Identification of Priority Research Questions Related to Health Financing, Human Resources for Health, and the Role of the Non-State Sector in Low and Middle Income Countries of the Middle East and North Africa Region

Synthesis Report

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Project Duration:

Research project jointly funded by the Alliance for Health Policy and Systems Research and the International Development Research Centre

Conducted in collaboration with the Middle East and North Africa Health Policy Forum

October 2008
This report is the outcome of a multi-country study that is being conducted in collaboration with the Middle East and North Africa Health Policy Forum. The objectives of this work are to (1) identify and rank regional policy concerns related to three thematic areas (health care financing, human resources for health and the role non-state sector) as perceived by policy makers and civil society organizations in Low and Middle Income Countries (LMICs) of the Middle East and North Africa (MENA) and (2) identify and rank regional research priorities related to the three thematic areas in the LMICs of MENA. The nine countries included in this study are: Algeria, Egypt, Jordan, Lebanon, Morocco, Palestine, Syria, Tunisia and Yemen.

This project is jointly funded by the Alliance for Health Policy and Systems Research and the International Development Research Centre.

The focal persons responsible for conducting the planned work at the country level are:

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<tr>
<th>Country</th>
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<tr>
<td>Algeria</td>
<td>Dr. Larbi Lamri</td>
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<tr>
<td>Egypt</td>
<td>Dr. Hassan Salah</td>
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<tr>
<td>Jordan</td>
<td>Dr. Musa Ajluni</td>
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<tr>
<td>Lebanon</td>
<td>Dr. Nabil Kronfol</td>
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<td>Dr. Fadi El-Jardali</td>
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<tr>
<td>Morocco</td>
<td>Dr. Drhimeur Abdelghani</td>
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<td>Dr. Belghiti Alaoui</td>
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<td>Palestine</td>
<td>Ms. Joan Jubran</td>
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<td>Dr. Tawfiq Nasser</td>
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<td>Syria</td>
<td>Dr. Yaser Al Saleh</td>
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<td>Dr. Waleed Al Faisal</td>
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<td>Tunisia</td>
<td>Dr. Noureddine Cherni</td>
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<td>Yemen</td>
<td>Dr. Jamal Nasher</td>
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*Note: Appendices are not included in this version.*
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Executive summary

This synthesis report summarizes the outcome of a research study that identifies policy relevant research priorities and questions in the Middle East and North Africa (MENA) region. The objectives of the study are to (1) identify and rank regional policy concerns related to health care financing, human resources and the non-state sector as perceived by policy makers, researchers and academics, health professional groups, Non-Governmental Organizations, civil society representatives and consumers in Low and Middle Income Countries (LMICs) of the MENA region and (2) identify and rank regional research priorities related to the three themes. The nine countries included in this study are: Algeria, Egypt, Jordan, Lebanon, Morocco, Palestine, Syria, Tunisia and Yemen.

To our knowledge, this is the first priority setting exercise in the MENA region that engaged policy makers, researchers and professional associations including the non-state sector and civil society groups in identifying and ranking policy relevant research priorities. This is particularly important since several MENA countries are challenged by fragile health systems that fail to utilize evidence to inform their health policies. Health system and policy researchers in several countries in the region are not informed about policy priorities, and this creates a mismatch between knowledge production and policy uptake. In addition, policy makers are challenged by the limited opportunity they have to communicate with researchers their policy concerns and priorities. One of the indirect objectives of this study is to initiate a dialogue between policy makers and health systems and policy researchers in the MENA region.

This research study utilized a primarily qualitative approach to identify the policy concerns and policy relevant research priorities. Such an in-depth approach allows researchers to obtain a wider understanding of the various aspects that govern health financing, human resources for health and the role of the non-state sector in each of the study countries. Data collection was mainly through focus groups and key informant interviews and was carried out by focal people in each of the nine countries. Over 200 key informants were interviewed including representatives of policy makers in the public sector of health professional groups such as (Order of Physicians, Order of Nurses, etc.), researchers and academicians, representatives of the non-state sector coming from the Civil Society Groupings, Private Sector, NGOs, Faith Based...
Organization including Organizations, in addition to consumers of care who were interviewed using a separate study methodology.

The common policy concerns and research priorities related to the three themes were:

<table>
<thead>
<tr>
<th>Health Financing</th>
<th>Human Resources for Health</th>
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<tbody>
<tr>
<td>1. Health Spending</td>
<td>1. Poor HRH planning and lack of data</td>
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<td>2. Quality of Care</td>
<td>2. Shortages</td>
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<tr>
<td>5. Centralization</td>
<td>5. Out-migration</td>
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<tr>
<td>7. Social justice and Equity</td>
<td>7. Lack of re-licensing of health professionals</td>
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<td>8. Performance evaluation</td>
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<td>9. Curricula and Educational Programs</td>
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<td>10. Regulation of foreign-educated health workforce and non-national health workers</td>
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<td></td>
<td>11. Social Image of the health workforce</td>
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<tr>
<td></td>
<td>1. Population health needs and resources</td>
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<td></td>
<td>2. Quality of Services</td>
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<td>3. Equity</td>
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<td>4. Social Health Insurance System</td>
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<td></td>
<td>5. Public-Private Partnerships</td>
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<td></td>
<td>6. Health Expenditure and Financing</td>
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<td>7. Coordination between governmental bodies</td>
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<tr>
<th>Role of the non-state sector</th>
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<tbody>
<tr>
<td>1. Regulation of the Non-State sector</td>
<td>1. Public-Private Partnerships</td>
</tr>
<tr>
<td>2. Monitoring of performance</td>
<td>2. Role and responsibility of the non-state sector</td>
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<td>3. Mistrust between state and non-state sectors</td>
<td>3. Magnitude and capacity of the Non-State Sector</td>
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<td>5. Misuse and over-utilization</td>
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<td>6. Dual Employment</td>
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<td>7. Role of Civil Society</td>
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</table>

In fulfillment of the study objectives and to validate the common list of policy concerns and research priorities generated from this regional exercise, a regional validation and ranking workshop was held in Beirut, Lebanon, on July 3rd and 4th 2008. The title of the workshop was
“Validating and Ranking Research Priorities related to Health Financing, Human Resources for Health and the Role of the Non-State Sector in the Middle East and North Africa Region.” The objectives of this workshop were to: (1) validate the common list of research priorities related to Health Financing, Human Resources for Health and the Role of the Non-State Sector that emerged from the nine selected countries; (2) identify the highest research priorities on the 3 themes in the MENA region; and (3) reach a consensus among researchers, policy makers and other stakeholders on a policy relevant research agenda for the region. This workshop was attended by over 30 participants from the nine countries and beyond and included policy makers such as ministers and directors of ministries, esteemed researchers and academicians and renowned representatives of the non-state sector. This was the first opportunity for policy makers, researchers and representatives of the non-state sector to discuss health system issues in the region. A ranked list of policy relevant research priorities for the coming 3 to 5 years related to each of the three themes is detailed below:

<table>
<thead>
<tr>
<th>Health Financing</th>
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<tbody>
<tr>
<td>Elements of an equitable health financing system</td>
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<tr>
<td>Household ability to pay for health care</td>
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<tr>
<td>Linking population health needs to health spending</td>
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<tr>
<td>Role of the Social Health Insurance system in guaranteeing equity</td>
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<td>Identifying best practices to develop and implement a national social health insurance system</td>
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<tr>
<th>Human Resources for Health</th>
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<tbody>
<tr>
<td>Means to develop HRH information systems in ministries of health and national observatories</td>
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<tr>
<td>Gaps in existing education and training programs</td>
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<tr>
<td>Information on patient satisfaction</td>
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<tr>
<td>Accurate estimates and needs in numbers and specialties (mapping)</td>
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<tr>
<td>Ways that can enable education and training programs to meet the population health needs</td>
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<tr>
<th>Role of the non-state sector</th>
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<tr>
<td>Ways to regulate and monitor the quality of care in the private sector</td>
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<tr>
<td>Ways to optimize the use of the existing resources of the Non-state sector to meet health system objectives</td>
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<tr>
<td>Ways for the public and private sector to complement their service delivery</td>
</tr>
<tr>
<td>Areas where the state and civil society groups can complement each other</td>
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<tr>
<td>National database on the non-state sector</td>
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The list of policy relevant research questions generated from this workshop is outlined in a subsequent part of this report.
To sustain the momentum of this regional priority setting exercise, the next steps should include the following (pending availability of funding):

1. Conduct a research workshop for expert researchers to help translate priorities generated from the regional workshop into ‘researchable’ type of policy relevant research questions that can be addressed over the short term;
2. To assess the extent to which existing health system research in the region addresses the policy relevant research questions identified;
3. Develop country-specific briefs on policy challenges and research priorities related to the three themes that can be shared with donors and funding agencies;
4. Develop three policy briefs on regional priority research questions, one brief for each theme;
5. Prepare and submit manuscripts for publication in open-access journals and disseminate findings in regional and international conferences;
6. Identify additional themes pertaining to the nine study countries;
7. Maintain, develop and sustain the regional health system and policy research network that was generated from this project including finalizing terms of reference and expanding its membership;
8. Disseminate country specific findings by conducting country specific workshops to ensure that the research priorities generated from this work are integrated into current and future strategic plans of Ministries of Health (and other groups) in the study countries;
9. Support capacity building for health system and policy research in the region, including workshops in the field of developing proposals for research funding and designing and conducting health system research;
10. Develop joint proposals (multi-country level) based on the policy relevant research questions for the region and seek funding from international funding agencies to fund future research studies that address the policy relevant questions identified; and
11. Identify and seek funding from international and regional sources to fund research studies that address the policy relevant research questions that were identified by this study.

It is hoped that the policy relevant research questions generated from this work become integrated into current and future strategic plans of Ministries of Health and related ministries in the study countries and that the evidence generated can help inform future health system policies.
in the region. We also hope that the study countries will become involved in developing joint proposals based on the policy relevant research questions for the region and seek funding from international funding agencies to fund future research studies that address the policy relevant questions identified. Study findings can help inform and direct future plans and activities for the MENA Health Policy Forum.
Acronyms

Acronyms are listed in Alphabetical order

AFRO  WHO Regional Office for Africa
BSN   Bachelors’ of Science in Nursing
CCO   Curative Care Organizations
CNAS  Cassise National des Assurance Sociale
CNSS  Caisse Nationale de Securite Sociale
CNOPS Caisse National des Organismes de Prevoyance Sociale
EM    Eastern Mediterranean
EMR   Eastern Mediterranean Region
EMRO  Eastern Mediterranean Regional Office
GDP   Gross Domestic Product
HIO   Health Insurance Organization
HPF   Health Policy Forum
HRD   Human Resources Development
HRH   Human Resources for Health
JD    Jordanian Dinars
JU    Jordan University
JUST  Jordan University of Science and Technology
LE    Egyptian Pounds
LMICs Low and Middle Income Countries
MENA  Middle East and North Africa
MOD   Ministry of Defense
MOF   Ministry of Finance
MOH   Ministry of Health
MOHE  Ministry of Higher Education
MOHP  Ministry of Health and Population
MOLA  Ministry of Local Administration
MOPH  Ministry of Public Health
<table>
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<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>MOPHP</td>
<td>Ministry of Public Health and Population</td>
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<tr>
<td>MOSA</td>
<td>Ministry of Social Affairs</td>
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<tr>
<td>MOSAL</td>
<td>Ministry of Social Affairs and Labor</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non-Governmental Organizations</td>
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<tr>
<td>NHA</td>
<td>National Health Accounts</td>
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<tr>
<td>PHC</td>
<td>Primary Health Care</td>
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<tr>
<td>RMS</td>
<td>Royal Medical Services</td>
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<tr>
<td>SPC</td>
<td>State and Planning Commission</td>
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<tr>
<td>UNRWA</td>
<td>United Nations Relief and Works Agency for Palestine Refugees in the Near East</td>
</tr>
<tr>
<td>US$</td>
<td>United States Dollars</td>
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<td>WHO</td>
<td>World Health Organization</td>
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I. Introduction

This synthesis report starts by outlining the study objectives and providing a brief overview of the three themes of Health Financing, Human Resources for Health and the Role of the Non-State Sector, according to available regional literature. Study methodology and protocol are also presented followed by study findings from interviews and focus groups with key informants pertaining to the three themes. The outcomes of the regional validation and ranking workshop conducted in Beirut on July 3rd and 4th, 2008 are also discussed in detail. Key findings and observations are outlined followed by the lessons learnt from this work and proposed next steps.

II. Study Objectives

The objective of this research project is to (1) identify and rank regional policy concerns related to health care financing, human resources and the non-state sector as perceived by policy makers, researchers and academics, health professional groups, Non-Governmental Organizations, civil society representatives and consumers in Low and Middle Income Countries (LMICs) of the Middle East and North Africa (MENA) region and (2) identify and rank regional research priorities related to the three themes. These three themes were selected by the Alliance for Health Policy and Systems research as they encompass a wide range of issues and the findings of such a study can sharpen the focus of the Alliance and maximize its impact.

The nine countries included in this study are: Algeria, Egypt, Jordan, Lebanon, Morocco, Palestine, Syria, Tunisia and Yemen. These countries represent the majority of LMICs in the MENA region (Sudan and Mauritania were not selected). This selection was based on the following:

- Availability of contact people in the nine countries
- Limited time available to conduct this study
- Recommendation by the Middle East and North Africa Health Policy Forum (this work was conducted with oversight from the forum).
III. Introducing the Three Thematic Areas in the MENA

A. Health Financing

Health care is a critically important social and economic sector in countries of the Middle East and North Africa. The MENA region is a low to middle income region, a fact that has serious consequences on health status, health financing and delivery. The health sector accounts for approximately 5% of all economic activity, half of which is attached to public entities. The methods in which health systems are financed and funds are spent are directly linked to equity, access, efficiency and financial sustainability. Many countries in the MENA have developed pluralistic systems of health financing and delivery. Ministry of Health based systems of financing and delivery are frequently uncoordinated making population coverage a challenging endeavor (Schieber et al., 1998).

Funding of the health sector is commonly divided between three sectors (the public sector, the semi-public sector and the private sector) with varying degrees between countries (De and Shehata, 2001).

Health financing systems in the MENA region generally fail to equitably pool population health risks and to protect populations from the costs of catastrophic illness. The region suffers from systematic under-financing of public health programs. The governments of LMICs have opted to search for additional sources of funding such as community-based health insurance or social health insurance (Task Force on Health Systems Research, 2005). However, such schemes are generally small and offer a limited contribution towards overall health system goals.

Despite the differences in health financing approaches, some challenges are common to all, including burden of disease (both communicable and non-communicable), rapidly growing population, poor resource allocation, poor public-private partnerships, lack of policies for financial sustainability, and quality problems (Schieber et al., 1998).

