

Public Disclosure Authorized

# Supporting Egypt's Universal Health Insurance System

# Draft

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## Stakeholder Engagement and Information Disclosure Plan

Egypt Ministry of Finance

February 2020

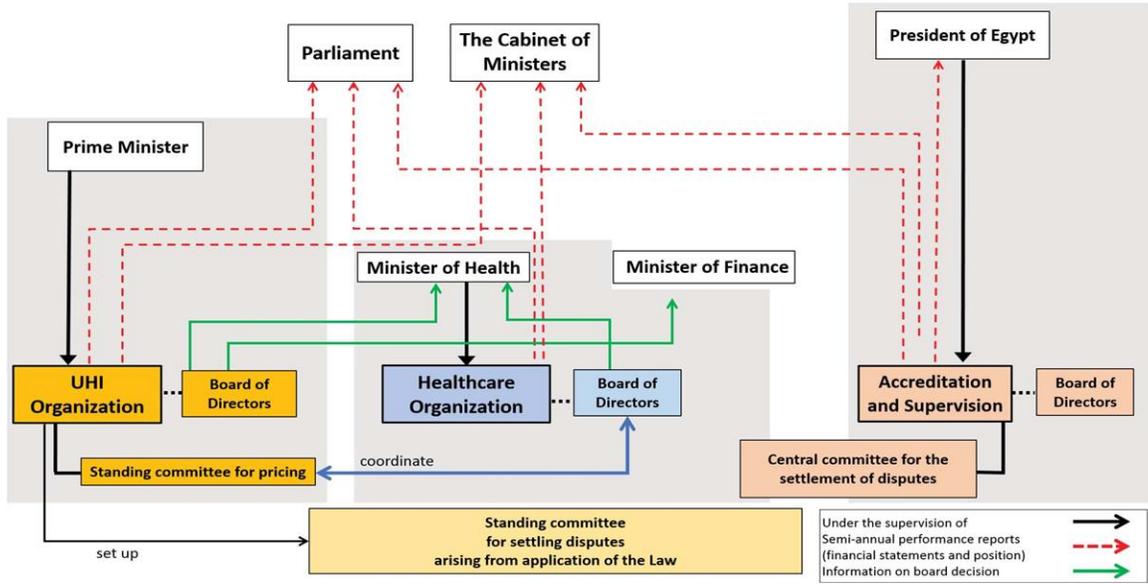
## Abbreviations

ACA	Administrative Control Authority
CAPMAS	The Central Agency for Public Mobilization and Statistics
CBOs	Community Based Organizations
DP	Development Partner
EGP	Egyptian Pound
ESCP	Environmental and Social Commitment Plan
ESRS	Environmental and Social Review Summary
ESF	Environmental and Social Framework
ESS	Environmental and Social Standard
GAHAR	The General Authority for Healthcare Accreditation and Regulation
GoE	Government of Egypt
GP	General Practitioners
GRM	Grievance Redress Mechanism
HCO	The Health Care Organization
IEC	Information, Education and Communication
M&E	Monitoring and Evaluation
MOF	Ministry of Finance
MOHP	Ministry of Health and Population
MOSS	Ministry of Social Solidarity
NGO	Non-Governmental Organization
PVO	Private Voluntary Organizations
OoP	Out of Pocket
PAD	Project Appraisal Document
PM	Prime Minister
SIA	Social Impact Assessment
SEP	Stakeholders Engagement Plan
UHC	Universal Health Coverage
UHIA	Universal Health Insurance Authority
UHIL	Universal Health Insurance Law
UHS	Universal Health Insurance System
WHO	World Health Organization

Contents

- Abbreviations .....2**
- 1- Introduction .....5**
- 2- Project Description .....5**
  - .2.1 Overview of project’s outcome .....5
  - 2.2.Project design in relation to social risks .....6
- 3. Brief Summary of Previous Stakeholder Engagement and Public Disclosure Activities:.....10**
- 4. Stakeholder Identification and Analysis: .....15**
  - 4.1. Project Affected Parties:..... 16**
  - 4.2. Other Interested Parties ..... 20**
  - 4.3. Summary of Project Stakeholder Needs ..... 21**
- 5. Stakeholder Engagement Program .....28**
  - 4.1. Stakeholder Engagement Program ..... 28**
    - 4.1.1. Purpose and Timing ..... 28**
    - 4.1.2. Topics of engagement ..... 29**
    - 4.1.3. Methods to be used in the stakeholder engagement ..... 30**
  - 4.2 Proposed Strategy for Information Disclosure ..... 30**
  - 4.3 Proposed Strategy to Incorporate the View of and Share Information with Vulnerable Groups ..... 32**
- 5. Grievance Redress Mechanism (GRM).....33**
- 6. Resources and Responsibilities for implementing stakeholder engagement activities.....35**
- 7. Stakeholder Engagement Budget .....35**
- 8. MONITORING AND REPORTING .....36**

Figure 3: New governance structure of the UHI system, as per the UHI Law



Source: Authors

..... 41

**Communication** ..... 44

**Uptake of complaints** ..... 44

**Registration of complaints** ..... 44

**Resolution and Follow-up**..... 44

**Feedback** ..... 44

## 1- Introduction

The Stakeholders Engagement Plan (SEP) is one of critical document aims to establishing a constructive relationship between the Program and the different stakeholders, to maintain the dialogue towards a unified vision for Universal Health Insurance System in Egypt, to enhance trust and decrease potential resistance, and to support sharing information about the Program. This is particularly important since the application of the health insurance model will entail changing in the culture of both the patients and the service providers. Given the citizens' financial contributions under the new system, there is a need to consider that this will come with certain expectations that need to be properly managed through constant, transparent and inclusive sharing of information and allowing room for beneficiaries' feedback. The SEP seeks to define a technically and culturally appropriate approach to consultation, disclosure and grievance redress, as well as to create an atmosphere of understanding that actively involves project-affected people and other stakeholders in a timely manner, and that these groups are provided sufficient opportunity to voice their opinions and concerns that may influence Program decisions. The SEP lays out the strategies to be applied by the Borrower as part of the World Bank's Environmental and Social Framework (ESF) and specifically Environmental and Social Standard 10 (ESS 10).

## 2- Project Description

### .2.1 Overview of project's outcome

The UHIL envisions coverage for all citizens, over 15 years, including disadvantaged groups (approximately 30-35% of the population) who will be covered for free by the government. The UHIS will be progressively rolled-out by phases throughout Egypt. In 2018, it was rolled-out in Port Said, initially as a pilot, and the plan is to continue roll-out in six phases over a 15-year period (see Table 1). The first phase of implementation includes the Governorates of Port Said, Ismailia, Suez, South Saini, Luxor and Aswan. The proposed Bank project will be limited to supporting the roll-out in Phase I Governorates.

**Table 1: Phases of UHIS roll-out**

Phase	Period	Governorates
1	2019 – 2021	Ismailia, Port Said, Suez, South Sinai, Aswan, Luxor
2	2022 – 2024	N. Sinai, Matrouh, Qena and Red Sea
3	2025 – 2027	Alexandria, Beheira, Damietta, Kafr Elsheikh and Sohag
4	2028 – 2029	Assiut, Beni Suef, Fayoum, Minya and New Valley
5	2030 – 2031	Dakahlia, Gharbia, Menoufia and Sharqia
6	2032 - 2033	Greater Cairo (Cairo, Giza & Qalyubia)

The Bank project is planned to support implementation of phase 1, which should cover 6 governorates—Port Said, Suez, Ismailia, South Sinai, Luxor, and Aswan<sup>1</sup>. Phase I governorates are roughly 2 million, with notable concentration in Luxor and South Sinai from GoE Officials. The first 3 governorates are located Luxor, South of Sinai and Port said. The 6 governorates are home to about 5.6 million people, out of nearly 100 million at the national level (Figure 1 and table 1).

In general, the project is expected to result in commendable social impacts, in terms of provision of financial protection to disadvantaged groups as well as delivery of good-quality healthcare. From a social perspective, the project's components will:

- **increase financial protection for disadvantaged groups** defined by a Prime Minister's (PM) decree (No. 1948/2019) through supporting enrollment of target beneficiaries, for whom the project shall incur contributions (Component 1). The identification process is expected to entail extensive efforts, particularly since Egypt's poverty tends to be rapidly changing nature. Consequently, ineligible inclusion and exclusion is expected to be one of the key social concerns, which is likely to result in a sizable volume of grievances.
- **improve quality of healthcare delivery in public facilities** through capacity building for UHIS-related agencies, with a focus on the UHIA and GAHAR to better help them carry out their mandates, particularly in establishing an accredited service provision network particularly in remote/ rural communities. The project will strengthen policy environment for private sector participation, citizen engagement mechanisms at both the central and governorate level such as 24X7 Call Center, and local and national Health Assemblies/Forums (component 2).
- **improve health outcomes of disadvantaged groups** through establishing procedures and monitoring mechanisms to ensure that health outcomes are continuously evaluated by all parties (Component 3). The Bank's Technical Assistance (TA) including capacity building and analytical activities for UHIA, GAHAR, and the Social Justice Unit of the Ministry of Finance (MOF), as well as other related entities.

## 2.2. Project design in relation to social risks

This document outlines three substantial social risks that may result from the project implementation including: (1) exclusion of the intended beneficiaries if eligibility screening system does not work well. (2) Financial burden on the near-poor; and (3) gap in institutional arrangements and governance for UHIS in relation to social risks. The Government will be taking forward the stipulated mitigation measures in this SIA. Some of the measures are already adapted by the Government. In the meantime, the design of the project was conscious to the social risks and number of relevant Disbursement-Linked Indicators (DLIs) and Disbursement-Linked Results (DLRs) were developed to build on the recommended actions to address the risks. This for instance includes:

- **DLI 2: Number of vulnerable populations enrolled in UHIS and empaneled with a GP in Phase I governorates.** This DLI will support results in identifying, enrolling, empaneling and subsidizing

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<sup>1</sup> According to UHIL, the phase 1 governorates are Port Said, Suez, Ismailia, South Sinai, and North Sinai, yet the government removed North Sinai governorate and shifted Luxor and Aswan from phase 2 to phase 1, allegedly due to security issues in the former governorate and infrastructure readiness in the latter governorates.

of contributory premiums and/or copayments of designated vulnerable groups in Phase I governorates as stipulated in the UHIL.

