Civic Participation in Health Policymaking in Egypt

Examining the Role of Civil Society Organisations in Health Policy Making in Egypt through Health Policy Analysis of Universal Health Coverage and Mental Health Laws: Ways Forward for Sustainable Civic Participation

Ahmed Farahat

Egypt

59th Master of Science in Public Health

KIT (Royal Tropical Institute)

Vrije Universiteit Amsterdam (VU)

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A thesis submitted in partial fulfilment of the requirement for the degree of Master of Science in Public Health

by

Ahmed Farahat

Egypt

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The thesis ***Civic Participation in Health Policymaking in Egypt*** is my own work.

Signature: .

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Contents

Abbreviations

Civil Society Organizations (CSOs)

Gross Domestic Product (GDP)

Lower-Middle-Income Country (LMIC)

Middle East and North Africa (MENA)

Ministry of Finance (MOF)

Ministry of Health and Population (MOHP)

National Health Assembly (NHA)

National Council for Mental Health (NCMH)

Non-Governmental Organizations (NGOs)

Out-of-pocket (OOP)

Universal Health Coverage (UHC)

Universal Health Coverage Law (UHC LAW)

World Health Organization (WHO)

World Bank (WB)

list of Figures

List of Tables

Abstract

Background: Limited civic participation in Egypt poses challenges for creating more equitable health policies and for effective implementation of health laws. This research focuses on mental health and the new universal health coverage (UHC) laws, examining the notable contribution of civil society organisations (CSOs) in shaping and creating these laws through advocacy strategies.

Objective: The research aims to analyse the health policymaking landscape in the areas of mental health and new universal health coverage laws in Egypt, using the Walt and Gilson (1994) triangle framework's four components: content, context, actors, and process. Specifically, this research aims to describe and analyse the forms of civic participation by CSOs that contributed to the development and creation of these laws.

Methodology: The research applied an approach that combines a literature review, analysis of policy documents, and key-informant interviews.

Findings: CSOs have played a prominent role in the new UHC law development and creation. The findings demonstrate that the new UHC law has brought about several improvements. The context within which the law emerged underlines the health system and political contextual factors. Similarly, the mental health law has substantially improved mental health policy and practice in Egypt. The context of the development and creation of the law highlights historical contextual factors, donor involvement, and the active participation of CSOs.

Conclusion and recommendations: The analysis concluded that civic participation, citizens' voices, and transparency in the implementation process are critical to maximise the benefit of implementing the two laws. The research recommends institutionalising civic participation in creating and implementing health policies and laws to sustain the momentum for health reform.

Keywords: Health policy; participation; mental health; universal health coverage; Egypt

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Introduction

Civic participation involves organised engagement, interaction, and influence on issues of public concern. It encompasses several forms, such as the participation of political parties, advocacy by political or rights groups and the participation of civil society organisations in influencing and shaping public policies.

In well-established democratic countries, there is a good record of literature that analyses policy environments because the democratic process is well-established and mature. However, in non-democratic countries and contexts in which democratic mechanisms have not yet been established, it is challenging to outline and analyse the policymaking environment. This thesis seeks to answer why, how and under what circumstances civic participation occurred in shaping and creating two health laws and policies in Egypt.

From my background as a pharmacist and public health professional who worked in public, private and non-governmental health sectors, I have reached the conviction that civic participation is vital in formulating and creating as well as implementing health policies and laws, particularly in low- and middle-income countries. This is particularly essential for Egypt and also most of countries in the Middle East and North Africa region (MENA), where there has been historical record of limited civic participation.

This is because it ensures the participation and representation of all components of society, including marginalised and vulnerable groups, in making policies that will be applied and implemented to them. That is the reason behind my choice of the area of the thesis.

1. Chapter One: Background on Egypt

1.1 Geography and Administrative Structure

Egypt is situated in Northeastern Africa and is categorised as a Middle Eastern country, and it shares common characteristics with several countries in the MENA region, including language (Arabic) and similarities in the social context. The area of Egypt is around one million square kilometres. It is divided administratively into 27 administrative units, and each administrative unit is called a governorate, each governorate having its own capital and its local administrative units (See Fig 1) (1,2).

Figure 1: Map of Egypt, source: World Atlas 2021 (3).

1.2 Population and Socioeconomic Environment

Egypt is a numerously populated country and the third considerably populated country in Africa, after Nigeria and Ethiopia, with a population size of approximately 104 million in 2023 (4). The River Nile determines the distribution of population where the majority of the population lives in the Delta and the Nile Valley. Outside the valley, the population lives mainly in the oases and coastal towns of the Red Sea and Mediterranean regions (5).

Egypt is classified as a lower-middle-income country (LMIC), and it has been experiencing economic instability for the past ten years, including high inflation rates, fluctuation in GDP growth and significant inequality (See Fig 2 and Fig 3). This inequality is evidenced by Egypt's high GINI coefficient (31.9% in 2019). Looking at the standard set by the World Bank to define the poverty line for LMICs (US$ 3.65 per day), poverty rates reached 17.6% of the population in 2019. At the same time, national official data indicate that the poverty rate reached 29.7% of the population in 2019 (See Fig 4) (6–10).

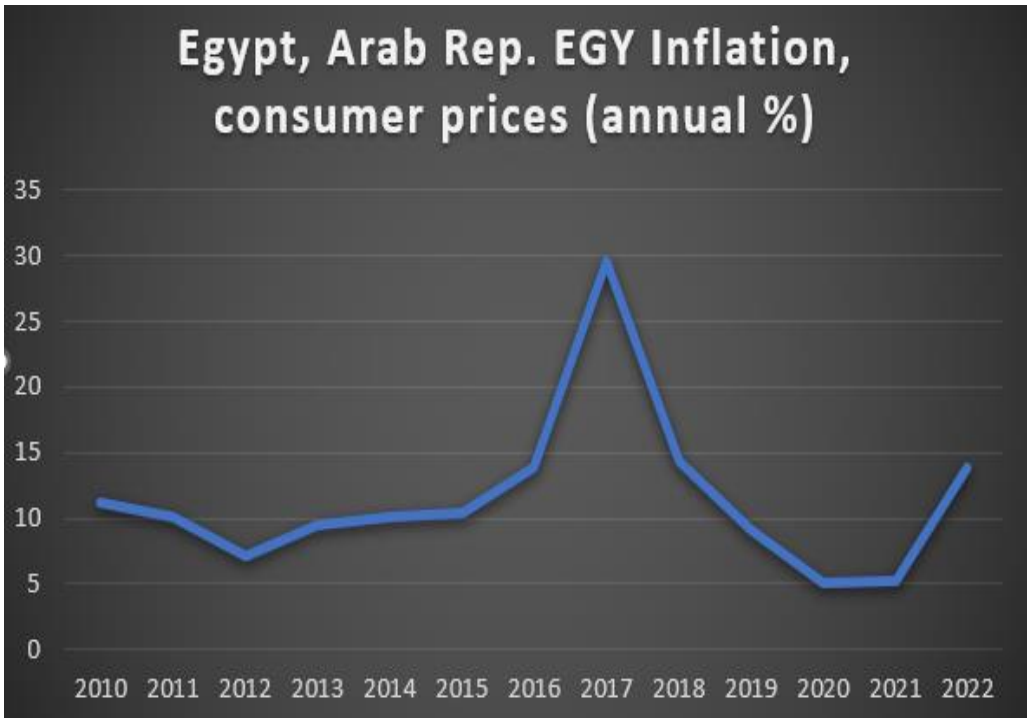

Figure 2: Annual inflation of consumer prices in Egypt over the past 12 years. (As an example of economic instability, the inflation in relation to consumer prices reached around 29.5 % in 2017) Source: The World Bank., 2022 (8)

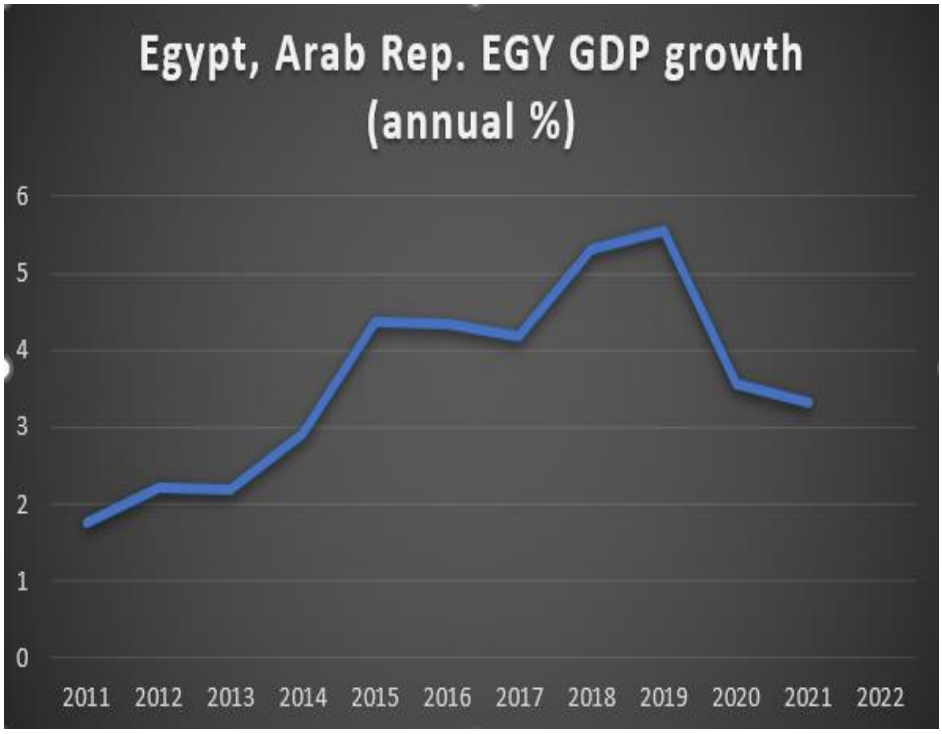

Figure 3: Annual GDP growth in Egypt over the past decade. (This is to show the fluctuation of the GDP growth over the past years.) Source: The World Bank., 2022 (11)

POVERTY	Number of Poor (million)	Rate (%)	Period
National Poverty Line	31.4	29.7	2019
International Poverty Line 13.3 in Egyptian pound (2019) or US$2.15 (2017 PPP) per day per capita	1.5	1.5	2019
Lower Middle Income Class Poverty Line 22.6 in Egyptian pound (2019) or US$3.65 (2017 PPP) per day per capita	18.6	17.6	2019
Upper Middle Income Class Poverty Line 42.3 in Egyptian pound (2019) or US$6.85 (2017 PPP) per day per capita	72.6	68.8	2019
Multidimensional Poverty Measure		2.3	2019
SHARED PROSPERITY			
Annualized Consumption Growth per capita of the bottom 40 percent		-1.75	2015-2019
INEQUALITY			
Gini Index		31.9	2019
Shared Prosperity Premium = Growth of the bottom 40 - Average Growth		-0.18	2015-2019

Figure 4: Poverty and Inequality in Egypt, Source: The World Bank., 2023 (9)

The economy counts on the following sources: agriculture, transfers from Egyptians employed outside the country, tourism, and the incomes of the Suez Canal. The economy has the following characteristics: a lack of industrialisation and dependence on imports for intermediate and final commodities. In addition to these economic challenges, Egypt faces several social issues, including gender inequality and corruption (1,12,13).

1.3 Political Environment

The 2011 revolution, which was carried out by the people against Hosni Mubarak's autocratic regime, has been considered a major political shift in Egypt and completely changed the shape of the political environment (14).

Following the 2011 revolution, civil society and civic movements have experienced a surge, creating more spaces and opportunities for activism. There has been an increase in calls for political reforms addressing social and economic rights. This included emergent civil society organisations focused increasingly on the necessity for universal health coverage (UHC) and the significance of health as a human rights issue (14–16).

Despite this, the country witnessed a military coup in 2013, representing a major setback in challenging human rights and public freedoms. In the post-coup time, the press freedom status and the space available for civic movement and civil society witnessed a significant setback. The current president and ruling party are under increased public scrutiny due to poor economic performance and alleged human rights violations (17–19).

1.4 Health System Organisation, Finance, and Policymaking

The Egyptian health system is characterised by fragmentation and the dominance of the concept of curative care at the cost of preventive and primary care. Three main sectors play a role in providing health services: the public, private, and charitable sectors (20,21).

The public sector provides primary health care through public health units, along with providing secondary and tertiary care offered through public hospitals. The private sector focuses more on specialised secondary and tertiary services offered through private clinics or commercial and corporate hospitals. The charitable sector (religious-based entities) also focuses on secondary and tertiary services and is not-for-profit (12,20,22).

Health service provision in the public sector goes beyond the Ministry of Health and Population (MOHP) including other ministries such as: higher education, defense and police, providing health services to their employees (12).

In the sense of government spending on health, health spending reached 5% of total government spending (in 2019/2020). It was at most 1.5 of GDP. Health was ranked fifth among government spending priorities (12,23,24).

Egypt's government spending on health is low compared to the average government spending in the MENA region, which is around 8% of total government spending. It is low compared to countries comparable to Egypt in the region. In countries like Tunisia, where the government spending on health was around 10%, and in Morocco was around 7% of total government spending (in 2020) (23–26).

The low government spending on health has led to high private source spending on health; most of this private source is out-of-pocket spending (OOP); OOP was 59% (in 2020). This percentage is considered high compared to the average in the MENA region (40%) and compared to countries like Morocco (around 42%) and Tunisia (36.4%) and is higher than the benchmark put for the UHC (20%) (12,23,27).

Figure 5 shows the shape of health expenditure in Egypt by the source of expenditure over the past twenty years.

Regarding health policymaking in Egypt, the state actors, mainly the MOHP and the Ministry of Finance (MOF), are the most significant actors that shape public health policies. At the same time, the role of non-governmental actors is limited in the involvement and engagement in making and creating health policies and laws (1,21).

Indicators	2000	2005	2010	2015	2020
Current Health Expenditure (CHE) as % Gross Domestic Product (GDP)	5	5	4	5	4
Domestic Health Expenditure (DOM) as % of Current Health Expenditure (CHE)	100	99	99	100	99
Domestic General Government Health Expenditure (GGHE-D) as % Current Health Expenditure (CHE)	35	32	33	31	32
Domestic Private Health Expenditure (PVT-D) as % Current Health Expenditure (CHE)	65	66	66	69	67
Out-of-pocket (OOPS) as % of Current Health Expenditure (CHE)	62	65	63	59	59
Domestic General Government Health Expenditure (GGHE-D) as % Gross Domestic Product (GDP)	2	2	1	2	1
Domestic General Government Health Expenditure (GGHE-D) as % General Government Expenditure (GGE)	7	5	4	5	5

Figure 5: The shape of health expenditure in Egypt by the source of finance. Source: Global Health Expenditure Database., 2020

2. Chapter Two: Background, Problem Statement, Justification, and Objectives

2.1 Background and Problem Statement

Health policies are procedures, plans and laws that are put in place to achieve certain goals of these policies within societies. Health policies can be expressed and represented through different forms and manners, such as programs, interventions, projects, laws, and legislations (28).

Health policy analysis aims to understand and analyse the environment around shaping the policies as well as examine the impacts of these policies that have been developed and implemented within societies (29,30).

While there are several definitions of health policy, this research adopted the following definition "*to embrace courses of action (and inaction) that affect the set of institutions, organisations, services and funding arrangements of the health system"* (28,29).

This definition was chosen because it is comprehensive and includes decisions and actions affecting various health system components. The definition is valuable as it captures and analyses all actors involved in making health policies, not only the government but also non-governmental organisations and external actors.

The development and making of health laws and policies often involve several actors including government actors and non-state actors such as political parties, the media, international actors, and civil society organisations (CSOs) (31).

In this sense, CSOs have been involved in the health sector policies at the national and global levels. Their role in the health sector is principally through either providing health services directly or through advocacy (32–34).

Health advocacy is described as *"the act of supporting or arguing in favour of a cause, policy, or idea. It is undertaken to influence public opinion and societal attitudes or to bring about changes in government, community or institutional policies."*(35).

Health advocacy is also a broad spectrum of activities, practices and methods used for many purposes. Sometimes it is used to influence health policies to achieve health reform, monitor the implementation of health policies and laws or to maintain the status quo. It can be used to advocate for improving the access of society or some marginalised groups to health (34,36).

Globally, using advocacy is one of the tools civil society organisations (which include non-governmental organisations (NGOs) and advocacy and rights groups) have employed to engage with health policies, guaranteeing the rights of several marginalised groups in society, or influencing government health policies (34).

One example is the role of human rights groups and NGOs in grass-rotting public opinion, advocacy, providing policy advice and consultations and lobbying for a more transparent global policy for access to HIV/AIDS medicines; the aim was to reduce HIV/AIDS medicines prices so that people can have access to it (37–39).

Historically, autocratic regimes put restrictions on civic movements and organised civil society in Egypt. This led to limitations in the involvement and participation of civil society in making public and health policies (16,40).

Following a short period of democratic openness after the 2011 revolution, the public landscape witnessed the emergence of civic movement and organised civil society in influencing and engaging with public policies and health policy (16,40,41). However, after the military coup in 2013, the situation has deteriorated in terms of reducing the spaces available for civil society engagement with public (and health) policies (19,42).

