compliance assessment reports.

➢ Requested services

The overall mission activities will be undertaken in a sole phase. The consultants are expected to work in close cooperation with the main stakeholders involved (Ministries of Health & Population, Finances and Social Solidarity, etc.). Ministries of Health & Population, Finances and Social Solidarity will assist them in the organisation of their agenda which should preferably be set before their arrival in Egypt. To this effect, before their mission, the consultants will prepare a list of the relevant stakeholders they would like to meet. The Ministries of Health & Population, Finances and Social Solidarity will make their best efforts to contact them and propose a schedule, which should be finalised during the first days of their arrival in Cairo. According to the compliance assessment needs, the consultants may request to travel to select Governorates.

During their mission, the consultants will:

- review all the documentation officially submitted by the Beneficiary with the payment request,
- collect any additional relevant needed information and documentation concerning the assessment of the performance of the Reform Benchmarks of the programme,

[3] Remark concerning the contracting of the Technical Assistance: Several meetings were held involving the EU Delegation and representatives of the Ministry of Health and Population in order to identify the needs and to define the scope of work of the Technical Assistance. Due to an instability existing at high level in the Ministry of Health & Population (the Minister has changed 7 times), no formal request was submitted to the EU Delegation until de deadline for signature was passed.

- analyse the conformity of the documentation obtained with the means of verification stipulated in the matrix of Reform Benchmarks and Means of Verification of the programme,
- assess the HSPSP-II General Condition towards the implementation of the Government Primary Health Care National Development Policy,
- assess all the Reform Benchmarks (Performance Indicators and Means of Verification) and their performance to date for disbursement purposes. Whenever a target is not achieved (or only partially met), the experts should also indicate to which extent the target has not been met, the reasons for not achieving it and estimate the probability of achievement within a defined timeframe and draw recommendations on disbursement.
- update and finalise the compliance assessment report (in relation with the Beneficiary's payment request) with recommendations for disbursement.

During their analysis, the experts may provide guidance to the beneficiaries in structuring their performance assessment and compliance report, if requested by the EU Delegation.

➢ **Required outputs**

1. An inception report (end of the first week of the mission).
2. A compliance assessment report (see above) in which the compliance analysis must include:

- an assessment of the general condition towards the implementation of the Government Primary Health Care National Development Policy,
- an assessment of all the Reform Benchmarks (Performance Indicators and Means of Verification) and their performance to date for disbursement purposes.
- a full set(s) of means of verification (including an assessment of conformity of the means of verification for all the targets).

➢ **Language of the Specific Contract**

The working language is English. However, most of the means of verification requested to assess the achievement of the agreed target are in Arabic.

➢ **Subcontracting**

Subcontracting is not foreseen.

3. EXPERTS PROFILE

➢ Number of requested experts per Category and number of man-days per expert.

The assignment requires two Category I experts. The Health expert will work for 25 working days and the Finance expert for 20 working days each over a period of approximately four months. The Team Leader will be in charge of the revision and final production of all the mission deliverables, organising the team coordination for the duration of the mission, and will ensure the quality and timely delivery of all products.

➢ Profile per expert.

1. Senior Public Health Specialist – Team Leader

- Category and duration of equivalent experience

Category I expert with at least 12 years of experience in the health sector (essentially in Primary Health Care development).

- Education

Master degree or equivalent academic qualifications in Public Health, Primary Health Care or other areas related to public health sector management.

- Experience

At least 12 year of experience in Primary Health Care development, preferably in Policy development, planning, monitoring and budgeting processes of the Primary Health Care sector.

Thorough knowledge of the Egyptian Health system is required.

S/he should have a good understanding of EU sector budget support approaches, with possibly experience in design and/or execution of sector support programmes.

Additional important qualifications include: expertise in public policy performance monitoring; experience in Health Sector Policy analysis, planning and programme design in a Middle Eastern country, knowledge of household surveys and exit-pools.