The six under-privileged groups that meet the Public Treasury criteria<sup>2</sup> to have their contributions covered by the UHIS live in the same geographical areas prone to climate change as those under DLI 1. Given their disadvantaged status, they are more vulnerable to natural hazards (such as extreme precipitation and flooding, and sea level rise), resulting price changes and have less access to support to cope and adapt to extreme climate events, fluctuations in heat and are at higher risk of vector-borne diseases. They are particularly vulnerable to health impacts of climate change and the safety net in health provided by the project is all the more critical.

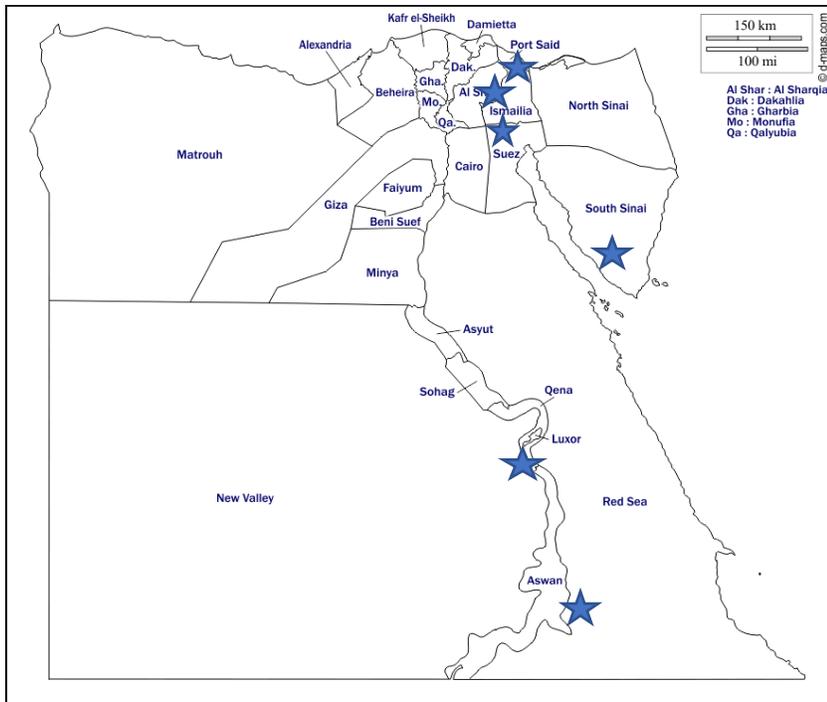
- **DLI 5: Strengthening accreditation and provider contracting.** This DLI will support the achievement of results in UHIA contracts with a set of accredited service providers (by types of services including public versus private). This will ensure the realization of key UHIL principles, specifically: (i) provision of quality services by UHIS providers, (ii) freedom of choice for beneficiaries; (iii) private sector inclusion and a level playing field that is conducive to market competition. The DLR (also supports contracting of individual provider entities, regardless of their affiliation with bigger holding/ownership arrangements to boost their responsiveness and autonomy.
  - DLR 5.1: Number of hospitals accredited by GAHAR and contracted by UHIA in phase I Governorates. - (at least 20 of which are 5 non-governmental)
  - DLR 5.2: Number of individual pharmacies accredited by GAHAR and contracted by UHIA in phase I Governorates. (at least 30 of which are 20 non-governmental)
  - DLR 5.3: Number of radiology services providers accredited by GAHAR and contracted by UHIA in phase I Governorates. (at least 8 of which are 4 non-governmental)
  - DLR 5.4: Number of laboratory services providers accredited by GAHAR and contracted by UHIA in phase I Governorates- (at least 15 of which are 10 non-governmental)
  - DLR 5.5: Number of ambulatory services providers accredited by GAHAR and contracted by UHIA in phase I Governorates- (at least 15 of which are 5 non-governmental)
  - DLR 7.2: *Dissemination of annual reports on patient satisfaction, grievances and utilization.* This DLR will support such reports as means to take stock of client experience and feedback for UHIS to improve its people-centeredness and boost accountability of the system including issues pertaining to gender and vulnerable groups. It will present gender-disaggregated data including a gender analysis.
- **DLI 8. Development and adoption of a set of complementary regulations and strategies for UHIS**

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<sup>2</sup> The Public Treasury will cover contributions for financially under-privileged persons who meet any of the following conditions: (1) The person or family entitled to cash support provided by Takaful and Karama Program and the Social Security Program; (2) The unemployed person or family head who is ineligible to or has exhausted his/her eligibility period to unemployment benefits and every dependent person in the family; (3) The person or family head with no bread-winner or income, who lacks family care and resides in a social or health care facility; (4) The disabled person or family head who cannot earn money or have any source of income, without prejudice to the Law on the Rights of Persons with Disabilities hereinabove; (5) Persons and families who reside in specific geographic areas and temporarily experiencing a natural or man-made disaster; (6) The person or family head whose average income does not satisfy his/her own needs or his/her family members' essential needs.

- DLR 8.1: Revision of the strategy to target the vulnerable groups for UHIS subsidies in Year 3. The revision will be based on an assessment of the impact of subsidizing the vulnerable groups under UHIS as per the prime-ministerial decree (1948/2019) after 3 years of implementation. The assessment will report on differentiated impacts on women and men.
- DLR 8.2: Completion of a Strategic Environmental and Social Assessment (SESA) study to examine the environmental and social risks associated with the roll-out of the UHIS in Year 2. Such a study will inform the finetuning of safeguards measures for UHIS in general and project activities in particular. The assessment will follow the WBG guidelines for safeguards assessments based on the newly adopted WBG Environmental and Social Framework (ESF).
- DLR 8.3: Development and Adoption of a Green Health Insurance System Strategy by Year 3. This DLR will support the development and adoption of a new 'Green Health Insurance System' strategy. The new strategy should be aligned with the 'Go Greener' initiative adopted by the GOE and will include mandatory measures over time including, but not limited to: (i) improved energy efficiency in health facilities; (ii) of a Climate and Health Vulnerability Assessment (CHVA); (iii) use of digital health records; (iv) promoting the use of Telemedicine; (v) use of local food sources; (vi) waste reduction; (vii) energy conscious sourcing and construction; and (viii) reduced usage of non-recyclables. DLR 8.3 will include climate adaptation measures, particularly through the promotion of telemedicine which can reduce the carbon footprint related to travel to health facilities.
- DLR 8.4: Satisfactory Adoption & Implementation of 3 hospitals (2 public and 1 non-public) of the Green Health Insurance System Strategy in target Phase I governorates. Disbursement will be made against the verification that three hospitals have met the requirements under the adopted Green Health Insurance System Strategy.
- **Under component 3, the project will address the gap in institutional arrangement and capacities** by supporting support for the Project Management Unit (PMU) which will be staffed with qualified calibers to support in managing the social risks of the project and in the implementation of the SEP.

**Figure 1: Map of UHIS Phase I targeted governorates**



★ Phase I governorates

Source: Map was retrieved from [www.d-maps.com](http://www.d-maps.com), December 2019. The star legends were added by the author.

**Table 2: Total Population and are of UHIS Phase I governorates**

	<b>Total Population</b>	<b>Total Area</b>
Port Said	749,371	1,345 km <sup>2</sup>
Ismailia	1,303,993	210 km <sup>2</sup>
Suez	728,180	17,840 km <sup>2</sup>
S. Sinai	102,018	27,574 km <sup>2</sup>
Luxor	1,250,209	2,960 km <sup>2</sup>
Aswan	1,473,975	33,140 km <sup>2</sup>

Source: information was retrieved from [www.gov.eg](http://www.gov.eg), January 2020

### 3. Brief Summary of Previous Stakeholder Engagement and Public Disclosure Activities:

In January 2018, the Universal Health Insurance Law (UHIL) was issued, and its executive regulation was also issued on 5 May, 2018. The Program is predominantly governed by the new UHIL which took several years (and multiple governments) to be developed. During the development process, the government entities in charge got heavily engaged in many consultations with key stakeholders. These included civil society organizations; syndicates, such as those of physicians, pharmacists, and dentists; and industries, such as pharmaceuticals; trade unions; as well as independent experts. The Parliament was also involved in the development process. In addition, some civil society actors were members of the committee that developed the new law. The Government agrees to adopt a very dynamic approach in implementing the Program and amendments to the executive regulations of the law sounds possible whenever there is a need. Since January 2018, a national level campaign using the mass and social media, as well as Information, Education and communication (IEC) approach has been utilized by GOE to discuss the law and inform citizens about the new Egypt's Health insurance System. All national level mass media and press (e.g. newspapers, magazines, radio and TV talkshows) were utilized widely and the most prominent events and press conferences that were organized are:

- In January 2018, The Minister of Finance, and Minister of Health and Population held a joint press conference to announce the details of the comprehensive health insurance law after its approval by parliament.
- In November 15, 2018, a joint press conference by all related parties and ministries conducted to announce commencement of the health insurance system in Port Said Governorate in June 2019.
- In July 2019, the Prime Minister, Minister of Health, and Minister of Finance have addressed the new health insurance system when they announced the Hepatitis and breast cancer treatment initiatives. They referred to the pilot operation of the comprehensive health insurance system in Port Said Governorate and the plan to expand it to other five governorates as part of phase one of the Program at a cost of EGP 1.5 billion which equivalent to around 100 million USD<sup>3</sup>. They also mentioned that the state will provide for those who cannot afford the price of treatment. The pilot operation will include the registration of poorer families, including the six categories of the disadvantaged groups that will be exempt from paying premium and copayment, as stipulated by the Prime Minister Decree No. 1948/2019.
- A full media coverage for these main events were widely utilized, as well as social media (mainly different Facebook pages for the UHIA, Health Care organization, Port Said, Ismailia, Luxor, Awan and South Sinai) to address, discuss and inform Egyptian citizens about the universal health insurance system, including specifically dissemination for the following information:
  - The universal health insurance law and its stages of enforcement;
  - Timeline of application of the law;
  - Citizen registration procedures;
  - Services that will be covered and services provision;
  - Terms of use for new comprehensive health insurance services;

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<sup>3</sup> As per the exchange rate of February 22, 2019

- Information about the key players and the three main organizations;
  - The benefit of individuals who will be enrolled under this system, as well as the disadvantaged groups.
  - The hotline number for filing a complaint (15344)
- In February 20, 2020, the first official national conference for the Universal Health Coverage in Egypt was launched under the auspices of the Minister of Health and Population. The universal health insurance was one of the key themes in the workshop. On the side of the national conference, a large scale media conference was conducted and a [comprehensive flyer](#) with FAQ was disseminated to the media, parliamentarians and other participating stakeholders.