Further, the role of civil society in Egypt to monitor, evaluate, propose, and collaborate with the government and other relevant parties in policies and decision-making in Egypt has been challenging in the recent decade because of non-democratic rule and legal restrictions on the work and activities of CSOs (NGOs) (19,42,43). Nevertheless, after the coup in 2013, CSOs (NGOs) have become more vocal in expressing citizens' grievances with regard to economic, political, and civil rights (14,40,43).

In this sense, there used to be little civic participation in policymaking in general and in specific health policy in Egypt; health policymaking has largely been centralised and primarily led by the government (state actors) and, with less extent, international actors (41,44).

Literature has shown that civic participation in policymaking in Egypt is rare (41,44,45). There are several reasons for limited civic participation, including the political history of non-democratic rule, the hierarchical way of formulating top-down policies that give little space for citizens and society to express their input, and legal restrictions on organised civil organisations (41,45,46).

Although civic participation in policymaking in Egypt is rare, civil society organisations (CSOs) have already played a role in promoting more responsive, effective, and efficient health policies. They have done so by relying on specific health advocacy strategies at the policy level in Egypt (40,47,48).

These strategies include proposing legislation and laws drafts and policy consultations to decision-makers, strategic litigation, participation in drafting laws, and monitoring and evaluating the policies' implications and performance of governmental institutions (15,16,48,49).

Two significant health laws were passed in Egypt to address some of the limitations in relation to health regulations and governance. These laws are the mental health law and the new universal health coverage law.

The first law is the mental health law issued in 2009. This law explicitly aims to provide more guarantees for patients' rights, establish regulations for the work of mental health care facilities, and give more space for patients to monitor the law's implementation (50).

The second is the new universal health coverage law (UHC law), issued in 2018, which aims to overcome the shortcomings of the Egyptian health system. Such shortcomings comprise but are not limited to high private sources expenditures on health (OOP, for example), catastrophic spending on health, and consequently, impoverishment of individuals and families (51,52).

The common factor between the two laws is that they witnessed the civic participation of CSOs (NGOs) in shaping them through using different advocacy strategies, including active participation in drafting the two laws, such as the participation of a member of the Egyptian Initiative for Personal Rights (EIPR; local NGO) in the committee formed to draft and create the new universal health coverage law (15,40,50,53).

2.2 Justification

Understanding how these two laws came into existence and involved organised civic participation in the Egyptian context is of interest to NGOs, civil society movements in Egypt, and scholars and policymakers in the region and globally.

A crucial component in understanding this process involves highlighting the importance of CSOs' (NGOs') participation in health policies in Egypt and what can be done in such a complicated political-economic context to improve civic participation in shaping health policies.

The topic is relevant because the two cases under study are still in progress. Although the mental health law was issued in 2009, there is still an effort for amendments to the law. Further, the new universal health coverage law was disseminated in 2018. However, it is still under implementation, and it is in its first phase only, and full implementation will take ten years (52,54). Thus, the two cases are relevant and current to the context.

In addition, in developed countries, there is considerable literature analysing health policies, while in low- and middle-income countries (LMICs), there is little literature (28,44). Also, there is a scarcity of studies describing and investigating the role of CSOs (NGOs) as well as civic participation in shaping health policies in the MENA region, including Egypt (See Annex 1) (44,55,56), an area of the literature that this research aims to contribute to.

In addition, most of the writings on health policy analysis in Egypt focus on governmental or international actors, and few studies have analysed the role of CSOs (NGOs) in influencing health policy-making (15,44). Hence, there is a need to address this research gap, and this research seeks to contribute to sufficing this gap by shedding light on the role of CSOs (NGOs) in shaping the two health laws and describing the advocacy strategies used.

Moreover, this research aims to make policy recommendations for health policymakers and contribute to a way forward for further studies to explore the impact of CSOs (NGOs) participation in shaping health policy in Egypt, the region and other LMICs.

This research follows a three-step approach: first, it gives a broader picture of the health policymaking landscape in the areas of mental health and new universal health coverage laws in Egypt. Then, it aims to

describe and analyse forms of civic participation and advocacy strategies used by CSOs (NGOs) that contributed to the development and creation of these two laws. And finally, drawing lessons learned and recommendations.

To achieve this, this research seeks to answer the following research questions:

- What was the health policymaking environment around drafting and creating mental health and universal health coverage laws in Egypt?
- What were the forms of civic participation and advocacy strategies used by CSOs (NGOs) in Egypt to engage with the drafting and creation of mental health and new universal health coverage laws?
- What applicable policy recommendations can be developed for Egypt to improve civic participation in health policies making and implementation?

2.3 Objectives

2.3.1 General Objective

To analyse the policymaking environment for mental health and new universal health coverage laws in Egypt. The focus is on describing the forms of civic participation by CSOs (NGOs) that contributed to the development and creation of these two laws. Also, to create recommendations to improve civic participation in health decision-making.

2.3.2 Specific Objectives

1. To analyse the health policymaking environment around mental health and universal health coverage laws, using the Walt and Gilson (1994) triangle framework with its four components: content, context, actors, and process.
2. To describe the forms of civic participation and advocacy strategies used by CSOs (NGOs) that contributed to the development of mental health and new universal health coverage laws.
3. To review experiences across other LMIC countries in order to bring lessons learned on enhancing civic participation in health decision-making in Egypt.
4. To formulate applicable and concrete recommendations for health policymakers and other relevant stakeholders in order to enhance civic participation in health policymaking in the Egyptian context.

3. Chapter Three: Methodology and Conceptual Framework

This chapter presents the methodology followed during the research process.

3.1 Study Type and Design

This research applied an approach that combines a literature review, including a desk review and analysis of policy documents (See Annex 2), as well as Key-informant interviews (KIIs).

Walt and Gilson's (1994) policy triangle framework (See Fig 9 below) was used to guide the search strategy, analysing the data obtained from the documents, and the literature, directing the topic guide tool for the interviews and presenting the findings (57).

3.2 Data Collection Methods

To fulfil the objectives, answer the research questions, and triangulate data, this research employed three methods: a literature review, analysis of policy documents, and key-informant interviews (See Annex 3 for explaining and justifying the methods for each specific objective).

The search strategy for sources and data relied primarily on the four components of Walt and Gilson's framework (content, context, actors, and process), which is used in this research as an analytical and conceptual framework. This framework is explained and described in detail in the conceptual framework section.

The research utilised the Walt and Gilson framework to develop themes and sub-themes that guided the search strategy and data collection from sources such as literature and policy documents. These themes and sub-themes were aligned with the research objectives. Table 1 presents the combination of research objectives one and two with related themes and sub-themes derived from the Walt and Gilson framework (29,57).

Table 1: The search matrix: Combining Walt and Gilson (1994) framework components, themes and sub-themes with research objectives.

Research objective	Main themes	Sub-themes
Specific objective number one	Content	Technical content. Objectives of the law. The new changes happened by the law. Description of the law and how it is applied.
	Context	Political, social, economic, historical, donor support, and international cooperation contextual factors.
	Process	Formulation, negotiations, and implementation.
	Actors	State actors, donors, local CSOs (NGOs), and medical syndicates
Specific objective number two	Under the following themes, context, actors, and process	Advocacy process. Litigation. Suggesting and advocating for the two laws to decision-makers. Multisectoral advocacy. Producing educational and advocacy materials

Literature review: The extensive review was performed of the literature on the health policy-making landscape that accompanies issuing new universal health coverage and mental health laws, and a comprehensive check of the literature investigated the role of civic participation of CSOs (NGOs) in the development of the two laws. The search included peer-reviewed studies and grey literature.

Documents analysis: The desk review was conducted by analysing several policy documents, reports, and the texts of the two laws. The documents that describe and contain data about the health policy-making environment that accompanied the drafting and creation of the two laws (including the context, content, actors, and process) were reviewed. These documents include publicly published official government documents, as well as CSOs (NGOs) advocacy and commentary reports. See Annex 2 for the list of the key documents used in the research.

Table 2 outlines the search strategy for operationalising the key terms related to the first, second, and third specific objectives.

Table 2: Operationalisation of the key terms.

Search engines and databases	**Objectives**	**Key terms used independently or in combination with each other.**	
Google, Google Scholar, Vrije Universiteit Amsterdam Research Data base, PubMed, and Medline. Further, WHO, UN, World Bank, and the Egyptian Ministry of Health and Population and Ministry of Finance and Ministry of Social Solidarity online databases.	Specific objective one		Health insurance; health coverage; universal health coverage; new universal health insurance law; health law; health insurance legislation; mental health; mental health law; mental health act; law development; law formulation; legislation development; legislation formulation; implementation; Walt and Gilson (1994) triangle; Walt and Gilson framework; content; context; actors; process; health policy; policy analysis; heath policy analysis; policy triangle; agenda setting; political economy; health decision-making; health policy making; effective implementation; public institutions;
	Specific objective two	And/or	Civic participation; civic engagement; community engagement; public participation; citizen participation; political participation; people's participation; local CSOs; NGOs; role of NGOs; role of CSOs; role of civic participation; advocacy; advocacy tools; advocacy strategies; advocacy activities; civil society; non-governmental organisations; forms of civic participation;
	Specific objective three	And/or	Egypt; MENA; Middles East; Developing Countries; Eastern Mediterranean; low-middle income countries; Africa; North Africa; LMICs; Asia; Thailand; southeast Asia; Iran; lessons learned, experiences; evidence; sustainable health policies; civic participation; transparency; accountability; leadership; Participatory governance; governance; national health assembly; inclusion; strengthening participation;

Semi-structured KIIs: Six interviews were conducted through online digital tools (Zoom and Google Meet) with respondents who were selected through purposive sampling technique in their professional capacity of having been involved and participated in the creation of these two laws (See table 3 for interviewee characteristics). The interviews were conducted until the data saturation was reached.

Written informed consent was presented and signed before each interview. It was translated into Arabic too. The interviews were conducted to provide more validation and context to the research. They aimed to give a different perspective on the findings and add more insights and context to the research. The topic guide for the semi-structured open questions for KIIs is attached in Table 4.

The duration of the interviews was about thirty minutes to one hour; the interviews were translated from Arabic to English, and translated back to Arabic to validate the preciseness, then transcribed and coded, guided by the topic guide tool.

The data collection tool for the KIIs (the topic guide tool) was developed following the four components of the Walt and Gilson (1994) framework.

The coding process was performed manually. Further, the deductive thematic analysis was applied manually to analyse and extract the outputs of the interviews by using the themes and sub-themes derived from the Walt and Gilson framework (See Table 1 for the themes and the sub-themes) (57).

Table 3: Interviewee characteristics

Position	**Total**	**Code**
Government (MOHP) official who has been involved and participated in the creation of the Universal Health Coverage (UHC) law	1	Gov_Official_UHC_#
An official working in an international organization who has been involved and participated in the creation of new UHI law. The informant also has been working closely in health reform in Egypt.	1	Int_Official_HealthReform_#
Advocates from NGOs who have been involved and participated in the creation of new UHC law.	2	Advocate_UHC_#
Advocates from NGOs who have been involved and participated in the creation of mental health law.	2	Advocate_MentalHealth_#

Table 4: Data collection tool guide for the key informant interviews (Themes, Topic guide, and questions guided by Walt and Gilson framework.)

Theme	Topic	Questions
Content	- Background on both laws	- How have the two laws affected the state of health of the population, their needs, and their rights? - Are there any areas where the laws could be improved or strengthened regarding their content or implementation? - Are there any criticisms or concerns that have been raised about the content or implementation of these laws?
Context	- New universal health coverage law and mental health law	- How do these two laws differ from the previous systems and frameworks? - What innovation/improvement/etc. What did these laws bring? - Are there any unintended consequences or adverse effects that have resulted from implementing these laws? If so, how have these been addressed?
Actors	- Government - Actors outside the government with more focus on CSOs (NGOs)	- What were the actors/stakeholders in the development/advocacy process leading up to the law? - How did government officials react/interact with CSOs' (NGOs') lobbying and advocacy work in relation to the development of mental health and universal health coverage laws? Were they in favour, against, or neutral? - What were opportunities/champions, and what barriers/bottlenecks/difficulties during the interactions with the stakeholders/other actors? - What is your perception towards the challenges and barriers that face the CSOs (NGOs) working in the health sector, on a policy level, in Egypt?
Process	- Advocacy process - Policy formulation	- What advocacy process did you follow in these two cases (the universal health coverage and the mental health laws)? And how do you describe the steps and different stages of advocacy? - Can you describe in detail the tools/methods/tactics that were followed? (Probes from the literature for this question: a. Litigation: b. Suggesting and advocating for the two legislations to decision-makers: c. Multisectoral advocacy: d. Changers of the status quo and washers.) - What were the processes and forms of participation in those two cases? How did the involvement in decision-making in these two laws developed/formulated?

3.3 Inclusion and Exclusion Criteria

The criteria for the inclusion and exclusion of sources (literature and policy documents) have been developed based on the following factors (See Fig 6 to show the flow of literature search steps and application of inclusion and exclusion criteria):

3.3.1 Inclusion Criteria

- Studies and documents covered and investigated the two laws and analysed the content, context, actors, process, forms of civic participation and advocacy role of CSOs (NGOs) in the development and creation of two laws. Note that the mental health law was issued in 2009, and the new universal health coverage law was issued in 2018.
- Regarding the language, scientific literature in English, as well as the documents related to the two laws in both Arabic and English, were reviewed.
- A wide range of study types was included: peer-reviewed, grey, qualitative and quantitative studies; systemic literature; documents, policy papers, press releases; media analysis, reports of international organisations, NGOs, and government reports.
- The geographical location of the research is Egypt. However, literature and evidence across other countries similar to Egypt's political-economic, social and cultural context were reviewed.

3.3.2 Exclusion Criteria

- Literature and policy documents that did not cover health sector policies, universal health coverage, health reform or mental health policies and laws were excluded.

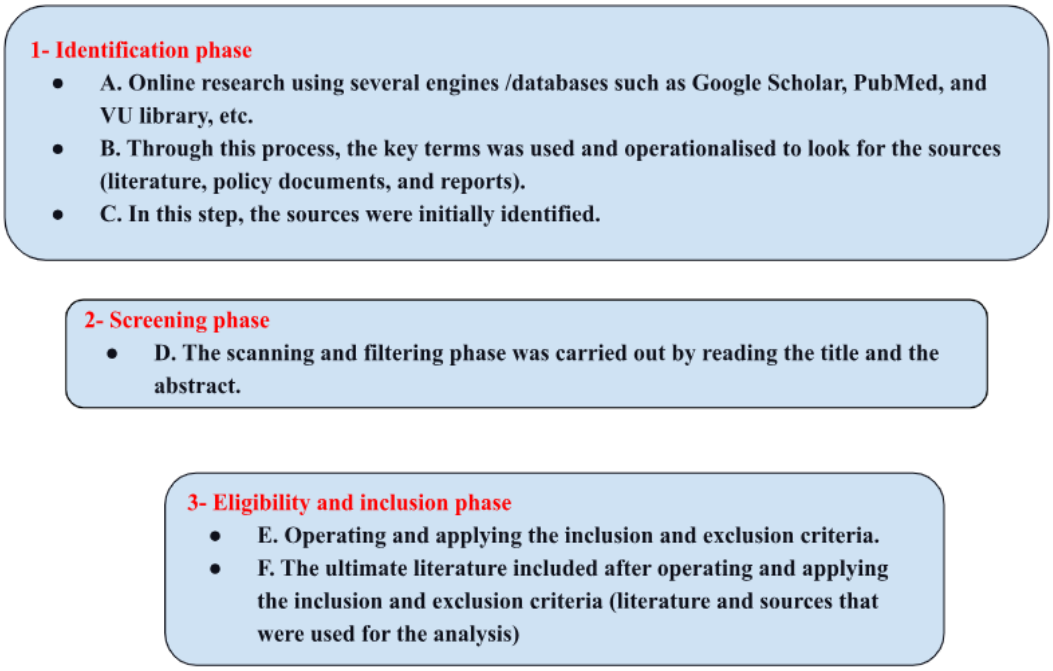

Figure 6: The flow of literature search steps and application of inclusion and exclusion criteria.

I chose these two laws (cases) based on the following criteria:

- Due to the relative recentness of the two laws' enactment in the field of health in Egypt.
- Because they represent a rare case where civic participation of CSOs (NGOs) contributed to health policymaking.
- Choosing two cases also allows for comparative analysis, showing similarities and differences and more valuable findings than presenting one case.
- A deeper analysis of them provides rich material to reflect on the broader context of civic participation in relation to health policymaking in Egypt.
- For their significance in relation to health policies and laws in Egypt.

Concerning the inclusion and exclusion criteria that were set to define civil society organisations (CSOs) as well as forms of civic participation. The following lines clarify and define the type of CSOs that fall within this research's scope.

CSO refers to a "*Group or organisation which is outside government and beyond the family/household*". Thus, CSOs include but are not necessarily limited to NGOs, charity and faith-based organisations, labour unions, civic, political and advocacy movements and groups etc. (See Fig 7) (29,58).

This research primarily examines the role of local non-governmental organisations (NGOs). Therefore, when I refer to CSOs, I indicate local NGOs. The research does not cover, for example, the role of the private sector as it is beyond the scope of this research objectives.