In this context, policy makers may be reluctant to be frank about the inadequacy of current systems: solutions are likely to be disruptive and/or expensive. The difficulties faced by policy makers are augmented by the lack of health systems research on this delicate topic and have to resort to whatever information is available to make decisions that ultimately deepen the crises in which health financing systems are entrenched.
B. Human Resources for Health (HRH)

The Annual Report of the Eastern Mediterranean Regional Office (EMRO) of the World Health Organization in 2005 emphasized the need for developing evidence-based guidelines for policy making, planning and management of HRH. The issues hindering HRH development in the MENA include shortage, skill mix, underemployment, geographic maldistribution, and poor work environments (EMRO, 2005). In most countries the competence of health care providers is often in question due to inadequate/inappropriate training, and in many cases, doctors perform nurses’ jobs, who in turn perform nurse aides' jobs, etc. In addition to the questionable competence of the existing workforce, there is a virtual absence of some types of healthcare professionals. The region also suffers from poor recruitment and retention strategies, emigration of skilled health personnel, and absence of a minimum HRH database for better decision making constitute the major challenges that threaten health systems reform (Chen et al., 2004). These issues are of critical importance in the MENA since this region has the second lowest HRH density (Africa has the lowest) among the six administrative regions of the WHO (WHO 2006). The literature suggests that the presence of HRH in sufficient numbers and with adequate qualifications saves lives (Anand and Barnighausen, 2004). Yet there is limited understanding of how some countries achieve better health outcomes with similar or lower densities of HRH (Task Force on Health Systems Research, 2005). A recent study found that while HRH can improve population health indicators, it cannot be considered in isolation of socio-economic factors (such as education, poverty, income etc…) which also exert an effect on the health of the population (El-Jardali et al., 2007 (a)). Evidence shows that the HRH shortage is more complex than a simple imbalance in supply and demand.

The challenge in identifying principal policy concerns will be to uncover respondents’ understanding of the shortcomings of the system that are related to HRH problems uncolored by vested interests (associated with particular clinical groups) or implicit theories relating to healthcare delivery. Solutions may lie in improved training, enhanced recruitment, in effective management and better utilization of the existing health workforce, or elsewhere.

C. Role of the Non-State Actors

The non-state sector encompasses many players such as the private sector, Non-Governmental Organizations, the civil society, faith based organizations and the informal sector. The size and capacity of the non-state sector differs from one country to another, but one
common issue is the poor information on their role and activities. Moreover, upon exploring the literature in the nine countries, we found much more information on the private sector than other non-state players. The limited information does not imply that other players do not exist or are not as active as the private sector, but that there is little documented information available on their size, role, capacity and activities in these countries.

Many countries are experiencing a rapid growth of the private sector, with little if any understanding of its role. There is a need to consider how regulation of the private sector can help the state adequately address public health concerns. The Non-State Sector is attractive to consumers in most MENA countries. The quality of services provided outweighs their limited managerial capacity and absence of accreditation systems. For instance, in Egypt, Jordan, Lebanon Morocco and Tunisia, private providers are attractive for secondary and tertiary services since they are equipped with advanced medical technology (Siddiqi et al., 2006). Some countries in the MENA region such as Lebanon, Morocco, and Tunisia have developed significant private health insurance markets (Sekhri and Savedoff, 2005).

Several MENA governments are increasingly contracting with the non-state sector, particularly the for-profit private sector, to improve efficiency, access, and quality of care, in addition to creating a favorable environment for public-private partnerships (Siddiqi et al., 2006). Contracting with the private sector came about as a result of many factors and has been promoted across many countries in the MENA. In Lebanon, for instance, a national policy to engage the private sector encouraged the public sector to outsource services. As for Morocco, the underlying reason for contracting out was the policy for decentralization. Tunisia, on the other hand, contracted with the private sector as an attempt to decrease cost of treatment of patient sent abroad for medical care. Jordan contracted with the private sector to improve the use of private hospitals and save capital investments on public facilities while Egypt engaged in contracting to improve coverage, quality of services and increase access. Only Syria has not had any documented experience with contracting with the private sector (Siddiqi et al., 2006).

The region is in the early stages of engaging in public-private partnerships since the poor stewardship functions of the state leaves it in poor condition to properly regulate and manage such activities. For such activities to be effective, ministries of health should not only have a clear understanding of the role and capacity of the private sector, they should also have the capacity to design, award and manage contracts with the non-state sector. The evidence for public private partnerships is still mixed in light of potential market and government failures. In
fact, while the non-state sector is mushrooming, it remains heavily politically contested. Moreover, debates also continue on the role of civil society organizations in health care, in addition to the relationship between the public health sector and civil society. Limited knowledge is available in MENA on the role and impact of service provision by civil society organizations in terms of the social objectives of health.

IV. Literature Search

To review previous priority setting exercises in the MENA region and to document what is known about each of the three thematic areas, the research team conducted an extensive literature search and synthesis of literature and grey reports. This section begins by addressing our findings on previous priority exercises in the region and then continues to document what is known about the policy concerns and priorities related to the three thematic areas in each of the nine selected countries. In this brief version of the report, the detailed description of the policy concerns and priorities related to each of the three themes is included in an appendix.

A. Priority setting exercises

A search of previous priority setting exercises on the three themes (Health Financing, Human Resources for Health and the Role of the Non-State Actors) in the MENA region was conducted using a database (Medline, CINAHL, EMBASE) search, as well as websites of international organizations and governmental agencies.

To date, many priority setting activities for health research have been conducted in many developed and developing countries. Many of them have set priorities, held consultations and workshops and developed lists to define the directions for their health research agendas. But a closer look at countries in the MENA region shows that there has been no previous priority setting exercise in health systems and policy research.

In fact, the WHO report on Knowledge Transfer for Better Health (2004) reported that the Eastern Mediterranean Region (EMR) has the second lowest proportion of scientific publications addressing health topics in the world (0.8% among all WHO regions); the lowest rate is in Africa (0.6%) (WHO, 2004).

A related document found through our literature search is a report on the Eastern
Mediterranean (EM) Regional Consultation on Health Research for Development (2000). Participants in the regional consultation meeting reported that there were forums for priority setting which include workshops and consultations at national and sub-national levels, and national commissions. Priorities were set according to consensus within these forums. Some countries used other approaches to priority setting which include the use of data from scientific studies such as burden of disease analysis in Pakistan. While there were some priority setting activities in the region, countries did not employ sound research methodologies in these activities. For instance, those activities did not involve a mix of stakeholders including policy makers, private sector, NGOs and civil society groups. Stakeholders that were involved in research were found to be limited to managers, academia and the medical community, with few linkages between these groups (Council on Health Research for Development and WHO EMRO, 2000).

According to this report, some of the challenges facing health research in the region is the extreme diversity within and among the twenty-three countries in the Eastern Mediterranean Region (EMR). The report highlighted that health systems in many LMICs in the region are under-funded and have been slow to participate in health systems research which hinders their ability to better manage their health system. These countries do not have a culture of research and the type of research being carried out in LMICs varies across countries. Many countries suffer a weakness in identifying problems, have poor capacity for data analysis and result preparation. Associated with this problem is the fact that research results are often ignored and not translated into action. Moreover, the research agendas of donor agencies tend to distort the priorities of recipient countries (Council on Health Research for Development and WHO EMRO, 2000).

In this regional consultation meeting, several policy concerns were voiced, namely (Council on Health Research for Development and WHO EMRO, 2000):

- Rising cost of health care which the governments of LMICs are increasingly unable to bear;
- The moral obligation to provide basic health care to the poor and under-privileged;
- Pressure for decentralization of administrative services;
- Increasing the effectiveness and efficiency of health care systems;
- Mismatch between production of some health workforce categories and health system needs; and
– No dependence on evidence in decision making; among other challenges.

Many suggestions for future health research in the MENA region was documented in this report. This includes involving academia, government, nongovernmental organizations and media in the priority setting exercises; holding regular consultation meetings to help strengthen the role and capacity of the civil society; establishing linkages between research and decision making; developing and maintaining direct links of communication with important parliamentarian and legislative committees, opinion leaders and the media; in addition to holding specific meetings within a regional network.

It was expected, in view of the outcome of our literature review on priority setting exercises for health systems research in the MENA region that no structured, credible and participatory priority setting exercise was done in the region. To fill this gap, we believe that our study is the first priority setting exercise which is shaped by consensus views of informed and diverse stakeholders using a grounded research methodology. It is the first study that provides a central role for health system policy makers, health professionals, academia, private sector, civil society and consumers alike in setting priorities for research.

V. Methodology

A. Process

Before commencing with the research activities pertaining to this project, focal people in each of the 9 countries were identified and contacted (names mentioned on page 1). The criteria for selecting focal people were:

- Previous experience in undertaking health systems research;
- Working in an independent academic or research institution, NGO/CSO etc.;
- Having access to policy makers and stakeholders;
- Knowledge about the three thematic areas; and
- Ability to produce the required deliverables.

The role and responsibilities of the focal people identified were to:

- Identify and finalize the preliminary list of key informants in their country.
Identify key relevant documents, literature, reports, research priority exercises, policy documents, policy statements that are specific to their countries
Perform key informant interviews and focus groups with all the key informants identified
Administer the survey of policy concerns to stakeholder organizations and informants
Analyze the difference between priorities of policy makers and the civil society organizations, other non state sector, private sector and consumers
Provide status update to the project lead on biweekly basis (by phone and e-mail)
Document a list of policy concerns and research priorities on the three themes
Share the results with the project lead on an ongoing basis during the study period
Validate the policy concerns and research priorities
Prepare a country specific report

After the focal people were identified, an extensive literature search of reports, articles and grey literature pertaining to the three themes in the 9 selected countries was conducted. A search strategy was created to identify documents related to the three thematic areas at three levels: the country level, regional level and global level (the full search strategy is enclosed in Appendices I-A and I-B). The search encompassed international organizations, professional associations and websites of Ministries of Health in addition to an extensive health database search. The search yielded over 370 reports (in hard and soft copy), articles and documents. Key related literature was reviewed to shed light on the concerns and priorities related to each of the three themes in the MENA region. The list of all documents is enclosed in Appendix II.

The focal people were also asked to identify key informants in their study country. The research team requested the inclusion of participants from:

- Public Sector: Ministry of Health, Ministry of Finance, Ministry of Education, and Ministry of Labour
- Health Professionals groups such as Order of Physicians, Order of Nurses, Order of Pharmacists, Order of Dentist (and other health professionals), Syndicate of Hospitals, and Associations of public health
- Academic institutions including major universities, and key researchers and experts in the three themes
• Civil Society Groupings, Private Sector, NGOs, Faith Based Organization including Organizations that are active in the health field and Media

• Consumer groups

B. Research Study Approach

The study used a combination of qualitative and quantitative research designs as appropriate for the study phases. This study was guided by the listening priority setting approach that was developed by Lomas et al (2003) and slightly adapted to accommodate the context of the nine countries. The 6 steps of this model followed in the study included identifying stakeholders; compiling information; consulting with identified stakeholders; validating the priorities and translating the priority issues into priority research themes. This was followed with a regional validation and ranking workshop to validate the common list of policy concerns and research priorities and rank regional research priorities.

A qualitative approach was used to identify the policy concerns, policy priorities and research questions. Such an in-depth approach allows researchers to obtain a wider understanding of the various aspects that govern health financing, human resources for health and the role of the non-state sector in each of the study countries. The researchers relied on generating data by interviewing key informants through individual interviews and/or focus group discussions. Interviews with key informants provided more insight into the many facets of policy environment which shape a country’s health system. A list of positions and organizations of key informants in each country is included in Appendix III. Consumer groups were also interviewed to explore the views of lay people on research priorities related to the three themes.

An interview tool for the purpose of collecting data on the three themes was developed for the purpose of this study. The interview tool (Appendix IV-A) consists of an interview schedule used to guide individual interviews and focus group discussions translated to local colloquial dialects and languages (Arabic and French – enclosed in Appendices IV-B and IV-C respectively) and piloted in Lebanon during June 2007. The interview schedule was structured to allow the focal people to address policy concerns, policy priorities and research priorities through a series of short open ended questions under each theme. It also included probes that the focal people could use to guide and structure the discussion and keep it discussion on track.
The focus groups and interviews were audio-taped with the consent of the participants and consequently transcribed and coded. For each country, the research team cross validated the content of selected audiotapes against the transcripts to validate the country-specific findings.

A quantitative approach (survey) was used for the validation of policy concerns, policy priorities and research questions with key informants. Key informants who had participated in the qualitative part of the study were asked to fill a questionnaire to cross-validate the emerging policy concerns, policy priorities and research questions using a 5-point Likert Scale. Details on both approaches are discussed below including a summary of key project activities:
Figure 1: Summary of key project activities

Spring 2007

Preparatory Work

Preparatory Work

Framework

Country Specific Work

Literature Review and Synthesis

Methodology Workshop

Country Specific Activities

Interviews/
Focus Groups &
Synthesis of
Country Relevant Reports

Presenting Country Specific Results (Sept. '07)

Analysis and Synthesis of Results

Knowledge Gap

Policy concerns and Research Priorities

Translation into Research Questions

Validation and Ranking

- Qualitative Research Guide
- Matrix for Presenting Results

Cross-Validation and ranking at the country level

Cross-Validation and ranking at the regional level July 3rd and 4th 2008

Fall 2007 and Winter 2008

- Public Sector
- Health Professionals
- Academia
- Civil Society
- Consumers

- Pilot in Lebanon

Modifications

Summer 2007

Interview Schedule

- Preparatory Work

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To analyze the qualitative data from the nine countries, thematic analysis was used. The findings from the three themes were coded and brought together from the nine countries in a spreadsheet to better manage the rich data. These findings were transferred into matrices to facilitate data analysis. The findings from the key informants were inserted into a matrix comprised of 9 columns and 9 rows. The 9 columns represented policy concerns, policy priorities and research priorities under each of the three themes while the 9 rows represented each of the 9 countries (Please refer to Appendix V-a).

The consumers’ matrix comprised 15 columns and 9 rows. The columns represented problems faced by the consumers, problems faced by people they knew, suggested interventions, potential action if they had been in a position of power and stories about each of the three themes. Similarly to the first matrix, the 9 rows represented the 9 countries (Please refer to Appendix V-b). These matrices were used for thematic analysis to derive recurring policy concerns, policy priorities and research priorities under each of the three themes.