[Citizens' Guide](#) for the Universal Health Insurance developed and widely disseminated by UHIA and HCO the awareness campaigns conducted on different Governorates and on different social media and electronic platforms (e.g. <https://www.facebook.com/UHIEG/> <https://www.facebook.com/UHIA.Egypt/>)

Moreover, during the course of the December 2019- February 2020, Luxor, Aswan, and South Sinai Governorates utilized the Community Health Workers of the MOHP to reach out to the citizens and disseminate facts and information about the new health insurance system in the remote villages as well as tribal communities.

In addition, several IEC materials were prepared and used during the face to face communication and in the social and national level campaigns, includes brochures, leaflets, posters, info graphs, and short educational videos.

Several rounds of consultations were also conducted as part of the project preparation and particularly during the preparation of the SEP and Social Impacts Assessment (SIA). Engagement activities with various stakeholders including beneficiaries were carried out by UHIS' organizations in Port Said (where the project was already piloted) and in Luxor and South Saini Governorates where the system will be rolled out in March 2020. The consultations allowed stakeholders' views and concerns to be considered in the project design, and to provide inputs to the project social assessment and mitigation plan, as well as to plan for monitoring and evaluation arrangements.

Annex 1 includes summary of the conducted sessions.

Through those consultation activities, the feedback of the communities was obtained on the project and how to improve the different interventions as the examples shown in Box 1 below.

**Box 1: Examples of the received feedback from the targeted beneficiaries in Port Said, South Sinai and Luxor**

**Gatekeeping system:** Concerns were pronounced in urban areas (specifically in Port Said) on the use of the referral/gatekeeping system more than in other rural and remote governorates such as Luxor and South Sinai, whose populations are more used to primary care.

**Contributions:** Contrary to expectations, a lot of people stated that they do not have an issue with paying their due premiums and copayments as long as they will receive good-quality care whenever needed.

**Absence of identification card:** A significant number of beneficiaries, mainly working in the informal sector, did not have Identification Documents, namely birth certificates, marriage certificates (tribal communities <sup>4</sup>in South Sinai rely on customary marriage), and IDs. This is a required document for the registration to the new system, as well as for applying for an exemption from payment if beneficiary is eligible. . Accordingly, the MOHP approached respective entities to identify such groups of people and issue the necessary identification cards for them. in order to be able to be registered as a household on the system.

**Polygamy:** Men who are married to more than a wife may not have all wives in the same area. Accordingly, the MOHP mapped each of the wives to the closest primary healthcare facility to make it easier for each of them to access the service. Though, all the wives will be registered under a single household number. Each family file will be linked to the head of household but will receive a unique code to ensure privacy and confidentiality.

**Extended families:** In South Sinai and in Luxor, the family structure is the extended model (grandparents and several families stay in the same house. For registration and logistical purposes, such large households were disaggregated accordingly.

**Female doctor:** In some conservative areas, e.g. in Luxor (Esna district in particular), women and men voiced their preference of having female physicians to whom their female household members can comfortably have access to.

**Disadvantaged groups:** Some people, such as day-laborers and farmers, raised a question on how the system is going to identify the disadvantaged groups who should be exempted from paying premiums and copayments.

**Immigrated labor:** A lot of workers in South Sinai and Luxor, in particular, come from other governorates where the new system is not yet applicable. Accordingly, such groups will be exceptionally enrolled into the system as long as they provide the necessary supporting documents that they work regularly in the host governorates. Yet, the enrollment will be individual-based in this case as long as the worker's household is still residing in their home governorate.

The Government is utilizing the feedback that they received from the consultation to improve the implementation of the Project in different Governorates and ensure that it is appropriate for the local conditions and the local

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<sup>4</sup> As explained in details in the SIA, in applying the criteria for classifying a group as Indigenous People as stipulated in ESS7, it does not fully align in the cases of the local tribes in South Sinai and Ismailia. Unlike the rest of the areas of Sinai Peninsula, tribes in South Sinai got in recent decades more open to the tourism industry which resulted to a large extent in changing the characteristics of the local tribes by making them more open to outsiders and less attached to the geographically distinct habitats, ancestral territories, or areas of seasonal use or occupation. Despite the fact that tribes in the target area have a unique dialect, it is predominantly composed of Arabic vocabulary which makes it understandable to most of Egyptians in normal cases. Customary institutions and tribal laws are still applying but only on land and fame related issues. The same applies to Ismailia' local tribes.

requirements. Most of the raised points above were responded to through taking appropriate measures to address them. Among the key locally appropriate techniques that the Government has also utilized is the use of outreach mobile campaigns to approach people in different places to register them into the new system. These include a registration bus that tours different locations, in addition to the MOHP's community health workers who also registered people at their own homes or encouraged them to go to the closest health unit to get themselves registered.



**Consultation with Citizens in Luxor, February 2020**



**Women-only Consultation in Port Said, February 2020**



**Registration in the mobile clinics in South Sinai, November 2020**



**Consulation with citizens in South Sinia, February 2020**

## 4. Stakeholder Identification and Analysis:

In order to ensure an inclusive and meaningful engagement process, a stakeholder identification was conducted to precisely define the key groups of relevance to the Program and to get better understanding of the various groups and their roles, interests and influence on the Program, as well as to define the substantially affected groups. ESS 10 recognizes two broad categories of stakeholders: i) Project Affected Parties; ii) Other Interested parties. This section of the SEP identifies those stakeholders who will be directly or indirectly, positively or negatively affected by the Program or who may have an interest in the Program and will accordingly be informed and consulted about the Project.

The Stakeholder Engagement Analysis aims to identify (i) who will be directly or indirectly affected by the project, (ii) how the project will reach out to the different groups of stakeholders, and (iii) how would the project share information and get stakeholders involved in the decision-making and implementation of the project. This SEP, therefore, summarizes findings of the analysis and describes the timing and methods of engagement with stakeholders throughout the life-cycle of the project.

The Universal Health Insurance System is a mandatory system that will be covering all citizens through financial equity program that mandates financial contribution of all segments of the society. The family is the main unit for insurance coverage and the State shall bear the cost for underprivileged groups in accordance with the controls of exemption that have been established by the Prime Minister's (PM) Decree 1948/2019. So, the **proposed project will benefit, directly and indirectly, the entire population of Egypt** and the phase one will target all populations in the six target Governorates, of which 52% of the population are males and 48% are females. As per the definition of ESS1 for disadvantage and vulnerable groups, the exclusion of beneficiaries based on ethnicity, gender orientation, sex, gender and religion is not likely. However, there is a potential risk that some vulnerable group, namely women living in rural and remote areas, and people living with HIV, may not fully benefit from the project's planned services due to the gate-keeping mechanism which increase access to basic services, but limits access to secondary and third services. Refer to chapter 5 section 5.2 of Social Impact Assessment for more analysis and details.

The major stakeholders include also government and private sector health service providers including, physicians (specialized or general practitioner), dentists, pharmacists, lab technicians, nurses, physical therapists, and others who are working in the governmental and public hospitals, health care centers, health units or in private service provision establishments. Community Based Organizations (CBOs) and NGOs providing health services, including religiously affiliated clinics and other charitable organizations, all of which are registered with the Ministry of Social Solidarity. Among the stakeholders that also have interest in the project are the insurance companies and the pharmaceutical companies. Furthermore, **the new UHIS will be managed by a several central governmental agencies**. These include, but are not limited to MOF, MOHP, the office of the President, and Prime-Minister's office. **Figure 2** illustrated the key stakeholders

## 4.1. Project Affected Parties:

### - Egyptian Citizens in the six Governorates:

**Currently most of citizens are** suffering from poor health outcomes and inadequate medical services. Disparities exist across geographic regions with the population of the rural, remote and slum areas being the most unprivileged. Despite the multiple providers, healthcare financing is also inequitable with out-of-pocket (OoP) being the principle source of healthcare financing. Families in the lowest income quintile spend 21 percent of their income on healthcare-related costs, versus 13.5 percent for those in the highest income quintile.<sup>5</sup> By the full implementation of the Universal Health Insurance System (UHIS), it is envisaged that all Egyptians will be covered with quality health services while ensuring adequate level of financial protection. The new system is expected to markedly reduce high OoP (around 60 to 70 percent out of the total health expenditure at the country level), which in turn should help alleviate related financial burdens, particularly on the poor, and increase access to services.

The Egyptian citizens in the targeted Governorates are expected to benefit from a much improved high quality health care service that will be equally available for all and will be offered following high level sets of international standards that will be very rigorously applied to allow the health establishments to get accredited. The patient-centered approach and what it will entail from a huge shift in the mindset of the service providers and the health care institutions is also expected to bring a lot of benefits to the patients by giving them space for feedback about the quality of the service and more orientation about their rights.

### - Poor population (who are meant to be exempted from the premium and copayment) :

The Prime Minister Decree (No. 1948/2019) that identifies the financially-underprivileged persons and the controls of exempting them and their families from the payment of the premium and the copayments of the health insurance. The Public Treasury will cover contributions for financially under-privileged and vulnerable persons who meet any of the following conditions<sup>6</sup>: (i) the person or family entitled to cash support provided by the social safety net Takaful and Karama Program and the older Social Security Program; (ii) the unemployed person or family head who is ineligible to or has exhausted his/her eligibility period to unemployment benefits including every dependent person in the same family; (iii) the person or family-head with no bread-winner or income, who lacks family care and resides in a social or health care facility; (iv) the disabled person or family head who cannot earn money or have any source of income, without prejudice to the Law on the Rights of Persons with Disabilities; (v) persons and families who reside in specific geographic areas and temporarily experiencing a natural or man-made disaster; and (vi) the person or family head whose average income does not satisfy his/her own needs or his/her family members' essential needs after appealing to a dedicated Committee, Disadvantaged Persons Enrolment Committee, to assess eligibility. According to available national data- which is to great extend limited; the estimated no of the vulnerable, as per the mentioned criteria is 2,218,948 individuals based on national poverty rate per governorate detailed in national census 2017<sup>7</sup>.

In the long term, these groups could turn to be better off when they are enrolled in the health insurance system, as the new health insurance system appeal as the main approach to improve health care systems. Accordingly,

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<sup>5</sup> Rafeh N, Williams J, and N Hassan. (2011). Egypt Household Health Expenditure and Utilization Survey 2010. Bethesda, MD: Health Systems 20/20 project, Abt Associates Inc

<sup>6</sup> Prime-Ministerial Decree No.1948/2019

<sup>7</sup> Annex 3 No of the vulnerable individuals based on the national poverty rate

the citizens under these categories will have a great potential to benefit from this system, as the state will sponsor their' premiums and co-payment.