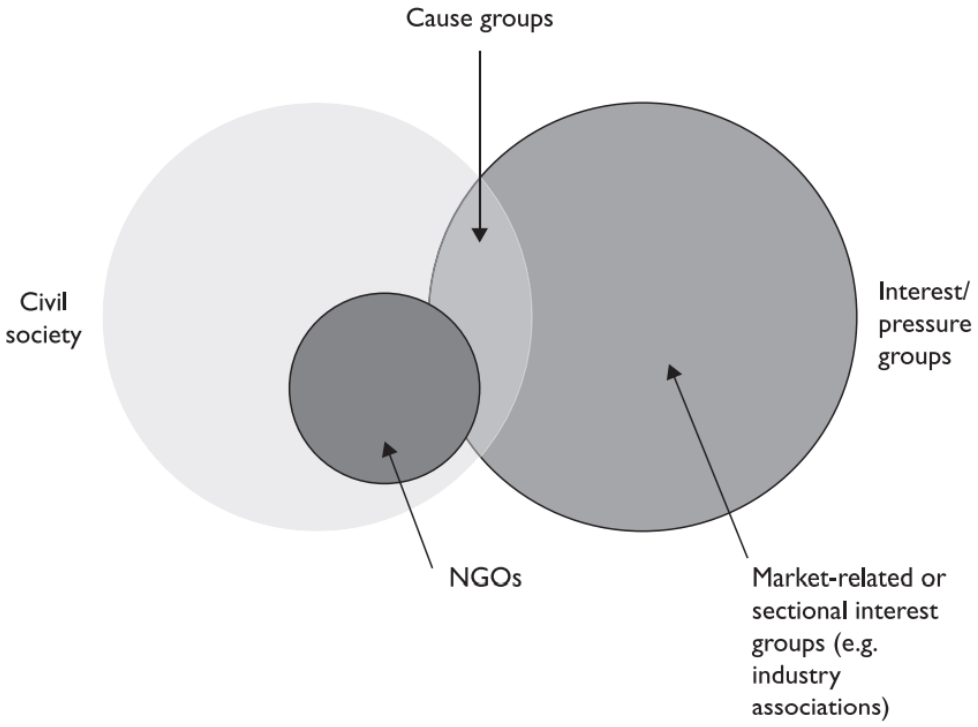

Figure 7: Civil society organisations, interest/pressure groups and NGOs, source: Kent Buse et al., 2012 (29).

3.4 Conceptual Framework

After establishing this research's inclusion and exclusion criteria, this section explains the conceptual framework upon which this research relied.

Several theoretical and conceptual frameworks exist for analysing public health policies (24,54). Therefore, the process of selecting a conceptual framework went through three stages.

I consulted a wide range of scientific literature to search for conceptual frameworks that have been used and applied to analyse public health policies and then assess their applicability to serve the objectives of this research (See figure 8 for the process of selecting a conceptual framework to be applied and used in this research).

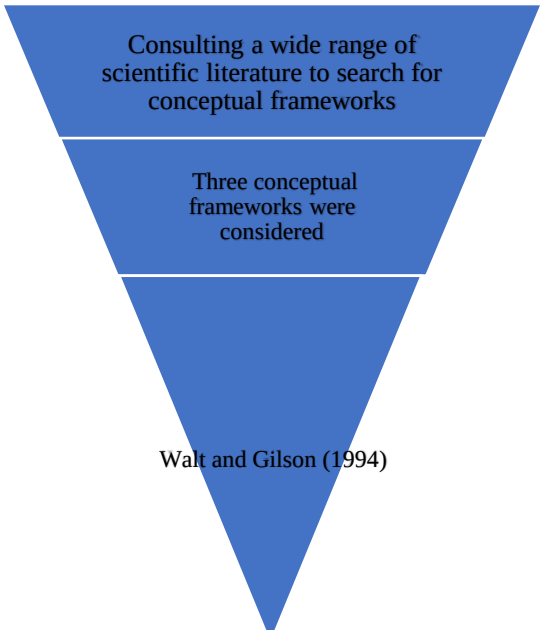

Figure 8: The process of selecting a conceptual framework to be applied and used in this research.

Initially, *network frameworks* were considered to apply. However, it was excluded due to its few prior uses and applications in LMIC settings and its descriptive nature rather than analytical. It also primarily focuses on actors and less on the process, and context (28). Thus, using it to serve this research's objectives was not applicable.

Also, the *stages heuristic framework* was considered to apply for this research but excluded as it is established on an assumption of the linearity of the public policymaking process (24). Compared to the health policy triangle framework, it does not provide space for understanding health policymaking environments' complexity (non-linearity) (28,57).

The *policy triangle framework* by Walt and Gilson (1994) was chosen and used for this research as a conceptual and analytical framework for extracting and analysing the data from [the literature and policy documents] as well as for guiding the topic guide for the questions for [KIIs] and analysing the output of [the KIIs], arranging and organising the research's findings.

Walt and Gilson's (1994) framework is valuable for analysing different forms of health issues, including but not limited to universal health coverage, health laws, health reform, the political economy of health and mental health policies. Furthermore, it is well-grounded and established within health policy research (28,57,59).

I chose this conceptual framework because it not only assists in analysing the content of health policies and laws but also includes context, actors, and processes. Moreover, due to its simplicity (in terms of operationalisation) and, at the same time, its ability to capture the complex nature of the policy environment (See Fig 9) (28,44,56).

This framework can be used for retrospective and prospective analysis. This research used it as a retrospective. Also, it was utilised to explore and discuss the concurrent and prospective challenges of civic participation in health policymaking in Egypt to develop applicable recommendations.

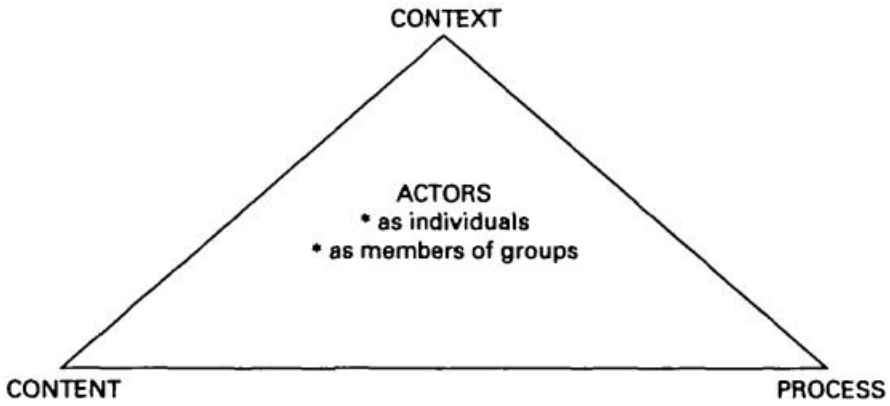

Figure 9: Health policy triangle framework, Source: Walt and Gilson (1994) (57)

3.5 Ethical Consideration

A waiver from full ethical clearance was asked from Research Ethics Committee (REC) at the Royal Tropical Institute (S-206) on 7-4-2023. The waiver was approved and obtained on 14-4-2023, and the proposal has been exempted from full ethical clearance.

3.6 Limitation of the Methodology

This methodology has some limitations. Firstly, it focuses on only two cases. Therefore, caution should be taken in generalising this research's findings to the entire health policymaking landscape in Egypt. Although these two cases were chosen for particular reasons, they may not fully represent the broader environment of health policymaking in Egypt.

Further, due to the limited time for writing the master's thesis, the number of interviews conducted was small and more interviews could have yielded additional insights.

Moreover, the nature and design of the health policy analysis research is qualitative rather than quantitative. Therefore, the findings are not measurable with quantitative data. The qualitative design emphasis is on capturing and analysing qualitative information. This makes it difficult to specify causal relationships.

Lastly, due to the nature and the design of health policy analysis research, there is a space for the researcher's own biases in terms of analysis and interpretation. However, I adhered to the conceptual framework based on Walt and Gilson (1994) to achieve methodological discipline and eliminate bias.

4. Chapter Four: Findings

This chapter presents the findings in three sections. Sections 4.1 and 4.2 analyse the health policymaking environment surrounding UHC and the mental health laws, with a particular focus on describing and analysing the forms of civic participation and advocacy strategy used by NGOs. The findings in the two sections follow the components of Walt and Gilson's policy triangle framework.

Section 4.3 reviews experiences from other LMIC countries, aiming to draw lessons learned on enhancing and sustaining civic participation in health decision-making.

4.1 The New UHC Law

4.1.1 Content (What is new in this law?)

The new UHC law that was decreed by Parliament in 2018 aims to "*achieve universal health coverage for citizens*" in compliance with Article 18 of the Egyptian Constitution, which referred to the necessity of enforcing the right to health (60–62).

The new law abolished all previous insurance systems schemes and transferred them to one financial scheme with one fund pool at the national level; in addition to that, the law has created only one purchaser at the national level (60,63).

The new law has separated the funding and provision of healthcare by establishing three independent bodies. The first body manages the funds and acts as the single purchaser of health services at the national level. The second body oversees the provision of health services, and the third body focuses on quality and health accreditation to ensure the quality of care (52).

Concerning new UHC funding sources, the new UHC relies on the public source; it has required contributions from all citizens (compulsion contributions). New UHC law has recognised three sources for the UHC fund pool: compulsory contributions from the formal workers (the financially able citizens), the allocation of the state’s general budget and revenues through the MOF to cover and subsidise people experiencing poverty (those who are unable to contribute financially), and earmarked special taxes on specific goods like cigarettes that have been allocated and assigned to the new UHC pool (52,63).

The new law made improvements by consolidating all the funds into one fund pool, creating only one purchaser for less fragmentation in health system governance and effective strategic purchasing. Also, the role of the MOHP has been as a general regulator of public health and health policies (52).

The new law also relies on the concept of the gatekeeper through the general practitioner (also called family doctor or primary care doctor in the Egyptian context) as an essential entry point and patients can only access higher levels of health care after being referred by the general practitioner. The general practitioner is assigned based on the patient's place of residence, limiting the patient's choice. Still, after a general practitioner refers, a patient can choose their secondary or tertiary provider (52).

Informants agreed that the most significant improvements that have been brought about by the law are compulsory contribution, subsidisation for people experiencing poverty and for those who are financially unable to pay the contributions and institutional reform. For example, two informants said:

"…The essential thing that the law has done is that it brings the power of the mandate and the institutional reform by creating three new bodies that did not exist before, and the law made the funding compulsory. For example, before, the accreditation and quality processes existed through a unit within The Ministry of Health, which was ineffective. No one was interested in activating it well; there was nothing obligatory. Now there is a particular independent body for accreditation and quality." Int_Official_HealthReform_01

"The law mandates the compulsory collection of contributions and subsidisation for those who cannot pay. This is the first time there has been an explicit legal provision on compulsion on contributions and subsidisation." Advocate_UHC_01

Evidence and experience across several LMIC contexts support these key findings on the importance of compulsory contributions and subsidisation. Compulsion is a vital tool to prevent opting out of people who are at low risk, which is known as adverse risk selection. Subsidisation is also essential to ensure cross-subsidy among society, making it a pro-equity and pro-poor policy (64–66).

4.1.2 Context within which New UHC Law Emerged

This section is presented following two main concepts in Walt and Gilson policy triangle framework.

Political Context

Literature shows that health reform is connected to the aspirations of societies and civil society to achieve improvement in health policies that are more equitable and fairer. Reforms in the health sector are often the result of political and social changes. For example, in Brazil, health reform and health for all movements were part of the demands of the opposition and civil movements during the period of military rule. After the democratic transition, one of the reasons for improving universal health coverage was the efforts of the political and civic movements (67–69).

This theory can be applied in Southeast Asian settings as well as Middle Eastern countries like Turkey, where there has constantly been a close connection between political and social change and health reforms (70–72).

In the Egyptian context, the connection between the history of health reform and the changes in political and social landscapes is not an exception to this theory (See Fig 10). The first attempt (in the middle of the 60s) to make a health insurance system began after independence. However, it focused mainly on public sector workers (16,45,73).

In parallel, other insurance systems emerged with different financial arrangements and packages of services, for example, a particular scheme for school students, a scheme for pensioners, and another scheme for widows (45).

After 1974, the state's role in spending on public services, including the health sector, diminished due to the policy of economic liberalisation and structural adjustment programs. As a result, there was a notable expansion in the private sources of spending on health, primarily through out-of-pocket health expenditures (16,45,74).

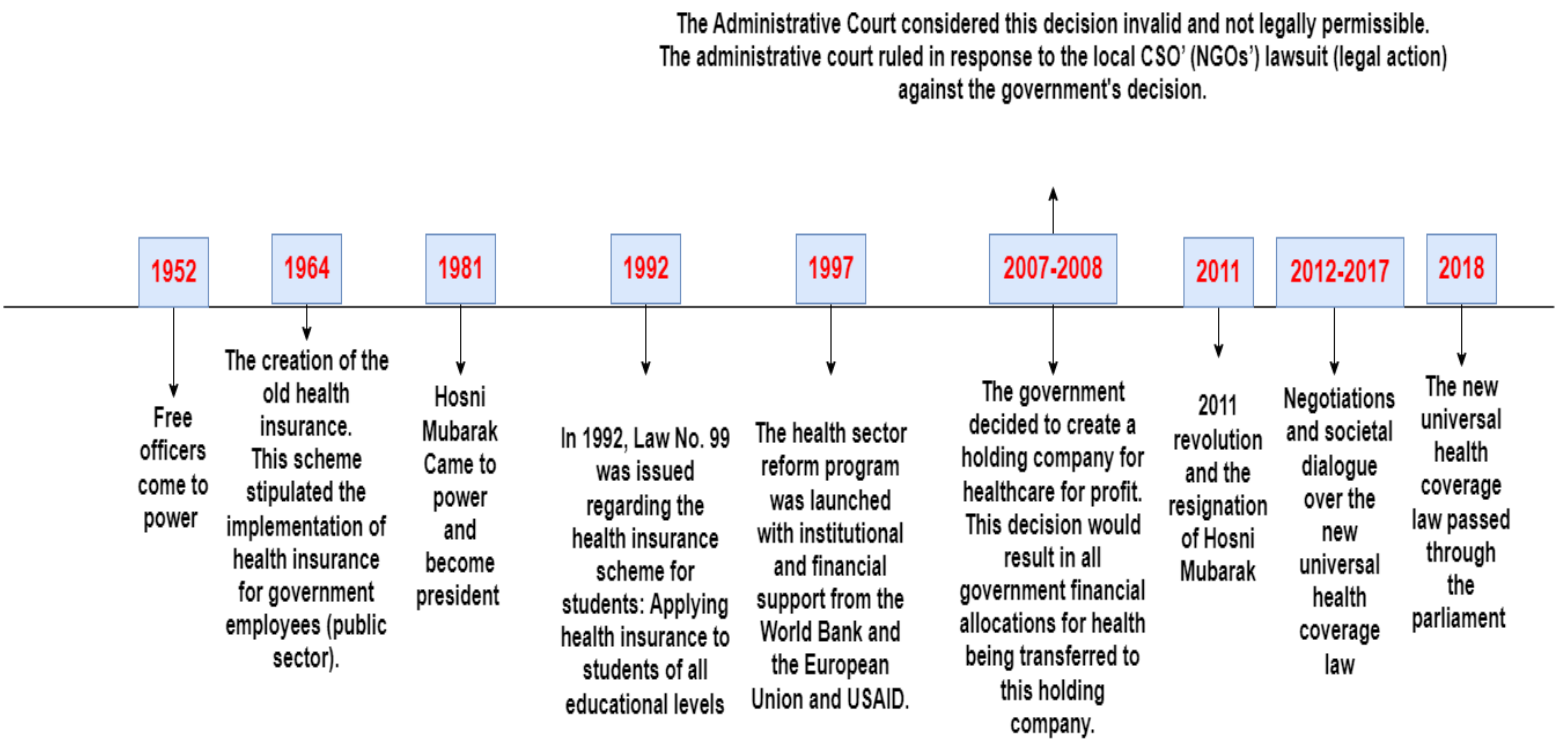

Figure 10: History of health reform in relation to the key political-economic turning points in Egypt; this figure is adapted from Fig 2. in Ismail's study on the rocky road to universal health coverage in Egypt: A political economy of health insurance reform from 2005–15. source: Ismail, 2018

Moving forward in highlighting the context within which the new UHC law emerged, in 2007 (a few years before the 2011 revolution), the government issued a decision to establish and create a holding company for healthcare for profit. This decision would result in all government financial allocations for health being transferred to this holding company, which would manage and finance the health service as an alternative to the existing insurance systems (16,40,75).

Interestingly, the Administrative Court considered this decision invalid and not legally permissible because this decision, according to the court's statement and explanation, " *will ultimately change health insurance from a social right to a commercial project"* (76).

The administrative court ruled in response to the local NGOs' lawsuit against the government decision. This litigation (legal action) was among the first advocacy strategies employed by local NGOs to engage with health reform as a public opinion issue. The literature on health reform in Egypt shows that the court ruling and the active participation of NGOs in the lawsuit played a vital role in establishing and grounding the right to health in Egypt (15,16,45).

