Moving toward UHC

Sudan

NATIONAL INITIATIVES, KEY CHALLENGES, AND THE ROLE OF COLLABORATIVE ACTIVITIES

Sudan's snapshot

UHC Service Coverage Index *(SDG 3.8.1, 2015)*

41%

Catastrophic OOP health expenditure incidence at the 10% threshold *(SDG 3.8.2)*

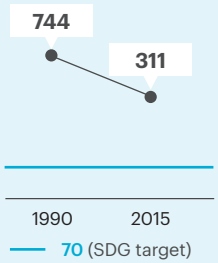
NO DATA

Results of Joint External Evaluation of core capacities for pandemic preparedness *(JEE, 2016)*

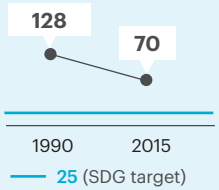
Score (for capacity)		# of indicators (out of 48)
5	Sustainable	4
4	Demonstrated	7
3	Developed	14
2	Limited	19
1	No capacity	4

Health results

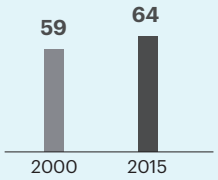
Maternal Mortality Ratio *(WHO)*
Per 100,000 Live Births



Under-Five Mortality Rate *(WHO)*
Per 1,000 Live Births



Life Expectancy at Birth *(WHO)*



Wealth Differential in Under-Five Mortality *(PHCPI)*

NO DATA

More deaths in lowest than highest wealth quintile per 1,000 live births

Performance of service delivery – selected indicators

(PHCPI, 2014-2015)

	Sudan	LMIC average
Care-seeking for symptoms of pneumonia	48.3%	61.5%
Dropout rate between 1st and 3rd DTP vaccination	4.1%	7.5%
Access barriers due to treatment costs	NO DATA	47.4%
Access barriers due to distance	NO DATA	35.8%
Treatment success rate for new TB cases	82%	80.1%
Provider absence rate	NO DATA	28.9%
Caseload per provider	NO DATA	9 per day
Diagnostic accuracy	NO DATA	47.9%
Adherence to clinical guidelines	NO DATA	33.6%

See page 8 for References and Definitions.

Existing national plans and policies to achieve universal health coverage (UHC)

SERVICE DELIVERY REFORMS

Sudan's new National Health Policy details several service delivery reforms. Priority areas include: (1) strengthening the management capacity of decentralized health services through state and local capacity building and integrating vertical programs into primary care principles; (2) improving equity in coverage and the quality of primary health care (PHC) through investments in facility infrastructure; (3) strengthening the quality, safety, and efficiency of secondary and tertiary services; and (4) strengthening efficient ambulatory systems and emergency medical care through the development and implementation of referral systems and guidelines, as well as strengthening emergency care and triage systems.

Increasing access to care and service coverage. Sudan has recently committed to moving away from a hospital centric delivery system to increase PHC coverage, especially for the poor. The scope of services offered has expanded, resulting in coverage for certain chronic conditions. The government also supports the implementation of a family health approach, which started in five states with the deployment of family physicians with master's degrees. Community health workers are also trained and deployed, to increase outreach to communities and support the utilization of health services.

HEALTH FINANCING REFORMS

Expansion of the national health insurance program for the poor. Sudan has recently taken steps to expand its National Health Insurance (NHI) program from civil servants and formal sector employees only, to include all poor and vulnerable populations. Enrollment is now offered to all citizens under the same scheme, and coverage of vulnerable groups (pensioners, indigents) is subsidized by public funds. As a result, insurance coverage is reported to have increased rapidly in the past two years. The government has also recently implemented a free maternal and child health medicines program for all. Coverage with free medicines for children under 5 has increased; however, the availability of free pregnancy-related medicines remains low. The 2016 NHI law also attempts to address other challenges: moving toward national pooling, introducing a split between provider and purchaser functions, and initiating strategic purchasing.

GOVERNANCE REFORMS

Federal leadership. In recent years, the Federal Ministry of Health (FMOH) has led efforts to strengthen the planning process under the Ministry's leadership and to improve harmonization of donors' plans with country priorities. At the highest level,

the National Health Sector Coordination Council (NHSCC) was created, chaired by the President of the Republic, with membership from federal ministers, state governments, and other government entities. The FMOH acts as Secretariat of the Council, to govern the health sector and promote inter-sectoral coordination. A network of civil society organizations working in health was developed to harmonize efforts with health sector priorities, improve the effectiveness of their participation, and maximize outcomes.