- **Near poor population:**

Near poor could be left behind in terms of contribution-exemption. Since they will be categorized as eligible *payers*, percentage deduction of premiums and copayment might push them into poverty. It is not clear how many people may encounter this risk. The process that such groups would go through to self identify themselves to qualify for an exemption is too lengthy and complicated and will likely discourage the groups to apply for exemption. Therefore, the exemption process needs to be evaluated considering actual practice. Recently, Disadvantage Persons Enrolment Committee announced that it has received a total of 15,000 applicants from Port Said governorate that are under consideration. The process needs to be evaluated and again strategies that focus on enrolling eligible household should be central to the process and addressing restrictions that may exclude qualified households.

- **Other disadvantaged and vulnerable individuals and groups**

As detailed in SIA there is a potential risk that some vulnerable group may not be making the best use or might get excluded from the project benefits. Those groups are:

**People with disability:** They are expected to greatly benefit from the UHIS including from exemptions offered by the State. GAHAR's standards on personal safety provides a range of measures to allow physical access to individuals with disabilities to health premises at primary and higher level of services. In addition, the UHIS is planning to equip many primary health care facilities with necessary health personal in rural and remote communities. This in turn, will support persons with disabilities and their families to have access to health services that are closer to them. However, the potential burden of the other expenses that is associated with disabilities including medical escorts, cost of transportation, sometimes lodging to access services in urban centers and nursing that will not be covered by UHIS should be monitored. Capacity building for health staff and providers does not address issues of disability and therefore beneficiaries belonging to this category may not receive appropriate services. Thus, it is important to monitor and further consult this group during implementation of the program.

**Women living rural and remote communities:** Under UHIS, individuals wishing to access higher health services must be referred by a family physician located at primary health care unit. This mechanism may limit the access to women from more conservative communities, for example, some communities will be more comfortable to be examined by female physicians (mentioned in public consultation with tribal communities in South Sinai). Similarly, people living in rural areas and belonging to specific religion, will be more comfortable to be examined by a physician belonging to the same faith, sex and gender. There is a general shortage in family physicians and therefore assigning a female physician in rural and remote areas will be particularly challenging for the government.

**People living with HIV:** the absence of Standard Operating Procedures (SOPs) and trained health care personal at primary healthcare unit, PLHIV may experience discrimination at health facilities, due to several reasons, including

stigma<sup>8</sup> and fear of infection due to the lack of health teams' knowledge and experience in dealing with such an infectious disease. Accordingly, PLHIV could refrain from seeking medical attention at the primary care facilities or not declare their HIV status.

The Project needs to keep monitoring the impact on those groups very closely and appropriate mitigation measures should be introduced to address any emerging impacts. The SEP should support the Government through ensuring that a continuous line of communication is open with those groups to get their feedback.

- **Citizens working in private entities:**

This sub group of Egyptian citizens covers people who are working in petroleum, investment companies, private banks, and other sectors that are not owned or operated by the government. According to UHIL #2/2018, it is expected that individuals working in private entities will pay 5 percent premium per individual/employee, and 10 percent if providing for a family comprising of a wife (non-working) and two children. In phase one of the Program, an estimate of **505,764 individuals, a total of 10 percent of the targeted population in phase I** (CAPMAS 2017), counts for individuals insured under private sector only. This group could be potentially affected if they are asked to pay twice for health insurance (the cost of premium, as well as cover the cost of their private insurance company). The decision to fully switch to UHIS is at the discretion of their own employers and it is not their own. In addition, they will be obliged to pay arrears via a one-off payment or in installments as mention in the health insurance law – The article (48) stipulates that the use of comprehensive social health insurance services requires that the beneficiary be a participant in the system and is paying their share. Individuals who do not join the universal health insurance from the beginning but decide to do so later will be obliged to pay the arrears via a one-off payment or in installments, except in case of an emergency, as defined by the authority. Some employees are also comfortable with their current health insurance providers and might be resisting to change to the governmental service.

**Health Care Providers:**

- **MOHP/ Governmental and Public Health Services Providers:**

Government-sector service providers are the manpower who actually deliver various modalities of care. The provision staff includes physician or general practitioner, dentists, pharmacists, lab technicians, nurses, physical therapists, and others who are working in the governmental and parastatal hospitals, health care centers, and units. All of these positions will be transferred to the Health Care Organization (HCO). It is anticipated that this transfer will result in a broad range of positive impacts on the healthcare providers. For instance, new salary schemes will be applied particularly in the human resources who will be mobilized to serve remote areas, learning and training opportunities will be provided, better work environment, strict application for OHS requirements, applying high international services standard, delivery protocols and guidelines. Consequently, most of the health care providers will be positively affected.

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<sup>8</sup> The public judgmental mindset sometimes perceives PLHIV as infected due to the lack of faithfulness, ignoring the fact that they could have caught it at sub-optimal health facilities as a result of inadequate infection control measures.

- **Private service providers, including traditional private pharmacies, private doctor clinics, and private hospitals of all sizes**

The private sector includes for-profit such as traditional private pharmacies, private doctor clinics, and private hospitals of all sizes. Private facilities shall fulfill the required accreditation criteria, within three years of Law implementation within their respective governorate, in order to be contracted by the UHIL (Article 31 UHI Bylaw). In that context, the application of the Law provides very good opportunity for the private facilities that will get accredited and integrated in the system. In the meantime, those who will not be able to meet the accreditation criteria might be negatively affected. To address this risk, GAHAR is having a comprehensive outreach program to the private service providers where the benefits of the system is explained along with all the required standards to meet for accreditation. Other proactive support methods to support the private service providers are also being considered out of the Government belief that the private sector is a key and essential partner in offering services. The need for this integration for the private service providers is specifically important in certain Governorates where the ratio of the service they offer compared to the Government is significantly high. Please note annex 2, the number of health units with beds by sector (public/private) in the phase one governorates ranged from 4.5 in Aswan to 45.2 in Suez.<sup>9</sup>

- **Community Based Health Organizations / Service Providers**

There are a broad range of community-based health organization, e.g. Private Voluntary Organizations (PVOs) and NGOs providing health services, including clinics that belong to religious establishments and other charitable organizations, all of which are registered with the Ministry of Social Affairs. These NGOs and PVOs are very active in remote poor rural areas and villages who have limited access to health care services. Current statistics are lacking the number of these organizations in the six governorates. The Government is aware of the core functions that this category of service providers is offering particularly for the rural and remote areas. Thus the Government, specifically GAHAR is paying considerable attention to support those NGOs to raise their standards to be able to get accredited. In light of that, those NGOs as service providers are expected to benefit from the project. However, the small scale NGOs and those with limited capabilities, may find challenges in meeting the accreditation criteria. This may suggest potential negative impacts on them and the human resources involved in there. It is worth noting that GAHAR is having the same comprehensive outreach program with the NGOs to help them to get accredited. This is especially valid in governorates with high reliance on the NGOs services like Luxor and South Sinai.

- **Private Commercial Health Insurers Companies**

Private commercial health insurance companies are currently the main health insurance service providers for many governmental and private entities and beneficiaries (e.g. for banks, syndicate, companies ...etc.). The nature of the impact anticipated from the project on those companies is not very clear. While there seems to be a risk from the roll out of the project on the business that those companies are offering, the consultations conducted during the preparation of the SIA and the SEP reveals that the private health insurance continues to be important even in countries where universal coverage has been achieved. The Government is also aware of the size of the business of the private commercial health insurance companies and is planning to maintain dialogue with them to explore the best options to collaborate with them rather than disengage them. Companies, through the consultations, showed that they are confident that the government's universal health insurance scheme will have little impact on them due to many reasons including the planned gradual implementation of the government-run

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<sup>9</sup> Egypt in Figures – CAPMAS 2018

health insurance as well as the ongoing dialogue which is suggesting that a complementary role for the commercial health insurances will be reached.

- **Partners /Government Stakeholders:**

These include, but are not limited to (i) MOF which oversees UHIA and has a central role in the financing of the system and ensuring financial protection for the poor; (ii) MOHP which oversees the HCO through upgrading and adequately operationalizing public health facilities; (iii) the office of the President which oversees GAHAR as an independent regulator of quality services within the public and private providers spheres; and (iv) the Prime-Minister's office overseeing the EASPMTM. In very general terms, all the involved Government entities will be directly affected with the project in positive way. The success of the project is one common goal for them despite the challenge related to coordination and managing additional work load. Annex 3 illustrated the main organizations involved in UHIS and main functions of the key ones.

## 4.2. Other Interested Parties

- **Other Ministries and Governmental Agencies:**

Those agencies most importantly include, the Ministry of Social Solidarity (MOSS), the Administrative Control Authority, the Central Agency for Public Mobilization and Statistics. The agencies are members in the Disadvantaged Persons Enrolment Committee. This committee was created by a decision from UHIA Chairperson to receive, examine and decide on applicants for vulnerable persons enrolment. The Ministry of Planning is part of a Steering Committee (SC) that will be established to be responsible of overall project stewardship, oversight and monitoring of implementation progress.

- **Medical Syndicate:**

The Medical Syndicate is the country's association of different groups of practitioners with medical background. It is among the most powerful professional association in the health sector. The Medical Syndicate is regarded as being the most likely professional association to become engaged in any health reform. The syndicate will closely monitor the implementation of the Program and the potential impacts on its member and may lobby for changes to protect the rights of doctors in case this is needed.

- **Development Partners (DPs):**

There has been mutual agreement between different partners to conduct, as much as possible, combined client engagement and missions. The Agence Française de Développement (AFD) is supporting the new UHIS with a DPF of Eur 60 million focused on supporting the system's main legal pillars. Furthermore, JICA is exploring opportunities to engage on parallel financing with the Bank on a results-based funding modality (after April 2020). Finally, the WHO has been providing on-time TA to UHIS and is planning to coordinate its efforts with the Bank in that regard. Early coordination and engagement with other DPs to ensure consistency and harmonization in responding to the financial and technical needs of the UHIS is being pursued.

- **Media and Community Based Organizations (CBOs),**

Other stakeholders who might be interested in the project include CBOs and Media who are active in the health sector in Egypt on various fronts. These organizations could support the UHIS during implementation of the ESP by performing community awareness campaigns, facilitating consultation activities, implementing face to face and IEC activities on benefits of UHIS, as well as could support the registration and enrollment activities. In the

meantime, there are groups of NGOs that are active in offering third party/independent monitoring for the health related programs. Recently, the Egyptian Initiative for Personal Rights and Shamseya for Innovative Community Health Care Solutions, have conducted a community-based evaluation of UHIS system in Port Said governorate. The results have been discussed with GAHAR and is informing the way forward.