Open coding was first conducted; findings were read and broken into chunks that relate to different concepts or ideas. Axial coding was then conducted; this involved organizing the emerging concepts into themes. The data were then analyzed by recurring themes and emerging patterns. The framework used to guide the analysis was taken from/inspired by the socio-ecological model which brings to the front stage the different levels of commonalities from the:

i. macro or state levels issues such as policies;

ii. meso level of management and research issues; and

iii. the micro level pertaining to household level issues

In addition to the afore-mentioned key informant categories, we also included consumers who were interviewed using a separate survey tool. For the purpose of this study, consumers were referred to as clients or utilizers of services. However these terms cover only those who use these services and exclude others who do not have access to them because they are either expensive or not equally available to everyone. Despite the fact that some people may not be able to access these services, they may be able to give their opinion about them and other issues related to them. So for the purpose of the study, the participants classified as ‘consumers’ may be called ‘lay persons’ to differentiate them from the academic and professional persons interviewed earlier.
So lay persons are citizens who are untrained in the area of health services, delivery or management. They are ordinary citizens who are either employed or unemployed, educated or not, men and women from all walks of life and from all age groups capable of answering our questions on their perceptions of services, conditions and ideas on what and how to improve. In country contexts which allow for group discussions, one way to access them is through existing groups, where they gather for any kind of activity, such as social or sports clubs, women’s groups, school teachers and so on.

The interview schedule designed for consumers is enclosed in Appendix III (the English version in Appendix III-d and the Arabic version in Appendix III-e).

C. Regional Validation and Ranking Workshop

As detailed in a subsequent part of this report, a regional validation and ranking workshop was conducted on July 3rd and 4th 2008. The workshop brought together policy makers, researchers, and representatives of the Non-State Sector from the nine countries together for the very first time in the MENA region. The objectives, methodology and findings generated from this workshop are detailed in a separate section of this report.

VI. Findings from Key Informants

For each of Health Financing, Human resources for Health, and the Role of the Non-State Sector, we present and discuss the recurrent themes that emerged from the countries in no specific order and show relevant quotes from the interviews. The common list of research priorities across study countries was validated and ranked at a regional consensus and validation workshop.

Tables detailing the findings across countries on each of the three themes are enclosed in Appendix VII.
A. Health Financing

Policy Concerns

1. Health Spending
Insufficient public spending on health care was raised as a key policy concern in many countries. Participants discussed that the budget allocated to health care is too low compared to health needs and quality expectations. Closely linked to this theme was the frustration with the high private (out-of-pocket) expenditure on health. Another policy concern that was raised is the issue of allocative inefficiency where some countries spend too much on curative care and tertiary care vs. primary care. To remedy the issue of insufficient funding and its relation with health spending, many countries identified the need to explore new sources of revenue to finance the health systems as a policy priority. This priority includes options for unifying public funds in a few countries, better fund pooling, risk and cost sharing in others, in addition to defining the role of the private sector in financing health care. Participants believe that finding additional sources of funding might help health care system increase coverage of publicly funded services particularly to decrease private out-of-pocket spending. In addition, some countries expressed value in developing/updating their National Health Accounts.

2. Quality of Care
A number of countries voiced serious concerns regarding poor quality of health services. This was of particular importance for countries that have high spending on health care with low value for money such as Egypt and Lebanon.

“Organizational and functional weaknesses of the health system led to the decreased responsiveness of health services to population needs, inequitable distribution of services, and deteriorating quality and economic efficiency”

Key informant in Syria
3. Social Security Insurance System
The absence of a comprehensive social security insurance system continues to emerge as a major concern in most of the countries. Policy concerns include poor risk protection and lack of universal coverage.

“The health insurance law neglects the concept of social insurance and only focuses on commercial/for profit insurance.” Key informant in Egypt

4. Needs Assessment
The issue around health needs-assessment at the country level continues to be of concern to some of the selected countries. This may be linked to the concern expressed by countries regarding the limited evidence available from health systems research in the region. For instance, studies to determine the Burden of Disease in many countries are absent due to the limited capacity and training of health systems researchers in the nine countries. Better information is required on population needs and country burden of disease so that financial resources can be more efficiently allocated.

5. Centralization
National systems are viewed to suffer from a rigid and centralized financing system which delays setting health budgets and priorities. For instance, ministries of finance play a leading role in determining budget allocation without necessarily relating it to country health needs. Added to this are issues of mistrust and lack of coordination between the ministries of health and ministries of finance.

6. Mechanism of paying private providers
Funding of public-private partnerships is raised as a recurring policy concern in many of the countries. Of major concern under this theme is the issue of contracting of services that can be provided by the private sector. There are two levels of concern that can be summarized as the poor capacity of the state to regulate the private sector and to monitor its performance. In this context, contracting out recurred across many countries as one method of paying private providers. This is related to improving the capacity of the state to contract with and regulate the
private sector. This includes the capacity to devise and monitor contracts, evaluate performance, reduce informational asymmetry, develop criteria to assess quality of care and make the private sector more accountable.

7. Social justice and Equity
The policy concern related to social justice and equity is raised in nearly all of the countries. This policy concern regarding social injustice and inequity encompass both financing and delivery of services. As such, key informants in many countries believe that they have to experiment with a Social Health Insurance model that is context-specific and which will help provide equitable coverage to their population. This is linked to what was discussed by countries on the importance of devising a health financing system which is more equitable in resource allocation (with emphasis on preventive care) and protection for the poor.

RESEARCH PRIORITIES

Within the theme of Health Financing, the countries have identified the following research priority areas.

1. Population health needs and resources
   - Ways to identify different the poor and underprivileged people within the population
   - Population health status
   - Population health needs, and ways to link them to health spending
   - Needs-based budgeting
   - Household ability to pay for health care

2. Quality of Services
   - Ways to measure and regulate quality of care, particularly in the private sector
   - Role of the consumers/clients in improving quality of care
3. Equity
- Elements of an equitable health financing system
- Ways for the Social Health Insurance system to guarantee equity

4. Social Health Insurance System
- Identifying best practices to develop and implement a national social health insurance system

5. Public-Private Partnerships
- Effective contracting mechanisms
- Ways to develop effective contracting mechanisms with the non-state sector

6. Health Expenditure and Financing
- Causes of high expenditure on health
- Accurate estimation of the health expenditure from the public and the private sectors including out-of-pocket expenditure
- Best practices for ensuring efficient operation of the health care systems including ways to measure value for money
- Means to track financial resources invested in health care

7. Coordination between governmental bodies
- Clarifying functions and coordination processes between Ministries (for example the Ministries of Health and Finance) to improve health system financing and quality of services
B. Human Resources for Health

POLICY CONCERNS

1. Poor HRH planning and lack of data
   The lack of HRH planning continues to top participants’ concerns in all the nine countries as they expressed their concerns about the lack of national HRH minimum database. This database should include accurate estimates of the existing stock of practicing Health Human Resources in addition to a forecast of future needs, in both numbers and specialties. The lack of HRH planning in many of the countries is leading to oversupply or undersupply of certain professions. Some explained this in terms of the lack of coordination between the ministries of education, health and labor, and professional associations and syndicates. To remedy this, almost all the countries identified the need to develop HRH planning models that include needs assessment and forecasting. This includes suggestions for developing strategic HRH vision and policies in addition to establishing a national observatory that can provide an accurate estimate of the existing workforce and its level of preparation. Many participants believe that needs-based HRH planning can address/tackle the issue of shortages in numbers and specialties in addition to the geographic and sectoral mal-distribution.

2. Shortages
   Closely linked to the previous concern is that related to shortages in numbers, specialties and skilled health workforce in almost all the nine countries.

3. Geographic and Sectoral Mal-distribution
   HRH maldistribution continues to be a recurring concern for all countries and includes both geographic and sectoral mal-distribution. The geographic mal-distribution focuses on the concentration of the health workforce in the urban areas, leaving rural and remote areas underserved. Some participants justified this as due to the lack of incentives for the health professionals to work in those areas. Key informants raised the issue of sectoral mal-distribution in terms of dual employment of the health workforce in both the public and the
private sectors. Participants justified this as due to economic reasons which force health professionals to complement their poor wages from the public sector by working in the private sector.

“We have internal problems of geographical mal-distribution. Some areas have very low numbers of qualified personnel which presents a very serious problem. All health educational institutions are located in Beirut. (University name) has campus in the North, however, trainees have to go to Beirut at some point during their education. Even if students are not from Beirut, after spending some years there to study, they don’t want to go back. Decentralization and community based education have a role in this. The fact that big institutions like (Public hospital name) are located in Beirut makes the problem harder. Maybe it could have been built outside Beirut.” Key informant in Lebanon

4. Financial and Non-Financial Incentives
Closely linked to the issue of poor wages is the lack of financial incentives for the health workforce in many countries. The issues of non-financial incentives, particularly the availability of career development programs, career path, and recruitment and retention strategies, was also raised in almost all the countries. The lack of non-financial incentives is leading to high attrition rates, high turnover, and short professional life-span of the health workforce. The scope of this theme is further covered in the following theme on continuing education and training programs. Financial incentives proposed by key informants included increasing wages of the health workforce, particularly those working in the public sector. Non-financial incentives include strategies to improve the practice environment, to provide rewards and recognition and to develop effective recruitment and retention mechanisms. Key informants also raised the issue of equalizing the incentives for the health workforce working in both the public and the private sectors. Many believe this will address the concern related to dual employment and the unwillingness to work in the public sector.
5. Out-migration

Migration out of health professionals was raised as a natural outcome of all the difficult circumstances mentioned above including the poor practice environment that exists in many of the countries.

“Problems of brain drain and migrations exist in Tunisia. Good physicians are leaving the country due to the low salaries” Key informant in Tunisia

While the majority of countries expressed policy concerns related to out-migration, only Lebanon and Jordan have identified the need to better manage the migration of the health workforce. They suggested developing country-specific retention strategies that can help retain their existing workforce. Jordan emphasized the importance of drafting bilateral agreements between the sending and receiving countries.

6. Continuing Education and Training

An important new theme in the region raised by participants is their concern about the lack of continuing education and needs-based training for the existing stock of the health workforce. For instance, some countries do not face a major challenge in terms of shortages in certain specialties; however, their concerns are more focused on the inadequacy of their skills which will not help meet the health needs of the population. In this context, several countries identified the need to develop and institutionalize continuing education and training programs for the health workforce in all health care organizations. For those education and training programs to be effective, participants believe that they should be needs-based to meet the expectations of the population.

7. Lack of re-licensing of health professionals

The issue of lack of re-licensing of health professionals was raised in several countries, particularly for physicians. This adversely affects their ability to provide quality services based on current knowledge and evidence-based medicine.
“Poor medical practice is a result of absence of re-licensing and implementation of a continuing education system. It might be informative to assess the degree of physicians’ malpractice, and I would not be surprised if findings prove that over 30% of fatal cases are a result of medical malpractice. Yes, it is very serious.” Key informant in Egypt

“The current licensing system for health professionals is similar to the driving licensing system: Once a health professional obtains his or her license, they have it forever.” Key informant in Palestine

Key informants cited the need for re-licensing and re-certification of certain health professionals. Many believe that this mechanism will help improve the quality of the services provided by the health workforce.

8. Performance evaluation
An important new theme raised by many countries was the absence of performance evaluation of the health workforce. Many linked this to concerns about the impact on quality of care provided to patients. Study countries lack the means and methods to measure and evaluate the performance and productivity of the health workforce. Many opined that performance evaluation will help improve the quality and outcome of care and will eventually make the health workforce more accountable.

9. Curricula and Educational Programs
The issue of outdated curricula was raised in many countries where participants expressed serious concerns about the content and the quality of the educational programs that train and educate health professionals. They emphasized that the current educational programs are not providing the necessary skills for the health labor market. For instance, some of the current curricula are not context-specific and do not meet the health needs of the population. Added to this concern is the poor quality of the teaching staff in some of the programs. Key informants in several countries identified the need to review, revise, update and unify the curricula to better prepare and train the future health workforce. The suggestion raised by
many countries to address this issue is the need for accrediting schools and educational programs. Many believe that accreditation will help schools and programs meet the needs of the population.

10. Regulation of foreign-educated health workforce and non-national health workers

Although this issue is not mentioned as frequently as others, some countries such as Algeria, Jordan and Lebanon expressed the need to better regulate the entry of non-national health workers into the local workforce. For instance, Lebanon has an out-dated entry to practice exam called “colloquium” which screens candidates for professional clinical practice. The work of Palestinian doctors and nurses is also unregulated in both Lebanon and Jordan. In Algeria, Cuban doctors are preferred over locally trained physicians. Many countries believe that regulating foreign trained health workforce will help improve the quality and outcome of care.

11. Social Image of the health workforce

The concern for the poor social image, particularly for the nursing workforce, was voiced in almost all the countries. This leads to low inflow, high attrition (early outflow), and high turnover rates in the nursing profession. In this context, only two countries mentioned the need to develop strategies to improve the social image of certain professionals in the health workforce.

RESEARCH PRIORITIES

Within the theme of Human Resources, the countries have identified the following research priority areas. The research priorities from all the countries focused on HRH planning, management, and education and training.

1. HRH Planning
   - Develop simulation models for HRH planning
   - Accurate estimates and needs in numbers and specialties
   - Mapping of HRH and gap analysis
2. Minimum HRH Database
   • Numbers and distribution (geographical and sectoral) of the existing health workforce
   • Means to develop HRH information systems in ministries of health and national observatories
   • Data on the supply and demand

3. HRH Management
   • Develop incentive mechanisms to better-manage the existing stock of HRH
   • Means to develop country-specific retention strategies
   • Methods to measure HRH performance and productivity
   • Elements of performance evaluation
   • Reasons for migration
   • Staff satisfaction
   • Patient satisfaction
   • Ways to improve staff satisfaction

4. Education and training
   • Ways that can enable education and training programs to meet the population health needs
   • Gaps in existing education and training programs
   • Ways to develop re-licensing programs
   • Requirements for establishing a program for accreditation of health professionals
   • Relationship between re-licensing and quality of care

C. Role of the non-state sector

It is worth noting that in all of the 9 countries, there is more emphasis on the role of the private sector than the civil society and NGOs.
POLICY CONCERNS

1. Regulation of the Non-State sector
    Poor control of the non-state sector, as raised by almost all the countries, includes poor stewardship of the government, corruption, lack of a strategic vision about the role and responsibility of the non-state sector in the health system. As an outcome of poor regulation some countries reported service duplication and concerns around the mal-distribution of services provided by the non-state sector leading to geographic disparities between urban and rural areas. All the countries identified the need to regulate the role and activities of the Non-State Sector. This regulation would include mechanisms such as contracting out, defining roles and responsibilities in meeting health system objectives, monitoring of performance, setting quality standards for their service provision (such as accreditation), and better coordination of activities and services between both sectors. Such regulation is believed to lead to a system of improved services, minimal duplication, more accountability and better coordination and collaboration.

2. Monitoring of performance
    An outcome of poor regulation, almost all countries voiced the challenge in monitoring the performance and quality of services provided by the non-state sector. Many alluded to the poor reporting mechanisms and lack of basic information. This leads to poor accountability of this sector.

3. Mistrust between state and non-state sectors
    It is not surprising given the poor regulation, lack of information and poor monitoring that mistrust exists between the state and non-state sectors as voiced by the participants.