National Health Strategy. Substantial progress was made in 2016 to define a coherent health sector strategic plan with a defined policy direction, measurable targets, and estimated costs, based on policy dialogues across different sectors. Mechanisms to strengthen coordination and improve transparency were also established.

Key challenges on the way to UHC

WEAKNESSES AND BOTTLENECKS IN SERVICE DELIVERY

Coverage of essential health services. Although Sudan has not met the health-related Millennium Development Goals (MDGs), several key health indicators have improved. Child mortality has decreased, DPT3 immunization coverage has increased, and a large majority of women now deliver in the care of a skilled birth attendant. However, challenges remain with health results in Sudan below the average of comparable countries. Neonatal mortality has stagnated and child undernutrition remains a serious issue. The high fertility rate is coupled with an unmet need for contraceptives, low institutional delivery, and high maternal mortality. In spite of recent investments, it is estimated that many people lack geographic access to a health facility, with significant disparities between states. Most PHC facilities cannot provide the five essential components of a PHC package (reproductive health, immunization, nutrition, prevention and treatment of common diseases, and essential drugs). Access to basic health services is constrained, especially in rural areas where the majority of the Sudanese population live.

Quality of care. Investments in primary care are insufficient and the referral system is not always functional. Additional challenges include a lack of specialized staff trained in management, human resources, and finance in public hospitals. Fragmentation of service delivery between multiple providers, including the National Health Insurance Fund (NHIF), military, police, nongovernmental organizations (NGOs), universities, and the private sector, may negatively affect the efficiency of the system. Lines of responsibility need to be clarified. Many health facilities face shortages of staff, absenteeism, drug stock-outs, and limited staff performance.

Pandemic preparedness. A 2016 Joint External Evaluation (JEE) of International Health Regulations (IHR) core capacities identified a wide range in terms of Sudan's pandemic preparedness, with areas where systems are already established and sustainable to areas where currently no capacity exists at all. Sudan has sustainable capacity in the following aspects: national vaccine access and delivery, linking of public health and security authorities during a biological event, and systems in place for sending and receiving medical countermeasures and health personnel during a public health emergency. Future capacity development is needed for: antimicrobial resistance detection, antimicrobial stewardship activities, an electronic real-time reporting system that is interoperable and interconnected, and functioning mechanisms for detecting and responding to chemical events or emergencies.

THE STATE OF HEALTH FINANCING

Overall funding for health. Sudan spends just over 5% of its GDP on health, with private spending as the largest source for health spending. Out-of-pocket payments represented 75.5% of total health expenditure in 2014 (WHO Global Health Expenditure Database—GHED, 2017). One of the main challenges faced by Sudan in health financing is overreliance on these out-of-pocket payments, which creates a barrier to access for the poor in spite of recent

efforts to increase free and subsidized care for vulnerable populations. Spending is skewed toward curative services and does not prioritize PHC.

Major financial protection schemes. The National Health Insurance Fund (NHIF) covered 43.8% of the Sudanese population at the end of 2016 (nhif.gov.sd), and premiums for households living below the poverty line were covered by public funds. While significantly expanding coverage, the efficiency of health financing is impeded by fragmented pools, especially those of the FMOH and NHIF and the overall lack of coordination and management capacity. Social security taxes, such as the Zakat Fund, subsidize the health care costs of lower income groups by higher income groups. The free care for the under-five initiative incentivizes the utilization of health services.

Challenges of fragmented financing. Health facilities receive funds from different sources, each with distinct accountability mechanisms and incentive structures. External financing is managed by the FMOH and used to finance vertical programs such as tuberculosis, malaria, and HIV. Staff salaries are managed by the state health ministries, while curative care is funded by the NHIF, the Ministry of Health, and the Ministry of Welfare and Social Security. Recurrent spending for medical supplies (e.g., on drugs) relies on a combination of user fees, co-payments, and claims reimbursements. Overall, health facilities are challenged in mobilizing adequate financing for their functioning.

GOVERNANCE CHALLENGES

Institutional challenges. While leadership for the development of policies and strategies is strong, this does not always translate into action. Efforts to decrease verticalization and fragmentation must continue, supported by the policies of integration adopted as part of the 2012–2016 health strategy. Furthermore, horizontal knowledge sharing mechanisms and coordination require strengthening, despite recent progress from inter-sectoral groups (i.e., committees, task forces, steering groups) and the establishment of the new structure of partnership forums.