- Language skills

Proficiency in both English and Arabic is compulsory.

2. Senior Health Economist and Health Financing Specialist

- Category and duration of equivalent experience

Category I expert with at least 12 years of experience in health sector financing.

- Education

Master degree or equivalent academic qualifications in Health Sector Financing or other areas related to public sector management and financing.

- Experience

At least 12 years of experience in issues related to Health Sector Financing and Reform, and more particularly Primary Health Care Financing and budgeting.

Experience in advising, designing and supporting the implementation of Primary Health Care reform processes and institutional change, preferably in middle income countries.

A recent and relevant experience of Health developments in Egypt is highly desirable.

Familiar with EU approaches on sector budget support and public policy performance monitoring.

- Language skills

Proficiency in both English and Arabic is compulsory.

➢ Management team member presence is not required for the briefing and debriefing.

4. LOCATION AND DURATION

➢ Starting period

The assignment will start in October 2014

➢ Foreseen finishing period or duration

The Assignment will end mid February 2015.

➢ Planning including the period for notification for placement of the staff as per art 16.4 a)

The 2 experts will have to be mobilised according to the table below (indicative table):

Mission	No. of Experts	Working Days	Envisaged start date*
Inception Phase	Expert 1	3	12th October 2014
	Expert 2	3	
Field phase	Expert 1	17	November 2014
	Expert 2	15	
Total days	**Expert 1**	**5**	December 2014
	Expert 2	**2**	

* Dates are tentative: the precise dates of mobilisation will depend on proposed timetable / Programme during the mission.

➢ Location of assignment

The main location of the assignment will be Cairo. Trip up to two days to governorates may be foreseen for each expert in case requested by the mission (following a prior approval by the EU Delegation).

5. REPORTING

➢ Content

1. An inception report (end of the first week of the mission).
2. A compliance assessment report (see above) in which the compliance analysis must include:

- an assessment of the general condition towards the implementation of the Government Primary Health Care National Development Policy,
- an assessment of all the Reform Benchmarks (Performance Indicators and Means of Verification) and their performance to date for disbursement purposes.
- a full set(s) of original copies (stamped and signed by the Ministry of Health and Population) of the means of verification (including an assessment of conformity of the means of verification for all the targets).

➢ Language

The language of all communication and reports will be English.

➢ Submission/comments timing

All the reports will be submitted (for approval by the EU Delegation) not more than 2 weeks following the end of the Team Leader field mission in Egypt.

➢ Number of report(s) copies

The report will be provided in 5 original copies and in electronic MS Word format.

6. INCIDENTAL EXPENDITURES

This will be a global price contract. For the purpose of budget preparation, the budget should be calculated in a way to include: per diems for the expert requiring an overnight stay away from the place of residence in the beneficiary country, international travels and local travels.

Flights (round-trip flights from Europe to Egypt indicatively cost EUR 600 per flight).

7. ADDITIONAL INFORMATION

Throughout the duration of the mission, and following its completion, the experts will maintain strict confidentiality vis-à-vis third parties with respect to all information gathered and published.

During all contacts with the Egyptian Authorities or any other Organisation, the experts will clearly identify themselves as independent consultants and not as official representatives of the European Commission. All documents and papers produced by the experts will clearly display a disclaimer on the first page, stating that the views expressed in the documents are the views of the Expert and do not necessarily reflect those of the Commission.

Attention is drawn to the fact that the Commission reserves the right to have the reports redrafted by the experts as many times as necessary and that financial penalties will be applied if deadlines indicated for the submission of reports are not strictly adhered to.

The experts will be fully autonomous in terms of equipment (laptop computers and mobile phones, etc.) and will make their own arrangements for travel and hotels.

The experts will regularly report to the Delegation throughout the assignment.

The framework-contractor is expected to reflect local marked fees when an expert is hired on the local marked. Indicatively, the fees per working days for a local Category I Expert in Egypt are EUR 500.