4. Needs assessment and duplication of services
    Countries expressed concern about the lack of information about the nature, scope and activities of the non-state sector involved in health. For instance, the countries lack basic information on the kinds and quality of services provided by this sector. Many believe that this results in duplication of services between the state and non-state actors. For example,
almost all countries report excess in capacity, immense duplication of services, and a lack of common vision on the ways those two sectors can better coordinate service provision. In this context, The need for a national database on all the non-state actors involved in health, their functions, resources and distribution is voiced in many countries. Participants believe that this database will allow for joint and coordinated planning that will eventually lead to a comprehensive and complementary system.

5. Misuse and over-utilization

Since the non-state sector operates with very little regulation by the state, it often engages in providing expensive and unneeded services to the population. This results in inflation of costs as in the case of Algeria and Lebanon.

“Liberal economy allowed private sector to purchase advanced technological equipment and made people use it whether they need it or not. This is a waste of money due unneeded and unjustified cost escalation.” Key informant in Lebanon

6. Dual Employment

Similarly to the concerns expressed previously in the HRH section, three countries (Algeria, Syria and Tunisia) raised the issue of dual employment in both the state and the non-state sector as a problem.

7. Role of Civil Society

Civil Society organizations involved in health in many of the countries have limited involvement in the decision making process. Many believe that this sector is marginalized resulting in limited partnerships and duplication of services.

“The essential problem is the lack of participation of the Non-State Sector in the decision-making and policy development.” Key informant in Tunisia
Countries emphasized the need to involve the Non-State Sector in setting defining health needs, setting priorities, and working in partnership with the state to evaluate the health of the population. This is because this sector is seen to possess multiple resources and may have greater outreach than the state.

“The Ministry of Health and Population does not realize that the Non-State Sector has a major impact on health financing, that is why they need to be part of the decision making process” Key informant in Egypt

RESEARCH PRIORITIES

Within the theme of the Role of the Non-State sector, the countries have identified the following research priority areas:

1. Public-Private Partnerships
   - Foundation/elements for building a strong public-private partnerships
   - Effectiveness of the non-state sector in meeting health system objectives
   - Areas where the state and non-state sector can complement each other
   - Ways for the public and private sector to complement their service delivery

2. Role and responsibility of the non-state sector
   - Defining the role and responsibility of the non-state sector
   - National plan for the contribution of the non-state sector

3. Magnitude and capacity of the Non-State Sector
   - Scope, resources and kind of services provided by the non-state sector
   - Ways to optimize the use of the existing resources of the Non-state sector to meet health system objectives
   - National database on the non-state sector
4. Performance and evaluation

- Quality standards for the non-state sector
- Accreditation
- Methods to monitor and evaluate service provision and performance
- Develop an accountability framework for the non-state sector
- Measuring client satisfaction

D. Differences in responses among key informants

Due to the different backgrounds and diversity of key informants and different country contexts, it was expected that there would be some differences in the responses between the key informant groups (academicians and other categories of key informants). The reported commonalities and differences between key informant groups per country are summarized below. Some examples of such differences are presented below.

In Algeria, professionals seemed to be more concerned with the problems themselves whereas academicians were concerned with the underlying reasons. Health professionals were more concerned with the health financing issues, such as insufficiency of financial resources, problems of resource pooling and management, regional disparities and contracting. Academicians on the other hand were interested in evaluating national health expenditure, national health accounts, health information systems, and the high household contribution which raises questions on equity. They also highlighted health priorities as an effective means for better planning for resource allocation. In regards to human resources for health, health professionals were concerned with the problems the country faced in shortages of certain specialties, regional disparities and mal-distribution, as well as migration out and within. In contrast, the academicians in Algeria were more interested in the policy making process, and policies regarding reimbursement and employment. In regards to the Non-State Sector, health professionals spoke of the uncontrolled expansion of the sector, its high prices and poor quality of care, and how to make this sector complement rather than compete with the state sector. Academicians were more interested in the behavior of the private sector and the dynamics of its evolution.
In Egypt, academics were more welcome to involving the NSS and NGOs in setting country priorities, however, the policy makers were apprehensive about this step due to a voiced immaturity of the relationship with the NSS. Policy makers were looking for practical solutions to solving system problems while academicians were seeking more hypothetical and theoretical views on the problems and priorities.

As for Jordan, the only significant variation among key persons was revealed when policy makers spoke more of cost containment and governance issues, researchers and academicians concentrated on training and quality problems, while professional associations brought up equity and partnership issues.

In Lebanon, in regards to health financing, health professionals focused on system issues such as health system reform, funding sources and inadequate resources while academicians focused on quality of care, the need for research and preventive care to decrease household burden and out-of-pocket expenditures. Civil society groups and NGOs discussed the effect of politics on health financing schemes; they were also concerned with the shortage of funding and with creating a costing model for the health system. The key informants were in agreement on most HRH issues such as shortages, mal-distribution and migration; however, health professionals focused on educational curricula and accountability while academics and civil society groups and NGOs focused on the quality of care rendered by inadequately trained health workforce groups and shortages in some auxiliary medical assistants. It is worth noting that the key informants knew very little about challenges facing the non-state sector in Lebanon and they reiterated the need for better knowledge of its role and function and the need for regulating and coordinating its activities with the MOPH. Civil society groups and NGOs stressed the importance of this sector in improving outreach and access but also stressed the need for coordination with the state.

Findings from the focus groups in Palestine varied and it was hard to distinguish differences in responses. Health researchers focused on the importance of accurate information and the need for applied research for the development of the health sector, mainly in the area of health financing. Civil society and the private sector organizations concentrated more on the role of the non-state sector, whereas the governmental sector highlighted the importance of defining the role of each stakeholder in the development of the health sector taking into consideration the role of the Ministry of Health as a regulator.
Differences were also observed between health professionals and researchers in Syria. On the issue of health financing and human resources for health, policy makers concentrated on service-related issues (for example cost of health care services and financing health sector, in addition to the salaries of the health workforce, their performance and motivation) while researchers concentrated on the magnitude of the problems and the determinants in addition to employee satisfaction, unemployment, and working in rural areas. As for the role of the non-state sector, both groups alike touched upon the issue of information systems. However, policy makers focused on PPP, monitoring, regulations, and quality of the service whereas researchers concentrated on the scope of the services.

Many focal people also reported varying degrees of knowledge of the key informants on the three themes, particularly prominent decision makers. In some instances, decision makers who had been expected to be knowledgeable of some issues were found to be less informed than academicians and researchers. This has critical implications as many of these decision makers control health policy making in their countries.

VII. Findings from Consumer Groups

A. Health Financing challenges and potential solutions

1. Health system issues

The lack of a universal social insurance system, in their views, this means access to free health care services, and equitable distribution of services which came up as a main recurring theme in the 9 countries. In their views, this means access to free health care services, and equitable distribution of services. In some countries, participants pointed to the absence of health insurance while others described the health insurance system already existing as inequitable.

As a solution to this concern, participants suggested that countries should have an effective health care system (establishing a social security system) that provides universal coverage and access, particularly for the poorer segments of society, including children and the
elderly, who they see should not be forced to pay for any form of health services. Such systems should provide good quality care to users. Other suggestions included effective mechanisms for price control, including physician charges.

2. Ability to pay

The rising cost of health services and the subsequent impact on high out-of-pocket payments by consumers was raised as a main concern in many countries. Participants expressed dissatisfaction with affordability, high premiums, high tariffs, and over-billing. In a few countries, free vaccines are being sold in the private sector. Care is still based on ability to pay rather than on need. Health care services are inequitable because they are accessible based on people’s ability to pay. The cost of drugs, for example, recurred as one of the items that people cannot afford to pay.

“I heard about certain families that spend more on health than they do on food. My neighbors do not seek healthcare services for lack of money. As a result, their health problems have become more complex and severe because they do not seek care early enough, so they end up being hospitalized with severe complications.” Consumer in Algeria

“My brother had an accident but was not admitted into the emergency unit of a private hospital because we did not have 2,000 shekels (Israeli currency) and it was in the middle of the night. Because we were not able to get the admission fees immediately, my brother could have lost his leg” consumer in Palestine

To remedy this situation, participants suggested that the poor should be fully exempt from any payments related to health care. Participants also suggested measures to control cost of medications by reducing the cost of drugs, provision of free drugs and the use of generic drugs.
3. Private Sector dependence and quality of care

Participants voiced concern around the over-dependence on the private sector which may be problematic in terms of cost and quality of care, especially that in their views, the objective of the private sector is profit making. Issues such as cream-skimming and overuse in the private sector were raised as well, which is an outcome of the doubtful quality of public services and of the dissatisfaction with long waiting times and delays in providing health services in a timely fashion.

To participants, health care systems should provide improved quality of care, particularly in the public sector. While the private sector was seen as problematic, there were mixed feelings around its expanded role and contribution.

4. Resources

While participants raised the issue of shortages of financial resources, some in a number of countries highlighted the mismanagement of existing resources, including donor funding, particularly in the public sector. Other related problems mentioned include corruption, the lack of transparency and control and auditing of both public and private sectors.

To mitigate these problems, participants indicated the need for more accountability and transparency in their health care systems.

B. Human Resources for Health challenges and potential solutions

1. Health System issues

The focus under this theme included concerns related to the poor referral systems and the preference of health professionals to refer to private clinics and to each other. Favoritism by health professionals and accepting bribes and kickbacks were raised as problems in many countries. In addition, the limited number of qualified health professionals working in the public sector, in addition to dual employment, is leading to low trust in the public health systems. The absence of a clear scope of practice, including role definition for some categories of health professionals, and poor accountability were voiced as major concerns. Challenges related to migration out were also raised and discussed.
Several solutions were suggested to address the above concerns such as: improving management of the public sector, introducing a mechanism to monitor the performance of the health workforce, the development of effective recruitment and retention strategies, eliminating dual employment, better control of over neoptism and eliminating favoritism. Other suggestions include a patient bill of rights and a law to govern the medical profession.

2. Education and training

Consumers raised several concerns related to education and training, such as poor quality of training, particularly for fresh graduates and paramedical personnel graduating from private schools, in addition to the lack of qualified personnel and continuing education programs.

Suggested solution to the problems facing the health workforce included better education and training programs (particularly for paramedical personnel), improving continuing education programs for staff and health personnel, and improving the standards of education offered by medical schools.

3. Salaries and Incentives

Despite the high dissatisfaction with the working conditions for the health workforce, consumers cited the poor salaries and lack of incentives as the main problem.

Suggested interventions to remedy these issues included improving salaries, improving work environments, as well as motivation and incentives (particularly for HRH categories in shortage).

4. Shortage of Resources/ staff

Consumers in many countries complained of a shortage in some HRH categories and specialties. Shortages especially extended to rural areas and to the public sector. One of the reasons behind this shortage, as expressed by the participants, was migration of skilled health workforce.

Potential interventions to mitigate the above cited challenges included increasing the supply of HRH by encouraging entry into health professions such as nursing and other
categories. Other suggestions include encouraging expatriates to return to practice in their home countries.

“If I was a minister of health, I would re-evaluate all hospitals and assess which specializations are lacking and place people in their right positions.”
Consumer in Palestine

5. Quality

Poor quality of care, including poor safety practices provided by the health workforce was voiced as a main concern for the participants. Quality problems identified are: poor interpersonal skills, poor hygiene and sanitary systems, lack of professionalism, misdiagnosis, medical errors, fake medical results, negligence, poor patient education, limited time offered to patients, lack of respect for patients (including privacy and confidentiality) and delays in response as well as overuse and misuse of health services.

“Medical errors are frequent: bandages, small scissors are frequently forgotten inside the patient’s body which often results in death. My aunt gave birth through Caesarean section and a pair of scissors was forgotten in her stomach, she ended up dying.” Consumer in Algeria

“My wife had an operation in her stomach after which she had serious problems in her leg due to a mistake done by the doctor. They gave her strong medications afterwards but it affected her stomach. Twenty years later, she still suffers from this medical error. In Palestine, there is no rule or law to defend citizens’ rights against medical malpractice.” Consumer in Palestine

Suggested solutions to mitigate problems related to HRH included improving patient-provider communication, patient education, improving hygiene and sanitary practices, controlling medical errors and malpractice, and accreditation of schools and educational curricula.
C. Non-State Sector challenges and potential solutions

1. Health System issues

The absence of a regulatory framework for the role and contribution of the Non-State Sector in health care systems was raised as a key challenge/problem in almost all the countries. The Non-State sector, in particular civil society groups, is not structured in many of those countries. Issues voiced by the participants include the lack of complementarity between the public and private sectors, politicization of the NSS, the lack of monitoring of services, in addition to inaccessibility and inequity. The commercialization of the Non-State Sector (in particular the private sector) was indicated as a problem.

Solutions to the above problems included formalizing the link of the state with the civil society, better public-private partnerships, defining the role of the Non-State Sector, monitoring and regulation of their role, improving the equity and accessibility of their service provision, and improving cooperation and coordination. A number of other suggestions include empowerment of the Non-State Sector, and more investment on their role in primary health care.

2. Role and contribution of Private sector

When discussing pricing and the ability to pay, consumers only discussed issues related to the private sector. While some mentioned the good quality of the services provided (including safety) by the private sector, others voiced concerns about the inequity of their services which include expensive services, overcharging and non-standardized tariffs. Additional issues were voiced, such as poor public-private partnerships, non-constructive competition, and the profit-making objective of the private sector.

3. Quality

Quality problems in the Non-State Sector such as overuse, the occurrence of medical errors, poor patient education, and poor communication between patient and providers were also raised.
“I do not like the public hospitals in Algeria, I am afraid to acquire a nosocomial infection during my stay there. Those who can afford the private sector should seek care there.” Consumer in Algeria

Suggestions such as developing uniform standards for the operation of the Non-State Sector were expressed.

D. Observations on Findings from Discussion with Consumers

Findings from discussions with consumers seemed more consistent between health system problems and interventions needed to remedy them. The main issues that emerged within the health financing theme focused on health system issues; ability to pay; private sector dependence and quality of care; and resources. As for HRH, the main issues that emerged from the results were related to health system issues; education and training; salaries and incentives; shortages of resources and staff; and quality of care. Within the Non-State Sector, the main issues that emerged focused on health system issues; the role and contribution of the private sector; and quality of services.

Many of the concerns raised by the consumers reflect the felt effect of poverty in the region. People are unable to pay for quality health care and they are aware that what they want is available in the private sector but for a higher price than they can afford. This raises issues around equity. Health care systems in the nine countries are portrayed as inequitable and do not provide access and appropriate services for the population particularly the poor and the disadvantaged, and therefore do not meet the social objective of health as a public good. This is not surprising given that health development in the region has neglected the social development aspect of health provision.