A new UHC law committee member who actively participated in drafting and creating the law said:

"*A group of NGOs filed a very famous case against the Prime Minister and the Minister of Health…Civil society succeeded in discontinuing the transfer of health insurance into a holding company...the situation remained as it was until 2011. After the 2011 (revolution), a new committee was formed to formulate a new health insurance law. This committee, which included members of civil society, kept working for seven years until 2018 when the law was passed."* Advocate_UHC_01

Although it was new to the Egyptian context, strategic litigation has long been one of the strategies, which according to Gostin et al. 2019 and Burris et al. 2010, used by advocacy groups and NGOs to engage with the health sector policies in an effort to change and improve them (77,78).

Strategic litigation is when non-state actors take legal action to change health policies with the aim of improving them. For example, in 2002, a South African NGO used litigation to overturn the government's decision to limit the provision of Nevirapine, an anti-retroviral drug that protects and reduces mother-to-child transmission of HIV. The court's decision obligated the South African Ministry of Health not to limit this drug's provision and to provide it in the public sector (77,79).

The 2007 health litigation case was significant in grounding the right to health in Egypt and was a vital step in grass-rooting society's awareness of the need for a more equitable health insurance system (15,45,74).

Building on this case and moving forward to the context of drafting and creating the new UHC law, according to the literature and the validation from four informants (who participated in the law's creation), the committee tasked with drafting the new UHC law was formed after the 2011 revolution. The committee was inspired by the political change and hoped to reform the health system (15,45,73,74).

Despite the military coup in 2013 and the limited space for civil society, NGOs have become increasingly vocal in advocating for social issues such as health (40,42,45). This contrast, where NGOs continue to participate and exert pressure despite the coup and continuing regime from that era, can be explained in multiple ways.

One interpretation is that the foundation established, advocating for the right to health and UHC, has been grounded and has a solid base. This has moved the public discourse toward the development of a new legal framework that ensures and achieves UHC (15,45,80). Additionally, the international political trend and interest supported by donors have been pushing for UHC (40,45,81).

A health advocate, who played a role in drafting and creating the new UHC law, explained the context:

"Both sides (the government and NGOs) had an interest. There was a shared interest because society wanted this law (UHC), and the government also had the same goal to give something in that political context." Advocate_UHC_01

Another perspective on the continued involvement of NGOs in drafting and creating the new UHC law is that it was achieved through continuous advocacy strategies, such as using the media and producing educational materials on the right to health and the importance of UHC (15,45,73).

This aligns with the insights provided by informants. For example:

"…Our advocacy strategies were based on raising awareness of the importance of the concept of UHC, the right to health, and the state's responsibility to provide it. We also created educational materials focused on the right to universal health coverage." Advocate_UHC_02

Health System Context

The new UHC law was created in a political context that involved the civic participation of NGOs. The health system context was also a critical factor in this regard.

As stated in the background chapter on the health system (section 1.4), out-of-pocket expenditures (OOP) on health have remained constant, around 60%, over the past years. Further, government spending on health has remained low compared to countries in the region and LMICs. As a result, 3.9% of the population was exposed to catastrophic expenditures on health (spending more than 25% of their income as out-of-pocket spending on health), and about 1% were exposed to impoverishment due to spending from their savings on health (52,82,83).

Moreover, the fragmentation of the health system elements also contributed to this situation. There was more than one purchaser, more than one package of services, and multiple insurance fund pools. This health system context created a general conviction that there is a necessity for reform to contain such problems (45,74,82).

Annexes 4, 5, and 6 contain illustrations that compare the health system governance arrangements, structure, and finance schemes before and after the new UHC law.

4.1.3 Actors

Figures (11) and (12) reveal an overview of actors actively being involved and participating in creating and making the new UHC law. Data from the literature and supplementary data from informants show that the actors involved officially in making the new UHC law were several and varied. By names, the MOHP, the Ministry of Finance, local NGOs like the Egyptian Initiative for Personal Rights, with four seats for CSO (NGOs) on the table of the law-drafting committee, labour unions, the parliament and medical syndicates and representatives of the private health sector providers who also participated in the law-making committee (45,81).

In the context of the new UHC law, informants agreed that it is challenging to identify one actor who had the most prominent influence. Instead, political and systemic factors made this different combination of actors coordinate with each other for the issuance of the law.

"…We cannot say that there was a main or more important actor; you can say that several circumstances were prompting that this law was necessary for the state at a transitional moment for political change…

There were several actors, not one actor, not the Ministry of Finance, not the Ministry of Health, and not civil society. I mean all of these actors together…." Advocate_UHC_01

In this sense, adopting and adjusting Smith et al. 2014 approach to analysing the *ideas, power, and interest* in priority settings politics can be insightful to understanding the formal and the informal relation within the actors during the drafting and creation of the new UHC law (84,85).

Data from four informants highlighted that during the committee discussion on drafting the law, the MOF representative opposed the final draft based on financial considerations. The MOF proposed to increase the proportion of the contributions and set copayment mechanisms for dispensing the medicines and the laboratory tests until a sealing point; after this point, the beneficiaries are exempted. Eventually, the MOF succeeded in passing its proposal, reflecting the power dynamics and the relation among the actors involved in drafting and creating the law.

This power dynamic within the law-drafting committee is further described and clarified by a member of the committee who said:

"…*After the committee finished the final draft, the representative of the Ministry of Finance objected to it and insisted on increasing the proportions of the contributions…We agreed as civil society representatives because the Ministry of Finance was insistent on its proposal. We believed it was better than nothing, as it would prevent the committee's effort from being wasted and starting over*."
Advocate_UHC_01

The stakeholders had different motivations and ideas. The NGOs wanted the law to include and fulfil the right to health principle. The MOF focused on financial technical issues such as contributions and copayments. The MOHP was more neutral and coordinated the dialogue (45,81).

After analysing data from the literature, documents and informants, a picture of the stakeholder actors can be redrawn according to each actor's position, ideas, and power.

The MOF was a critical stakeholder and the most crucial state actor, which, as explained, had the right to veto, for example, when there was a discussion around determining the proportion of the contributions. The MOHP was more neutral and open to various ideas and opinions (45).

NGOs were motivated by the right to health concept in the broadest sense. They believed that participating in the UHC law drafting and creation committee would improve the legal framework for the UHC and establish more legal guarantees to realise and enforce the right to health (45,73).

The MOHP official who participated in the lawmaking and drafting committee said, an expression of the somewhat neutral position of the MOHP:

"…As a session facilitator and advisor to a minister of health. I conducted numerous meetings with civil society and NGOs, seeking their input and suggestions. Additionally, these organisations played a role in presenting proposals. Subsequently, we engaged in extensive discussions at the parliament, working towards achieving a consensus…."
Gov_Official_UHC_01

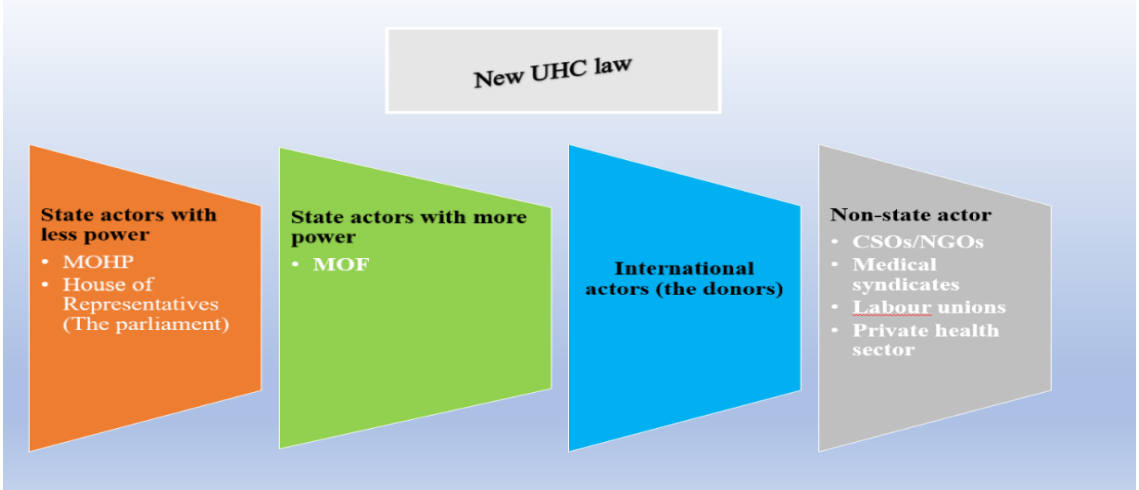

Figure 11: Overview of the actors actively being involved in making and creating the new UHC law. Source: Developed by the Author.

MOHP: Through the new UHC law-making and creation, its role was to coordinate between the different actors with a neutral position.

House of Representatives (The parliament): its role was to review the legal provisions and vote to pass the law.

MOF: As shown in the UHC law actor's section, it was an influential actor in shaping the UHC law, it is motivation was financial issues like co-payments and contributions proportions etc.

International actors (the donors): They have been providing technical support (WHO, for example) and with less-extent financial assistance. UHC pool fund is established to get its resources primarily from domestic sources. Still, some international organisations like the world bank supported the UHC pool financially.

CSOs/NGOs: They focused on the right to health perspective to ensure that the law includes and fulfils the right to health within a legal framework. Also, they achieved some success as the law clearly mentioned that the state is obligated to cover and subsides the poor, and the law explicitly stipulates the role and responsibility of the state in guaranteeing, realising and enforcing the right to health.

Medical syndicates: The doctors, pharmacists, nurses, and dentists' syndicates. Note that the doctors' syndicate is the most influential actor among the medical syndicates.

Labour unions

Private health sector

Figure 12: Overview of the interest, position and ideas of each actor who being participated and involved in making and creating the new UHC law. Source: Developed by the author. This mapping is influenced and inspired by reading the following four papers (Walt & Gilson, 1994), (Arts & Van Tatenhove, 2004), (Smith et al., 2014) and (Widdig et al., 2022) (57,84–86).

4.1.4 Process of Drafting and Creating the UHC Law

This section presents the process of drafting and creating the UHC law, focusing on the following sub-themes: formulation, negotiations, and the implementation process, developed from Walt and Gilson's (1994) framework.

Formulation and Negotiations

UHC law was formulated under complex and lengthy political changes. The process of drafting and creating the new UHC law lasted seven whole years, from 2012 until late 2017, and the law was approved by Parliament in 2018 (45,73,74,81). In other words, it took around seven full years for community discussions to make the law under complex political circumstances; this was described in detail in the political context section (section 4.1.2).

Data from the key informants highlighted several critical ideas and concepts that dominated the discussion during the drafting and creation process. These included the following:

- Adopting the concept of compulsion (mandatory scheme).
- The separation of financing from service provision.
- Issuing a legal provision (text) that obliges the state to cover and subsidise contributions for people experiencing poverty or those who are financially unable to pay.
- Introducing proportional contributions based on the total income of individuals or families.
- Applying the concept of the general practitioner as an entry point to the system.
- Establishing mechanisms for co-payments and cost-sharing.

When the committee finished drafting the law, there were disagreements between NGOs and the Ministry of Finance around the proportion of contributions, co-payments and cost-sharing mechanisms. The MOF had reservations about the latest version and insisted on increasing contribution rates and setting co-sharing (See Fig 13 for cost-sharing mechanisms that have been identified in the new UHC law). This disagreement was solved by agreeing to the MOF proposal (Visit the section on actors: 4.1.3). The draft law went through the state's council and then to parliament, which was approved in 2018.

Medical services	Cost-sharing rates and ceilings[a]
Home visit	100 EGP
Medications (except for chronic diseases and tumours)	10% up to a ceiling of 1000 EGP The percentage rises to (15%) in the tenth year of implementation of the Law
Radiology and all types of medical imaging (not related to chronic diseases and tumours)	10% of the total value up to a ceiling of 750 EGP per case
Medical and laboratory tests (not related to chronic diseases and tumours)	10% of the total value up to a ceiling of 750 EGP per case
Inpatient departments (except chronic diseases and tumours)	5% for a ceiling of 300 EGP per admission

[a]1 USD = 15.5 EGP (Egyptian pound). February 2020.

Figure 13: The cost-sharing mechanism identified in the New UHC law, source: Khalifa et al., 2022 (82).

Law Implementation Process

The law has set the plan for the implementation process in six phases over 10 to 15 years (See Annex 7). The philosophy behind this gradual implementation is to allow for experimentation and learning from mistakes. The implementation started initially with small governorates like Port Said Governorate, and in the sixth phase, it will expand to Cairo, the capital (52).

The implementation of the new UHC law began in July 2019. The first phase has been fully advanced in all six governorates. However, there are quite a few sources and studies evaluating and assessing the implementation in the governorates of the first phase (82,87).

Data from informants highlighted several policy concerns that have impacted the law implementation process. One of these concerns relates to the frequent turnovers in health leadership. This frequent turnover loses health reform stability and slows down the momentum. According to a health advocate:

"*A lot of changing (turnovers) ministers disrupts stability. Imagine, for example, that there were about nine ministers of health in a short period from 2011 to 2023. This has created many problems in keeping the continuity of the reform. Imagine if a minister of health started to understand the health situation, he or she would change."* Advocate_UHC_01

Moreover, there is an absence of civic participation in the process after the law has been drafted and passed (82,88). This was supported by data from an informant who had been involved in drafting the law: "…*The problem is that civil society, which contributed to drafting and creating this law, should have been invited to participate in monitoring the implementation process. This is the main weakness in the*

implementation process, as there has not been the participation of civil society and engagement of the communities after the law was implemented in 2019." Advocate_UHC_01

In addition, one of the issues that has restricted civic participation in the law implementation process is the lack of transparency and information provision. There is a scarcity of sharing precise and reliable data on the implementation of the law, which makes it difficult to evaluate and monitor (82,88). This was confirmed and described by an informant as*:*

"…Among the challenges is providing limited information shared by the health authority regarding the implementation of the law, and even if there is information, it is not often accurate. Thus, the ability of NGOs to engage and effectively follow up and monitor the implementation is currently inadequate." Advocate_UHC_02

To summarise, figure 14 shows the policy triangle synthesis in relation to drafting and creating new UHC law in Egypt.

Furthermore, figure 15 shows forms of civic participation and advocacy strategies used by NGOs that contributed to the development of the UHC law.

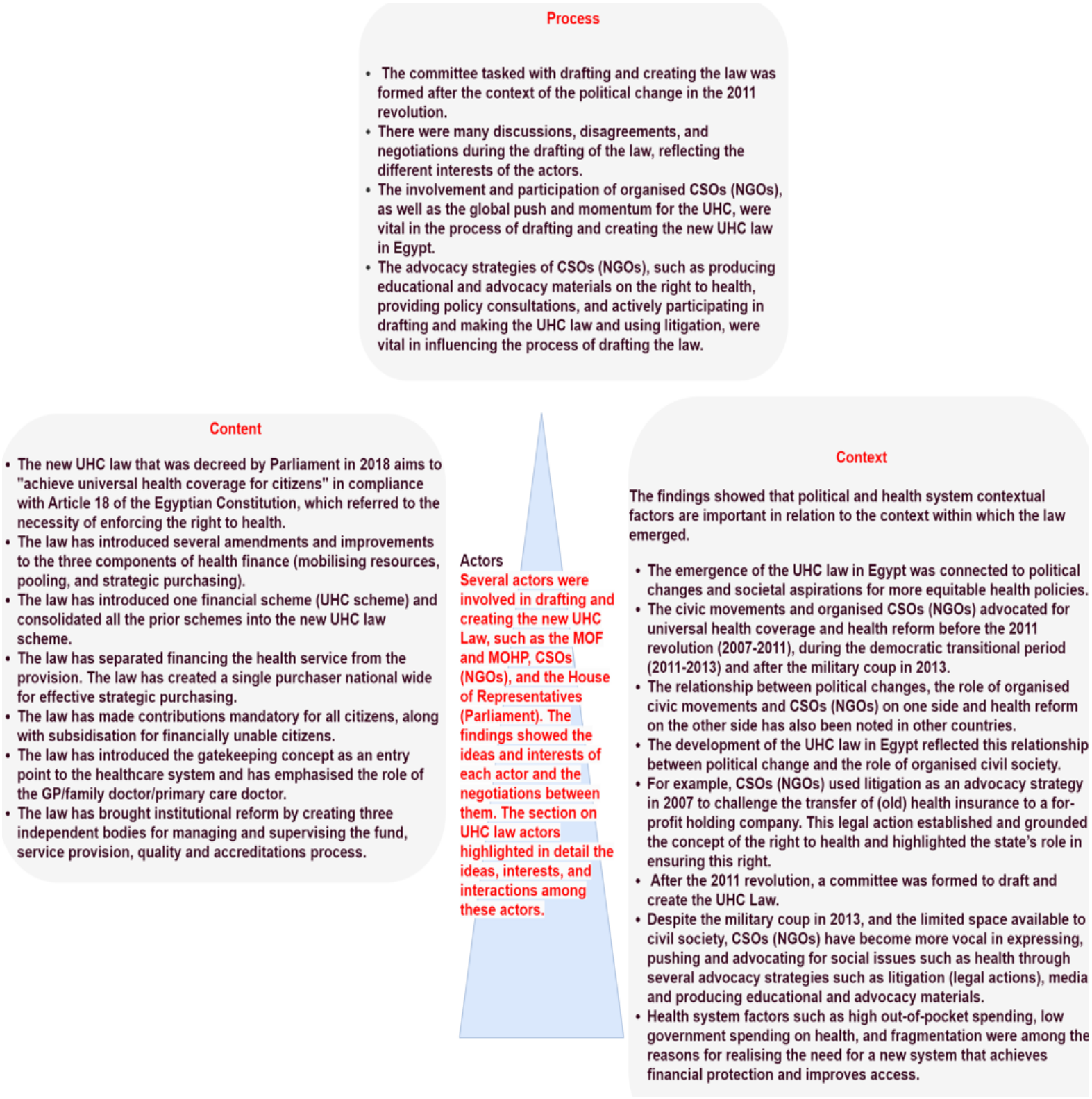

Figure 14: Policy triangle synthesis (Content, context, actors, process) in relation to drafting and creating new UHC law in Egypt. This was developed by the author following the policy triangle framework by Walt and Gilson (1994).

