Policy Dialogue Summary

Promoting Access to High Quality Primary Health Care Services in Sudan

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The views expressed in the dialogue summary are the views of the dialogue participants and should not be taken to represent the views of the Ministry of Health, WHO EMRO or the authors of the dialogue summary. The protocol and design for the policy brief and policy dialogue including the monitoring and evaluation are part of the Global Health Research Initiative program. The template format for the dialogue summary was adapted from the McMaster Health Forum.

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Dialogue
The policy dialogue about Promoting Access to High Quality Primary Health Care Services in Sudan was held on 12 January 20112 at the Federal Ministry of Health, Nile Avenue Khartoum, Sudan.

The policy dialogue was facilitated by Dr. Fadi El-Jardali, who assisted with the deliberations.
SUMMARIES OF THE DELIBERATIONS

Several dialogue participants noted that unmet needs in primary healthcare settings in Sudan are mostly about:
1) Populations that are not well-served in primary healthcare;
2) Shortages in human resources for health (both in numbers and training), particularly in underserved areas;
3) Limited availability of primary health care facilities that provides good quality and comprehensive care;
4) Absence of health system reform that integrates primary health care including social determinants of health; and
5) Fragmented financing mechanisms and limited inter-sectoral collaboration.

DELIBERATION ABOUT THE PROBLEM

Dialogue participants discussed both the overall framing of the problem as the lack of Access to High Quality Primary Health Care Services in Sudan and the specific features of the problem that had been described in the policy brief. Many dialogue participants agreed with many of the problem features as they were described, including that demands on primary healthcare are growing, the care being delivered in many primary healthcare settings is not as timely or as high quality as patients want and need it to be, and current health system arrangements are contributing to the problem. However, a number of dialogue participants argued strongly that in order to have a comprehensive understanding of the Primary Health Care (PHC) problem in Sudan, there is need to clarify certain boundaries and concepts in terms of the need to:

Background to the Policy dialogue

The Policy dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:
1) Addressing an issue currently being faced in Sudan;
2) Focus on different features of the problem, including (where possible) how it affects particular groups;
3) Focus on four options of an approach (among many) for addressing the policy issue;
4) Informed by a pre-circulated policy brief that mobilized both global and local research evidence about the problem, four options of a comprehensive approach for addressing the problem, and key implementation considerations;
5) Informed by a discussion about the full range of factors that can inform how to approach the problem and possible elements of an approach for addressing it;
6) Brought together many parties who would be involved in or affected by future decisions related to the issue;
7) Ensured fair representation among policymakers, stakeholders, and researchers;
8) Engaged a facilitator to assist with the deliberations;
9) Allowed for frank, off-the-record deliberations by following the Chatham House rule: “Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed”; and
10) Did not aim for consensus.

Participants’ views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue and by those who review the dialogue summary. (McMaster Health Forum)
1) Decide on the level of policy reform to be addressed through the policy brief: is it a macro level health system/sector reform or it is a reform at PHC service delivery level.
2) Clearly define PHC framework and services in the context of Sudan and answer questions such as: what are the components of PHC package in Sudan (including community component); what is meant by "promoting access" and access to what; what is needed: an optimal care or minimum care or quality care or all; what is the gap versus the standard; the role of non-governmental stakeholders; the cost of the PHC package, and cost of in-action.

Some participants noted that the ministry of health is in the process of redefining PHC package and health facility norms and standards. They emphasized that this exercise needs to be highlighted in the policy brief. They also agreed that there are significant gaps in the existing PHC package such as services related non-communicable diseases including chronic disease management services and programs.

Additional issues that were brought forward strongly by several participants relate to geographical access to PHC services, mainly due to imbalanced distribution of facilities, failure of existing facilities to provide services and gaps in numbers and training for human resource for health. Some dialogue participants argued that root causes to the problem needs to be mentioned, particularly those related to the political and demographic context such as:

1) Population distribution, poverty, immigration to towns, the urban poor, rural development, ongoing emergencies (e.g. Darfur) and emerging issues such as substance abuse and disability
2) Health as a cross cutting issue, relations with stakeholders and social determinants of health
3) Fragmentation of the governance system in terms of management and financing
4) Inadequate resources and in-equitable distribution of resources, poor governance of health financing, weak budgeting and fund flow mechanisms and role of the community (particularly in health facility construction which could be seen as an opportunity)
5) Capacity of the decentralized system, existing policies and legislations and the gaps particularly with the interim constitution been revised to be amended. This could be seen as another opportunity to incorporate reform policies.