E. Similarities and differences between key informants and consumers

It is worth noting that consumers were aware of and articulated several of the issues raised by key informants on the three themes. For instance, consumers voiced concerns about
ability to pay, and dependence on the private sector which were also raised by key informants within the health financing theme. Equity was also addressed by key informants and consumers, a cross cutting theme across all countries and all perspectives. Both consumers and key informants also raised topics of education and training, salaries and incentives, shortages and quality under the HRH theme; as was the case with the Non-State Sector, where the role and contribution of the private sector were recurring consumer themes. One may conclude that consumers are informed about issues pertaining to health systems through their experiences and are able to see the impact of poor policy and decision making on their lives. While consumers and key informants were in agreement on the problems and interventions needed, they posed different interventions which is somewhat expected given the background, knowledge and experience of the participants. Consumers focused more on what needs to be done (practical solutions) whereas key informants were more preoccupied with the technicalities of how the interventions should be carried out. The findings from the consumer discussions are an eye-opener for future health system research studies for policy makers to instigate effective change.

VIII. Regional Consensus Workshop

In fulfillment of the study objectives and to validate the common list of policy concerns and research priorities generated from this regional exercise, a regional validation and ranking workshop was held in Beirut, Lebanon, on July 3rd and 4th 2008. The title of the workshop was “Validating and Ranking Research Priorities related to Health Financing, Human Resources for Health and the Role of the Non-State Sector in the Middle East and North Africa Region.” The objectives of this workshop were to: (1) validate the common list of research priorities related to Health Financing, Human Resources for Health and the Role of the Non-State Sector that emerged from the nine selected countries; (2) identify the highest research priorities on the 3 themes in the MENA region; and (3) reach a consensus among researchers, policy makers and other stakeholders on a policy relevant research agenda for the region.
A. **Preparatory Work**

A research panel was formed to prepare a plan of action for the workshop, finalize the methodology, as well as identify potential participants. In addition to the research team, the research panel included a policy maker and an expert in qualitative research.

**Participant Selection**

The research panel concurred that participants in the workshop should include the research team, focal people, key policy makers, research experts and representatives of key civil society groupings in the region in addition to representatives from the Alliance for Health Policy and Systems Research (AHPSR), the MENA Health Policy Forum and WHO-EMRO. The rationale behind this decision was creating a diverse group of participants to obtain a comprehensive view on each of the research priorities under the three themes. This also helped encourage healthy discussion from all participants and garner a better understanding on the different aspects of each policy concern and research priority under each of the three themes.

To identify potential participants, the focal people in each country were asked to select up to 3 key informants who were interviewed in the study country. The following criteria were considered in this selection:

1. Potential participant was interviewed during country specific work
2. Potential participant is well informed about the three themes
3. Potential participant contributed well to answering interview questions
4. Potential participant has at least 3 years of experience and/or previous work in the health system
5. Potential participant is either a policy maker, academician, or an active representative from the civil society
6. Whenever possible, maintain a gender balance in the selection

Focal people were asked to provide the names, titles and contact information of potential participants with the research team. An official invitation letter was then sent to the potential participants by the project lead (See Appendix IX).
A total of 58 potential participants were contacted. Upon receiving an attendance confirmation, we sent participants a Project Brief (See Appendix X) and the Meeting Agenda (See Appendix XI) to prepare for the workshop.

**Validation and Consensus Methodology**

In this two days workshop participants were divided into groups that have up to 6 participants. To ensure systematic and fruitful discussions, groups were diverse and included participants from different countries and different backgrounds (See Appendix XII for the seating chart adopted at the workshop).

On Day 1, the participants had a short meeting to validate the common list of policy concerns and research priorities. Two surveys were developed for this purpose; one for policy concerns and the other for research priorities. Policy concerns and research priorities were to be validated through scoring each item on a 3-point Likert Scale (1 = Unimportant, 2 = Important and 3 = Very Important). Each participant validated the items individually. Research priorities exceeding 50% agreement on items reported as “Very Important” were extracted from the first day’s questionnaire for ranking on the next day of the workshop. Items scoring “Very Important” reflect priorities that should be addressed within the next 1 to 3 years, the remaining ones can be addressed at a later stage.

The surveys included an English and an Arabic version of each item on the same questionnaire. Prior to the workshop, both surveys were piloted for language and editorial consistency in addition to format and clarity of instructions. Samples of the validation questionnaires for policy concerns and research priorities are enclosed in Appendix XIII and XIV.

For Day 2, research priorities that attained a score exceeding 50% on Day 1 were ranked. Ranking was conducted based on a preset list of criteria. These criteria were adapted from Varkevisser et al. 1991 (See Appendix XV for sample survey from Varkevisser et al.) which was slightly adapted to fit the regional context of the MENA region. The criteria adopted for the workshop were:

- **Relevance**: of the research priorities to policy
- **Urgency**: are they needed within the next 3 to 5 years?
- **Feasibility**: are the research priorities do-able in your country?
- **Applicability**: once we have evidence on these research priorities, can they drive policy changes?
- **Originality**: has this priority not already been addressed in your country?

The above criteria were to be ranked on a three point Likert scale (1 = Low, 2 = Medium and 3 = High). Ranking was done in three rounds, one for each theme. The data was entered and analyzed once the rounds were complete so that findings could immediately be shared with participants. This allowed participants to discuss findings and suggest any changes to the ranking of the items. In addition to ranking of research priorities, each group was asked to concede on three policy relevant research questions under each theme that should be addressed in the region over the coming 1 to 3 years. Below is a figure summarizing the steps and activities during the two-day workshop.
Figure 2: Summary of proceedings of regional validation and ranking workshop

Day 1
Validation of Policy Concerns & Research Priorities

STEF 1
Validation of Policy Concerns on three themes

STEF 2
Validation of Research Priorities on three themes

Validation Criteria
Items were validated on a three-point Likert Scale: 1 for "Unimportant," 2 for "Important," and 3 for "Very Important"

Data Analysis
Items with a score less than 5% or "Very Important" were eliminated

Day 2
Ranking of Research Priorities

STEF 3
Ranking Round One
Health Financing

STEF 4
Ranking Round Two
Human Resources for Health

STEF 5
Role of the Non-State Sector

Ranking Criteria
Items were ranked based upon 5 criteria

- Relevance: Does the research priorities to policy
- Urgency: Are they needed within the next 3 to 5 years?
- Feasibility: Are the research priorities do-able in your country?
- Applicability: Once we have evidence on these research priorities can they drive policy changes?
- Originality: Has this priority not already been addressed in your country?

Each item was ranked on a three-point Likert Scale ranging from 1 for "Low," 2 for "Medium," and 3 for "High"
B. Workshop Proceedings and Findings

DAY 1 – Validation of Policy Concerns and Research Priorities

The meeting was attended by 30 participants from the following countries: Algeria, Bahrain, Egypt, Jordan, Lebanon, Palestine, Syria, Tunisia, and Yemen. Participants included focal people, and selected key informants from the nine countries who comprised policy makers, researchers, academicians and representatives of civil society (See Appendix XVI for list of participants). The opening session was attended by the Dean of the Faculty of Health Sciences at the American University of Beirut who welcomed participants with an opening address. The Lebanese Minister of Public Health also attended the opening session and briefly addressed the participants with a short overview and current status of the Lebanese health care system. He also emphasized the importance of the workshop whereby policy makers and researchers have started to work together to set health priorities. After the opening remarks, the project lead gave a short presentation to the participants on progress on the study, preliminary findings and the next day’s activities.

Participants were assigned to their workgroups. They were then asked to validate the list of common policy concerns and research priorities that emerged from the nine countries. After the meeting, the research panel met to enter and analyze the data collected on Day 1. The surveys for the next day were modified based on the first day’s validation round. The outcome of validation of policy concerns and research priorities on the three themes is detailed in the table below.
### Table 1: Validation of Policy Concerns on the three themes°

<table>
<thead>
<tr>
<th>Health Financing</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Insufficient health spending</td>
<td>16</td>
<td>69.57%</td>
</tr>
<tr>
<td>2. Absence of a comprehensive social health insurance system</td>
<td>14</td>
<td>66.67%</td>
</tr>
<tr>
<td>3. Lack of health needs assessment</td>
<td>16</td>
<td>69.57%</td>
</tr>
<tr>
<td>4. Ministry of finance plays a main role in determining budget allocated to health</td>
<td>13</td>
<td>52.00%</td>
</tr>
<tr>
<td>5. Mechanism of allocating resources to private providers</td>
<td>7</td>
<td>36.84%</td>
</tr>
<tr>
<td>6. Inequitable health financing system</td>
<td>10</td>
<td>47.62%</td>
</tr>
<tr>
<td><strong>Human Resources for Health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Poor HRH planning</td>
<td>14</td>
<td>63.64%</td>
</tr>
<tr>
<td>2. Lack of HRH data</td>
<td>12</td>
<td>54.55%</td>
</tr>
<tr>
<td>3. Shortages of skilled health professionals, both numbers and specialties</td>
<td>9</td>
<td>37.50%</td>
</tr>
<tr>
<td>4. Geographic and sectoral mal-distribution</td>
<td>15</td>
<td>65.22%</td>
</tr>
<tr>
<td>5. Lack of financial and non-financial incentives</td>
<td>9</td>
<td>45.00%</td>
</tr>
<tr>
<td>6. Out-migration of health workforce</td>
<td>7</td>
<td>30.43%</td>
</tr>
<tr>
<td>7. Outdated curricula and educational programs</td>
<td>8</td>
<td>36.36%</td>
</tr>
<tr>
<td>8. Lack of re-licensing of health professionals</td>
<td>13</td>
<td>61.90%</td>
</tr>
<tr>
<td>9. Poor social image of the health workforce, particularly nurses</td>
<td>4</td>
<td>18.18%</td>
</tr>
<tr>
<td>10. Absence of performance evaluation</td>
<td>18</td>
<td>81.82%</td>
</tr>
<tr>
<td><strong>Role of the Non-State Sector</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Poor control and regulation of the Non-State sector</td>
<td>15</td>
<td>68.18%</td>
</tr>
<tr>
<td>2. Mistrust between state and non-state sectors</td>
<td>11</td>
<td>47.83%</td>
</tr>
<tr>
<td>3. Lack of needs assessment and duplication of services (between state and non-</td>
<td>13</td>
<td>59.09%</td>
</tr>
<tr>
<td>state sectors)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Misuse and over-utilization of non-state sector, particularly private sector</td>
<td>7</td>
<td>30.43%</td>
</tr>
<tr>
<td>5. Dual Employment in state and non-state sector</td>
<td>13</td>
<td>56.52%</td>
</tr>
<tr>
<td>6. Marginalized role of Civil Society</td>
<td>8</td>
<td>34.78%</td>
</tr>
<tr>
<td>7. Challenge in monitoring the performance of the non-state sector</td>
<td>13</td>
<td>59.09%</td>
</tr>
</tbody>
</table>

°N and % in the table reflect number of participants who reported that the above policy concerns were “Very Important”
The outcome of validation of research priorities for each of the three themes is summarized below.

### Table 2: Validation of Research Priorities on the Health Financing*

<table>
<thead>
<tr>
<th>Sub-theme 1: Population health needs and resources</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1. Ways to identify the poor and underprivileged people within the population</td>
<td>9</td>
<td>45.00%</td>
</tr>
<tr>
<td>1.2. Population health status and needs</td>
<td>13</td>
<td>68.42%</td>
</tr>
<tr>
<td>1.3. Linking population health needs to health spending</td>
<td>15</td>
<td>78.95%</td>
</tr>
<tr>
<td>1.4. Household ability to pay for health care</td>
<td>12</td>
<td>63.16%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub-theme 2: Equity</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1. Elements of an equitable health financing system</td>
<td>14</td>
<td>70.00%</td>
</tr>
<tr>
<td>2.2. Ways for the Social Health Insurance system to guarantee equity</td>
<td>12</td>
<td>60.00%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub-theme 3: Social Health Insurance System</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1. Identifying best practices to develop and implement a national social health insurance system</td>
<td>12</td>
<td>57.14%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub-theme 4: Health Expenditure and Financing</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1. Causes of high expenditure on health</td>
<td>9</td>
<td>42.86%</td>
</tr>
<tr>
<td>4.2. Accurate estimation of the health expenditure from the public and the private sectors including out-of-pocket expenditure</td>
<td>12</td>
<td>57.14%</td>
</tr>
<tr>
<td>4.3. Means to track financial resources invested in health care to ensure value for money</td>
<td>11</td>
<td>55.00%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub-theme 5: Coordination between governmental bodies</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1. Clarifying functions and coordination processes between Ministries (for example the Ministries of Health and Finance) to improve health system financing and quality of services</td>
<td>15</td>
<td>71.43%</td>
</tr>
</tbody>
</table>

*N and % in the table reflect number of participants who reported that the above research priorities were “Very Important”
Table 3: Validation of Research Priorities on the Human Resources for Health

<table>
<thead>
<tr>
<th>Sub-theme 1: HRH Planning</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1. Accurate estimates and needs in numbers and specialties (supply and demand)</td>
<td>11</td>
<td>52.38%</td>
</tr>
<tr>
<td>1.2. Develop simulation models for HRH planning</td>
<td>14</td>
<td>66.67%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub-theme 2: Minimum HRH Database</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1. Numbers and distribution (geographical and sectoral) of the existing health workforce</td>
<td>8</td>
<td>38.10%</td>
</tr>
<tr>
<td>2.2. Means to develop HRH information systems in ministries of health and national observatories</td>
<td>15</td>
<td>71.43%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub-theme 3: HRH Management</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1. Develop incentive mechanisms to better manage the existing stock of HRH</td>
<td>16</td>
<td>76.19%</td>
</tr>
<tr>
<td>3.2. Means to develop country-specific retention strategies</td>
<td>9</td>
<td>42.86%</td>
</tr>
<tr>
<td>3.3. Methods to measure HRH performance and productivity</td>
<td>11</td>
<td>52.38%</td>
</tr>
<tr>
<td>3.4. Elements of performance evaluation</td>
<td>16</td>
<td>76.19%</td>
</tr>
<tr>
<td>3.5. Reasons for migration</td>
<td>6</td>
<td>27.27%</td>
</tr>
<tr>
<td>3.6. Information on staff satisfaction</td>
<td>9</td>
<td>42.86%</td>
</tr>
<tr>
<td>3.7. Ways to improve staff satisfaction</td>
<td>11</td>
<td>52.38%</td>
</tr>
<tr>
<td>3.8. Information on patient satisfaction</td>
<td>14</td>
<td>66.67%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sub-theme 4: Education and training</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1. Ways that can enable education and training programs to meet the population health needs</td>
<td>11</td>
<td>52.38%</td>
</tr>
<tr>
<td>4.2. Gaps in existing education and training programs</td>
<td>11</td>
<td>52.38%</td>
</tr>
<tr>
<td>4.3. Ways to develop re-licensing programs</td>
<td>5</td>
<td>22.73%</td>
</tr>
<tr>
<td>4.4. Requirements for establishing a program for accreditation of health professionals</td>
<td>7</td>
<td>35.00%</td>
</tr>
<tr>
<td>4.5. Relationship between re-licensing and quality of care</td>
<td>8</td>
<td>38.10%</td>
</tr>
</tbody>
</table>