*It should be mentioned that the stakeholder groups identified and analysis conducted as part of project preparation, (during preparation of PAD) must be revisited after six months of the Program effectiveness, as the stakeholder groups to be engaged may be expanded during project implementation. Moreover, the SEP should be considered as a living document, thus to be continually updated by the PMU as the Program progresses.*

### 4.3. Summary of Project Stakeholder Needs

Table 2 summarizes the stakeholder categories identified above and identifies the preferred means of communication with these stakeholders, and frequency of engagement. Communication and consultation meetings with different affected groups of stakeholders should consider the level of education and local language terminologies, especially when communicating with villagers and tribal communities specifically when these meeting take place in upper Egypt and South Sinai governorates.

**Table 2: Summary of Project Stakeholder Needs**

Stakeholder group	Key Characteristics	Frequency of Engagement	Preferred notification	Specific needs
<p><b>Egyptian Citizens in the six Governorates:</b></p>	<p>Diverse socioeconomic characteristics, including different social classes and, level of education, urban/ rural division, and tribal populations</p>	<ul style="list-style-type: none"> <li>Engagement should be done as an ongoing process at the different stages of the project implementation</li> <li>During registration phase for the five governorates, and as needed during the lifetime of the program.</li> <li>On regular basis /monthly Egyptians should be informed and updated about UHIS and reach information about the results of the regular customer satisfaction surveys and results of GRM.</li> <li>At the different milestones related to the assessment of the system</li> </ul>	<p>Broad range of notification modalities according the socio-economic status, educational and cultural level. This includes but is not limited to:</p> <p>Mass and Social media - television and radio network,</p> <p>Public opinion; blogs; websites; and written information, reports and UHIS' Publications</p> <p>Visual tools to meet the requirements of illiterate people</p>	<p>Needs of the different groups are diverse and the messages and the modality for engagement should be formulated according the needs of each target groups to ensure that the process is done in a collaborative and culturally appropriate manner and in a way that fits with the capabilities of the targeted groups. Strengthen participation and accountability mechanisms towards the public, through the establishment of a feedback mechanism within or outside the UHIS organization</p> <p>Disseminate information about GRM</p>
<p><b>Poor population (who are meant to be exempted from the premium and copayment)</b></p>	<p>limited voice, low representation, lack of access to information, most vulnerable according to the</p>	<ul style="list-style-type: none"> <li>At early stage for registration in the system.</li> <li>During the preparation for the roll out of the system by the MOHP</li> <li>During the life cycle of the project.</li> </ul>	<p>Engagement of local NGO's; opinion leaders; health workers to reach out the vulnerable people at the community level to help disseminate information; Organize</p>	<p>Meetings in close by locations within the communities; reach out to unprivileged groups to ensure that information about the project and the GRM are available.</p>

Stakeholder group	Key Characteristics	Frequency of Engagement	Preferred notification	Specific needs
	Government and PM decree		consultations event at community level. Visits to social or health care facilities Television and radio network, Newspaper and Websites; social media.	separate meetings with women in South Sinai and Upper Egypt.
<b>Near poor population:</b>	limited voice, low representation, lack of access to information, may encounter challenge to demonstrate that they qualify for exemption	<ul style="list-style-type: none"> <li>At early stage for registration in the system.</li> <li>During the preparation for the roll out of the system by the MOHP</li> <li>During the life cycle of the project.</li> </ul>	Various modalities as above.	Support in completion of the self-identification eligibility document. Information sharing using locally appropriate modalities.
<b>Other disadvantaged and vulnerable individuals and groups (specifically women in remote rural areas/tribal communities), PLHIV,</b>	Social stigma Risk of exclusion Limitation in mobility	At early stage of the project consultation with those groups should be done to discuss their needs  During implementation  To receive feedback	Reach out activities to the targeted population (women in remote areas and people with disability) using appropriate teams (e.g. female workers to address women, trainer health workers to address PLHIV)	The vulnerable characteristics of those individuals should be considered. Appropriate (anonymous if needed) GRM should be developed to address potential confidentiality needs.

Stakeholder group	Key Characteristics	Frequency of Engagement	Preferred notification	Specific needs
<b>individuals with disability</b>			Engage and consult in a manner that respects confidentiality and the cultural specificity.	
<b>Citizens are working in private entities:</b>	Private sector staff with socio economic characteristics, including different social classes and, different level of education.	At early stage for registration in the system.	Consultation sessions with large private sector; Formal correspondences; Conference with employers, especially with private sector has branches in the phase one governorates.	Before this meeting UHIA will have a clear vision about how will involve private insurance companies that are currently dealing with private sector
<b>Health Services Providers MOHP/ Governmental and Public Sector employees</b>	Health providers working in governmental and public health facilities that will not be accredited or in facilities have overstaffing	As needed during implementation of the UHIS	Formal correspondences policy papers; consultation meetings and round table discussions; labor complain mechanism	Policy statement about the transformational training and education opportunities will be offered for staff relocations-redistribution
<b>Private sector and community-based health organizations</b>	The private sector includes for-profit and non-profit organizations such as private clinics, all sizes hospitals, labs, Physical Therapy Centers, etc.	Before commencement of the Program in each governorate of the phase one, and during implementation as needed for Port Said governorate.	Formal correspondences mass/social media; traditional press channels (newspapers, television, radio channels); press conferences; policy papers; consultation meetings and round table	Written information about the UHIS accreditation criteria: Registration - a clear requirement for the different types of health facilities; clarification about the role of not

Stakeholder group	Key Characteristics	Frequency of Engagement	Preferred notification	Specific needs
			discussions, labor complain mechanism	accredited facilities; opportunities for the service providers to join / countenance in the UHIA program accreditation criteria for all types of medical facilities.
<b>Private Health Insurers Companies</b>	Egyptian and global level Private sector. The insurance companies have a health team is composed of general practitioners and specialists who provide services in the health insurance through a network of health providers.	Before the commencement of the Program in the new governorate.  During the implementation as needed for Port Said governorate	Formal correspondences; Round table discussion; Consultation session.	A clear vision from UHIA on how the private health insurance will be involved on the UHIS.  A draft policy paper for the supplementary role of commercial health insurances to be prepared before consultation.
<b>Partners /Government Stakeholders: MOF,MOHP, UHIA, HCO, GAHAR, and EASPMTM.</b>	Partners organization who are responsible of UHIS implementation.  Steering Committee will be established for oversight, monitoring implementation, and for policy making	Regular (weekly).  Steering committee will meet at least every six months	Formal correspondences all types of reports; conferences; meetings; surveys; policy papers; forums of discussion. annual work-plans and budgets; an	

Stakeholder group	Key Characteristics	Frequency of Engagement	Preferred notification	Specific needs
	Disadvantaged Persons Enrolment Committee. This committee was created by a decision from UHIA Chairperson to receive, examine and decide on applicants for vulnerable persons enrollment			
<b>Development Partners (DPs):</b>	The Agence Française de Développement, JICA and WHO has been providing on-time TA to and UHIS and is planning to coordinate its efforts with the Bank in that regard.  Engage in technical and non-technical (operational management) assistance	Frequent (monthly)	Formal correspondences, meetings; workshops; conferences; online platforms, Regular updates on work progress.	
<b>Medical Syndicate:</b>	The Medical Syndicate is the country's association	As needed	Formal correspondences, meetings; workshops; conferences.	

Stakeholder group	Key Characteristics	Frequency of Engagement	Preferred notification	Specific needs
	of physicians, and by far the most powerful professional association in the health sector.			
<b>Other stakeholders</b>	<b>Other stakeholders</b> including Civil society, Community Based Organizations (CBOs), Non-Governmental Organizations (NGOs), and media who are active in the health sector in Egypt. May have in-depth knowledge about the health and can support the UHIS during implementation of the ESP.	At early stage and during the implementation at different stages.	Formal correspondences mass/social media; traditional press channels (newspapers, television, radio channels); press conferences; consultation meetings.	

## 5. Stakeholder Engagement Program

Stakeholder engagement is a continuous process used by the project to engage relevant stakeholders for a clear purpose to achieve accepted outcomes. It includes a range of activities and interactions over the life of the project such as stakeholder identification and analysis, information disclosure, stakeholder consultation, partnerships, grievance management, stakeholder involvement in project monitoring, offering feedbacks, reporting and management functions.

The Key Objectives of the SEP can be summarised as follows:

- Understand stakeholder engagement requirements for the Program and identify key stakeholders that are affected, and/or able to influence the Program and its activities;
- Outline the stakeholders' consultation process and communication activities throughout the duration of the Program;
- Identify the most effective methods, timing and structure through which to share project information, and to ensure regular, accessible, transparent and appropriate consultation;
- Encourage equal participation of all affected groups in the consultation process and create appropriate circumstances to encourage all groups, including the most vulnerable to engage (including using tailored consultation approaches);
- Facilitate open and continuous communication and consultation between the Government and the range of project stakeholders, including the governmental and private sector, and the general public;
- Establish and operate a functioning grievance redress mechanisms (GRMs);
- Define reporting and monitoring measures to ensure the effectiveness of the SEP and define periodical reviews of the SEP.

Stakeholders risk has been identified as substantial in light of the complexity of the institutions involved in the Project and the uncertainty about the capacity to carry out ongoing stakeholders engagement.

### 4.1. Stakeholder Engagement Program

#### 4.1.1. Purpose and Timing

The envisaged plan of engagement with identified stakeholders throughout the project cycle is listed below:

- Based on the Government plan, the UHIS will start in Luxor and South Sinai on the second quarter of 2020. In the last quarter of 2020, Aswan, Suez and Ismail will follow. Based on this, **several consultation, information dissemination to all stakeholders and engagement activities** already started by the Government as explained above and elaborated in Annex 1 particularly in Port Said, Luxor and South Sinai and will continue to be implemented. The time schedule for implementing engagement and information dissemination activities during will be as follows:
  - Luxor and South Saini: First quarter of 2020 and will continue throughout the project cycle
  - Aswan, Suez, and Ismailia: Third quarter of 2020 and will continue throughout the project cycle
- Before rolling out the UHIS in the rest of phase one governorates, **comprehensive evaluations with stakeholder in Port Said needs to be conducted to evaluate the previous implementation period of the**

**pilot.** Different categories of relevant stakeholders and interested parties including citizens with disabilities, disadvantaged/vulnerable groups should participate in this evaluation to hear their feedback and consider in the rest of the Governorates. Lessons learned should be considered in scaling up UHIS in the phase one governorates. This activity should be planned to take place in first and second quarter of 2020.