A number of dialogue participants pointed out that existing health system arrangements hamper efforts to support access to needed programs and services in primary healthcare settings in Sudan. Dialogue participants gave a number of examples of problems with existing health system arrangements.

A number of dialogue participants pointed out the need to use more local evidence from Sudan in the policy brief (i.e. evidence from Sudan national health accounts, Sudan household expenditure and utilization survey)
One dialogue participant emphasized that discussions the importance of PHC and unmet needs require awareness of key policy makers who can influence the level of investment in primary healthcare in Sudan.

**DELIBERATION ABOUT OPTIONS FOR ADDRESSING THE PROBLEM**

Dialogue participants discussed four options that had been examined in the policy brief. Many dialogue participants agreed that each of the four options held promise with an emphasis on continuing activities that are already underway.

**Option 1 - Expand social health insurance system by generating revenues in order to improve coverage, access and reduce out of pocket expenditure**

A large number of dialogue participants agreed that social health insurance is the most important option in generating new resources for health. However, they emphasized the need for taking it – cautiously- as a strategic option. They pointed out that more research and information is needed to evaluate existing experiences and test future actions. Some dialogue participants indicated that the policy brief needs to incorporate more strong international experiences with health insurance. To some, the National Health Insurance (NHI) reform is seen as closely linked to the overall (macro) health financing reform and the development of the health financing policy. They recommended that the Policy Brief needs to specifically focus on the role of health insurance in improving the expansion of PHC services in order to come up with a plan for expansion.

A number of dialogue participants pointed out that the national health insurance is already planning an evaluation exercise which needs to include the effect of quick expansion on converge and quality of services. Some dialogue participants mentioned that the Khartoum State experience can be a suitable case study for this purpose.

Many dialogue participants argued that there are key challenges that need to be considered in designing this option. These are:

1) Legislation/regulation gaps including the fact that registration in not mandatory, which may defy the principle of cost sharing.

2) Existence of other government policies that contradict the health insurance. These conflicting policies include parts of the free of charge policy. This means the need for harmonizing policies

3) Enrollment of the informal sector, given that most of the population belongs to this group. The Khartoum state experience might give insight about appropriate means to enroll them. Khartoum state has managed to enroll a number of vulnerable populations (poor families and students) through partnership (Zakat fund). It is important to explore other ways to
involve the informal sector and private organizations. The existing opportunity in this regard is that many of the states have declared universal coverage by health insurance as target and it is quite appealing to politicians.

4) Other challenges include: political interventions that focus on curative versus preventive care; high administrative cost; and payment of premium.

Some dialogue participants argued that over the longer term what is really needed is structural change to the primary healthcare within the broader health system. This could mean transformative steps such restructuring, clarification of relations, policy and legislation changes and more research to guide the reform. Some participants pointed out that the latest NHI report needs to be reviewed and addressed properly in the policy brief including a correction to the coverage by NHI (i.e. 36.6%).

Option 2 - Increasing the share expenditure on PHC in Sudan by improving the allocative efficiency formula

Dialogue participants felt that it is important to acknowledge the fact that the total government spending on health is low (as compared to Abuja recommendation) and needs to be increased. They noted that the imbalanced allocation (curative vs. preventive and hospital care vs. PHC care) needs to be corrected. Dialogue participants identified several issues related to allocation including:

1) Roles of different levels in the decentralized system are not clear and overlapping
2) PHC is not considered as part of the federal level mandate. Most of the resources are transferred to the states, with no clear road map
3) There is no national budget (or fund) for PHC and the budget transferred to the states is not earmarked, where Governors control the spending according to their priorities
4) Budgeting follows traditional models and allocation at all levels does not occur on scientific bases
5) Amount of budget is not consistent with the expected responsibilities to be taken by different levels
6) There is a lot of competition over few resources and some departments are more influential than the health department, and as a result, they are getting bigger shares from the national budget
7) The government resources for health are fragmented, with a number of individual projects. And it is not clear who is preparing them.

Many dialogue participants agreed that more evidence is needed to convince policy makers (ministry of finance, governors, etc.) that more spending on PHC means more cost effective care, better health outcomes and lower cost. They noted that it is important to make this argument in a written
document and present it with the suggested means to increase health budget. The advocacy process should address issues of favoring hospital care over PHC and the fact that decisions are been taken based on political grounds. They pointed out the importance of mapping the need and having joint meetings between Federal Ministry of Health (FMOH), Ministry of Finance (MOF) and states to coordinate and share information. They noted that a constitutional amendment to clarify the roles of the concerned federal institutions (FMOH, MOF and Resource allocation Commission) and of levels (National, state and locality) is needed. Few dialogue participants pointed out that the parliament is a good place for discussion and advocacy and the health committees can be used effectively to influence decision making.