Forms of civic participation and advocacy strategies used by CSOs (NGOs) that contributed to the development of the UHC law

1- Launching advocacy campaigns: Local CSOs (NGOs) launched advocacy campaigns to increase awareness of the importance of the concept of the right to health and UHC. They used the media and public information tools to mobilise and carry out these campaigns and grass-root public opinion; such advocacy campaigns aimed to raise awareness and create public demand for more equitable health policies as well as for UHC.

2- Litigation: CSOs (NGOs) used strategic litigation to discontinue the government's decision to transfer health insurance schemes to a holding company for profit in 2007. The court decided to suspend and discontinue the transfer decision and highlighted that health is a social right. This litigation strategy has created and grounded public awareness and the realisation of health as a right. Further, it has ground litigation as a strategy for health advocacy.

3- Direct participation and involvement in the law drafting committee: Representatives of CSOs (NGOs) actively participated in the committee responsible for drafting and creating the law.

4- Advocacy for subsidisation: CSOs (NGOs) advocated that the law ensures and includes subsidisation for people experiencing poverty and who can not pay the contributions. This effort was along with ensuring the compulsion in relation to collecting the contributions from financially able citizens.

5- Encouraging institutional reform: CSOs (NGOs) encouraged and contributed to making institutional reform through creating three new bodies (One for supervising the fund and collecting the contributions, the second for supervising the health providers, and the third for health accreditations and quality) and separating service provision from financing.

6- Engagement in the political field after 2011: CSOs (NGOs) became actively involved in the political movement after the 2011 revolution. They have focused on health as an issue that needs attention and improvement. This political moment created an area of common interest with the government to develop and create a new legal framework to improve access, and financial protection and enhance the quality.

Despite the non-democratic rule, the military coup in 2013, and the limited space available to civil society, CSOs (NGOs) have become more vocal in expressing and advocating for social issues such as health through several advocacy strategies such as litigation (legal actions), media and producing educational and advocacy materials.

Figure 15: Forms of civic participation and advocacy strategies used by CSOs (NGOs) that contributed to the development of the UHC law. This was developed by the author based on interpreting, analysing, and synthesising the findings.

4.2 The Mental Health Law

4.2.1 Content

The law has created a bureaucratic structure to oversee and regulate mental health services and practices in Egypt for the first time. Also, the law has created the National Council for Mental Health (NCMH) and local councils in the governorates to supervise, oversee, and watch mental health institutions and services (50,89,90).

The National Council and its local branches in the governorates have been responsible for setting policies that ensure respect for the rights and safety of patients as well as monitoring patients' conditions and ensuring that they enjoy the necessary legal guarantees (50,89,90).

The law has brought about several basic improvements in relation to creating a legal-binding framework for ensuring the patient's rights. In this sense, the law has established the concept of "*informed consent*" as a condition for the first time to perform any medical intervention or provide service to patients (50,89,90).

Further, the law has set criteria and rules consistent with international practices and the guidelines of the World Health Organisation concerning cases that require involuntary admission or emergency intervention (50,89,90).

4.2.2 Context

This section is presented following two main concepts in Walt and Gilson policy triangle framework.

International Cooperation and Donor Support Context

The development of mental health policy in Egypt first began through donor support with the collaboration of MOHP. The first reform and development of mental health policies occurred through the Finnish bilateral aid project that started in 2001 and continued until 2009. This project focused on integrating the mental health component into the existing health reform policies at that time and integrating it into the basic services provided by the MOHP (91).

One of the recommendations of this program was to establish a new law for governance because there were no modern national frameworks for regulation, governance and accountability concerning mental health practices and policies (91).

In this sense, Egypt had outdated old mental health regulation dating back to 1944, which required development and modernisation. Therefore, the project recommended the creation of modern mental health law, which occurred by making a law in 2009 (91,92).

Moreover, data from the mental health policy documents indicate that the MOHP recognition and realisation of the need for modern mental health was vital for drafting and creating the mental health law (89,90,92,93). Data from two informants (who actively participated in drafting and creating the law) added more insights and validation for this finding. For example,

"The Ministry of Health recognised at this time that there was a critical need for improvements (concerning mental health policies). It is usual in Egypt for health policies to change when the minister changes, as there are no fixed and continuous health policies. So, with the appointment of a new minister in 2009, there was a desire to develop a modern mental health law from the new health leadership at that time." Advocate_MentalHealth_01

Historical Context

The historical context was vital in the context surrounding the emergence of the law. This historical context was influenced by the poor patient rights situation, violations in mental health facilities, as well as the disease burden of mental health conditions (50,91,93). Data from the literature and documents show that the poor patient rights situation and violations in mental health facilities necessitated the development of the law (50,92–94). Additionally, official estimates indicated that mental illness prevalence reached 17% in 2009 among the population aged 18-64 (See Annexes 8 and 9) (54,95).

This finding is supported and validated by data from two informants. For example, according to one informant:

"…There was a recognition and rising awareness that the existing mental health policies needed to improve. Also, internationally, there was increasing attention to mental health and patient rights...the concept of patient rights and human rights have emerged, and there was a gap to address with a modern legal framework (law). Grave violations of the patient's rights, such as the physical abuse of individuals with mental conditions, pushed the formation of a formal committee in which I participated. This committee was formed and created to study and investigate the mental health situation and to contribute to the drafting and creation of the new mental health law that came out and issued in 2009."
Advocate_MentalHealth_01

4.2.3 Actors

The actors who contributed to drafting and creating Egypt's mental health policy and law are shown in Figures 16 and 17. The MOHP was the most influential actor as the primary state actor. The donor financed the beginnings of the creation of policy and law, working in collaboration with the MOHP. NGOs joined and were involved in drafting, developing, and creating the law by invitation from the MOHP and the donor, specifically the Finnish bilateral aid project. This inclusion of NGOs extended the circle of participation and involved NGOs during the law drafting and creation process (53,91,96).

Data from informants highlighted additional details not stated in the literature. According to the informant who participated in drafting and creating the law:

"The initial involvement of NGOs with mental health policymaking began through the General Secretariat for Mental Health (a department within the MOHP). They (the MOHP) wanted civic participation of NGOs working in mental health policy to evaluate and assess the performance of mental health services, particularly concerning the patients' rights. MOHP began to work in committees with various actors, including NGOs, to examine and study the conditions of patients in mental health facilities; they tried to keep a kind of observation and follow-up; I mean, the thoughts were not very clear at that time." Advocate_MentalHealth_01

Similar to what was done in the UHC law case of adopting and adjusting Smith et al. 2014 approach to analysing the *ideas, power, and interest* (section 4.1.3), Adopting this approach can add insights into the ideas and the interests of involving the NGOs in law drafting and shaping process (84,85).

The idea and the concept behind involving NGOs in creating and developing the mental health law and policy was to ensure that the law aligns with human rights principles, particularly concerning patients' rights and establishing legally binding guarantees for patients' protection. This was especially important in a relatively neglected and under-tackled area of the health and social context in Egypt, where public awareness about the importance of giving protection and special priority to mental health was not yet fully developed (91–93,96).

This data from the literature was confirmed and validated by data from two informants. For example, according to one informant:

"*The General Secretariat for Mental Health (a department within MOHP) started a dialogue for creating the mental health law. They expected that the law would face resistance from doctors, nurses, and society. This was understandable in the Egyptian context because patients are often viewed as incompetent, and*

there is a paternalistic view towards them. It was also rare to discuss with the patients or share or explain to them…Mental health laws are serious because they can legally limit the patient's freedom. It is a broad authority. Bringing NGOs and advocacy groups was an intelligent move by the General Secretariat for Mental Health. They felt that this area requires human rights principles and NGOs because these NGOs have experience in changing opinions, advocating, and defending rights."
Advocate_MentalHealth_01

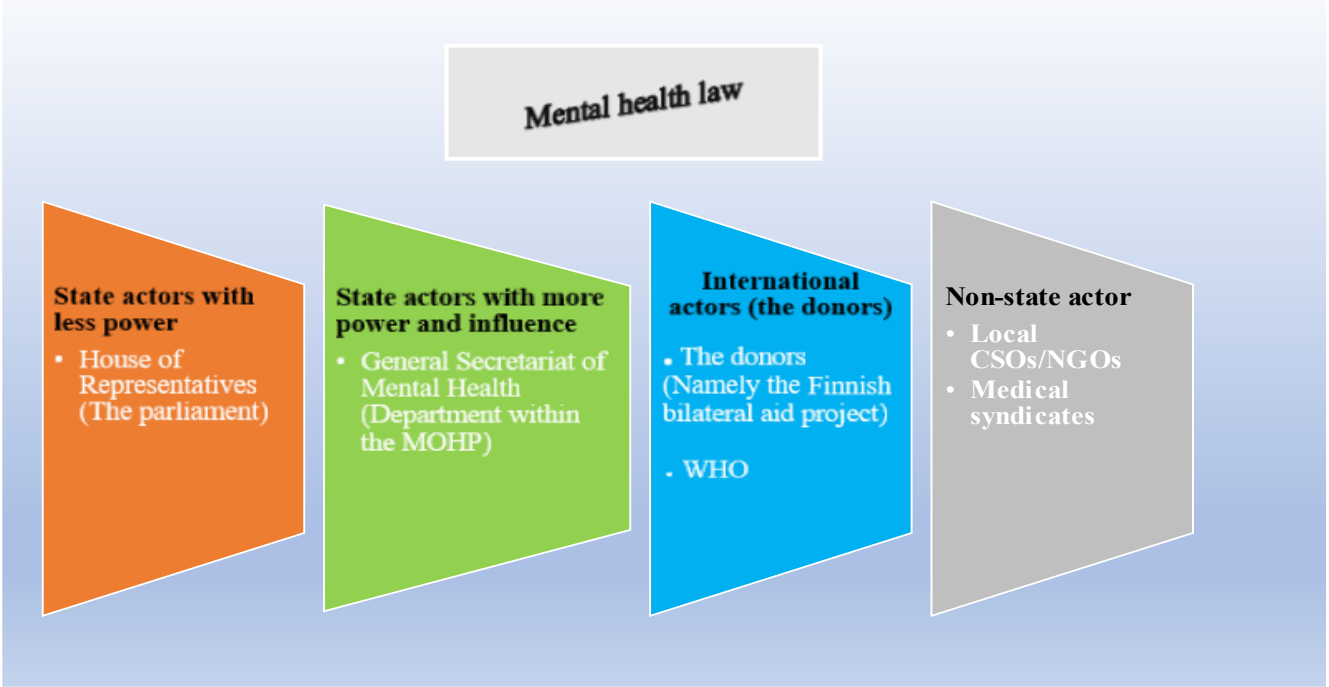

Figure 16: Overview of the actors actively being involved in making and creating the mental health law. Source: Developed by the Author.

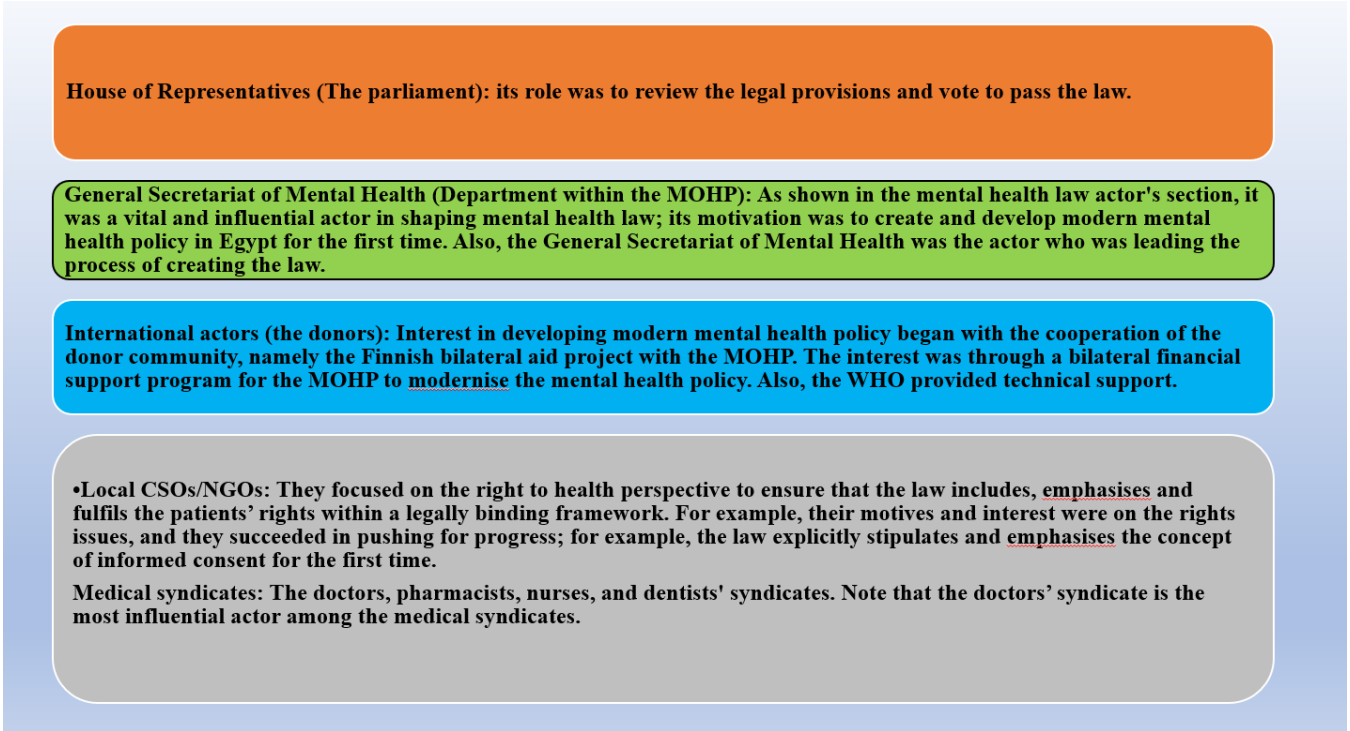

Figure 17: Overview of the interest, position and ideas of each actor who being participated and involved in making and creating mental health law and policy. Developed by the author. This mapping is influenced and inspired by reading the following four papers (Walt & Gilson, 1994), (Arts & Van Tatenhove, 2004), (Smith et al., 2014) and (Widdig et al., 2022) (57,84–86)

4.2.4 Process

This section presents the process of drafting and creating the mental health law, focusing on the following sub-themes: formulation, negotiations, and the implementation process, developed from Walt and Gilson's (1994) framework.

Formulation and Negotiations

As mentioned in detail in the context and actors' sections (sections 4.2.2 and 4.2.3), the process of developing the mental health law and policy in Egypt began through the donor support along with the collaboration of MOHP.

In this sense, the General Secretariat for Mental Health (a department with the MOHP) invited NGOs working in mental health to participate in drafting Egypt's mental health law and policy from 2007 to 2009. The NGOs provided insights into patients' rights provisions and participated in the national advocacy campaign to promote the law (50,53,91,92).

NGOs employed several advocacy strategies during the law drafting process. These included assessing mental health service provision, conducting advocacy campaigns for patients' rights, submitting policy papers and recommendations to health decision-makers, and actively participating in drafting the law (50,93,94).

Data from informants validated this finding and added more insight on the forms of civic participation and the advocacy strategy used by NGOs:

"*NGOs worked on multiple levels. Initially, they participated in the committee created by the MOHP to study the situation in mental health facilities and develop recommendations for a new law. This involvement provided insights into the situation within these facilities. Also, NGOs conducted follow-ups, documented cases, and raised awareness. They also participated in the seminars organised by the General Secretariat for Mental Health to explain the law draft. All these efforts aimed at preparing for the law to ensure that the people to whom the law would apply were represented*."
Advocate_MentalHealth_01

Furthermore, data from informants highlights that the power dynamics between the actors in the law-drafting and creation process were not always balanced, and NGOs' involvement was limited.