- Egyptian citizens in the six Governorates: Public Awareness campaign to inform citizens in phase one governorates about the UHIS and registration process will be continued. The same locally appropriate approach that is being followed (mobile campaigns in difficult to reach areas) will continue to be followed. All relevant stakeholders and interested parties in Luxor and South Sinai will be consulted and engaged in different stages. Most of following engagement activities will be implemented before the official announcement of the UHIS in the two governorates.
- Through the Disadvantaged Persons Enrolment Committee as well as first hand engagement with relevant stakeholders on the ground (including the vulnerable groups), establish an on-going dialogue around the unprivileged groups that the state will sponsor their families' premiums and other **Disadvantaged/Vulnerable** who may be disproportionately impacted by the program if they are not enrolled in any of the cash and social care programs. The objective of this engagement is to ensure that any emerging issues related to vulnerable groups and those who could be excluded are properly and promptly addressed. This is expected to be conducted monthly as part of the planned meetings for the Disadvantaged Persons Enrolment Committee
- Engagement of local NGO's; opinion leaders; health visitors to reach out the vulnerable people at the community level to help disseminate information; organize consultations; and facilitate for registration. Timing of implementation will be according to previously mentioned dates of scaling up the UHIA in the phase one governorates.
- Building on the current Public Awareness (PA) practices of MoH, PMU will collaborate for more engagement activities to reach out the Sinai tribes and remote communities in the first phase governorates. Mobile units will continue to be used to inform, consult and encourage registration by the all beneficiaries in these areas including disadvantaged groups, especially individuals with disabilities. Those activities have been organized and are ongoing in Luxor and South Sinai governorates.
- **Citizens are working in private entities:** UIHA team/ PMU will prepare a list of private sector companies and large size organizations who have are using the private sector insurance companies, including petroleum, investment companies, banks and other private sector that are not owned or operated by the government. A details consultation plan for addressing the need of the **Citizens are working in private entities is expected** to be developed as appropriate for each governorate. This plan will focus on the requirement of joining the Universal Health Insurance System (UHIS), the timeframe for development of these plans as follows, implementation will be on-going.
  - Port Said: March, 2020
  - Luxor and South Saini: Second quarter of 2020
  - Aswan, Suez, and Ismailia: Third quarter of 2020

#### 4.1.2. Topics of engagement

Different categories of relevant stakeholders and interested parties in each governorate will be provided with diverse range of information, depending on the stage of the project. The UIHA /PMU team will select the best method to disseminate to the targeted public. The information should be package in different ways as appropriate to the target groups to include: This most importantly include:

- Objective of Egypt's Universal Health Insurance System (UHIS)

- The benefit of individuals will be enrolled under this system, as well as the disadvantage group.
- UHIS Implementation plan
- Enrollment and registration procedures
- Requirement of registration
- Documents needed for self-identification (to qualify for exemption)
- The locations of primary care and family physician for registration, timings of services provisions, referral system, and required documentation.
- Services that will be covered and details on services provision (including the referral system);
- Terms of use for new comprehensive health insurance services;
- Updated list of services providers including the family care units and hospitals in each governorate
- The GRM system including hotline number for filing a complaint (15344)
- Results of beneficiaries feedback surveys.

The Government should engage on regular basis with the different stakeholders including the disadvantaged and vulnerable groups to also update the prepared SIA and SEP, get feedback on the quality of implementing the different commitments stipulated in the documents.

#### 4.1.3. Methods to be used in the stakeholder engagement

The method to be used should be selected based on the characteristics of the target stakeholders to be approached. Below are examples of the methods that should be used:

- Use of different forms of media (including social media)
- Door to door visits (particularly for remote areas or for groups with mobility challenges- e.g. elderlies and disabled)
- Awareness campaign
- Health facilities meetings
- Focus groups discussion (including women only)
- Feedback surveys
- Utilizing community leaders (particularly with the tribal groups)

Written and visual material should be developed and be used by qualified teams to support in the different engagement methods above as needed.

#### 4.2 Proposed Strategy for Information Disclosure

Timing and advanced planning of engagement is one key element that ensures that consultations are relevant, information dissemination also is very critical to involve stakeholders in the project. Information should be accessible to the stakeholders for effective implementation to the project, Information and documents to be disclosed include, but are not limited to, the following:

Project stage	Topic of consultation	Method	Timetable: Locations & dates	Target stakeholders	Responsibilities
Before appraisal	SIA	Meetings with different stakeholders, at the central and local levels, outreach events, social media, websites of different involved agencies	Premises of different entities at the central and local levels, as well as in public places and local councils	Implementing agencies, service providers, syndicates, civil society, target beneficiaries	MOF in coordination with related entities
	SEP				
	ESCP				
After appraisal/during project implementation	Factsheets & FAQs about the project		Specific dates will be decided upon with the implementing agency and other involved entities		
	Updated SIA, SEP, ESCP, as required				
	GRM & related reports/statistics				
	Benefit package				
	Non-contributory coverage for disadvantaged groups				
	Other updates				

Materials should be made available in the formats and languages that are needed for disadvantaged and vulnerable groups including individuals with disability.

**For private and community-based health providers:** a comprehensive communication and information dissemination strategy to be developed to engage the wide-range of health service providers, especially those outside the umbrella of the healthcare organization, such as private hospitals, NGOs, private practitioners, etc. This needs to clarify the roles and responsibilities of the providers as well as the requirements to join the new system. Documents and information dissemination should focus on accreditation process and standards. Including but are not limited to the following:

- General information about the two-tier accreditation process which include: (i) registration: ensuring that the provider meets the basic safety, regulatory and licensure procedures; and (ii) accreditation: certifying higher quality of administrative and clinical processes, care and health.

- Registration requirements for the following health facilities:
  - Hospitals;
  - Radiology centers;
  - Pharmacies;
  - Labs;
  - Primary Health Care (PHC); and
  - Physical therapy centers.

Website to be used for publishing this information is important to be established by GAHAR, in addition to the other modalities for disclosure and dissemination of information.

In addition to the websites, a variety of methods of communication should be used to reach the majority of stakeholders through:

- Traditional national media channels for example written press e.g. newspapers, radio and TV network;
- Local radio and TV stations;
- Online news portals
- Online blogs
- Social media
- Other information disclosure mediums include posters, brochures, billboard signs, and leaflets.

#### 4.3 Proposed Strategy to Incorporate the View of and Share Information with Vulnerable Groups

The MOF will ensure that the views of vulnerable or disadvantaged groups will be sought and well-taken into account during the consultation process. The Project is following a very dynamic approach and is trying to adopt and locally sensitive approach. It is, thus, of critical importance to ensure that that feedback received from the local communities are taken into consideration in the implementation and that appropriate mechanism for closing the feedback loop are in place.

Information sharing techniques will be tailored according to the nature and common types of vulnerabilities. These can include, for example, visuals and sign language interpreters for people with hearing disabilities and illiterate persons; in addition to making sure that the venue will be easily accessible to people with physical disabilities. Measures can also include arrangement of specific sessions for women in conservative communities in South Sinai or Upper Egypt governorates.

## 5. Grievance Redress Mechanism (GRM)

Grievance redress mechanisms are methods and processes by which a resolution to a grievance is sought and provided. A GRM provides a predictable, transparent and credible process to all parties (citizens, government officials, service providers), resulting in outcomes that are seen as fair, effective and lasting. A well-functioning GRM can provide benefits to both the government and service providers, and beneficiaries. It can also help staff catch problems before they become more serious or widespread. Annex 5 provides a brief summary about the GRM Feedback Loop and Key Blocks

The roll out of the UHIS is already generating a large number of complaints, suggestions and queries that necessitated the creation of a responsive and interactive GRM. Currently, there is a 24/7 call center mandated to respond to beneficiaries' inquiries and complaints. This center is assumed to be a key uptake channel, through which complaints can be received and rechanneled to relevant bodies (e.g. HCO, GAHAR or UHIA) for further action/feedback. The call center number is widely disseminated through all the conducted consultations, promotional material and outreach activities. Since its establishment in September 2019, the call center received 4968 complaints and inquiries. Complaints received are 1424 and all the remaining are queries. From the received complaints, 1377 complaint have been resolved and the rest are under investigation<sup>10</sup>. It is worth mentioning that, in addition to the complaints and queries, the call center also offers booking services.

Complaints can also be handled at the facilities level, where an officer at each healthcare facility is responsible for client satisfaction. As indicated earlier, the Law granted certain channels through the HCOs branches, for patients to complain or report certain incidences that may occur during the interaction with system (Article 17 UHI Bylaw). PM decree 1948/2019 also stipulated a higher level of GRM in a form permanent committee that is mandated to resolve disputes on exclusion-related complaints made by Disadvantaged Persons Enrolment Committee. The committee is chaired by UHIA's chairman. Furthermore, inspecting exclusion-related complaints is mandated by Prime Ministerial decree 1948/2019 to a permanent committee, formed by the UHIA's chairperson. In addition, in anticipation of the disputes that may arise from the application of the Law, a standing committee for the settlement of disputes is established with representation from all three organizations and the party of conflict (Articles 60 UHI Law and 69 UHI Bylaw). This committee will presumably focus on major issues such as pharmacy practice, private insurance status, etc.

The existing GRM mechanisms have number of strengths, most importantly the vast dissemination for information which made the public (particularly in the targeted Governorate) aware of the system and how to use, the use of multiple channels and the cultural appropriateness. The roll out of the system will need to be monitored carefully to ensure that different requirements of ESS10 are met. Most importantly the evolvement of the GRM should consider the following:

- The different existing formal or informal grievance mechanism are well mainstreamed to allow for solid documentation and responsiveness to all types of complaints regardless of the uptake location.
- Culturally appropriate channels might need to be established in certain areas (e.g. in remote areas in South Sinai or in Luxor). For example, in a way that would allow rural women, illiterate, persons with disability are also able to spell out concerns equally.

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<sup>10</sup> As reported in Alyoum Al Sabea, Feb 23, 2020

- Time commitments should be made clear to acknowledge and resolve issues. Communication with the complainant throughout the process?
- How will the existence of the grievance mechanism be communicated to all stakeholder groups? Are separate processes needed for vulnerable stakeholders?
- If a complaint is not considered appropriate to investigate, will an explanation be provided to the complainant on why it could not be pursued?
- Will there be an appeals process if the complainant is not satisfied with the proposed resolution of the complaint? In all cases, complainants need to be reassured that they still have all their legal rights under their national judicial process.
- A summary of implementation of the grievance mechanism should be provided to the public on a regular basis, after removing identifying information on individuals to protect their identities. How often will reports go into the public domain to show that the process is being implemented?