Option 3 - Strengthening the quality of primary healthcare either by ensuring PHC is emphasized within the existing higher council for quality accreditation, or by establishing a separate PHC higher accreditation body

Many dialogue participants agreed that the idea of accreditation of PHC is important and needs to be implemented. They did not have any doubts that this option will improve PHC services in terms of access and quality. Some participants pointed out that the process has already started in Sudan; however it is still in its early stages. They noted that accreditation is still focused on curative care. However, many dialogue participants argued that this must be corrected to redirect accreditation to include PHC. Dialogue participants felt that the option of having one accreditation body to deal with both hospital and PHC services is more practical and feasible. They recommended integrating PHC accreditation within the existing higher council for quality accreditation.

Few dialogue participants cautioned that this option requires significant amount of resources to be implemented. They emphasized the need to learn from other country experiences, particularly countries with similar context and size. Some pointed out the need to link financing mechanisms to accreditation, hence providing incentives to organizations to invest in quality improvement. Some recommended the need to conduct readiness assessment of PHC to implement accreditation and pointed out that the Arab Standards for Accreditation would be a good start in order to develop specific standards on PHC for Sudan.

Options 4: Building the capacity of the existing primary health care settings to enable them to deliver the minimal health package

Several dialogue participants agreed that this option is critical and important to be implemented. Some felt that this is an option about the basic minimum requirements that need to be in place for PHC in Sudan. However, they pointed out that this option includes mostly "interventions that are not included in option 1 or 2 or 3". They suggested that this option be edited by deleting the word
"existing" -so as not to deprive areas with no coverage- and to substitute "integrated" for "minimum".

The option will then read: “Building the capacity of primary health care settings to enable them to deliver the integrated health package”.

Dialogue participants mentioned a number of on-going activities that are linked to this option. Some of these activities are in advanced stages (e.g. the new document of Health Facility Norms and Standards which is already under implementation and the Mapping of Health Facilities Exercise)

Dialogue participants agreed that it is important to address the following points as part of this option:

1) Definition of the PHC package (to include non-communicable diseases (including chronic diseases) and the community package) must guide this option (referred to in the situation analysis).
2) Planning should take into account the demographic changes and the ongoing emergency context.
3) The policy of certificate of need must be adopted when constructing new facilities to minimize political interventions on the health facility distribution. Meanwhile; the role of communities on building health facilities must be stressed.
4) Equity issue must guide the planning process.
5) Implementation of the referral system (including law for gate-keeping) is critical for efficient service provision and quality improvement.
6) Integrated training for PHC cadres and multi-tasked providers are to be adopted as they proved successful in improving the coverage (e.g. Gedarif State has a successful experience). The importance of Human Resources for Health (HRH) needs to be explicit and mapping of HRH needed in PHC is required.
7) Other issues to be addressed include: verticality (program-based service), demand side and expectations of people, role of the private sector and "health in all policies" approach.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Many of the implementation considerations that were described in the policy brief did emerge repeatedly as issues over the course of the deliberations:

1) Primary health care must be put as a top priority in the agenda
2) The macro level reform policies – including health financing policy – must be well-developed to clarify the broad issues and directions. There is a wealth of new information to guide this process
3) Need to leverage on the opportunity related to the revision of the current Sudan Constitution to clarify roles and responsibilities
4) Importance to include higher level policy makers and conduct PHC advocacy workshops. As such, private sector must be involved.
5) HRH is a critical factor and must be given its due attention
6) Develop, test and advocate for a successful model that shows how investment in PHC can improve health outcomes

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

The deliberations about next steps focused reiterated many of the points from early deliberations. Dialogue participants agreed that collective responsibility, continued work and coordinated actions are required. Some dialogue participants emphasized that the ministry of health should take the leadership role in steering the concerned groups toward action. Dialogue participants agreed to the following framework for the follow up:

1) For issues where the vision is clear and many actions and activities are already initiated (mainly option 3 and 4), commitment is required from participating organizations to support and continue the process.
2) For issues where the vision is clear, but there a need to include higher level decision makers and make constitutional/regulation changes (mainly option 2), effort must made to initiate the process through different mechanisms.
3) For issues where the vision in not clear, (mainly option 1), more research evidence (context-specific; actuarial studies, etc.) is required and additional dialogue meetings are needed to guide planning for the health system reform.

Finally, all dialogue participants agreed that strengthening primary healthcare in Sudan is urgently needed. They pointed out that this policy dialogue meeting was an important opportunity for a large and diverse group to deliberate about the problem and options. They emphasized the need to move forward to the next steps.