Informants provided additional details and insights on the process of drafting and creating the law that was not found in the literature and the documents. According to an informant:

"The General Secretariat for Mental Health recognised that NGOs should have a role in the law-making process, but their role was limited so that they could not make decisions independently. Sometimes their (NGOs) independence was not welcome. However, there was also a political will to improve patients' conditions and respect their rights. Egypt was behind compared to the international trend in terms of developing modern mental health policies, laws, and legal frameworks; therefore, there was a need for change. That's why NGOs and advocacy groups were seen as essential allies in enhancing mental health policies and human rights." Advocate_MentalHealth_01

The informant who was involved in the law drafting committee added that *" the General Secretariat for Mental Health included some NGOs members in the law-making and drafting process. However, when some NGOs raised objections and requested modifications to some law articles (law texts), their objections were ignored. Additionally, sometimes NGOs felt that their role was limited to promoting the law and that they were not welcome when they had a different opinion."* Advocate_MentalHealth_01

Law Implementation Process

Since the mental health law was passed in 2009, this law has been governing and regulating the mental health sector. Several challenges and gaps have emerged during the implementation process, which indicates that the expected benefits and improvements from the law were not fully achieved. (54,97).

Such challenges and gaps include low funding directed to mental health (no more than 1% of total government spending on health; See annex 10 for more details about this figure in comparison to other comparable countries/contexts). Further to this, scarcity of infrastructure designed for mental health, the concentration of service delivery provisions in cities and urban areas and their lack in rural areas, shortage of doctors and health service providers in the area of mental health, reliance on advanced levels of mental health services provision and insufficient services at the primary health care level and lack of community and civic participation in the implementation process of the law (26,54,97,98).

Data from informants provided additional insights into the law implementation process. For example, according to an advocate and medical doctor have been involved in the mental health policy in Egypt:

"The law brought about improvements, particularly by creating a legal framework to regulate mental health, a tool for accountability and responsibility. The idea is that, before the law, it was common to do medical interventions without informed consent…the law has reduced many of these practices. However, there is a lot to do to improve mental health practice and policy; for example, more public spending on mental health is needed, and there should be civic participation and citizens' voices in the implementation process … the law itself cannot solve the problems." Advocate_MentalHealth_02

To summarise, figure 18 shows the policy triangle synthesis in relation to drafting and creating mental health law in Egypt.

Furthermore, figure 19 shows forms of civic participation and advocacy strategies used by NGOs that contributed to the development of the mental health law.

Figure 18: Policy triangle synthesis (Content, context, actors, process) in relation to drafting and creating mental health law in Egypt. This was developed by the author following the policy triangle framework by Walt and Gilson (1994).

Forms of civic participation and advocacy strategies used by CSOs (NGOs) that contributed to the development of the mental health law

1- Contributions in the assessment and documentation efforts: local CSOs (NGOs) participated in the committees established by the MOHP to study the situation in mental health facilities, analyse the conditions, and develop recommendations for a new law, which was issued in 2009.

2- Launching advocacy campaigns: CSOs (NGOs) launched advocacy campaigns that focused on explaining the importance of human rights principles as an essential component to be included in the patient's rights provisions of the law. They particularly promoted and advocated for critical concepts such as informed consent. Further, they participated and were involved in seminars organised by the MOHP to explain the details of the law. The aim was to safeguard the representation of all the sectors of society, particularly the marginalised groups. This was especially important in a relatively neglected and under-tackled area of the health and social context in Egypt, where public awareness about the importance of giving protection and special priority to mental health was not yet fully developed

3- Policy consolation: CSOs (NGOs) provided recommendations and policy consultations as inputs and insights to health policymakers (namely the MOHP) while drafting and developing the mental health law, particularly on the provisions related to the patients' rights.

4- Direct participation in the law committee: CSOs (NGOs) actively participated and were involved in the committee that was responsible for drafting and creating the law. They participated based on their capacity and experience in changing opinions, advocating, and defending rights.

Figure 19: Forms of civic participation and advocacy strategies used by CSOs (NGOs) that contributed to the development of the mental health law. This was developed by the author based on interpreting, analysing, and synthesising the findings.

4.3 Lessons Learned from Other Countries on Enhancing Civic Participation in Health Decision-Making

The following section reviews and analyses two relevant experiences from other LMIC countries. The aim is to draw and bring lessons learned on enhancing and sustaining civic participation in health decision-making.

4.3.1 Thailand Experience

The case of Thailand is a valuable example, from an LMIC country, of how giving voice to citizens and civil society in policymaking can contribute to promoting and enhancing UHC (99,100).

By issuing the National Health Act in 2007 in Thailand, the act (the law) has created what is called the principle of the National Health Assembly (NHA), which contains three components, the government component of politicians and government officials, the second component is civil society, NGOs working on health and citizens, and the third component is the knowledge sector (the academics, for example) (See Fig 20) (100).

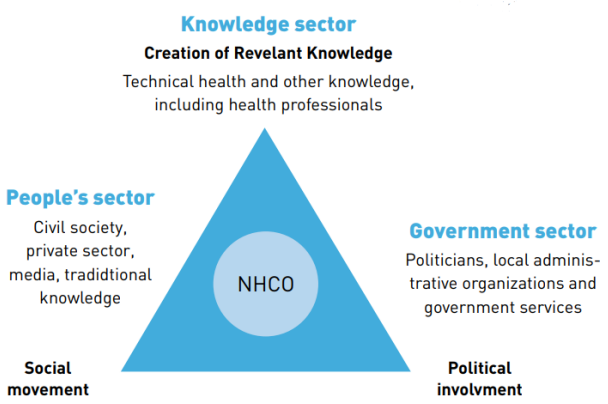

Figure 20: The National Health Assembly principle, source: Rajan et al., 2017 (100)

NHA seeks to involve a broad spectrum of stakeholders in health decision-making, aiming to ensure that decisions and policies made by politicians and bureaucrats do not change when governments or political circumstances change. Thus, the continuity and sustainability of health reform policies are maintained by creating a mechanism to involve the voices of citizens and civil society (99,100).

NHA is supervised by the National Health Committee, which consists of 39 members equally represented from the three components (government, civil society, and academics). It acts as a participatory governance body to provide health policy advice and recommendations as well as monitor the implementation and follow-up of the policies (See Fig 21) (100).

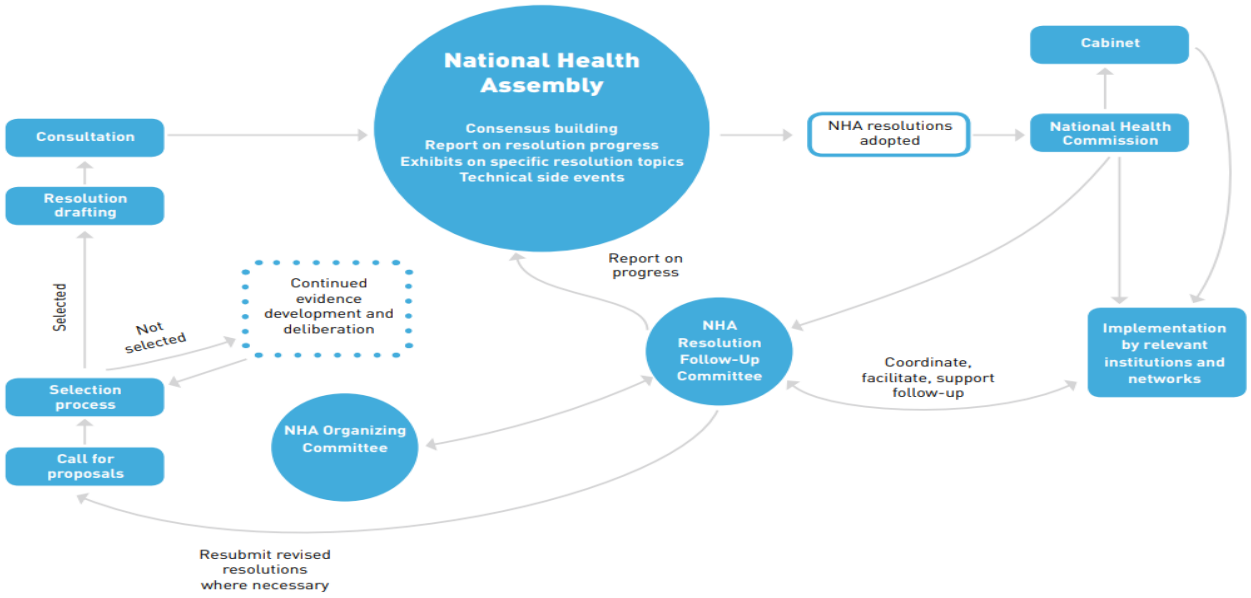

Figure 21: The National Health Assembly (NHA) structure and governance arrangement, source: Rajan., 2017 (100)

NHA has contributed to the drafting, creation, and implementation processes of health policies in Thailand. It has become a model for how the integration of community and citizens' voices as well as the involvement of a wide range of groups and actors in health policymaking can contribute to the sustainability of health policies (99,100).

This experience is especially relevant to the Egyptian context, where the sustainability of health reform policies has always been a significant challenge (45). As highlighted in the UHC and mental health laws sections, maintaining the sustainability of health reform and the absence of civic participation in the implementation process has been one of the challenges in implementing and fully maximising the benefits of the UHC and mental health laws.

Therefore, Thailand's experience has shown that institutionalising civic participation (through institutional mechanisms) in all health policymaking processes, from creation to implementation, has contributed to improving and ensuring the sustainability of health reform (99,100).

4.3.2 Iran Experience

Reflecting on the case of civic participation in health decision-making in Iran is relevant to the Egyptian context for lessons learned.

In 2017, the National Health Assembly (NHA) was launched in Iran for the first time to create community dialogue and to involve citizens' voices in health policies making and implementation. It should be noted that CSOs (NGOs) have a unique nature in Iran due to political and cultural circumstances. They are predominantly charitable and religious in nature and are not entirely independent from the state (101,102).

In 2017, NHA was undertaken at the national level and at local and regional levels. This platform, the NHA, was seen as a positive tool for civic participation and the exchange of views and information among several actors such as Ministry of Health bureaucrats, NGOs' volunteers and municipalities officials. This dialogue aimed to improve governance, reduce inefficiency and improve coordination in efforts, and combine the efforts of charitable civil societies with national health policies (101,102).

However, with the change in the political circumstances and priorities in Iran, this assembly was not held regularly, and its sustainability was not maintained. This experience raises a question about the importance of sustainable and durable mechanisms for ensuring civic participation in health policymaking rather than being fragile, volatile and subject to the fluctuations of political circumstances (32,101).

The experience of civic participation in health policymaking that occurred through the NHA in Iran, which was characterised by volatility and non-sustainability, can be compared to the Egyptian context. In the Egyptian context, there was momentum and motivation for civic participation when the political environment encouraged and facilitated the civic participation and involvement of NGOs in health policymaking (visit section 4.1.2 on the context within which the new UHC law emerged) (16,45).

However, because there is no institutional framework (institutionalisation) in Egypt and Iran that guarantees and ensures civic participation and no democratic rule that promotes the culture of participation, civic participation was volatile (45,88,101). For example, as highlighted in the UHC and mental health laws sections, civic participation did not continue during the implementation processes of the UHC and mental health laws in Egypt.

Therefore, the lesson that can be learned from this experience, applicable to the Egyptian health context, is that it is vital to institutionalise civic participation so that it is not subject to political changes in government priorities.

To summarise, figure 22 shows the synthesis of the findings on the key lesson learned on enhancing civic participation from reviewing the two experiences of Thailand and Iran. Further, this weighs the relevance of such key lessons for the Egyptian context.

Thailand experience	Iran experience
2007 National health act in Thailand	2017 National health assembly launched in Iran
Involving three sectors: government, civil society and knowledge sectors like academics.	Community dialogue between charitable NGOs and health governmental officials to improve and combine the efforts and involve the citizens.
Continuity and sustainability of health reform plans and durability of civic participation.	Volatility and non-sustainability of civic participation.

Figure 22: Assessing the relevance of lessons learned for the Egyptian context. This was developed by the author based on analysing, interpreting, and synthesising the findings.

5. Chapter Five: Discussion

This research analysed the health policymaking environment around the new UHC Law and the mental health law in Egypt using Walt and Gilson's (1994) health policy triangle framework.

The research also described and analysed forms of civic participation and advocacy strategies used by NGOs in relation to the development and creation of the two laws.

Furthermore, the research reviewed experiences and lessons learned across other LMIC countries to draw lessons applicable to the Egyptian context on enhancing civic participation in health decision-making.

This chapter aims to present the discussion section that summarises, interprets and highlights the findings as well as identifying interlinkages. It also zooms out to reflect on the broader macro context of civic participation in health decision-making in Egypt in light of the international literature and evidence.

5.1 New UHC Law (Objectives 1 and 2)

5.1.1 Content

The content of the law aims to achieve UHC for all citizens to fulfil the constitutional commitment to the right to health. For the first time, the law constitutes the compulsory collection of contributions, along with the state covering and subsidising the poor and those who are financially unable to pay. In addition, the law abolished all prior insurance schemes and consolidated them into the new system (The new UHC scheme).

5.1.2 Context

The findings showed the context within which the new UHC emerged is necessary to understand how and why the law was drafted and created. The findings highlighted political and health system contextual factors.

In the context of the UHC law, the findings analysed the connection between political and social changes on the one hand and the process of drafting and creating the new UHC law on the other hand.

In 2007, a government decision was issued to establish a holding company (for profit) as an alternative to health insurance. NGOs challenged this decision through litigation. The court ruling to discontinue this

decision was a landmark in establishing and grounding the right to health as a public political issue. Additionally, this case has grounded the strategic litigation of health in the Egyptian legal and health context as an advocacy strategy.

After the 2011 revolution, civic movements and organised civil society have emerged, focusing on advocating for the right to health and UHC. The findings showed that this period formed the foundation that created momentum for UHC law.

Despite the non-democratic rule, the military coup in 2013, and the limited space available to civil society, CSOs (NGOs) have become more vocal in expressing and advocating for social issues such as health through several advocacy strategies such as litigation, legal actions, media and producing educational and advocacy materials.

The foundation and groundwork for the right to health, along with the international trend and momentum for UHC, encouraged the creation of the UHC law, which was passed through parliament in 2018.

5.1.3 Actors

Many actors were involved in drafting and making the new UHC law for seven years, including government actors, the ministries of finance and health, local NGOs and medical syndicates. According to the data from the informants and literature, it was difficult to identify a single actor as the most crucial influence. However, an interaction between all the actors led to the creation of the law.

The power dynamics within the committee tasked with drafting and making the law refer to the relatively vital role of the MOF when it rejected the final draft on financial grounds and insisted on increasing the proportions of contributions and setting co-payments (cost-sharing) mechanisms. At the same time, NGOs were motivated by the concept of the right to health and ensuring inclusivity by creating a legal-binding framework.

5.1.4 Process

The Findings showed that public awareness and recognition of the health system's shortcomings, such as impoverishment from the high direct out-of-pocket expenditures, were critical in identifying the problem.

The process of making the law witnessed the interaction of many actors in light of the change in the political and social contexts. It also witnessed disputes between the actors, such as the previously mentioned dispute between NGOs and the MOF.

One of the challenges regarding the law implementation process relates to stability in health leadership. Frequent turnovers in health leadership lose health reform stability and slow down the momentum.

Other challenges include a lack of civic participation and citizens' voices during the implementation process and the absence of transparency and sharing information about the implementation phase, which informants and literature showed.

5.2 Mental Health Law (Objectives 1 and 2)

5.2.1 Content

The findings showed that the mental health law has introduced reforms in mental health practice and policy in Egypt. For example, the law has introduced the concept of informed consent. Further, it has created a governance body called the "National Council for Mental Health" to supervise and ensure patient rights and good clinical practice.

5.2.2 Context

Mental health law was created as a result of historical, international cooperation and donor support contextual factors. Interest in developing modern mental health policy began with the cooperation of the donor, namely the Finnish bilateral aid project, with the MOHP.

Local NGOs played a substantial role in monitoring and advocating for patients' rights. Finally, the old and outdated regulation for mental health combined with the realisation of the need for change were among the factors that led to the emergence of the law.

5.2.3 Actors

Findings showed that the MOHP and the donor were the first to show interest in creating a mental health policy and law. The MOHP then included local NGOs in the process of preparing, drafting and creating the law.

NGOs were involved in drafting and creating the law for their experience and capacity in advocacy and human rights issues to promote the law.

5.2.4 Process

Findings highlighted that the General Secretariat for Mental Health formed a committee to create the mental health law and invited some NGOs working in mental health to participate in its creation.

These organisations employed several advocacy strategies, such as producing policy papers and recommendations, carrying out awareness and educational campaigns, highlighting the importance of human rights principles as an essential component of the mental health law, evaluating mental health services from the perspective of patients' rights, and active participating in drafting the law.

I found that despite the key improvements brought about by the mental health law (like the adoption and application of the concept of informed consent), the implementation process has several challenges. Such challenges include inadequate financing, inadequate infrastructure, scarcity of services in rural areas, lack of human resources in mental health, lack of civil society participation and integration of citizens' voices.

This finding interlinkages to the interpretation mentioned early in relation to the UHC law case. Implementing both laws lacks civic participation in its broad and comprehensive sense, such as phone calls, surveys, and incorporating citizens' opinions to improve implementation.

5.3 Lessons Learned on Enhancing Civic Participation: Ways Forward (Objective 3)

The findings section reviewed the experiences and lessons learned from other LMIC countries on civic participation. This section aims to highlight these experiences and identify their interlinkage with the key findings from the two case studies on UHC and mental laws. The aim is to zoom out to the broader macro context of civic participation in health policymaking in Egypt.