## 6. Resources and Responsibilities for implementing stakeholder engagement activities

The UHIA/PMU is responsible for project execution and for ensuring the implementation of the SEP at the whole-project level, as well as to allocate adequate budget for effective implementation and for capacity building. At least two social specialists should be recruited and mandated with GRM and SEP responsibilities. The staff member in charge of following up on the SEP implementation should:

- Set detailed schedules for the implementation of the stakeholder engagement as outlined by the SEP and as the case may evolve and the need emerges.
- Coordinate and collaborate with related organizations involved with UHCS for carrying out each of the stakeholder engagement related activities,
- Ensure that the raised feedback by stakeholders in the participatory sessions are considered through timely communication with related stakeholders in charge.
- Work to develop locally appropriate methods to close the feedback loop.
- Lead the reporting requirements and the production of reports including the compilation of different inputs from related entities.
- Address the emerging needs for updating the SEP and lead the update

The GRM Specialist will be mandated, most importantly, with the following responsibilities and duties

- Ensuring public communication about the GRM process is undertaken at level (as appropriate)
- Follow up and monitor the referred complaints to related entities and to the upper level (as appropriate)
- Prepare required and regular report on GRM results.
- Development of GRM operating procedures and make sure effective implementation by GRM related staff at all levels through offering training and capacity building.
- Work to ensure that the GRM results are locally disclosed in appropriate and user friendly manner.

Training and capacity building on range of topics should be offered to the human resources to ensure effective implementation for the SEP and the SIA (more elaboration on the capacity building topics is included in the SIA).

## 7. Stakeholder Engagement Budget

The different activities related to the engagement with the stakeholders, the outreach, awareness raising, conducting feedback surveys and training the different human resources in charge of implementing the SIA and the SEP are integral parts of the design of the project. As elaborated earlier, several DLIs are dedicated to address the social aspects as described on more details under the project description. In the meantime, several actions under the social commitment plan (developed within the SIA) overlap with the SEP requirements. It is challenging at this stage to decide on exact budget for the SEP implementation. **However USD 500,000 has been roughly estimated to be the indicative budget for the SEP implementation.**

## 8. MONITORING AND REPORTING

The implementation of a the SEP is one of the most crucial tasks related to this Proejtc given the nature of the substantial risks and the need for an ongoing engagment with stakeholders to build a constructive relationship and contribute to the Project success. The UHIS' main three organizations will be involved collectively in the implementation of the SEP. The project will be implemented by the MOF through the PMU that may include government and/or contracted staff. The PMU, will be responsible for coordinating between the three organization for effective implementation, as well as for monitoring and evaluation (M&E) and reporting to the MOF and the Bank on all aspects of the project. Component 3 of the Project will support monitoring and evaluation (M&E) activities to track, document, and communicate the progress and results of the project, including monitoring of the Stakeholder Engagement Plan. An M&E specialist within PMU will be responsible for overall compilation of progress and results. In addition to the Social Specialist who will be responsible for monitoring the Stakeholder Engagement Plan (SEP); he/ she should also document any commitments or actions agreed during consultations, any changes in the design of the project or in the SEP; and prepare regular report to be submitted to the Bank and steering committee for decision making. This could be carried out through establishing and maintaining a Stakeholder Engagement Log that records all stakeholder engagement undertaken or planned. The Engagement Log includes location and dates of meetings, workshops, and discussions, a description of the project-affected parties and other stakeholders consulted, the feedback received during the consultation and how this feedback was/will be addressed. Monitoring and tracking of stakeholder engagement is important to ensure effective continuous engagement and follow-up.

SEP specific indicators are proposed as part of Monitoring and Evaluation to help monitor the level of engagement during the project could include:

- Number of government agencies, affected parties, interested parties and other stakeholder groups that have been involved in the project implementation phase on a quarter and annual basis disaggregated by gender
- Number of citizens (sex disaggregated) that have been involved in consultation in each of the target governorates on quarter and an annual basis.
- Number of engagements (e.g. meetings, workshops, consultations) with stakeholders during the project implementation phase per governorates on quarter and an annual basis.
- Number of meetings and consultation sessions conducted for vulnerable groups in each governorate, disaggregated by gender on quarter and annual bases
- Number of decisions taken based on consultation sessions conducted with affected groups by governorates disaggregated by gender

In addition to the above mentioned internal monitoring system, the Government will also encourage any external monitoring initiative by third parties (e.g. the case of Shamsia NGO which conducted evaluation for Port Said system) and will coordinate to obtain results that would further enrich the Project way forward.

## Annexes

### Annex 1. Summary of consultation sessions

During the course of December 2019 – February 2020, the Government (most importantly the MOHP/HCO) have conducted the following indicated consultations in the table below. The meetings' objectives were most importantly:

- The introduction of the new Universal Health Insurance System
- The anticipated positive impacts of the system
- Risks and how the government is planning to deal with them.
- Introduction to the registration in the system

Location	Stakeholders <sup>11</sup>	Estimate number of participants <sup>12</sup>
<b>Luxor Governorate</b>		
Luxor City	Officials in the water and sanitation company, Luxor	30
Luxor Governorate	Luxor Governorate employees	30
Al Qorna City	Al Qorna City Council employees	50
Armant City	Armant City Council employee and citizens from non-employees	60
Masr Library	Citizens from Luxor City	50
Armant Hospital	Service providers	40
Family House, Luxor	Islamic and Christian religious leaders and community leaders	50
Esna City Council	Esna City Council employee and citizens from non-employees	100
Esna Hospital	Service providers	70
<b>Port Said Governorate</b>		
Port Said Fishing Club	Club members	50
Engineers syndicate	Members of the syndicate	30
Al Masry Football club	Club members	50
Rowing Club	Club members	40
National Council for Women	Women (members of NCW)	55
Youth groups	Youth	25

<sup>11</sup> It should be noted that all the government employees who attended the consultations attended with their capacity as government officials, local residents and future beneficiaries from the system in their Governorates.

<sup>12</sup> The participants' records were not gender-disaggregated so it will not be accurate to include percentage or numbers divisions. However, women were heavily engaged in the consultation. Moreover, women-only consultation sessions were organized as shown in the table above.

<b>Location</b>	<b>Stakeholders<sup>11</sup></b>	<b>Estimate number of participants<sup>12</sup></b>
NGOs (Women Empowerment NGO)	NGOs members	50
Fishing Club Port Fouad	Club members	150
Port Said Sports Club	Club Members	100
Cultural Center in Port Said	Government Officials in Port Said Governorates and line ministries	1000
Meeting Room of Al Mabara Hospital	Health care teams	120
Commerce Syndicate in Port Said	Syndicate members, political parties' members and Christian religious leaders	100
Masr Library	Citizens including Rotary and Rotaract members	30
Fishing Club in Port Said	Citizens (men and women)	50
<b>South Sinai Governorate</b>		
Consultation in seven Markazes.	Tribal communities in South Sinai. Each consultation targeted 20 individuals including representatives from tribal leaders, and governmental staff	Around 140
Local council in seven Markazes	Local council employees in seven Markazes	50
Large awareness raising session	Representatives from tribal leaders, elected leaders of the parliament, and heads of directorates of different sectors	300

Additional stakeholders' engagement during preparation of the SIA and the SEP

Engagement activities	Date	Location
<p><b>Field visit to Port Said Governorate:</b></p> <ul style="list-style-type: none"> <li>- Interviews with Port Said UHIA office including: Dr. Said Mahmoud, Head of Universal Health Insurance Authority (UHIA) in Port Said Governorates</li> <li>- UHIA's team: Dr. Nesreen Hassan Manager of Beneficiaries Department, and Dr. Alaa Mostafa the Manager of Claim Settlements Department.</li> <li>- Meeting with Complaining Management Office Staff</li> <li>- Interview with Deputy Director of Health Care Organization (HCO) - Dr. Hany Rashed, and Executive Manager, Dr. Amir El Telwany</li> </ul> <p><b>Visit to</b></p> <ul style="list-style-type: none"> <li>- El Kuwait Family Health Care Unit – Case Management Office, Family Doctor and Head of the customer satisfaction unit.</li> <li>- Nasr Al Nasr Children hospital, interviews were conducted with General Manager and head of communication and outreach.</li> </ul>	9-10 December 2019	Port Said governorate: operational primary health care unit and a tiretiary care hospital in Port Said governorate
<p><b>Ministry of Health- Office of Minister's Assistant for Monitoring and Follow-up, meeting with:</b></p> <ul style="list-style-type: none"> <li>- Dr Mohamed Nagi</li> <li>- Dr Radwa Ahmed</li> <li>- Mr. Ahmed Donqual</li> </ul>	December 23, 2019	MOH
Meeting with Dr Mohamed Ahmed Nasr – Consultant – National heart Insinuate Cairo	January 1, 2020	Private clinic
Meeting with Dr. Mohsen George, Technical Advisor to Minister of Finance for Universal Health Insurance Authority.	December 31, 2019	Nasr City Hospital for Health Insurance
Meeting with Eng. Saad Gad, IT Advisor to Minister of Finance for Universal Health Insurance Authority Advisor	December 25, 2019	UHIA – Heliopolis
Meeting with GAHAR's Executive Director, Dr. Dalia Badawi and team.	February 12 2020	GAHAR's office at National Population Council PC
Meeting with representatives of the three organizations and MOF	February 15	MOF

Annex 2. No. of Beds in Healthy Units by sector <sup>13</sup>

عدد الأسره بالوحدات الصحية طبقا للقطاع والمحافظه عن عام ٢٠١٦

## No.of Beds in Healthy Units By Sector and Governorate 2016

Unit : No.