*N and % in the table reflect number of participants who reported that the above research priorities were “Very Important”
Table 4: Validation of Research Priorities on the Role of the Non-State Sector *

<table>
<thead>
<tr>
<th>Sub-theme 1: Public-Private Partnerships</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1. Foundation/elements for building a strong public-private partnerships</td>
<td>13</td>
<td>61.90%</td>
</tr>
<tr>
<td>1.2. Effectiveness of the non-state sector in meeting health system objectives</td>
<td>9</td>
<td>42.86%</td>
</tr>
<tr>
<td>1.3. Areas where the state and non-state sector can complement each other</td>
<td>13</td>
<td>61.90%</td>
</tr>
<tr>
<td>1.4. Ways for the public and private sector to complement their service delivery</td>
<td>15</td>
<td>75.00%</td>
</tr>
<tr>
<td>1.5. Ways to develop effective contracting mechanisms with the private and other non-state sectors</td>
<td>12</td>
<td>60.00%</td>
</tr>
<tr>
<td>Sub-theme 2: Role and responsibility of the non-state sector</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1. Defining the role and responsibility of the non-state sector</td>
<td>11</td>
<td>55.00%</td>
</tr>
<tr>
<td>2.2. National plan for the contribution of the non-state sector</td>
<td>11</td>
<td>52.38%</td>
</tr>
<tr>
<td>Sub-theme 3: Magnitude and capacity of the Non-State Sector</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1. Scope, resources and kind of services provided by the non-state sector</td>
<td>11</td>
<td>55.00%</td>
</tr>
<tr>
<td>3.2. Ways to optimize the use of the existing resources of the Non-state sector to meet health system objectives</td>
<td>11</td>
<td>55.00%</td>
</tr>
<tr>
<td>3.3. National database on the non-state sector</td>
<td>16</td>
<td>80.00%</td>
</tr>
<tr>
<td>Sub-theme 4: Performance and evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1. Ways to measure and regulate the quality of care in the private sector</td>
<td>15</td>
<td>75.00%</td>
</tr>
<tr>
<td>4.2. Accreditation standards</td>
<td>16</td>
<td>80.00%</td>
</tr>
<tr>
<td>4.3. Methods to monitor and evaluate service provision and performance</td>
<td>13</td>
<td>68.42%</td>
</tr>
<tr>
<td>4.4. Develop an accountability framework for the non-state sector</td>
<td>9</td>
<td>47.37%</td>
</tr>
<tr>
<td>4.5. Measuring client satisfaction</td>
<td>12</td>
<td>60.00%</td>
</tr>
</tbody>
</table>

*N and % in the table reflect number of participants who reported that the above research priorities were “Very Important”
In addition to eliminating items scoring less than 50% from the second day’s round, the research panel also made modifications to the wording of some items based on input from the participants. One of the major changes was made to the themes on the Role of the Non-State Sector where participants suggested merging item 4.1 with 4.3 to become “Ways to regulate and monitor the quality of care in the private sector.” Item 4.5 on client satisfaction was given the number 4.3 instead of 4.5. Some minor changes were made to the wording of some other items under the three themes. Enclosed in Appendix XVII, XVIII and XIX are the modified surveys for ranking of research priorities for the themes Health Financing, Human Resources for Health and the Role of the Non-State Sector, respectively.

Discussion during the first day of the meeting focused on how the context of the region may influence future policies on the three study themes. Within the theme of Health Financing, some participants stated that poor resource allocation is one of the region’s biggest challenges. Others raised fears about implementing a social health insurance system without a proper actuarial study by the Ministries of Health and Finance. Implementing such an insurance scheme without proper analysis may lead to failure of the program, particularly that the poor segments of the population may not be able to afford it. This is linked to the issue of equity which participants believed should be better defined in the context of the region. Some linked equity to allocation of resources based on health needs of the population while others linked it to resource collection and pooling based on ability to pay. Others emphasized the importance of allocative efficiency issues in the MENA region particularly that most of the available resources are spent on curative care.

In terms of Human Resources for Health, discussion focused on planning which was linked to medical education programs. Participants stated the proper planning would be difficult in countries where medial education is offered by private institutions; this reduces and often eliminates the ability of the public sector to monitor and regulate entry into the profession and forecast future needs. Participants believed that a strong public program for medical and nursing education would facilitate HRH planning. Since different countries have different experiences in this regard, it would be hard to develop a regional policy for better HRH planning. Discussion on this theme also touched upon the
issue of re-licensing which participants believed should go hand-in-hand with continuing medical education.

As for the Role of the Non-State Sector, all participants agreed on the need to differentiate between the civil society and the private sector as they have different functions. Participants believed that the regulation of the private sector may be challenging in the presence of globalization, capitalism and liberal trade. This situation differs across some study countries since in some, the public sector generally provides most of the health services and the role of the private sector is rather limited. Therefore, governments should not try to control this sector, but rather try to govern and coordinate its functions and responsibilities to better serve the population.

**DAY 2 – Ranking of Research Priorities**

On the second day of the workshop, the project lead reported the results of the ranking exercise of the first day before commencing with the other scheduled activities. Participants voiced their concern about the validation score of some of the research priorities. Within the health financing theme, some participants were surprised that the item on population health needs had a higher score than some items which were removed. As for the HRH theme, some participants voiced concern that the poor social image of the nursing profession had a low score. Within the Role of the Non-State Sector, some participants were surprised that the marginalized role of the civil society was not given high priority. After some discussion, participants realized the importance of country specific priorities that do not apply to all study countries.

After this discussion, participants were asked to discuss within their groups the list of research priorities and rank them individually (to garner country-specific priorities). Based on the group discussion and consensus, each group reported the three priority research questions for each of the three themes that need urgent attention in the region within the coming 1 to 3 years.

Approximately two hours were allotted for each round, one hour for group discussion, 30 minutes for reporting priority research questions (data was entered and analyzed during this time) and 30 minutes for sharing the ranking results. Ranking was analyzed according to the preset criteria previously indicated.
Participants were asked to suggest if different weights should be given to each of the preset ranking criteria. After some discussion on the pros and cons of weighting the criteria, the participants conceded that all criteria can be given equal weights.

Below are tables detailing the means and standard deviations of the ranking conducted on each of the three themes.

### Table 5: Ranking of Research Priorities on Health Financing*

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Elements of an equitable health financing system</td>
<td>2.53</td>
<td>0.35</td>
</tr>
<tr>
<td>1.4 Household ability to pay for health care</td>
<td>2.46</td>
<td>0.65</td>
</tr>
<tr>
<td>1.3 Linking population health needs to health spending</td>
<td>2.44</td>
<td>0.43</td>
</tr>
<tr>
<td>2.2 Role of the Social Health Insurance system in guaranteeing equity</td>
<td>2.44</td>
<td>0.39</td>
</tr>
<tr>
<td>3.1 Identifying best practices to develop and implement a national social health insurance system</td>
<td>2.43</td>
<td>0.40</td>
</tr>
<tr>
<td>5.1 Clarifying functions and coordination processes between ministries (for example the Ministries of Health and Finance) to improve health system financing and quality of services</td>
<td>2.41</td>
<td>0.46</td>
</tr>
<tr>
<td>4.3 Means to track financial resources invested in health care to ensure value for money</td>
<td>2.40</td>
<td>0.41</td>
</tr>
<tr>
<td>4.2 Accurate estimation of the health expenditure from the public and the private sectors including out-of-pocket expenditure</td>
<td>2.38</td>
<td>0.49</td>
</tr>
<tr>
<td>1.2 Population health status and needs</td>
<td>2.28</td>
<td>0.42</td>
</tr>
</tbody>
</table>

*Sorted in descending order of mean

Further analysis was conducted including weighting of means by country and type of informant. Results are detailed in Table 6.
Table 6: Detailed weighting of Health Financing research priorities by country and type of informant

<table>
<thead>
<tr>
<th>Health Financing</th>
<th>Overall</th>
<th>Weighted by …</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rank</td>
<td>Mean</td>
</tr>
<tr>
<td>1.2 Population health status and needs</td>
<td>9</td>
<td>2.28</td>
</tr>
<tr>
<td>1.3 Linking population health needs to health spending</td>
<td>3</td>
<td>2.44</td>
</tr>
<tr>
<td>1.4 Household ability to pay for health care</td>
<td>2</td>
<td>2.46</td>
</tr>
<tr>
<td>2.1 Elements of an equitable health financing system</td>
<td>1</td>
<td>2.53</td>
</tr>
<tr>
<td>2.2 Role of the Social Health Insurance system in guaranteeing equity</td>
<td>4</td>
<td>2.44</td>
</tr>
<tr>
<td>3.1 Identifying best practices to develop and implement a national social health insurance system</td>
<td>5</td>
<td>2.43</td>
</tr>
<tr>
<td>4.2 Accurate estimation of the health expenditure from the public and the private sectors including out-of-pocket expenditure</td>
<td>8</td>
<td>2.38</td>
</tr>
<tr>
<td>4.3 Means to track financial resources invested in health care to ensure value for money</td>
<td>7</td>
<td>2.40</td>
</tr>
<tr>
<td>5.1 Clarifying functions and coordination processes between ministries (for example the Ministries of Health and Finance) to improve health system financing and quality of services</td>
<td>6</td>
<td>2.41</td>
</tr>
</tbody>
</table>

More detailed information on ranking of research priorities related to Health Financing appears in Appendix XX.
As observed in Table 5 & 6, the top three research priorities for health financing were:

- 2.1 Elements of an equitable health financing system
- 1.4 Household ability to pay for health care
- 1.3 Linking population health needs to health spending

When further analyzing the results to consider effect of weighting results by country and type of key informants, some interesting observations were noted. The ranking in Table 5 shows some difference between the overall mean and the weighted mean by country. These changes can be explained by the varying responses by type of key informant. Some changes to the top three priorities related to health financing can elucidate this difference:

- The highest ranked priority for health financing related to identifying the elements of an equitable health financing system. This item also ranked highest when weighted by country and seemed to be of most importance to policy makers as compared to researchers and representatives of the Non-State Sector. This is probably because the burden of developing an equitable system falls on the shoulders of policy makers in any given country.
- The second highest ranking item related to household ability to pay for health care. This item ranked lowest when weighted by country and was most important to researchers. It is surprising that this item was not as important to policy makers and non-state sector representatives who represent some of the major health providers in the study countries.
- The third highest ranking item related to linking population health needs to spending which ranked low when weighted by country. This item was most important to non-state sector representatives and researchers and surprisingly least important to policy makers. This is probably because policy makers believe that this issue can be an outcome of conducting other related health systems research.

It should be noted that the highest ranking item among policy makers was assessing the role of Social Health Insurance in guaranteeing equity. This item did not
rank as high among researchers and representatives of the non-state sector because of their limited decision making ability. As stated above, the highest ranking research priority for researchers related to the issue of household ability to pay which did not rank as high for other types of key informants. This is probably because of the role they can play in the actual assessment of this priority as compared to other key informants who may better serve the population in other aspects of health financing. Linking population health needs to health spending ranked highest among non-state sector representatives. This may be explained by the fact that this sector, particularly private health organizations, is the main health care provider in many of the study countries. Researching such a priority may help them develop services that are aligned with population health needs.

| Table 7: Ranking of Research Priorities on Human Resources for Health* |
|-------------------------------------------------|--------|--------|
| 2.2 Means to develop HRH information systems in ministries of health and national observatories | 2.59   | 0.27   |
| 4.2 Gaps in existing education and training programs | 2.54   | 0.38   |
| 3.8 Information on patient satisfaction | 2.50   | 0.43   |
| 1.1 Accurate estimates and needs in numbers and specialties (mapping) | 2.48   | 0.52   |
| 4.1 Ways that can enable education and training programs to meet the population health needs | 2.46   | 0.41   |
| 3.3 Methods to measure HRH performance and productivity | 2.45   | 0.39   |
| 1.2 Develop simulation models for HRH planning | 2.43   | 0.46   |
| 3.4 Elements of performance evaluation | 2.37   | 0.39   |
| 3.1 Develop incentive mechanisms to better-manage the existing stock of HRH | 2.30   | 0.61   |
| 3.7 Ways to improve staff satisfaction | 2.15   | 0.54   |

*Sorted in descending order of mean

Further analysis was also conducted for HRH research priorities including weighting of means by country and type of informant. Results are detailed in Table 8.
### Table 8: Detailed weighting of HRH research priorities by country and type of informant

<table>
<thead>
<tr>
<th>Human Resources for Health</th>
<th>Overall</th>
<th>Weighted by …</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rank</td>
<td>Mean</td>
</tr>
<tr>
<td>1.1 Accurate estimates and needs in numbers and specialties (mapping)</td>
<td>4</td>
<td>2.48</td>
</tr>
<tr>
<td>1.2 Develop simulation models for HRH planning</td>
<td>7</td>
<td>2.43</td>
</tr>
<tr>
<td>2.2 Means to develop HRH information systems in ministries of health and national observatories</td>
<td>1</td>
<td>2.59</td>
</tr>
<tr>
<td>3.1 Develop incentive mechanisms to better-manage the existing stock of HRH</td>
<td>9</td>
<td>2.30</td>
</tr>
<tr>
<td>3.3 Methods to measure HRH performance and productivity</td>
<td>6</td>
<td>2.45</td>
</tr>
<tr>
<td>3.4 Elements of performance evaluation</td>
<td>8</td>
<td>2.37</td>
</tr>
<tr>
<td>3.7 Ways to improve staff satisfaction</td>
<td>10</td>
<td>2.15</td>
</tr>
<tr>
<td>3.8 Information on patient satisfaction</td>
<td>3</td>
<td>2.50</td>
</tr>
<tr>
<td>4.1 Ways that can enable education and training programs to meet the population health needs</td>
<td>5</td>
<td>2.46</td>
</tr>
<tr>
<td>4.2 Gaps in existing education and training programs</td>
<td>2</td>
<td>2.54</td>
</tr>
</tbody>
</table>

More detailed information on ranking of research priorities related to Human Resources for Health appears in Appendix XXI.
The top three research priorities for HRH as detailed in tables 7 & 8 are:

- 2.2 Means to develop HRH information systems in ministries of health and national observatories
- 4.2 Gaps in existing education and training programs
- 3.8 Information on patient satisfaction

Further analysis to assess effect of weighting by country and type of key informants also revealed interesting observations. The ranking in Table 7 reveals more differences for this theme than for health financing. Key informants generally disagreed on degree of importance of health priorities related to HRH. A summary of these differences for the three highest ranked priorities are summarized below:

- Developing an information system for the health workforce ranked highest overall and also when weighted by country. It was most important among researchers, and slightly less important for non-state sector representatives and policy makers. This is probably because researchers can play a major role in the actual development of this information system which serves the interests of other key informants.
- Assessing the gaps in HRH educational and training programs ranked second overall and slightly less when weighted by country. It should be noted that this item was most important to policy makers and representatives of the non-state sector. This is probably because of the effect of poor education and training on quality of care delivered at health organizations for the public and non-state sector in all study countries.
- Information on patient satisfaction ranked third overall and slightly more important when weighted by country. The ranking for this item decreased when weighting by type of key informant but was most important for researchers. Researchers may be interested in the predictors of patient satisfaction, particularly those related to the health workforce. This can help inform future HRH policies in the study countries as well as the region.
It should be noted that the most important research priority for policy makers related to performance evaluation and methods for improving productivity. However, policy makers were least interested with researching ways to improve staff satisfaction (item 3.4) which can exert an indirect effect on productivity. Researchers were found to be most interested with developing accurate estimates for HRH and consequently country needs in terms of numbers and specialties. This is closely linked to their second highest priority which related to developing an HRH information system. This is probably because of the role researchers can play in this regard as compared to other issues which are more important to the other types of key informants. Representatives of the non-state sector had similar interests as researchers and found the issue of an HRH information system most important, followed by developing accurate estimates on HRH.