The findings showed that one of the major challenges to fully maximise the benefits of the two laws lies in the absence of mechanisms that allow civic participation and citizens' voices in the implementation processes.

Evidence, lessons learned and experiences across several countries show the importance of institutionalising civic participation and community voices in implementing health laws and policies. This is vital to ensure that the implementation meets the primary needs of the population (99,101,102).

This is particularly relevant to the new UHC and mental health law. In both cases, the absence of institutionalisation of civic participation in the implementation has hindered the potential reform. In this

sense, the two laws have failed to ensure civic participation in the implementation process, dramatically hindering the maximisation of benefits from the two laws.

Further, the absence of democratic principles in the current political environment in Egypt is one of the challenges facing civic participation and organised civil society work in contributing to health policymaking and implementation. Such challenges limit the potential of sustainable and durable health reform plans.

Moreover, the lack of information sharing and transparency during the implementation process is a notable challenge that has hindered civic participation. This makes it difficult to evaluate and monitor the implementation of the laws.

5.4 Relevance of the Conceptual Framework

In terms of my evaluation of the Walt & Gilson framework (1994), this framework was suitable to achieve the research objectives. Specifically, this framework helped to capture the forms of civic participation and advocacy strategies used by NGOs and situate them within the broader context of the health policy environment in Egypt. This approach was beneficial in showing forms of civic participation, taking into account the interrelation of political, social, health and economic contextual factors.

Further, the framework was relevant and simple for operationalisation; simultaneously, it facilitated capturing the complex nature of policy landscape analysis in this research. Therefore, I recommend using this framework for further research to explore the policy environment, specifically in LMIC contexts.

5.5 Strengths and Limitations of the Research

This research is one of the first to examine how CSOs (NGOs) contributed to shaping and developing health laws and policies in Egypt by analysing and capturing their forms of civic participation and advocacy strategies. Through this approach, the research contributed to addressing an under-tackled and researched area in literature as well as shed light on two current and relevant health topics, UHC and mental health laws.

In addition, I acknowledge that there could be possible limitations and/or biases that impacted the findings of this research. This includes recall bias: as recalling processes of prior activities may not be accurate and precise. For example, in the mental health law case, which passed in 2009, the informants

might have forgotten some details or information. Thus, the literature and documents were reviewed to validate the accuracy of the informants' narratives.

Moreover, information bias could be a limitation due to the relatively low number of policy documents, particularly the documents on the process that accompanied issuing the two laws (See Annex 2).

Further, selection bias could be another limitation: as most informants were advocates, and there were few governmental health policymakers as well as few other stakeholders. However, I validated and compared the informants' narratives with data collected from the literature and documents.

The further limitation is that this research did not comprehensively and thoroughly assess and examine the two laws' implementation process; instead, it highlighted the main implementation issues relevant to the research objectives. Nonetheless, it is critical to weigh the implementation's strengths and challenges. Thus, for further research, it is essential to study and systematically assess the implementation of both laws.

Also, I focused on capturing the forms of civic participation of NGOs in this research. However, civic participation goes beyond these organisations and includes medical syndicates, patient groups, the private sector, and other actors (refer to the inclusion and exclusion criteria in the methodology section). Capturing other forms of civic participation needs more resources and time.

Therefore, for further research, it is vital to explore and examine other forms of civic participation apart from NGOs in policymaking in Egypt and the region. This will facilitate a systematic understanding of how civic participation and involving citizens' voices can improve health policymaking and policy implementations.

Following the recommendation of Walt et al. 2008 in reflecting on the researcher's position (Positionality) in analysing health policies, I am an *"insider"* and familiar with the policy environment and health politics in Egypt because of my nationality. This insider position is a strength point for the research, for example, manageable access to informants. However, I might have missed the benefit of the *"outsider"* in relation to curiosity and inquisitiveness in asking unexpected and unfamiliar questions (28). Regarding my position with the two laws, I was not directly or indirectly involved in any stages of making the two laws. Therefore, this is a strength point for the research: the researcher's independence.

Finally, I have committed to complete transparency in revealing and explaining the methodology used in this research, particularly regarding data collection methods, the informants, their selection procedures, and the questions asked.

6. Chapter Six: Conclusion and Recommendations

6.1 Conclusion

This research analysed the health policymaking environment around two laws in Egypt: the new UHC and mental health using Walt and Gilson's policy triangle framework. The findings highlighted the content, context, actors, and process. Furthermore, the research described and analysed the forms of civic participation and advocacy strategies of NGOs that contributed to drafting and creating the two laws.

Lessons learned, and experiences across other countries were highlighted, particularly from Iran and Thailand. Further, the research reflected on the broader macro context of civic participation in health decision-making in Egypt.

The findings concluded that the content of the new UHC law has brought about improvements as it seeks to achieve universal health coverage and has introduced new concepts, such as compulsory contributions, subsidisation for those who are financially unable, and gradual implementation. The context within which the law emerged refers to the health system and political factors.

NGOs have played a prominent role through advocacy strategies contributing to law development and creation. Despite this, the lack of civic participation in implementation remained one of the most prominent challenges facing the law in the implementation process.

Similarly, the mental health law has reformed the mental health policy and practice in Egypt, and brought about substantial improvements, such as the concept of informed consent. The context of the development of the law highlights historical factors, the involvement of the donor, the political will for reform, and the participation and involvement of NGOs.

Several challenges appeared during the years following the implementation of the mental health law. Such challenges include insufficient government funding, lack of qualified human resources, insufficient infrastructure, lack of civic participation and citizens' voices in implementation.

The analysis concluded that the absence of civic participation and citizens' voices in implementation, as well as the absence of transparency and sharing information on the implementation process, have hindered the maximum benefit of implementing the two laws.

Evidence, international literature, lessons learned and experiences across several countries show that the institutionalisation of civic participation in implementing policies and laws and ensuring their sustainability beyond political changes is a way to improve and sustain the momentum for health reform.

6.2 Recommendations

The following recommendations are formulated for the health policymakers, particularly for the MOHP, the three new bodies governing the implementation of the new UHC law, the National Council for Mental Health, and CSOs (NGOs) working on health (See Annex 11 for feasibility of recommendations):

1- To maximise the impact and the benefits of the new UHC law
In order to follow the improvements that have been brought about by the law and address the expected challenges during the next ten years (since the implementation is gradual and is still only in its first phase), it is recommended to evaluate, monitor and follow up on the implementation process. This action should be combined with raising awareness and gaining society's trust in the new UHC law through applying good and effective communication and making the new UHC law everyone's concern and interest.
2- To maximise the impact and the benefits of the mental health law
Through improving the infrastructure for mental health in general and especially in rural areas as well as improving the capacities of human resources.
3- To enhance transparency and information sharing.
By enhancing accountability, promoting transparency, and sharing information with the public. Such recommendation includes circulating and sharing timely documents and data concerning UHC law and mental health implementations. This recommendation is closely related to the need for good communication in order to encourage the society's active participation as well as to gain society's trust.
4- To enhance the capacity of CSOs (NGOs) and facilitate their work.
This can be applied by improving capacities, skills, and advocacy strategies. One approach to apply this recommendation is through networking and partnerships to strengthen and enhance these organisations' involvement and participation in making and evaluating health policies.
5- To institutionalise civic participation in implementing the new UHC and mental health laws.
One approach to this recommendation is through creating assemblies or committees to include and incorporate representatives of citizens and CSOs (NGOs) to supervise, monitor and participate in the implementation process of health policies and laws (similar to the national health assembly in Thailand that has involved several relevant stakeholders). Practically, by amending the two laws so that there is an explicit provision for the participation of citizens' voices and CSOs (NGOs) in health decision-making, monitoring, and implementation.

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Annexes

Annex 1: List of scientific studies that were conducted on the health policy analysis in Egypt.

This list is arranged according to chronological order of the years from the oldest to the recent.

Year of publications	Author/s	Title
2000	Nandakumar et al.	*Health reform for children: the Egyptian experience with school health insurance*
2014	Saleh et al	*The path towards universal health coverage in the Arab uprising countries Tunisia, Egypt, Libya, and Yemen*
2017	Fouda and Paolucci	*Path Dependence and Universal Health Coverage: The Case of Egypt*
2018	Ismail	*The rocky road to universal health coverage in Egypt: A political economy of health insurance reform from 2005–15*
2020	Saber and Gomaa	*Policy networks as a unit of analysis of public policies a case study of the social and health insurance policy network in Egypt (2015–2019)*

Annex 2: List of the key documents used in the research

These documents, clearly, are not all of the literature used in this research. However, these are vital/key documents because they highlight both laws' content, context, process, and actors. Moreover, these are highlighted to improve transparency and give the reader an overview of the documents this research used. Note that they are mostly legal documents, and some of them may not be readily accessible in English.

Year	Title	Author	Summary of the document
2007	The explanatory memorandum of the draft mental health law	Parliament of Egypt	This document presents details about the process of drafting the mental health law as well as explanations of the content of the law. Further, it outlines some details on the context of drafting the law. In the Egyptian legal tradition, any law should be explained by a memorandum (note) from the Parliament to highlight the content, process and context, and the reasons for drafting the law.
2009	Mental Health Care Law. Law No. 71	Government of Egypt	The document contains the full legal text (Provisions) of the law
2010	The executive regulations of the Mental Care Law promulgated by Law No. 71 of 2009. Law No. 128	Government of Egypt	The document includes the content and process around the law (practical steps to implement the law), which is detailed and comprehensive.
2011	Report on the regional workshop on health and human rights	World Health Organization. Regional Office for the Eastern Mediterranean	The report highlights the most noteworthy key activities and strategies conducted by CSOs (NGOs) in relation to health and human rights in the eastern Mediterranean region. The report includes data on Egypt.
2014	The Constitution of Egypt	The Arab Republic of Egypt (Passed through voting)	It contains a particular article (section) on health (Article 18).
2016	Sustainable Development Strategy: Egypt Vision 2030	Ministry of Planning and Economic Development	It contains Egypt's sustainable development plan for all sectors, including health.
2017	The explanatory memorandum for the draft universal health coverage law	Parliament of Egypt	This document presents details about the process of drafting the new universal health coverage law as well as explanations of the content of the law. Further, it outlines some details on the context of drafting the law. In the Egyptian legal tradition, any law should be explained by a memorandum from the Parliament to highlight the content, process and context, and the reasons for drafting the law.
2018	The Universal Health Coverage System Law. Law No. 2	Government of Egypt	The document contains the full legal text (Provisions) of the law
2018	The Executive Regulations of the Universal Health Coverage System Law Promulgated by Law No. 2 of 2018. Law No. 909	Government of Egypt	The document includes the content and process around the law (practical steps to implement the law), which is detailed and comprehensive.

Annex 3: Explanation and justification of the methods for each of the specific objectives

Specific Objectives	Methods	Data Collection	Justification
Specific Objective 1 And Specific Objective 2	**Literature review**, **policy document analysis** and **Key Informant Interviews** (Semi-structured KIIs)	**- Literature**: Peer-reviewed studies, grey literature. **- Policy documents**: The texts of the two laws and other documents that contain data about the policy-making environment that accompanied the drafting and creation of the two laws (including the context, content, actors, and process) **- KII** Six interviews through online tools (Zoom, Google Meet)	- Besides **triangulating the data**, using the literature, document, and KIIs allows a **more comprehensive analysis of the policy environment**. Further, the use of **Walt and Gilson's (1994)** framework facilitated the organisation of the data analysis. It **aligned** the study with a **well-grounded health policy framework** in scientific research to achieve the **methodological discipline**. - **- KII**: interviews aimed to provide context to data, literature, and analysis and provide a different angle regarding the findings to add **more insights and context to the study**. Notably, Interviews also facilitated collecting experience and insights regarding **capturing forms of civic participation of CSOs (NGOs)**.
Specific Objective 3	**Literature review**	**Literature**: Peer-reviewed studies, grey literature.	Review experiences and evidence across other countries concerning enhancing civic participation in heath policy-making and implementation.
Specific Objective 4	Formulating the **recommendations** was based on interpreting, analysing, and **synthesising the findings, as well as drawing conclusions.**		

Annex 4: The health system governance structure and financial schemes before the new UHC[1] law *(82)*

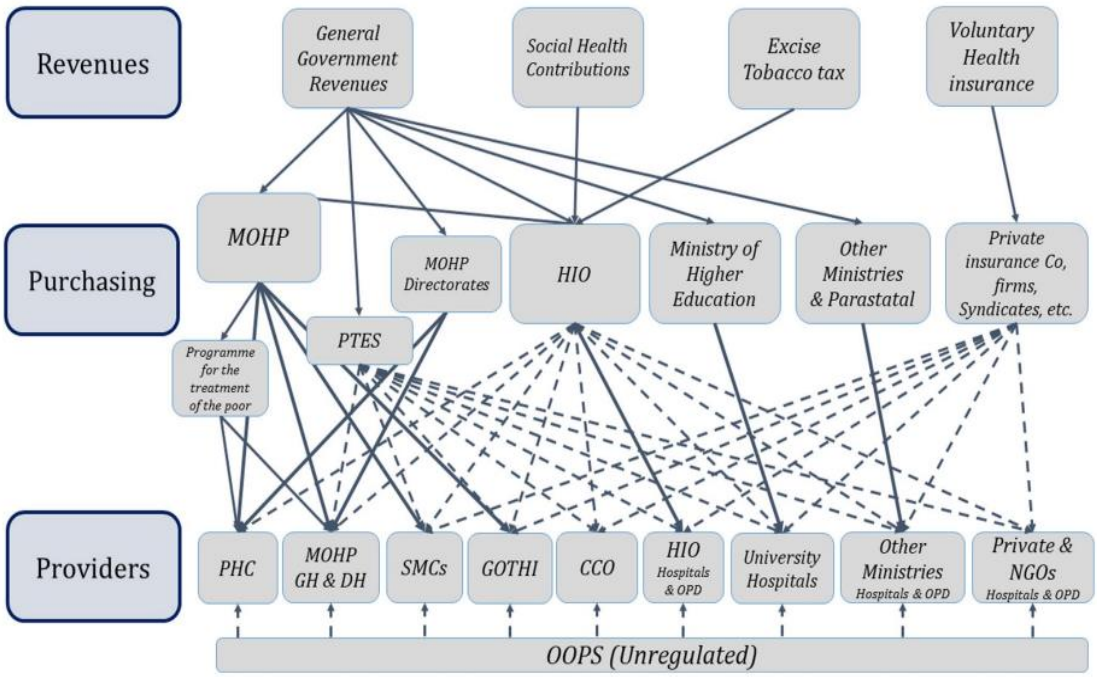


FIGURE 1 Current health financing system architecture and funding flows. For demonstration purposes. HIO was represented in one box (pool) although it is comprised of several pools. MOHP, Ministry of Health and Population; HIO, Health Insurance Organization; PTES, Programme for the Treatment at the Expense of the State; PHC, Primary Health Care; GH, General Hospitals; DH, District Hospitals; SMCs, Specialized Medical Centers; GOTHI, General Organization for Teaching Hospitals and Institutes; CCO, Curative Care Organization; OPD, Outpatient Department. *Source*: Mathauer et al.[4] [Colour figure can be viewed at wileyonlinelibrary.com]

Source: Khalifa et al., 2022

[1] When translated from Arabic to English, the new universal health coverage law is sometimes referred to in the literature and documents as the new social health insurance law, comprehensive health insurance law, or universal health insurance law.