الوحدة : بالعدد

Governorate	% القطاع الخاص /للجملة	الجملة	القطاع الخاص	القطاع الحكومى	المحافظة
	% Private Sector to Total	Total	Private Sector	Gov. Sector	
Cairo	27.9	29 600	8 267	21 333	القاهرة
Alexandria	33.5	12 399	4 154	8 245	الاسكندرية
Port-Said	26.1	1 402	366	1036	بورسعيد
Suez	45.2	990	447	543	السويس
Damietta	9.8	2 646	259	2 387	دمياط
Dakahlia	28.6	9 477	2 712	6 765	الدقهلية
Sharkia	33.4	6 854	2 289	4 565	الشرقية
Kalyoubia	15.7	7 330	1154	6 176	القليوبية
Kafr-El-Sheikh	20.2	2 481	502	1 979	كفر الشيخ
Gharbia	29.9	7 045	2 108	4 937	الغربية
Menoufia	19.9	5 197	1035	4 162	المنوفية
Behera	24.9	4 158	1037	3 121	البحيرة
Ismailia	169.5	1 829	432	1 397	الاسماعيلية
Giza	7.7	7 196	3100	4 096	الجيزة
Beni-Suef	7.4	2 607	554	2 053	بنى سويف
Fayoum	25.9	1 958	194	1 764	الفيوم
Menia	29.2	4 471	508	3 963	المنيا
Asyout	7.8	7 334	1304	6 030	أسيوط
Suhag	10.3	3 871	574	3 297	سوهاج
Qena	28.7	1 932	400	1 532	قنا
Aswan	4.5	1 932	555	1 377	أسوان
Luxor	8.9	975	87	888	الاقصر
Red Sea	53.5	724	387	337	البحر الاحمر
El-Wadi ElGidid	9.5	462	44	418	الوادي الجديد
Matrouh	5.1	829	42	787	مطروح
North Sinai	21.5	441	95	346	شمال سيناء
South Sinai	20.2	455	92	363	جنوب سيناء
<b>Total</b>	<b>25.8</b>	<b>126 595</b>	<b>32 698</b>	<b>93 897</b>	<b>الاجمالي</b>

Source : Ministry of Health &amp; Population

المصدر: وزارة الصحة والسكان

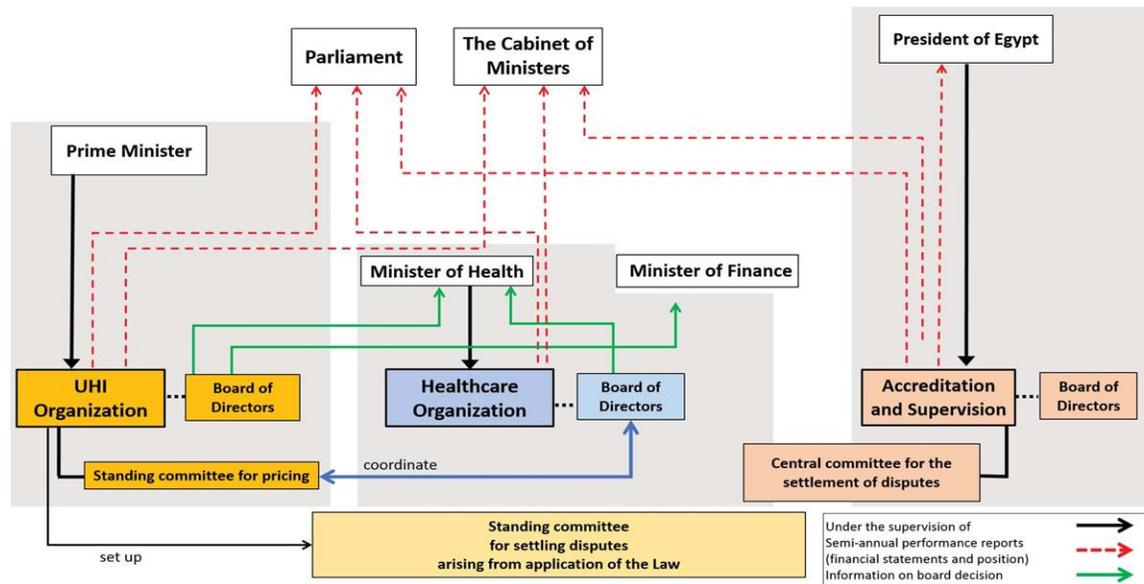
Egypt in Figures 2018

مصر فى ارقام ٢٠١٨

<sup>13</sup> Source: Egypt In Figures 2018 – CAPMAS

## Annex 3. Main Agencies of UHIS

Figure 3: New governance structure of the UHI system, as per the UHI Law



Source: Authors

Source: IMPLEMENTING THE UNIVERSAL HEALTH INSURANCE LAW OF EGYPT- HEALTH FINANCING CASE STUDY NO. 13 - Copyright World Health Organization 2019

### - **Universal Health Insurance Authority (UHIA)**

Falls under the general supervision of the MOF (Article 5 UHI Law). Responsible for registering beneficiaries, collecting contributions and receiving state budget, transfers, manage funds, pay providers and evaluate contracts; pricing of medical services through a standing committee under UHIA; managing outlets for serving the insured in a way that will guarantee geographical accessibility across Egypt. In addition of managing an Information System to undertake all of these administrative and management functions with interfaces with the providers and the Healthcare organization on enrolled into the UHI system. A standing committee has established by a decision from UHIA Chairperson to receive, examine and decide on applicants for unprivileged persons enrolment. The concerned persons can file complaints against the decisions made by the committee to grievances committees

### - **The General Authority for Healthcare Accreditation and Regulation (GAHAR)**

Falls under the general supervision of the president of the republic (Article 26 UHI Law). GAHAR is primarily responsible for accreditation of healthcare service providers; issue a detailed standard quality guidebook for service providers to abide by; ensuring and the continued improvement of the health services' quality; controlling and regulating the health insurance services including: developing standards, granting and

suspending accreditation and registering medical facilities and professionals, building capacities; and keeping the public informed about the medical services' quality levels. In accordance with the law, a central committee for disputes settlement will be established within the General Authority for Health Accreditation and Supervision to settle any relevant dispute within three months.

- **Health Care Organization (HCO)**

Falls under the general supervision of the Minister of Health (Article 15 UHI Law), and will serve as the state's main tool in regulating the health services provided. It will also provide health and therapeutic services – at all three levels, within or outside hospitals – to all insured people through its outlets and through the Ministry of Health's sub-entities. Administrative assets and financial rights and liabilities of HIO's health provision facilities and curative MoHP owned facilities will be transferred to the HCO. As well as the personnel working at the HIO and MoHP who perform functions related to the HCO with preservation of their income levels.

- **Egyptian Authority for Standardized Procurement and Medical Technology Management (EASPMTM)**

Falls under the Prime-Ministers office and is responsible for procuring pharmaceuticals, consumables and medical equipment as well as managing the efficient use of medical technology within all publicly owned healthcare facilities and hospitals including those which are funded by development partner organizations. The organization will also carry out the functions of Health Technology Assessments (HTA) on behalf of all public healthcare facilities.

**Annex 4. Estimated number of vulnerable individuals based on national poverty rate per phase one governorate detailed in national census 2017.**

<b>Governates</b>	<b>Population</b>	<b>% Poverty</b>	<b># of Individuals</b>
Port Said	749,371	7.60%	56,952
Ismailia	1,303,993	32%	422,494
Suez	728,180	20%	145,636
S. Sinai	102,018	51%	52,029
Luxor	1,250,209	55.30%	691,366
Aswan	1,473,975	46.20%	680,976
<b>Totals</b>	<b>5,607,746</b>		<b>2,049,453</b>

\*

## Annex 5. GRM Feedback Loop and Key Blocks

A GRM comprises the following steps.



### Communication:

GRM process starts with public communication i.e. when citizens are informed about existing mechanisms where they can register their grievances. Methods of how to register grievances and expectations from the process are also communicated. Information dissemination about the GRM process will be undertaken through various means. These means include but are not restricted to:

- Leaflets, brochures posters and printed material available at primary health care units and hospitals level and to be distributed during consultation sessions, as well as through face to face communication in phase one governorates
- At national level through mass media channels;
- Social media such as Facebook;
- Websites of UHIA; GAHAR; and HCO.

### Uptake

- Uptake will take place at multiple levels through broad range of channels:
- **Hotline/Call Center:** 15344 at national level
- UHIA and HCO front-line staff at regional/ governorate level offices
- **At the level of PHCs and hospitals, there are a number of staff has mandated to receive and handle all types of complaints.**
- At national level, the **Disadvantaged Persons Enrolment Committee** is mandated to resolve disputes on exclusion-related complaints

All previous uptake channels use the same complaint form to ensure that complaints are submitted properly<sup>14</sup>

### Registration of complaints

Once the grievances are collected, grievances need to be registered. Different types of grievances require different follow-up actions. At this stage complaints are categorized, assigned priority, and routed to the appropriate entity through a registration process. UHIS will have a fully integrated system, complaints registered at a centralized database which is currently under-construction that could be used by the three organizations- UHIA-GAHAR-HCO- for different purpose, as well as for producing various reports and statistics electronically.

All complaints received through various channels will be registered. A register should include the following information:

- Date the complaint was filed
- Name of the complainant and contact information
- Complaint in short
- Name of the person who received the complaint
- GRM main categories:

<sup>14</sup> Annex 5 attached as an example of complaint form

- Complaints about staff
  - Complaints about services
  - Complaints about drugs and other supplies
  - Complaints about infrastructure, e.g. cleanliness and Safety
  - Complaints about the payment and co-payment
  - Other types of complaints
- Main categories to be disaggregated to sub-categories

**Follow up and Resolution:**

This step involves referring the complaint to related entities to determine its validity, and resolving it. Grievances that are straight forward can often be resolved quickly. Grievances that cannot be resolved at one level of the system are referred to a higher level and/or an outside entity for verification and further investigation according to a clearly defined timetable. The UHIS' organizations should be responsible to follow-up with relevant departments and entities on the resolution of complaint.

**Feedback:**

Providing feedback to the complainant about the status of the complaint is essential. Complainants receive periodic updates on the status of their grievances. Especially, once the complaint has been resolved the complainant is informed of the results of the process. Feedback can be provided by contacting the complainant directly and/or posting the results of cases in high-profile locations and conveying the results through communication channels.

**Monitoring and evaluation:**

Monitoring refers to the process of tracking grievances and assessing the extent to which progress is being made to resolve them. Monitoring and evaluation involves analyzing grievance data and using it to make policy and/or process changes to minimize similar grievances in the future.

**Possibility to appeal**

In the event the complainant is satisfied with the response, the complainant has the right appeal at related entities based on the type of complaints

**Complaint / Suggestion Form**

**Complaint/Suggestion Form**

Governorate: ..... District: ..... Health unit/center: .....

Date: / / Number of the complaint: .....

Name of the citizen/ complainant: .....

Address: .....

Phone: .....

ID Number: .....

Complaint

Suggestion

**The Complaint/Suggestion**

Dear ....

Greetings,

.....  
.....  
.....  
.....  
.....  
.....  
.....

Signature of the citizen: .....

Name of the clerk: .....

Procedure: .....