Table 9: Ranking of Research Priorities on the Role of the Non-State Sector*

<table>
<thead>
<tr>
<th>Priority</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Ways to regulate and monitor the quality of care in the private sector</td>
<td>2.52</td>
<td>0.35</td>
</tr>
<tr>
<td>3.2 Ways to optimize the use of the existing resources of the Non-state sector to meet health system objectives</td>
<td>2.46</td>
<td>0.36</td>
</tr>
<tr>
<td>1.4 Ways for the public and private sector to complement their service delivery</td>
<td>2.42</td>
<td>0.35</td>
</tr>
<tr>
<td>1.3 Areas where the state and civil society groups can complement each other</td>
<td>2.38</td>
<td>0.41</td>
</tr>
<tr>
<td>3.3 National database on the non-state sector</td>
<td>2.38</td>
<td>0.47</td>
</tr>
<tr>
<td>1.1 Foundation/elements for building strong public-private partnerships</td>
<td>2.37</td>
<td>0.29</td>
</tr>
<tr>
<td>4.2 Accreditation standards for private sector</td>
<td>2.33</td>
<td>0.59</td>
</tr>
<tr>
<td>1.5 Ways to develop effective contracting mechanisms with the private and other non-state sectors</td>
<td>2.32</td>
<td>0.51</td>
</tr>
<tr>
<td>2.2 National plan for the contribution of the non-state sector</td>
<td>2.29</td>
<td>0.55</td>
</tr>
<tr>
<td>4.3 Measuring client satisfaction</td>
<td>2.29</td>
<td>0.54</td>
</tr>
<tr>
<td>2.1 Defining the role and responsibility of the non-state sector</td>
<td>2.19</td>
<td>0.61</td>
</tr>
<tr>
<td>3.1 Scope, resources and kind of services provided by the non-state sector</td>
<td>2.18</td>
<td>0.52</td>
</tr>
</tbody>
</table>

*Sorted in descending order of mean

Further analysis was also conducted on research priorities for the role of the Non-State Sector including weighting of means by country and type of informant. Results are detailed in Table 10.
<table>
<thead>
<tr>
<th>Role of the Non-State Sector</th>
<th>Overall</th>
<th>Country</th>
<th>Policy Makers</th>
<th>Academicians/Researchers</th>
<th>Non-State Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Rank</td>
<td>Mean</td>
<td>SD</td>
<td>Rank</td>
<td>Mean</td>
</tr>
<tr>
<td>1.1 Foundation/elements for building strong public-private partnerships</td>
<td>6</td>
<td>2.37</td>
<td>0.29</td>
<td>5</td>
<td>2.40</td>
</tr>
<tr>
<td>1.3 Areas where the state and civil society groups can complement each other</td>
<td>4</td>
<td>2.38</td>
<td>0.41</td>
<td>4</td>
<td>2.40</td>
</tr>
<tr>
<td>1.4 Ways for the public and private sector to complement their service delivery</td>
<td>3</td>
<td>2.42</td>
<td>0.35</td>
<td>3</td>
<td>2.43</td>
</tr>
<tr>
<td>1.5 Ways to develop effective contracting mechanisms with the private and other non-state</td>
<td>8</td>
<td>2.32</td>
<td>0.51</td>
<td>7</td>
<td>2.36</td>
</tr>
<tr>
<td>sectors</td>
<td></td>
<td></td>
<td></td>
<td>12</td>
<td>2.18</td>
</tr>
<tr>
<td>2.1 Defining the role and responsibility of the non-state sector</td>
<td>11</td>
<td>2.19</td>
<td>0.61</td>
<td>11</td>
<td>2.12</td>
</tr>
<tr>
<td>2.2 National plan for the contribution of the non-state sector</td>
<td>9</td>
<td>2.29</td>
<td>0.55</td>
<td>9</td>
<td>2.32</td>
</tr>
<tr>
<td>3.1 Scope, resources and kind of services provided by the non-state sector</td>
<td>12</td>
<td>2.18</td>
<td>0.52</td>
<td>12</td>
<td>2.12</td>
</tr>
<tr>
<td>3.2 Ways to optimize the use of the existing resources of the Non-state sector to meet health system objectives</td>
<td>2</td>
<td>2.46</td>
<td>0.36</td>
<td>2</td>
<td>2.45</td>
</tr>
<tr>
<td>3.3 National database on the non-state sector</td>
<td>5</td>
<td>2.38</td>
<td>0.47</td>
<td>6</td>
<td>2.36</td>
</tr>
<tr>
<td>4.1 Ways to regulate and monitor the quality of care in the private sector</td>
<td>1</td>
<td>2.52</td>
<td>0.35</td>
<td>1</td>
<td>2.48</td>
</tr>
<tr>
<td>4.2 Accreditation standards for private sector</td>
<td>7</td>
<td>2.33</td>
<td>0.59</td>
<td>10</td>
<td>2.19</td>
</tr>
<tr>
<td>4.3 Measuring client satisfaction</td>
<td>10</td>
<td>2.29</td>
<td>0.54</td>
<td>8</td>
<td>2.35</td>
</tr>
</tbody>
</table>

More detailed information on ranking of research priorities related to the Role of the Non-State Sector appears in Appendix XXII.
In summary, as observed in Tables 9 & 10, the highest three ranked research priorities related to the role of the non-state sector are:

- 4.1 Ways to regulate and monitor the quality of care in the private sector
- 3.2 Ways to optimize the use of the existing resources of the Non-state sector to meet health system objectives
- 1.4 Ways for the public and private sector to complement their service delivery

Similarly to the two other themes above, weighting of results by country and type of informant revealed interesting observations. For this theme, the overall ranking did not differ much from that weight by country as observed in Table 10. The major differences, however, can be observed when comparing responses of different key informants. These differences are summarized for the top three ranked research priorities:

- The issue of regulating and monitoring the quality of care in the private sector ranked highest overall and also when weighted by country and type of key informant. This reinforces the importance of such a research priority for the MENA region given that the private sector is the major health provider in most of the study countries.
- Optimizing the resources of the non-state sector to meet health system objectives ranked second overall and also when weighted by country. This item ranked highest for representatives of the non-state sector and lower for other types of key informants. This is probably because of the effect of such a priority on the non-state sector.
- Finding ways for the public and private sector to complement their service delivery ranked third overall and also when weighted by country. However, this item was most important for researchers who are probably interested in identifying a common ground for the two sectors to complement their service delivery.

Since key informants were in agreement regarding the most important research priority, it may be interesting to analyze the lowest ranked research priority for this theme. Policy makers found the issue of defining the role and responsibilities of the non-
state sector least important for the coming 3 to 5 years. This contrasts sharply with their ranking of the item related to regulating and monitoring the private sector (item 4.1) which would highly benefit from defining the role and responsibilities of this sector. For researchers, the lowest ranked item related to developing effective contracting mechanisms. This is probably because of the limited role they can play in this regard. As for representatives of the non-state sector, the lowest ranking research priority related to developing a national plan for the contribution of the non-state sector. Such a plan should include contribution from the non-state sector; but the limited role this sector plays in decision making in the study countries may have affected the response of the key informants on this item.

**Priority Research Questions**

The research questions reported at the end of each round were collected and analyzed by the research panel. It was interesting to note that many research questions recurred across groups. The research panel edited this list to eliminate any duplication. Questions falling under similar topics were clustered together. It was agreed that further work is needed to be done to refine the research questions below and phrase them in the form of researchable research questions. The information expected to be gathered during the next 1 to 3 years can feed into answering the research priorities identified above over the coming 3 to 5 years.

Below are the lists of policy relevant research questions related to the three themes:

**Policy Relevant Research Questions on Health Financing for the next 1 to 3 years**

1. What are the means and mechanisms and means to improve coordination between ministries?
2. How to measure the effectiveness of intersectoral cooperation and collaboration of health services (between ministries)
3. What are the best practices in promoting coordination to improve the efficiency and the quality of health care systems?
4. How do we link population health need to health financing (population health priorities)?
5. How to finance the health care system in an equitable way using population health needs data?
6. What are the elements of an equitable social health insurance system (determine mechanisms)? What are the components of an equitable health benefits package that meets funding abilities?
7. What is the role of national health insurance in promoting and ensuring equity?
8. How to develop research modalities to track financial resources (ongoing not only National Health Accounts (NHA) and assess their effectiveness? 
9. What are the reporting and tracking mechanisms necessary to identify the relative distribution of health expenditure?
10. What are the different approaches to have equitable and efficient health care systems?
11. How to develop different financing schemes to cover the poor (after identifying them by different associations such as the Ministry of Social Solidarity)?
12. What is the ability of household to contribute to social health insurance and what is the most effective way to enhance collection of premiums from households?

**Policy Relevant Research Questions of Human Resources for Health for the next 1 to 3 years**

1. What are the means and mechanisms to develop and adopt a national health information system for HRH (both in public and non-public sectors)?
2. What information system requirements are necessary to support accurate mapping and future projection of HRH?
3. What is the best way to develop an HRH mapping system which can also serve as a base for HRH management and development?
4. How to improve the current HRH education and training programs to overcome existing gaps?
5. What are the effective mechanisms for institutionalizing continuous professional development?
6. How should HRH education and training programs address the needs of a particular population?

7. What are the methods and indicators used to assess HRH performance and productivity?

8. How to develop an incentive program for health workers that would address performance, productivity, migration, attrition and working in underserved and remote areas?

9. How to establish a performance based incentive systems for HRH?

10. What are the reasons for the incompatibility between the education and training of HRH graduates and the needs of the labor market?

11. What is the extent of client/patient satisfaction and what are the means to improve it?

12. What are the best practices to improve HRH satisfaction?

**Policy Relevant Research Questions on the Role of the Non-State Sector for the next 1 to 3 years**

1. What are the effective ways to regulate and monitor the quality of care in the Non-State Sector?

2. What are the ways to monitor and control performance in service delivery in both the state and non-state sector?

3. What is the role of contracting out in building effective public-private partnerships?

4. What are the means and the mechanism to build a system for collaboration between the public and non-state sector (for and not-for-profit)?

5. What are the areas and ways for the public and non-state sector to complement their service delivery?

6. What are the requirements for building a strong complimentary public/private partnership in the healthcare field?

7. What are the means and mechanisms to include the private sector within the national health plan?

8. What are the responsibilities and the degree of participation of the non-state sector in the national health plan?

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9. What are the accreditation standards that should be developed to enhance performance and quality standards in the State and Non-State Sectors?
10. What is the role of an accreditation system in the region in improving service delivery?
11. How to optimize the use of the existing resources for the non-state sector to meet the health system objectives?

C. Workshop Discussion and Recommendations

Participants acknowledged that this workshop was the first opportunity for policy makers to meet with researchers and representatives of the non-state sector to discuss health system issues and identify policy relevant research questions in the region. Participants emphasized the need to sustain this policy and research network that has been formed.

At the end of the second day of the workshop, participants discussed and recommended the next steps for this work. Below are the recommendations provided by participants:

1. Sustain the policy and research network that has been developed in the region and develop terms of reference and seek funding for sustaining this network;
2. Develop country-specific briefs on policy challenges and research priorities related to the three themes;
3. Develop three policy briefs on regional priority research questions, one brief for each theme;
4. Prepare and submit manuscripts for publication in open-access journals and disseminate findings in regional and international conferences;
5. Identify additional themes pertaining to the nine study countries;
6. Develop a synthesis report that summarizes study methodology, key findings and lessons learnt.
7. Strengthen the priority setting exercise to include other countries in the MENA region and to cover more priority themes than the ones that were investigated;
8. Develop joint proposals based on the research priorities and questions that emerged from the workshop and seek funding from international funding agencies to fund future research studies that address the policy relevant questions identified;

9. Conduct country specific workshops to ensure that the research priorities generated from this work are integrated into current and future strategic plans of Ministries of Health in the study countries

Several of the recommendations generated from the report are reflected in the next steps for this research study at a regional level.

Please find enclosed in Appendix XXIII some pictures from the workshop.

IX. Discussion

A. Key Findings

The findings of this research study point out to the common policy challenges and research priorities among most of the study countries. Many of the study countries face similar challenges in terms of health financing, human resources for health and the role of the non-state sector. However, the limited capacity for generating research evidence in some countries affects the uptake of study results by stakeholders and the ability of the focal people to address some of the priority research questions generated from this work. Key findings within each of the three themes based on initial study findings and outcome of the regional consensus workshop are discussed below.

HEALTH FINANCING

Based on the findings generated on the theme of health financing, the region appears to be suffering from poor health spending which is reflected in poor health and quality of care. This is potentially an outcome of the absence of a social security insurance system to protect the population, particularly high risk groups. These issues are
exacerbated by the lack of regular needs assessment which impedes ministries of health and population from allocating resources efficiently to meet population needs. Inefficient allocation is a byproduct of centralized health systems which are not flexible enough to adapt to emerging needs. This is aggravated by limited communications between ministries of health and finance to resolve issues around limited funding, payment of private providers or other similar issues. Closely related to this is the mechanism of paying private providers which is mostly unregulated and unmonitored. The collective policy concerns summarized above have resulted in lack of social justice and equity which encompasses not only fund allocation but also health care delivery.

Several research priorities that can provide the evidence needed to remedy the above policy concerns were proposed. These included assessing population health needs and available resources; assessing and improving quality of health services; achieving equity within the health system; developing a social health insurance system; developing solid public-private partnerships; determining predictors of high health expenditure; and improving coordination between governmental bodies.