Annex 5: Health system financial shape and arrangement after the new UHC law *(82)*

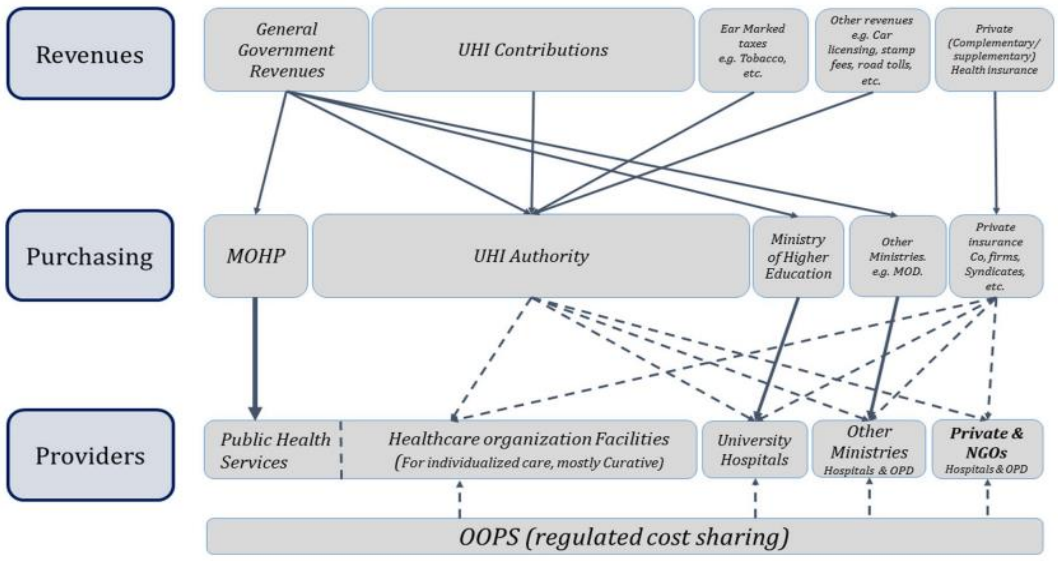
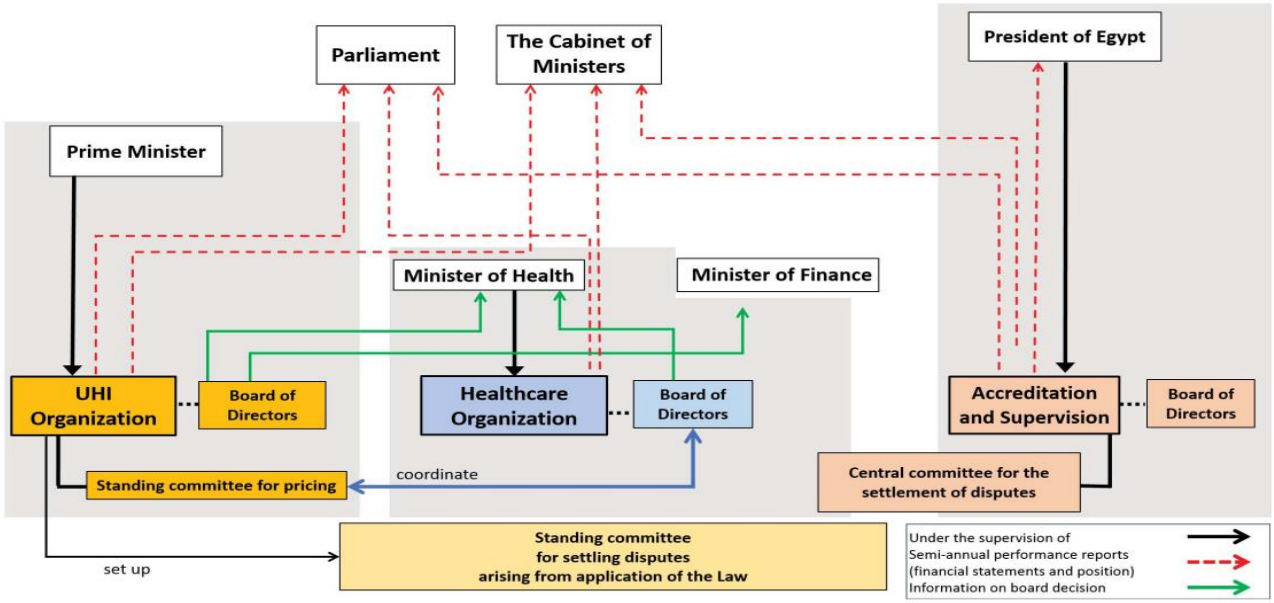


FIGURE 2 New health financing system architecture and funding flows as per the new UHI Law. Solid lines indicate line-item payment method. Dotted lines, except for OOPS, indicate a contractual arrangement using most likely output-oriented payment methods. UHI, Universal Health Insurance; MOHP, Ministry of Health and Population; MOD, Ministry of Defence; OPD, Outpatient Department. Mathauer et al.[4] [Colour figure can be viewed at wileyonlinelibrary.com]

Source: Khalifa et al., 2022

Annex 6: The new UHC law governance structure *(52)*

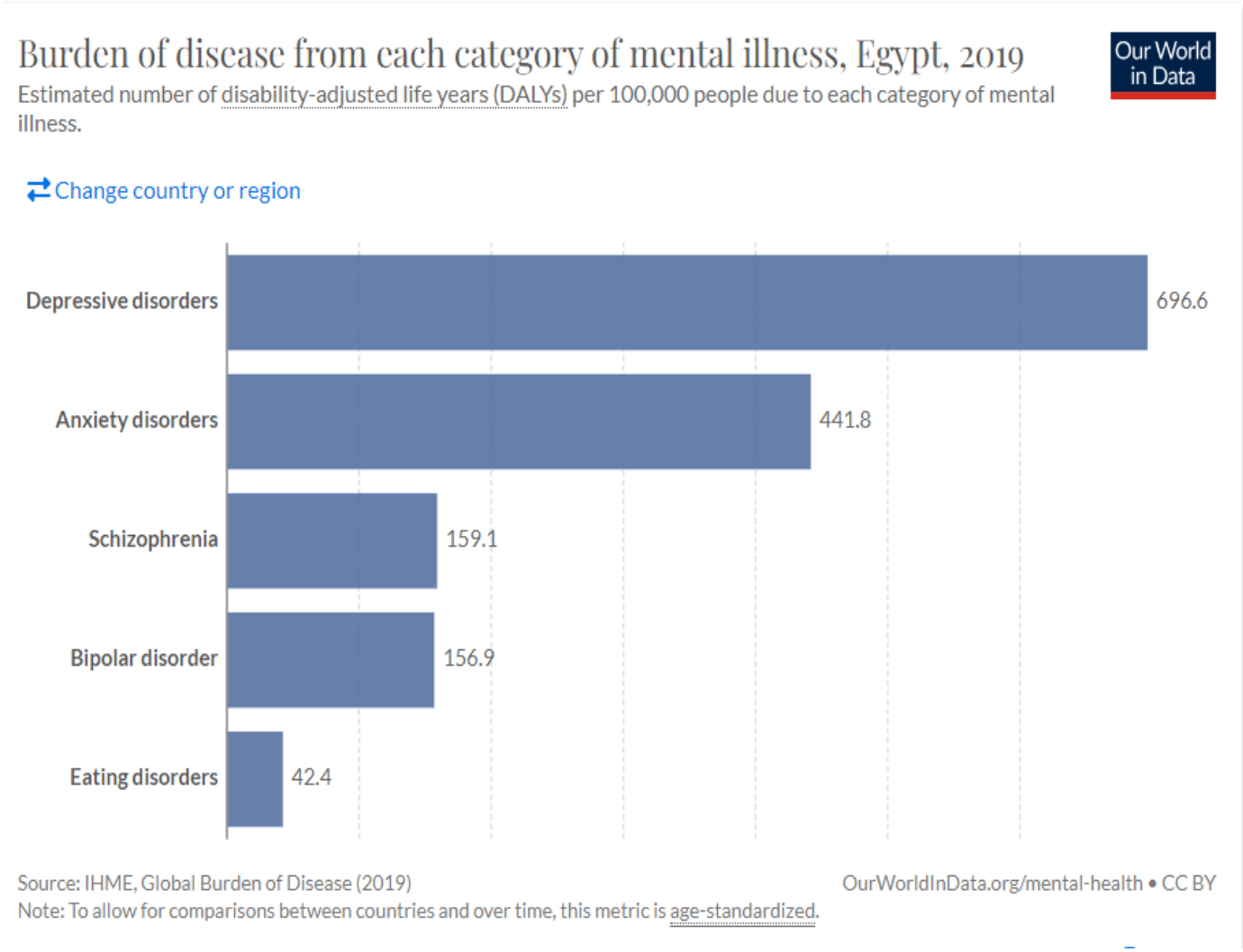


Source: Mathauer et al., 2019

Annex 7: The phases of New UHC law implementation and the governorates of each phase in a chronological order *(60,63)*

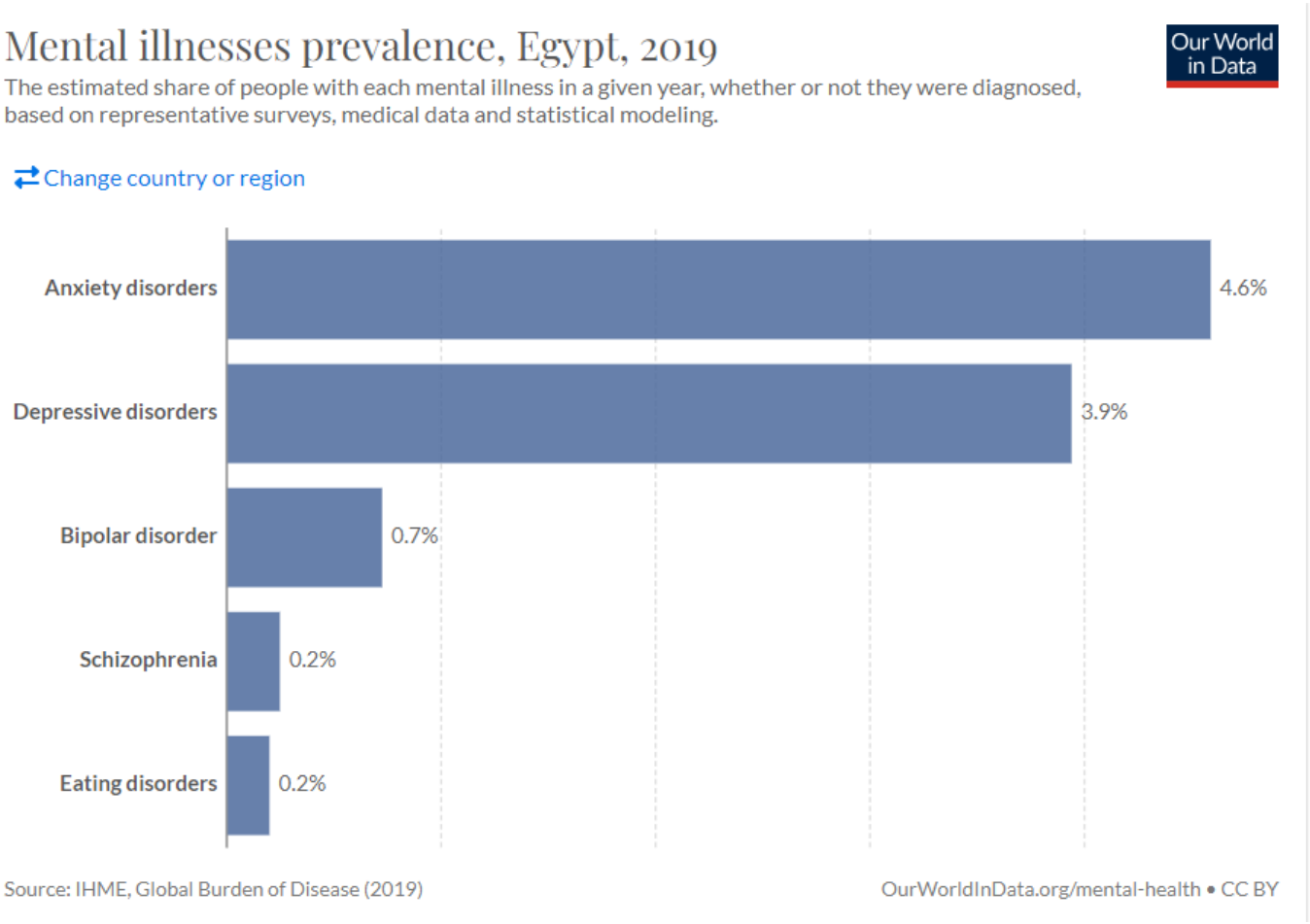
Source: This figure was developed by the author. It is based on the new UHC law text (law number 2 for 2018) and the executive regulation of the law.

Annex 8: The Burden of disease in relation to each category of mental illness in Egypt *(103)*



This is to show an overview of the recent data on the burden of mental health conditions in Egypt, Source: Dattani et al., 2023. based on data from The Institute for Health Metrics and Evaluation (IHME), Global Burden of the Disease (2019)

Annex 9: Mental health illnesses prevalence in Egypt *(103)*



This is to show an overview of the recent data on the mental health conditions prevalence in Egypt, Source: Dattani et al., 2023. based on data from The Institute for Health Metrics and Evaluation (IHME), Global Burden of the Disease (2019)

Annex 10: Government spending on mental health in Egypt in comparison to other countries/contexts *(26,104)*

This figure was drawn to give an overview for comparison between Egypt and some other countries from LMICs; This is to situate the Egypt government's spending on mental health in comparison to other comparable countries/contexts. Data for Egypt is based on the WHO dataset 2013 and the Egyptian Ministry of Finance financial statement for the fiscal year 2022/2023. Data for other countries are based on the WHO dataset, last updated in 2013, which is the most updated data in relation to global comparisons of governments spending on mental health.

	Egypt		Algeria	Ghana	Iran	Tunisia
	2013	Fiscal year 2022/2023	2013	2013	2013	2013
Indicator						
Government expenditure on mental health as a percentage of total government expenditure on health (%)	2.29	0.876	7.37	2	3.6	4.95

Source: World Health Organization., 2013 and Government of Egypt-Ministry of Finance., 2022

Annex 11: Feasibility of recommendations

Note that based on this analysis, I did order the recommendations in order of most to least feasible.

Recommendations	Time frame	Target	Feasibility
Recommendation 1: To maximise the impact and the benefits of the new UHC law	From 10 to 15 years	For the health policymakers, particularly for the MOHP and the three new bodies governing the implementation of the new UHC law.	High
Why: 1- Ongoing follow-up and periodic evaluation will help health policymakers assess the effectiveness of the law and make adjustments and/or amendments if needed. 2- This also will help provide evidence-based reporting; thus, policy interventions will be based on accurate data.			
Counterarguments: Conducting periodic assessments is financially, administratively costly, and technically complex exercise.			
How to address the counterarguments: It is valid that conducting periodic assessments is a financially and administratively complex exercise. On the other hand, the expected benefits of such exercise outweigh the financial barriers. This will eventually enhance the ongoing implementation of the law since the law will be implemented gradually during the next ten years.			

Recommendation 2: To maximise the impact and the benefits of the mental health law **Why:** **1-** This will improve the access and consumption of services for vulnerable and marginalised groups as well as rural populations. **2-** Reduce stigma: Improving mental health law and implementation will reduce stigma and thus encourage service consumption. **Counterarguments:** Administrative, financial, and technical barriers might exist because such exercise requires technical expertise and financial resources. **How to address the counterarguments:** Egypt can seek partnerships with international organisations working on mental health to improve its technical and resource capabilities. Furthermore, collaboration with local NGOs working on mental health can also facilitate the application of this recommendation. Through the law drafting and creation process, there was already collaboration with the local NGOs, so it is applicable and feasible to build upon this experience to include the NGOs and other civil society actors in the implementation process also.	Short to intermediate term	For the National Council for Mental Health	High

Recommendation 3: To enhance transparency and information sharing. **Why:** **1-** Transparency will gain and improve citizens' trust in implementing health laws and policies. Accordingly, gaining citizens' trust will enhance and increase demand for and consumption of health services. **2-** In addition, transparency will increase societal awareness of the contents of the two laws and thus increase participation and engagement. **3-** Transparency will also improve the opportunity to uncover challenges and problems in implementing health policies and laws quickly. This will act as an early detection system for the challenges in the implementation process. **Counterarguments:** **Resistance from the government bureaucracy**: There may be administrative-bureaucratic barriers to sharing information and official documents. Due to the political history of lack of transparency and non-democratic rule, the bureaucracy might resist sharing timely and updated documents and data on the implementation process. **How to address the counterarguments:** Good communication and collaboration within the governmental sector and enhancing bureaucratic capacities can address this issue. Further, changing how the bureaucracy perceives transparency as a burden can help in addressing such counterarguments or challenges. In other words, transparency can support the work of the health bureaucracy instead of being a burden. Note that political will is required to apply such a recommendation.	Short term	For the health policymakers, particularly for the MOHP, the three new bodies governing the implementation of the new UHC law, the National Council for Mental Health	Moderate to high

Recommendation 4: To enhance the capacity of CSOs (NGOs) and facilitate their work.	An ongoing process	For CSOs (NGOs) working on health	Moderate
Why: **1-** Strengthening NGOs' capacities will improve the opportunity to express the voices of society, especially vulnerable and marginalised groups. **2-** Strengthening the capacities of NGOs will further consolidate their technical skills and thus promote better and more efficient engagement in health policies.			
Counterarguments: The current undemocratic political environment may resist or unwelcome such a recommendation.			
How to address the counterarguments: Although the current political landscape presents challenges for CSOs (NGOs), highlighting their significance in advocating for marginalised groups, particularly in social issues like health policies, can convince policymakers of the importance of building their capacity. Engaging in dialogue with policymakers and health bureaucrats will facilitate this exercise and apply this recommendation.			

Recommendation 5: To institutionalise civic participation in implementing the new UHC and mental health laws.	An ongoing process	For the health policymakers, particularly for the MOHP	Moderate
Why: **1-** This will ensure that the implementation considers citizens' needs and meets their basic aspirations. **2-** This will also ensure the enforcement of accountability mechanisms and thus eliminate the possibilities of corruption or misuse of power and authority. **3-** This will also ensure the inclusion and participation of different opinions and points of view, thus, enhancing the participation of all the society components, particularly the marginalised groups.			
Counterarguments: **1-** Time and finances challenge: Establishing and institutionalising such committees or assemblies may require financial resources. Therefore, this could be a challenging technical and political exercise.			
How to address the counterarguments: It is correct that institutionalising civic participation requires financial resources. On the other hand, the expected benefits of such institutionalisation outweigh the financial challenges. Such proposed assemblies or committees can be incorporated and collaborated through the administrative unit system (localities) in Egypt. Thus, avoiding duplication in the administrative and financial costs. Therefore, it is a feasible option/recommendation to apply.			