Decentralization. The health system in Sudan is decentralized, with three levels of governance: federal, state, and local. Health care provision is devolved to the 18 states, with a significant share of the federal health consolidated budget transferred through federal block grants. However, the law that delegated responsibility and financing functions to states and localities lacks clarity. In certain cases, the health sector does not always receive resources on time and in full, with some states noting that many payments are not released to providers.

Collaborative efforts to accelerate progress toward UHC

EXISTING INITIATIVES SUPPORTED BY EXTERNAL PARTNERS

External partners are engaged in Sudan to build national capacity and strengthen the health system. The effort to institutionalize monitoring of effective development cooperation practices among the different sector partners (government, development partners, civil society organisations (CSOs), and the private sector) was initiated by the IHP+ 2016 monitoring round, where three-fourths of the development partners signed the local compact. Governments became the principal recipient for health system support from the Global Fund, with further plans to strengthen collaboration through the government system.

The Tokyo Joint UHC Initiative, supported by the government of Japan and led by the World Bank (WB), in collaboration with the Japan International Cooperation Agency (JICA), the United Nations Children's Fund (UNICEF), and the World Health Organization (WHO), and the UHC partnership, led by WHO and supported by the European Commission and Luxembourg, are supporting the government of Sudan and strive to accelerate progress toward UHC. This support will enable nationally-led strategic health system strengthening to achieve UHC, as well as pandemic preparedness.

PLANS FOR FUTURE COLLABORATIVE WORK

Policy and Human Resources Development (PHRD)-funded advisory support

The joint work under the Tokyo Joint UHC Initiative includes activities to identify priorities for initial work, on which to build future efforts. PHRD-funded activities aim to improve the delivery of a package of services that integrate the delivery of nutrition services, strengthen country capacity for pandemic preparedness, and support health workforce development. It is expected that the findings of analytical work by PHRD will contribute to further collaborations toward improving the entire health system.

Additional planned PHRD-supported activities include knowledge exchange activities and workshops on health financing, diagnostic studies on provider payment mechanisms, public financial management, and primary health care self-assessment. Bringing successful experiences from other countries for integrating nutrition in the delivery of health services in Sudan is also a planned activity. Furthermore, the Tokyo Joint UHC Initiative will closely cooperate with other investments in health, such as those by the Global Fund and Gavi, to contribute to health system strengthening. Considering that other sectors, such as nutrition and water and sanitation compose the foundations of heath for all, challenges in these fields also will be considered under the joint work.

Moving toward UHC: **Sudan**

References & Definitions (page 1 indicators)

UHC Service Coverage Index (2015) – WHO/World Bank index that combines 16 tracer indicators into a single, composite metric of the coverage of essential health services. For more information: WHO/World Bank (2017). Tracking UHC: Second Global Monitoring Report.

Catastrophic out-of-pocket (OOP) health expenditure incidence at the 10% threshold (Single data point, year varies by country) – WHO/World Bank data from Tracking UHC: Second Global Monitoring Report (2017). Catastrophic expenditure defined as annual household health expenditures greater than 10% of annual household total expenditures.

Results of the Joint External Evaluation of core capacities for pandemic preparedness (2016/17, year varies by country) – A voluntary, collaborative assessment of capacities to prevent, detect, and respond to public health threats under the International Health Regulations (2005) and the Global Health Security Agenda. 48 indicators of pandemic preparedness are scored using five levels (1 is no capacity, 5 is sustainable capacity). https://www.ghsagenda.org/assessments

Life Expectancy at Birth (2000-2015), Maternal Mortality Ratio (1990-2015), Under-five Mortality Rate (1990-2015) – WHO Global Health Observatory: http://apps.who.int/gho/data/node.home

Wealth Differential in Under-five Mortality (Single data point, year varies by country) – Indicator used by the Primary Health Care Performance Initiative (PHCPI) to reflect equity in health outcomes. For more information: https://phcperformanceinitiative.org/indicator/equity-under-five-mortality-wealth-differential

Performance of service delivery – selected indicators (Single data points, years vary by country) – Indicators used by the Primary Health Care Performance Initiative (PHCPI) to capture various aspects of service delivery performance. PHCPI synthesizes new and existing data from validated and internationally comparable sources. For definitions of individual indicators: https://phcperformanceinitiative.org/about-us/our-indicators#/

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