Our findings and observations from interview transcripts point out to the high levels of involvement and knowledge of key informants about problems with the health financing system of their countries which allowed them to easily identify the main policy concerns. But the limited policy and research priorities that emerged may reflect the lack of ideas on possible interventions that may address these concerns. This may reflect the lack of sufficient information and research evidence in these countries to use for possible interventions. Also worth noting, the key informants seemed to discuss health financing at the macro level and did not allude to micro level concerns or solutions which reflects their perspectives as a function of their education, work experience and positions. These observations persisted at the regional workshop whereby policy makers focused more on issues such as social health insurance systems, equitable health financing systems. Other issues that may help policy makers in deriving evidence to support the above were less important in the ranking exercise for health financing. These items included tracking financial resources, estimation of health expenditure, household ability to pay, and population health needs. Researchers, on the other hand, seemed to pay more attention to areas where they can contribute through generating evidence. Such areas pertained to...
household ability to pay, linking population health needs to health spending and clarifying roles and duties of ministries. This is possibly because of the limited role they can play in developing a social health insurance system, or in estimating health expenditure. As for the representatives of the Non-State Sector, the lowest ranked items related to estimating health expenditure, household ability to pay and population health needs. These are probably issues where they can have limited policy impact.

**HUMAN RESOURCES FOR HEALTH**

Within the HRH theme, the region is perceived to suffer from poor HRH planning which is encumbered by the lack of data on the numbers, types and qualifications of health workers. The lack of data hinders planning and decision making on HRH related issues, particularly health worker shortages in terms of numbers and specialties in most of the study countries. The shortages have forced few countries to rely on foreign-trained health workers (as in the case of Algeria and Tunisia). But this process is unstructured and has displaced nationally trained health workers in the afore-mentioned countries. Many of the study countries are reportedly suffering from major geographic and sectoral maldistribution of health workers. The majority of health workers are concentrated in urban areas, leaving rural areas severely underserved. Health workers also prefer working in the private sector than the public sector as the former offers higher wages. Moreover, health workers in the public sector may often choose to engage in dual employment in the private sector to complement their poor wages. Closely linked to this issue are the poor financial and non-financial incentives offered to health workers in the study countries. This is one of the main triggers to the excessive exodus of health workers through emigration, and the poor social image of the profession as well. Another important concern is the lack of a formal continuing education and training program that enables health workers to stay up-to-date and also to advance in their career. The issue of the lack of re-licensing programs for health professionals was also raised, particularly as it relates to quality of care provided by health workers. Formal systems of performance evaluation are also lacking in the region which is also contributing to the poor knowledge on qualifications of the health workforce in providing quality care to patients. The outdated
curricula and educational programs in many countries further complicates this issue as most of the study countries expressed serious concerns about the content and quality of the educational programs that train and prepare students to enter the health workforce.

Research priorities that emerged from the study findings related to HRH Planning; creating a minimum HRH database; improving HRH management; and creating education and training programs.

In general, findings with the HRH theme seemed more tangible and easier to relate to than the health financing theme. Despite the fact that there is limited information on this theme in the nine countries, key informants were more aware of the problems relating to HRH and their possible solutions. This observation also persisted during the regional workshop whereby participants seemed to be more aware of issues pertaining to this theme. For instance, although policy makers ranked measuring HRH performance as their top priority, however, they ranked staff satisfaction as their lowest priority. This is of importance as evidence points out to a link between satisfaction and performance of health workforce. Overall, policy makers found research priorities such as improving HRH performance and quality of education more important than the items that can generate evidence to help in attaining these priorities. For researchers, issues related to information systems, measurements of the numbers and types of HRH, and the development of simulation models ranked highest. This is possibly because these are the areas where they can contribute the most. Another potential reason is that such basic information are needed for conducting any basic research study on the health workforce of any given country, not just LMICs in the MENA region. The views of representatives of the Non-State Sector were somehow close to those of researchers. They also ranked issues around information systems and accurate estimates of health workforce as high priorities, but they also ranked research on education and training of health workforce as a high priority.

ROLE OF THE NON-STATE SECTOR

One of the major policy concerns related to the Non-State Sector was the poor regulation of this sector by the state. This issue encompasses poor stewardship of the
government, corruption, and the lack of a strategic vision about the role and responsibility of this sector by the state. The impact of this concern can be felt in lack of data on quality standards and services rendered by this sector. This is further exacerbated by the lack of a monitoring program over the non-state sector by the state. In light of this, it is not surprising that mistrust between the state and non-state sector exists. Findings strongly point out to the need to obtain more information on the nature, scope and activities of the non-state sector. This can eliminate any duplication of services across the state and non-state sector and also promote a common vision, better coordination and better service provision. Such an assessment is urgent as it can also identify areas of misuse or over-utilization and also help determine the extent of dual employment. Finally, all countries expressed concerns about the marginalization of the civil society and the need to involve them through defining its role and responsibilities.

Research priorities in this theme focused on strengthening public-private partnerships; assessing the role and responsibility of the Non-State Sector; assessing the magnitude and capacity of the Non-State Sector; and performance and evaluation.

In the nine countries, the Non-State Sector was presented to play an important role in the system. However the relationship between Non-State Sector organization and with the public sector is often one of mistrust which is affecting health care delivery. Findings point to a lack of information on the role of the Non-State Sector in the nine countries. Key informants focused more on the private sector as it is the most prominent non-state actor in MENA countries. The lack of information on the role of the Non-State Sector may indicate that previous decisions made regarding this sector were not based on evidence and that the lack of clarity about this sector exists. Still, the private sector in all the nine countries is highly visible despite the lack of clarity on its size and activities. Key informants in all countries encouraged and stressed the importance of public private partnerships in overcoming health system issues. This priority also emerged in the health financing and HRH themes which attests to the influence of the private sector but also to the effect of poor regulation on health system performance. In terms of priorities for research on the role of the Non-State Sector, more information is needed to understand the effective mechanisms of collaboration, involvement and partnership with the public sector.
According to these findings, a major problem relating to the Non-State sector, besides the lack of sufficient information, is poor state regulation. This is probably an outcome of globalization and economic liberalization, international and transnational organizations which are influential and uncontrolled by the state. Such organizations are more capable of providing services to the public. As a result, the state may be seen to have lost its control and credibility as a health service provider. Findings from the regional validation and ranking workshop attest to the importance of this sector and the needs for greater visibility in health systems in the study country. In fact, all types of key informants (i.e. policy makers, researchers and representatives of the non-state sector) all agreed that the highest priority for the region was regulating and monitoring the quality of care in the private sector. The private sector is a major player in many of the study countries when it comes to service delivery. There is generally limited control over the work of the private sector in many of the study countries, which is probably why this issue emerged as a high priority across the board.

B. **Strengths and Limitations**

The strengths and limitations of the nine country study pertain to the research methodology used and the process of follow-up on behalf of the research team.

**Strengths**

This is the first study in the MENA region to engage policy and decision makers, researchers, academicians, professional groups, NGOs, civil society representatives and consumers alike in setting regional health system priorities. This is the first study to actively involve consumers, the users of the health care system in setting health system priorities. Findings show that consumers are highly aware of health system problems and potential solutions. This is of particular importance since literature generally portrays professional views about health systems. This helped provide a holistic view of the problems and potential solutions on health financing, human resources for health and the role of the non-state sector. It also offered the research team rich data as the approach allowed participants the freedom to openly express their views.
The study employed a rigorous qualitative approach and grounded research methodology. Using this qualitative approach enabled reporting country specific findings. All focal people used the same interview schedule for data collection. The qualitative nature of the research approach allowed the generation of rich data on each of the three themes. Focal people all reported having acquired new skills that enriched their knowledge and expertise particularly in conducting qualitative research.

The study followed an interpretive listening priority setting approach which is validated in the literature. Two broad approaches on setting health system priorities exist: the technical assessment approach and the interpretive assessment approach. The technical approach is highly dependant on the availability of data and is better suited for diseases, health problems or treatment technologies while the interpretive approach relies on subjective judgements expressed through structured exercises, guided by criteria and subsequently refined to meet the desired objectives (Lomas et al. 2003). As mentioned in the methodology section, this study was guided by a priority setting framework developed by Lomas et al. (2003) and adapted to accommodate country contexts.

In addition to the thorough and rigorous methodology adopted for this research study, the findings were validated with the key informants who had been interviewed in the nine countries. The culmination in the regional validation and ranking workshop which brought together for the first time policy makers, researchers and representatives of the non-state sector to discuss issues related to health systems and policies. The objectives of this workshop were to: (1) validate the common list of research priorities related to Health Financing, Human Resources for Health and the Role of the Non-State Sector that emerged from the nine selected countries; (2) identify the highest research priorities on the three themes in the MENA region; and (3) reach a consensus among researchers, policy makers and other stakeholders on a policy relevant research agenda for the region.

**Limitations**

Despite the many efforts to unify the fieldwork and use of methods, some countries had difficulty adhering to the data collection protocol. The limited experience of most of the focal people in qualitative research also presented a limitation. Some focal
people reported initial difficulty in facilitating the focus groups and interviews and in keeping participants on track. To mitigate this, the project lead and research team held training and follow-up workshops and spent time supporting individual focal persons and offered continuous guidance as they conducted the fieldwork. Still, some parts of the research work cannot be accounted for despite the close follow-up.

Another difficulty was the lack of sufficient and up-to-date reports and data on the three themes in the nine countries to begin with. Important reports and studies conducted by major international organizations are not publicly accessible. Basic minimum information on country health systems do not exist. Central bodies to collect this kind of information also do not exist. Much of the health system literature in the region includes mostly grey literature that is not easily accessible by the public. Moreover, there was no previous priority setting exercises on health systems research in the region. Although international exercises are available, they could not be adopted due to differences in the contexts of developed and developing countries.

A final limitation relates to data collection and analysis for this study. Data collection and analysis at the country level did not take into consideration segregating the concerns and priorities voiced by policy makers, researchers and representatives of the non-state sector separately. Therefore, we were unable to define concerns and priorities related to the three themes as expressed by each type of informant. However, we made sure to consider this issue in the regional workshop whereby responses of different types of informants were analyzed and many similarities and differences were observed.

C. Lessons Learnt and Next Steps

Identifying policy concerns and research priorities in LMICs of the MENA region could be considered as a first step towards improving health systems. This exercise has been a useful method to help set the agenda for user-driven research. It will be necessary for funding agencies and countries to support and align financial and human resources towards addressing the priorities that have been identified. Otherwise, this would be a hollow priority setting exercise and countries, policy makers and key informants will soon lose interest.
While this study was conducted in a relatively short time period, it has generated unexpected momentum and was greeted with much enthusiasm by key informants in all countries. Dissemination of results is crucial since many key informants in several countries expressed interest to know about the study findings, including next steps. This has become more crucial after the regional workshop was held as many of the participants voiced an expectation that this work would move a step further, if at least through initiating some research studies that build on the research priorities generated from this work.

While the findings of this priority setting exercise highlight the need for evidence to set agendas for policy, a situational analysis based on the evidence available is required around health status, health care systems and health research in the MENA region. It is not surprising that policy making may be uninformed by evidence, a situation which requires having systematic reviews around policy concerns and priorities readily available to them. When evidence is scarce, it is important to help policy makers make good decisions by synthesizing existing evidence and disseminating it effectively. Due to the lack of systematic reviews in the region, there is a need to look at how to assess the relevance and applicability of international systematic reviews to the policy concerns and priorities identified in our study. Most systematic studies are being undertaken in high income countries. Customizing systematic reviews may play a role in informing policy and decision making in health systems of the MENA region.

There is a general agreement that policy and practice should be informed by the best available evidence that is applicable in a given setting. However there is a debate on its availability and the methods on which it can change practice. The MENA region has a unique context and diverse culture, where organizing meetings and solid follow-up were not easy, so research methods were tailored to country context (some countries can conduct focus groups, some only interviews). In fact, tremendous interest in regional studies and great momentum has been generated from this work.

Another conclusion is that there is a deficit in both systematic empirical research conducted in the region as well as in heath research capacity. To remedy this, capacity building for health systems and policy researchers in the region is required. This may improve the possibility of attracting much needed research funding to the MENA region.
There is an urgent need for health research capacity building particularly in the MENA region. There is a need for health systems researchers that can be able to partner with policy makers and the Non-State Actors in conducting research.

The richness and different perspectives offered by lay persons draw attention to the value of conducting research with lay persons as well as professionals. Lay persons, despite their differing levels of expertise in a seemingly technical area of interest are able to voice their opinions from an insider’s view as previously mentioned because they are users of the system. More research is needed to involving consumers in priority setting exercises.

In our study, it was found that the health care systems are inequitable and do not provide equal access and appropriate services to all segments of the population, particularly the poor and the disadvantaged. While there are certain similarities across the nine country contexts in terms of the nature of their health care systems problems, there is a wide variation in health system structures, values and expectations. For instance, while our findings show that many countries agree to the importance of extending financial protection, partnering with the private sector, providing incentives for health professionals, and improving quality of care and safety, they differ on the mechanisms through which this can be achieved in the context of their own country. This points to the need to pay closer attention to country specific contexts before devising solutions or one solution to apply to all. Therefore, specific research topics on themes of relevance to some countries and interventions that address their specific needs are crucial, as these country level issues might sometimes be missed in a multi-country research project.

To sustain the momentum of this regional priority setting exercise, the next steps should include the following (pending availability of funding):

1. Conduct a research workshop for expert researchers to help translate priorities generated from the regional workshop into ‘researchable’ type of policy relevant research questions that can be addressed over the short term;
2. To assess the extent to which existing health system research in the region addresses the policy relevant research questions identified;
3. Develop country-specific briefs on policy challenges and research priorities related to the three themes that can be shared with donors and funding agencies;
4. Develop three policy briefs on regional priority research questions, one brief for each theme;
5. Prepare and submit manuscripts for publication in open-access journals and disseminate findings in regional and international conferences;
6. Identify additional themes pertaining to the nine study countries;
7. Maintain, develop and sustain the regional health system and policy research network that was generated from this project including finalizing terms of reference and expanding its membership;
8. Disseminate country specific findings by conducting country specific workshops to ensure that the research priorities generated from this work are integrated into current and future strategic plans of Ministries of Health (and other groups) in the study countries;
9. Support capacity building for health system and policy research in the region, including workshops in the field of developing proposals for research funding and designing and conducting health system research;
10. Develop joint proposals (multi-country level) based on the policy relevant research questions for the region and seek funding from international funding agencies to fund future research studies that address the policy relevant questions identified; and
11. Identify and seek funding from international and regional sources to fund research studies that address the policy relevant research questions that were identified by this study.

X. Final Words

This synthesis report reflects on the findings of one of very few priority setting exercises that identify policy relevant research questions in the MENA region. It is hoped that the policy relevant research questions generated from this work are integrated into current and future strategic plans of Ministries of Health and related ministries in the
study countries and that the evidence generated can help inform future health system policies in the region. We also hope that the study countries will become involved in developing joint proposals based on the policy relevant research questions for the region and seek funding from international funding agencies to fund future research studies that address the policy relevant questions identified. Study findings can help inform and direct future plans and activities for the MENA Health Policy Forum.
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